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**Children, Parents with Mental Illness, Childhood**

Daphna Oyserman and Carol Thiessen Mowbray

**INTRODUCTION**

This entry deals with promoting the mental health of young children living at home with parents with a mental illness. Therefore, we focus on programs that promote well-being of the young child directly or indirectly by promoting the well-being of the caregiver (typically the mother). The reason for this broadened focus is that improving the caregiver’s well-being will have important positive consequences for the well-being of the young child.

**DEFINITION AND SCOPE**

According to a number of sources, at least 10 percent of women suffer a significant episode of postnatal depression meeting Research Diagnostic Criteria (RDC) for major

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depressive illness, and between 3–5 percent of women meet criteria for moderate to severe depressive illness. If not treated, a third of women with postnatal depression have episodes lasting for at least the first year of the infant’s life (for a review see Oates, 2000). Perhaps due to community-based care, the fertility of individuals with schizophrenia may be rising (Stocky & Lynch, 2000) and does not differ from that of the population as a whole (Oates, 2000). In fact, women are more likely to have a major psychiatric disorder and more likely to be referred for treatment after childbirth than at other times (Nicholls & Cox, 1999). Those with preexisting severe affective disorder or schizophrenia may be at risk of relapse following childbirth (Stocky & Lynch, 2000); having had one episode of puerperal psychosis increases risk of psychiatric illness in a subsequent pregnancy to as high as 60–80 percent (Stocky & Lynch, 2000). All told, about 2 percent of women are referred to psychiatric services following childbirth (Oates, 2000).

Children whose parents have a mental illness are at increased risk of having a mental health problem themselves due to complex interactions between the child and features of his or her environment (US Department of Health and Human Services [USDHHS]—US Surgeon General’s Mental Health Report, 1999). Environmental features—including relationships with parents, siblings, other family, peers, neighborhood, school, and the sociocultural context within which they live—interact with and shape child characteristics (biological, psychological, and genetic) over time. Previous experiences influence children’s subsequent risk for mental health problems, in part, because children attempt to adapt to their context in whatever way they can. Parenting and the caregiving environment are critical as resources as well as potential risk factors for these children. As will be outlined below, inadequate parenting can result in a child’s impaired sense of self-efficacy and negative attribution style, increasing his/her risk of depression and other disorders in childhood.

Mental health problems are relatively common in childhood. The most recent US Surgeon General’s Mental Health Report (USDHHS, 1999) estimates that 4 million children have serious mental health problems at any given point in time. Parental mental illness increases risk of child mental health problems, especially since maternal mental illness is associated with additional risk factors (single parenthood, family or marital discord, separation from parent due to maternal hospitalization, lack of social support, family and neighborhood poverty) that themselves can potentiate genetic and biological risks—US Surgeon General’s Mental Health Report (USDHHS, 1999). Thirty-two to 56 percent of children of parents with a serious mental illness (schizophrenia or affective disorder) will themselves have a DSM diagnosable disorder (Amminger et al., 1999; Rieder, 1973; Waters & Marchenko-Bouer, 1980). Heritability estimates vary from 75 (schizophrenia) or 80 percent (bipolar disorder) to lows of 34–48 percent (depression) (Rutter, Silberg, O’Connor, & Simonoff, 1999).

Heritability and Biological Factors

Biological factors exert especially profound influences on some mental health problems, including early-onset schizophrenia (McClellan & Werry, in press) and, according to the US Surgeon General’s Mental Health Report (USDHHS, 1999), biological factors are likely to play a large part in the etiology of social phobia and obsessive-compulsive disorders. Biological factors are not necessarily genetic or heritable factors but can include abnormalities of the central nervous system due to injury, toxins, poor nutrition, or infection. According to the National Institute of Mental Health’s Genetics and Mental Disorders Report (1998), autism, bipolar disorder, schizophrenia, and attention-deficit/hyperactivity disorders are likely to have genetic components, based on research with adults. Biologically based disorders can also be the result of family problems that preclude appropriate parenting, putting the fetus or infant at risk of pre- or postnatal developmental delays or deficits. Indeed disentangling family environment, biology, and genetic risk is a difficult task. For example, 20–50 percent of depressed children have a history of family depression. Children of depressed parents are three times as likely to become depressed as their peers, and also more likely to experience anxiety, conduct and substance abuse disorders, especially if both parents have a depressive illness or if depressive episodes occurred when the child was young or were recurrent (Downey & Coyle, 1990; Wickramaratne & Weissman, 1998).

Mental Illness and Parenting

Maternal depression is a common mental health problem in mothers of infants and young children, with 10–15 percent of these mothers estimated to meet DSM-IV criteria for depression severe enough to interfere with daily functioning, including parenting (O’Hara, 1997). The interplay between parenting and parental mental illness diagnoses other than depression has been the focus of less research attention (Oyserman, Mowbray, Allen-Meares, & Firminger, 2000). Even less research has focused on fathers, perhaps because men with a serious mental illness are less likely to have children or be involved in parenting. Current evidence suggests that maternal functioning and symptoms are at least as important as diagnosis itself, if not more so, in understanding current child outcomes. Though not well studied, the interface between course of maternal mental illness and child’s developmental phases is also likely to be important.
Diagnosis, Functioning, and Symptoms

Particular diagnosis (e.g., unipolar depression versus schizophrenia) may matter less than the specific nature of the symptoms the mother is experiencing and the extent that her mental illness impairs parenting (see Oyserman et al., 2000).

THEORIES AND RESEARCH

Course of Mental Illness and Parenting

The parent–child relationship is critical for early child development. Infants form close bonds with their primary caregiver—usually the mother—and this early relationship is the basis for later social relationships. From the parent’s perspective, these bonds often start during pregnancy when the mother feels fetal movement, but bonding may be delayed or not occur at all when mothers have a mental illness such as depression (Kumar, 1997). Children can overcome early neglect or inadequate development of the parent–child bond if the mother becomes able to provide a sensitive and stable relationship (Downey & Coyne, 1990). When mothers are unable to provide adequately sensitive care, developmentally appropriate stimulation and model reasonable coping, risk for children increases.

This means that the timing of maternal episodes of mental illness compared to infant and child developmental phases may be critical, with children being more vulnerable to problems when their mother has an episode of mental illness that lasts longer, covers more developmental phases, and is more severe.

Cultural and Cross-Cultural Issues

Field’s (1992, 1998) research over the past few decades has documented the negative effects of maternal depression on early mother–infant interactions, increasing risk for child developmental, mental health and behavioral problems. Although early mother–child interactions differ cross-culturally, most research has focused on the effect of maternal depression on interactions without regard to possible interactive influences of race–ethnicity or SES; it is thus possible that maternal depression has different effects on mother–child interactions in different cultures (Field, 1999). Mothers from different racial–ethnic subgroups may have different models of parenting, which themselves may result in differences in child responses. Cross-cultural differences in parenting goals can produce mismatches between in-group and larger societal socialization goals. These mismatches may exacerbate the negative effect of maternal depression on parenting. Moreover, culture is likely to play a major role in how mental illness develops and the meaning it has (Field, Greenwald, Morrow, & Healy, 1992).

Concomitant Contextual Risks

Research on the process by which maternal mental illness affects child development and risk for mental health problems indicates four interlocking pathways by which risk is increased for children of mothers with a serious mental illness. (1) Mothers may pass on genetic traits, including fussy temperament. (2) Maternal mental illness can be associated with other family stresses such as family and marital conflict and problems. (3) Maternal mental illness can relate to chronic and acute psychosocial stress generally, including negative life events and daily hassles. (4) Maternal mental illness may decrease mothers’ sense of competence and efficacy and increase use of punitive parenting styles (Oyserman et al., 2002; Oyserman, Bybee, Mowbray, & MacFarlane, in press).

Maternal mental illness is a risk factor for poorer parenting quality and is likely to co-occur with other stressors that may independently dampen parenting quality. These commonly co-occurring stressors include low income (Miller, 1990; Rudolph, Larson, Sweeney, Hough, & Aronian, 1990), larger than average family size (Ritsher, Coursey, & Farrell, 1997), lack of social support (Beile, 1990), increased incidence of other negative life events (Downey & Coyne, 1990), and the experience of social stigma and discrimination due to mental illness (Miller & Finnerty, 1996; Ritsher et al., 1997).

Parenting Skills and Deficits

Maternal psychopathology alone does not make a parent incapable of providing sufficient or “good enough” parenting and parents with a mental illness may feel competent as parents and function adequately at home even if they are highly anxious and have difficulties in out-of-home situations such as school or the workplace (Hall, 1996; Jacobsen, Miller, & Kirkwood, 1997). However, depressed parents may be withdrawn and lack energy and, consequently, pay little attention to or provide inadequate supervision of their children. Alternatively, these parents may be overly irritable, critical and intrusive, demoralizing and distancing toward their children (Field, Healy, Goldstein, & Guthertz, 1990). Depressed mothers often feel less competent generally and their distress can make children anxious (Downey & Coyne, 1990). Depressed parents may not model effective coping strategies and social skills (Garber & Hilsman, 1992). At each developmental phase, parenting deficiencies can reduce the child’s likelihood of successfully attaining their
developmental goal—resulting in impaired relationships, trust, and communication skills emerging in infancy, reduced sense of efficacy and competence in toddlerhood, and dampened cognitive–intellectual attainments in the early school years (Cicchetti & Toth, 1998).

Early parenting requires providing adequate stimulation and appropriate modulation of arousal as well as adequate physical care. In infancy, withdrawn, unresponsive, or depressed mothers can increase infant distress while intrusive, hostile mothers can “teach” infants to avoid looking at or communicating with the mother (Cohn, Tronick, & Lyons-Ruth, 1986). In the toddler stage, when mothers are depressed, they may be less adept at structuring or modifying the child’s behavior, resulting in both briefer interchanges and more out-of-control child behavior (Zahn-Waxler, Iannotti, Cummings, & Denham, 1990). As these examples of parenting deficits illustrate, children of mothers with serious mental illness are at risk of both lags in socioemotional development and impaired acquisition of social and relational skills, and reduced sense of competency, worth, and efficacy (Hammen, 1997). Because mothers with a serious mental illness may require hospitalization, their children are also at risk of physical separation, exacerbating the emotional withdrawal described above.

Supports and Stresses for Parents

Parental mental illness is often associated with marital discord, poverty, and social isolation—all of which are likely to have negative effects on parents and their ability to parent. Economic hardship stresses parents, reduces their ability to be warm, nurturing, and appropriately structured and these poor parenting practices increase risks for children (Zahn-Waxler et al., 1990). When children experience such unstable parenting environments, they are at risk of poor academic performance and poor social skills, further stressing parental ability to provide appropriate caregiving and family functioning. Stressful life events, such as loss of a partner through death or divorce, both stress parents and increase risk of depression in early childhood especially if they lead to permanent negative changes in the child’s circumstances and the family environment (Birmaher et al., 1996).

Mental Health and Temperament

Temperament difficulties in early childhood are associated with increased risk of mental health problems while positive temperament—including long attention span, goal orientation, lack of distractibility, and curiosity—are buffering factors. Difficult temperament and quality of parenting interact—high quality parenting and a sound relationship with the primary caregiver can buffer children from the negative effects of difficult temperament, including high reactivity. However, highly reactive, anxious, and behaviorally inhibited infants and toddlers are also more difficult to parent, increasing maternal stress. In infants and toddlers, insecure attachment, irritability, and less adaptive coping have all been associated with maternal depression (NICHD Early Child Care Research Network, 1999). In addition, risk of depression, anxiety, conduct, and attention-deficit disorders increase dramatically for children of depressed mothers (Hammen, Burge, Burney, & Adrian, 1990). Wickramaratne and Weissman (1998) found substantially increased risk of childhood depression in children of mothers with depression (15.5 vs. 1.7 percent in the general population). In infancy, children of depressed mothers display less mastery motivation, a marker of efficacy (Jennings, 1991).

Socioemotional, Social, and Relational Skills

Infants of mothers with mental illness are at risk for problems in developing secure attachments to their mothers and for other more subtle relationship problems. Relational skill deficits are important because, to be healthy, children must form relationships not only with their parents but also with siblings and with peers. Children’s abilities to form close relationships with peers constitutes a developmental resource, buffering other risks, as well being as a normal part of development. Children with better social skills are better able to form these relationships. Social skills are verbal and nonverbal. Verbal skills include the ability to appropriately articulate wishes or ideas as well as the ability to listen to other children’s ideas and forge an appropriate compromise. Nonverbal skills include the ability to interpret and understand other children’s nonverbal cues (body language, voice pitch) as well as provide appropriate nonverbal cues such as eye contact and nonintrusive touching. These skills are useful to entering already formed groups as well as maintaining one’s place in the peer group (Kagan, Snidman, & Arcus, 1998). Low skill children are at risk of active rejection as well as simple neglect by their peers, both of which increase risk for mental health problems.

Cognitive Development and School-Related Problems

Children of mothers with depression are also at increased risk of behavior problems in school, attention-deficit disorder, hyperactivity, and lower intelligence scores (Downey & Coyle, 1990; Hay, 1997).

Social Stigma and Social Acceptability

We did not find empirical literature on social stigma for young children of mothers with a serious mental illness.
However, the positive psychology and resiliency literature suggests that children who have better temperaments, are more socially skilled, and physically attractive are likely to elicit more positive and supportive responses from others. Risk for problematic temperament and dampened social skills are documented. Further, since in infancy and early childhood, children rely on their mother’s care for hygiene and grooming, children of depressed mothers may be generally less physically appealing, especially when mental illness combines with poverty, making access to routine medical care less likely. A fussy infant in soiled clothing with a runny nose and chafed skin is less likely to obtain positive responses from others compared to a happy, attractively clothed, and healthy infant. More subtly, other potential caregivers may view the infant of a depressed mother more negatively simply because of the stigma of her illness.

STRATEGIES: OVERVIEW

The literature suggests that child risks emerge early and that mothers with serious mental illnesses have multiple problems that increase risks for children. Therefore, appropriate preventive interventions need to take into account the pervasiveness of risk—including poverty, unemployment and low educational attainment, lack of social support, single parenthood, or marital discord. Preventive interventions dealing with these general risk factors have also been suggested as ways to reduce risk for other problems such as substance abuse (Hawkins, Kosterman, Maguin, Catalano, & Arthur, 1997) particularly when parental alcoholism is a risk factor (Chassin, Barrera, & Montgomery, 1997). Preventive interventions must also take into account the sequential nature of risk when parents have a serious mental illness—fussy infants make attachment more difficult, difficulties in attachment set the stage for difficulties with development of self-efficacy, mastery motivation and self-competence, which in turn heighten risk of retarded cognitive development and more negative cognitive style.

STRATEGIES THAT WORK

Clear evidence of effectiveness is not yet available.

STRATEGIES THAT MIGHT WORK

Through literature reviews, searches of conference presentations, and networking with other researchers, we were able to identify ten programs that provide community-based services to infants and young children living in families with a mentally ill parent. Table 1 summarizes the identified programs, their locations, and descriptions. To our knowledge, none of these has been systematically evaluated. In an earlier review, we also located literature on home visitation and mother and child hospitalization programs in England (Oyserman et al., 1994). These earlier programs focused on alleviating stress due to mother–child separation and deterioration of maternal mental health in the highly stressful early months of parenting. We include these in the Encyclopedia believing that these services act as preventive interventions for their children. We updated this review and found information on three models of care for women with puerperal mental disorder in the United Kingdom (Nicholls & Cox, 1999). Labeled as community-based, parent and baby day-units, and mother and baby units, these programs are in the table; however, their published description lacked specific details and did not provide information about program effectiveness. According to a review by Stocky and Lynch (2000), mother–baby admission principally exists in the United Kingdom, Australia, Canada, and New Zealand, has not been well evaluated, in part because randomized trials are viewed as unethical, and is based on theories of attachment and mother–child bonding. In her review, Oates (2000) calls for all psychiatric admissions of women to include their infants within specialized mother–infant psychiatric units to prevent future negative developmental outcomes for the child due to disruption in the mother–child bond; however, she does not report evaluations of this care. She suggests that provision of preventive mental health services for mothers can improve outcomes for their children, recommending regional 6-bed mother–infant units for areas including 11,000 births annually and dense populations, and more community-based supports in less dense and rural areas. We also found a brief report on a psychiatric clinic at a Dublin maternity hospital (Gannon, Barry, & Turner, 1998), suggesting that far fewer women are referred or accepted into treatment than would be predicted based on the Nicholls and Cox projects. Thus, in spite of clearly documented service needs, services do not appear to be provided in sufficient quantity—and perhaps not at all (i.e., see Nicholls & Cox, 1999, for a critique focused on services in the United Kingdom).

As can be seen from Table 1, programs vary widely in services, with some focused more on parenting skills and mother–child bonding and others providing more general services. Programs vary in location: some are residential;

1Primary sources of information were Drs. Judith Cook at the National Rehabilitation and Training Center in Chicago and Joanne Nicholson at University of Massachusetts Medical School—Center for Mental Health Services Research, who are both funded to identify and document the operations of model programs serving mothers with mental illness and their children.
<table>
<thead>
<tr>
<th>Program</th>
<th>Program type, focus/goals</th>
<th>Children</th>
<th>Parents</th>
<th>Services/methods</th>
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<tbody>
<tr>
<td>Community-based care, United Kingdom developed by Oates, Nottingham, England (Oates, 2000; reviewed in Oyerman et al., 1994).</td>
<td>Provide in-home support for mothers with serious mental illness in the months after childbirth.</td>
<td>Infants</td>
<td>Parents must live within 20 minutes of the hospital and have a responsible adult living with them. Duration of care begins with 8 hours daily and is reduced to visits on alternate days by community-based nurses.</td>
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<td>Parent and baby day-units, Charles Street Parent and Baby Day Unit, Stoke-on-Trent, developed by Cox (Nicholls &amp; Cox, 1999).</td>
<td>Joint admission of psychiatrically ill mothers and their babies. Either a specialized in-patient unit or a mother-child bed in a general psychiatric unit. Have existed in the UK since the 1950s.</td>
<td>Infants</td>
<td>Link parents to primary care and health visitors. Medication, 5-days a week day treatment during normal working hours, require good public transport and densely populated catchment areas.</td>
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<td>Mother and baby units (Nicholls &amp; Cox, 1999; Oates, 2000; Oyerman et al., 1994; Stocky &amp; Lynch, 2000).</td>
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<td>Allow mothers to maintain as much routine care as possible for infants while psychiatrically hospitalized. In 1991 a total of 133 such beds were available in England and Wales (Nicholls &amp; Cox, 2000). Oates (2000): (1) about 10 specialist mother–baby units with 6 or more beds exist in Great Britain; (2) concern for infant safety and financial difficulties led to closure of some other general psychiatric ward mother–infant admissions; (3) although Great Britain is a world leader in mother–infant admissions, fewer than half of the health authorities have such programs.</td>
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<td>Coombs Women’s Hospital psychiatric outpatient service, Dublin, Ireland.</td>
<td>Liaison psychiatry outpatient service within a Dublin women’s hospital. Goal is to identify and treat psychiatric disorders arising during pregnancy or the puerperium, as well as assess and monitor antenatal women with established psychiatric conditions through pregnancies and postpartum.</td>
<td>Infants</td>
<td>Medication, otherwise unclear.</td>
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<td>The Thresholds Mothers’ Project, Chicago, Illinois.</td>
<td>Psychosocial rehabilitation facility-based program with home-visiting outreach component. Goals: stabilize and normalize familial unit; provide social network for family members; improve quality of life via independent living and parenting skills; empower parents to effectively raise children.</td>
<td>0 to 5 years of age</td>
<td>Women ages 17 and above who have custody of at least one child. Current enrollment (1997): 64% African American, 28% White; 8% Latino.</td>
<td>Mothers and children participate in a 5-day per week program. Children participate in activities designed to enhance motor, cognitive, social, and emotional development. Other services include: independent living skills; children’s nursery/preschool and child development group; education—basic skills, GED, college prep, vocational and job training; health care referrals; psychiatric referrals; individual counseling; home visits; substance abuse support group; crisis intervention.</td>
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<td>Organization</td>
<td>Description</td>
<td>Eligibility</td>
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<td>The Peanut Butter and Jelly Preschool</td>
<td>Private not for profit agency. Stabilize family’s functioning; &quot;graduate&quot; children into appropriate placement; offer stabilization, reunification, and general improvement to families in conflict.</td>
<td>Infant to preschool aged</td>
<td>High-risk families living in poverty and experiencing problems such as substance abuse, family violence, developmental delays, or parental incarceration. Current enrollment (1997): 70% Latino, 20% White, 8% Native American, 2% African American. Primary caregivers ages 17 and above who are not active substance abusers, preference to pregnant women or mothers of newborns. Current enrollment (1997): 90% African American, 10% White.</td>
<td>Preschool includes parent training and education in conjunction with therapeutic early intervention for infants and preschoolers. Supported housing program. Program for parents leaving prison. Case management available to entire family, 24 hours per day, 7 days a week; staff includes teachers, other helping professionals and consultants.</td>
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<td>LAMB Program: Loving Attachments for Mothers and Babies</td>
<td>Voluntary prevention program connected with community mental health. Offers support to mothers with mental illness of all types and severities.</td>
<td>0 to 3 years of age</td>
<td>Day-treatment format. Meet 4 days per week, with optional Parent–Toddler play, Effective Positive Parenting groups and a weekly home visiting components. Children attend developmental therapeutic nursery. Activities enhance child’s language, cognitive, motor social, self-care and feeding development. Nursery can accommodate up to 16 children. Group sessions conducted by parent–infant specialists, focusing on parenting skills, stress management, daily living skills, nutrition, and information about child development. Other services include transportation, case management, psychiatric evaluations, and medication management. Referrals from mental health, CPS, and temporary shelter providers. Approximately one-year stay. Services include: mental health rehabilitation; vocational and parenting instruction; &quot;wrap-around&quot; services; cooperative child care program; child development support group. 8 to 10 families served at a time. Creates with its staff a &quot;surrogate family&quot; for its clientele; enrichment/daycare/preschool program is critical part of service system both for benefit of children and as training site for increased parental competence.</td>
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<td>Ashbury House of the Progress Foundation</td>
<td>Residential treatment program. Helps families develop skills and the support system needed for independent living in the community. Family preservation/reunification program for mothers at risk of losing custody of their children.</td>
<td>0 to 7 years of age</td>
<td>Women with history of hospitalization; especially single parents. Current enrollment (1997): White, African American, and Latino (no specific breakdown). Experiencing poor education, lack of marketable skills, substandard housing, inadequate medical care, and insufficient money to feed and clothe their children.</td>
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<td>The Parent and Child Education (PACE) Family Treatment Center</td>
<td>Community-based outpatient services. Basic tenets are to increase mutual support networks and utilize an empowerment model of mental health.</td>
<td>Infants to 5 year olds</td>
<td>Experiencing poor education, lack of marketable skills, substandard housing, inadequate medical care, and insufficient money to feed and clothe their children. Most are mothers in their 30s with a first-born child or with a young second child and a much older (elementary school age or adolescent) first born. Most are welfare recipients. Activities to foster healthy mother–child relationships and stimulate age-appropriate development in the children. Mothers seen by psychiatrist or psychiatric nurse who provides supportive therapy and medication. Services include: home visits, mother–baby school, a lunch program, social club for adults, stimulation groups for toddlers and preschoolers, transportation and community involvement.</td>
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<td>Project CHILD</td>
<td>Model demonstration program. Focus of project includes parent/child bonding and parenting skills. Two primary goals: to improve parenting skills and to remedy developmental delays in children</td>
<td>0 to 5 years of age</td>
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<td>Program</td>
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<td>CAPT Center, Children and Parents Together,</td>
<td>particularly in language, attention, attachment, and ability to separate.</td>
<td>0 to 5 years of age</td>
<td>Pregnant mothers or mothers with at least one child under 5.</td>
<td>Liaison. Staff include child psychiatrist, developmental psychologist, clinical MSW, special educators, clinical receptionist. Staff serve about 25 families and 35 to 40 children at any given time.</td>
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<td>Huntington, New York.</td>
<td>For mothers: prevent rehospitalizations. reduce isolation, promote socialization, foster rehabilitation and normalization, enable fulfillment of parental role.</td>
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<td>Current enrollment (1997): Mostly White, few African American or Latino.</td>
<td>Mothers' services: group counseling and support, parent education, education in community living skills, case management and crisis intervention; peer social network and activities that offer self-help and mutual support. Children's services: preschool socialization and education, age appropriate child care, early identification of developmental delays and physical or emotional problems, early intervention for these difficulties at CAPT or by referral to specialized services. Offer diagnostic assessment and evaluation, parent-infant dyadic therapy, parent psychotherapy, play therapy; marital-family therapy, therapeutic groups, consultation and evaluation. Also coordinates with other programs the mother and child are involved in—for example, respite and family support programs, public health services, the legal system, and social services. Staff include licensed psychologists and psychiatrists with expertise in the areas of infant development and mental health as well as early family relationships. Serves 30 families. Services offered 4 days per week. Services for parents include parent training (budgeting, parenting concerns, cooking classes, etc.) and adult education (GED completion, ESL classes, vocational training, etc.). Services for children include early childhood education and child care. Serves about 40 families each year; 8-10 families at a time.</td>
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<td>The Parent–Infant Development Program,</td>
<td>Outpatient program; meets needs of infants and young children by providing evaluation and therapeutic services to families experiencing difficulties in early parent-child relationships or emotional/behavioral problems of infancy/early childhood.</td>
<td>0 to 6 years of age, exhibiting sleeping/feeding regulation difficulties; irritable, depressed mood; aggressive or withdrawn behavior; hypersensitivity to touch or sound</td>
<td>Mothers from urban and rural communities. Current enrollment (1997): 70% White, 20% African American, 10% Latino.</td>
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<td>Madison, Wisconsin.</td>
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<td>The IMPACT Program, Dayton, Virginia.</td>
<td>Comprehensive adult education facility. Satisfies goals for &quot;welfare to work&quot; clients; court, social services, and self-referrals; young mothers wishing to complete high school.</td>
<td>Preschool to &quot;older&quot; children</td>
<td>Serves a wide variety of high-risk parents.</td>
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others are outreach; some focus on generally at-risk women and others target only women with mental health problems. Clearly, given the large scope of need of these mothers and children, interventions should be ongoing and family focused; provide a mix of services aimed at preventing, treating, rehabilitating, and supporting families; and be sensitive to the stigma of mental illness and the importance of custody concerns. Prevention for children thus requires interagency collaboration in treatment, support, and rehabilitation for parents.

**What Can Be Learned from Interventions That Work with Other At-Risk Children?**

Because the programs just described target general concerns about parenting as well as concerns specific to mental illness, we turn to interventions with other high-risk children—children growing up in poverty, at risk of abuse or neglect, and children growing up in families where the main caregiver is socially isolated and stressed. While not the focus of this entry, these issues are relevant, when children are abused or neglected, they are more at risk of depression, impaired social skill development, and insecure attachment (Kazdin, Moser, Colbus, & Bell, 1985). Similarly, risk factors like large family size, poverty, and low education can combine to produce measurable problems, such as academic lags, deficits in social skills, and conduct and affective disorders. A number of prevention programs targeting young children and their parents highlight the need for long-term, intensive interventions that include parent education and support components. In addition, when these programs are effective, it is often because they have helped structure contexts within which both parent and child can be supported and flourish, teaching social and relational as well as cognitive and other skills.

**Project Head Start**

Project Head Start is a nationally distributed, targeted prevention program aimed at improving the social competence and cognitive—logical capacities of preschool children at risk due to parental poverty. Although lacking a randomized trial, a number of evaluations show positive academic impact. Head Start children are more likely to graduate high school and less likely to be enrolled in special education than their peers (Barnett, 1995). That this occurs in spite of the fact that improved cognitive test scores require follow-up intervention to be maintained during elementary school (Lee, Brooks-Gunn, Schuur, & Liaw, 1990), suggests that Head Start's positive effect on graduation and reduction in special education placement may be due to its impact on children's ability to function appropriately in the social context of school. Available research cannot clarify the extent that the parent education components of Head Start are responsible for these effects or the extent that children's learning comes from their direct involvement in the program. However, programs like this one that help children and mothers in the context of school can alleviate risk due to gaps in social skills relevant to both peer and adult—child interactions. While school-based models may not work for older children, who are more likely to feel stigmatized by their parent's mental illness, daycare and preschool-based programs that include multiply at-risk children and their mothers are likely to be helpful for infants and young children of mentally ill mothers.

**Preventive Interventions for Children at Risk Due to Parental Poverty, Low Education and Other Stressors**

Federal funding to develop and evaluate preventive interventions has resulted in a number of model programs. As with Head Start, these programs were not designed specifically to deal with the needs of young children of mothers with a serious mental illness. However, they provide a model for the kinds of intensive, wrap around services that are needed for families with multiple risks and the added risk of parental mental illness.

**Carolina Abecedarian Project**

A rigorously tested preventive daycare program for children from infancy through age 5 who are at risk of school failure due to parental poverty and other factors, identifies children at birth and continues service through an at-home component until age 8. Infants and toddlers attend 8-hour daily, 50-week yearly; their parents receive educational and supportive activities. From kindergarten on, children were visited 15 times a year at home for 3 years by a teacher with a special home curriculum to supplement the school curriculum. The intervention produced positive intellectual and academic outcomes and maintained them at age 12, four years after the intervention (Campbell & Ramey, 1994).

**Infant Health and Development Program**

McCarton, Brooks-Gunn, Wallace, and Bauer (1997) enrolled low-birth-weight and premature infants at birth and provided pediatric care, home visits, parent group meetings, and center-based schooling 5 days a week for children aged 1–3 years. Like the other projects, it targeted and attained positive academic and cognitive outcomes, with the additional benefit of reduced behavioral problems in enrollees compared to control children.
Elmira Prenatal/Early Infancy Project

Olds et al. (1998) targeted women pregnant with a first child at risk due to maternal youth, single parent status, and poverty. A 15-year follow-up to the study that randomly assigned mothers to four levels of intervention, showed positive results for mothers and children who received the highest level of intervention. These mothers were given developmental screening, transportation to health care, and nurse home visits every two weeks during pregnancy with regular home visits the first two years of the child’s life. At age 13, their children had fewer behavioral problems and the mothers were less likely to be on welfare, use substances, or have been reported for child abuse/neglect.

STRATEGIES THAT DO NOT WORK

Given that preventive interventions to promote health and well-being of young children of parents with a serious mental illness have not benefited from empirical evaluation efforts, it is not possible to point to strategies proven not to work. We surmise that it is unlikely that strategies focused only on children that do not also support mother’s well-being and ability to parent will be effective.

SYNTHESIS

Even young children of parents with serious mental illness are at risk of developmental disruptions and problems in well-being. This risk to child healthy development is likely due to the interplay between parental mental illness and the associated increased risks—of problems in parenting, of family poverty, family instability, disrupted family support networks, and high parental stress among other family context risks. While current literature does not provide an effectiveness evaluation of programs focused specifically on the young children of parents with a serious mental illness, a number of programs that work for infants and young children at risk due to the poverty, young age, and low educational attainments of their mothers were located.

Each of these latter programs is both structured and intensive, underscoring the need for sustained and intensive efforts to support the parenting of mothers with serious mental illness. As prevention researchers, we should expect that these young children experience chronic stress due to the interaction between maternal mental illness and other concurrent environmental factors. Therefore, we speculate that effective preventive interventions for this population need to provide long-term and encompassing supportive services for mothers/caregivers and stabilize the normative transitions of childhood so that young children of parents with a serious mental illness will be able to successfully negotiate developmental milestones and their families will be able to provide adequate buffering and support.

We propose that effective preventive programs for children of parents with mental illness will need structures similar to those for other at-risk children but will need to include additional components specifically targeted to the additional needs of this group. That is, preventive interventions will need to include (a) long-term contact, (b) services for both the caregiver parents and their infants/young children, (c) comprehensive services (including social and cognitive developmental domains for children and parenting and other domains of daily living for parents), (d) services targeting the ramifications of mental illness. These latter service components include helping mothers to plan for alternative caregivers when psychiatric hospitalization is needed to minimize disruption in child/infant care and reduce risk of custody loss, educating family members about mental illness, and providing them with support so that they will not be overburdened with child care demands. Clearly targeted and well-designed evaluation of programs including these service components is a necessary part of the next decade of prevention research.

Following a prevention framework, these to-be-developed and empirically evaluated interventions must minimize risks and maximize protective factors—this means minimizing family dysfunction and stresses and maximizing family functioning, supports, and child and parent competencies. While it may seem simpler to focus only on the young child as a target of service, we believe that preventive program efforts must be multiply focused (on parents, family, and children) if they are to promote the well-being of children growing up with parents with a serious mental illness. Briefly, preventive focus on parents should be two-fold: bolstering, supporting, and maintaining the parent’s mental health and everyday functioning in light of their mental illness as well as concentrating on parenting itself, including support for carrying out positive, nurturing parenting and providing appropriate supervision and direction to children.

Preventive focus on family members is also necessary since these family members are likely to be turned to for support in caring for children when a parent is mentally ill. Child rearing cannot simply be displaced onto other family members. Preventive intervention for family members should be two-fold: providing information and education about mental illness generally (and what they can expect given the situation of their mentally ill relative) and helping families develop a workable plan to provide care for the young children of this family member, including setting up routines that structure and support normal development for
young children. Lastly, preventive focus must also be on the young children themselves, including infant care and preschool services that can support children’s social, emotional, and cognitive development and provide young children with a setting in which they can thrive independently.

To develop and empirically validate these programs, prevention researchers can begin with programs that are currently working with generally at-risk young children. These programs typically provide support for parents, structured outreach to develop parenting and daily living skills, and structured care for for young children in the form of infant and child care and play groups. By adding structured outreach work to help parents develop family supports and working with mental health and rehabilitative service providers, prevention researchers can develop and evaluate plausible wrap around services for this population in need.

Also see: Families with Parental Mental Illness: Adolescence; Family Strengthening: Childhood; Self-Esteem: Childhood; Social and Emotional Learning: Childhood.

References

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INTRODUCTION AND DEFINITIONS

This entry discusses promoting the healthy development of youth living with a chronic illness. Chronic illness has been defined as a condition that often appears at birth or early childhood, interferes with daily functioning, causes hospitalizations, and involves symptoms that can often be adequately managed but not cured (Pless & Pinkerton, 1975; Wallander & Thompson, 1995). Traditionally, chronic illness has been differentiated from terminal illness in that chronic illnesses are not typically fatal. However, advances in medicine have enabled previously fatal illnesses to become chronic. Diseases most often classified as chronic among adolescents include asthma, cancer, cerebral palsy, congenital heart disease, cystic fibrosis, insulin-dependent diabetes mellitus (IDDM), hemophilia, human immunodeficiency virus (HIV), juvenile rheumatoid arthritis, leukemia, renal disease, sickle cell anemia, epilepsy, and spina bifida.

One consistency across illnesses is the importance of adherence to treatment regimens, which include medications, medical appointments, and disease-monitoring techniques. Broadly defined, adherence, or compliance, is the extent to which the patient follows the prescriptions or recommendations of health care providers (Pidgeon, 1989). The most recent nomenclature uses the term adherence, which is seen as less pejorative and more client-centered than compliance (Mehta, & Graham, 1997).

SCOPE

Worldwide, over 33 million children and adolescents died in 1999 due to chronic diseases such as cancer, diabetes, asthma, and cardiovascular disease (World Health Organization, 2000). In the United States, severe chronic conditions affect approximately 1–2 children and adolescents out of 100 (Wallander & Thompson, 1995). Asthma, which affects approximately 4–9 percent of children worldwide, is the most common chronic illness among youth (Geller, 1996). Annual estimates of asthma in the United States indicate that about 4 million children and adolescents are affected and the number of asthma-related deaths is increasing (Bender, 1996; Mannino et al., 1998). About 1 in 600 US children and