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**Families with Parental Mental Illness, Adolescence**

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**INTRODUCTION**

The offspring of parents with mental illness have long been a focus of research and a concern for practitioners. During childhood and adolescence, this population is considered at risk for problematic behavioral, academic, and social outcomes. In adulthood, their likelihood of having a diagnosable mental illness is significantly elevated. Vulnerability emanates from a combination of biological and environmental sources, including genetic factors (US DHHS, 1999, pp. 129, 237, 251, 254, 276), problematic parenting, and parental separations, as well as from social/contextual factors such as poverty, social isolation, stigma, and discrimination (Oyserman, Mowbray, Allen-Meares, & Firminiger, 2000). This entry focuses on how interventions with school age and adolescent offspring of parents with mental illness may be planned and conducted to predict problems, protect their healthy functioning, and promote desired goals.

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**DEFINITIONS**

For the purposes of this entry, we have defined *mental illness* to be any disorder that fits the diagnostic criteria of DSM IV and is evidenced in more than one acute episode. We define *serious mental illness* additionally as a diagnosed disorder with duration more than 12 months and which seriously affects functioning in one or more major life areas.

**SCOPE**

A large body of literature exists concerning children of mentally ill parents, including some research outside the United States. The effects on children of parental psychiatric diagnosis or symptoms has been studied with individuals in Canada (Boyle & Pickles, 1997), New Zealand (Fergusson & Lysenkey, 1993), London (Rutter & Quinton, 1984), Australia (Cowling, 1999), and Sweden (Persson-Blennow, Naeslund, McNeil, & Kaj, 1986). Changes in the likelihood of parenting and in the efficacy of psychotropic treatment for adults with mental illness make continued attention to this topic critical. That is, because of the deinstitutionalization movement begun in the 1950s in the United States, which has become a worldwide phenomenon, adults with a serious mental illness are now likely to remain in their communities and participate in more of the normal experiences of adulthood, such as having children and parenting. Available research indicates that most women with mental illness do marry, have normal fertility rates, are likely to be sexually active, and bear an above average number of children (Mowbray, Oyserman, & Zemencuk, 1995). Thus, many are likely to be mothers (59 percent according to McGrath, Hearle, Plant, Drummond, & Baskle, 1999). Further, in the last decade, there have been substantial improvements in psychiatric rehabilitation treatments and psychotherapeutic
medications, positively affecting the community functioning of adults with serious mental illness and thus their abilities to parent successfully. Based on several sources, we estimate that about one third of women with serious mental illnesses in community treatment have minor children and are carrying out childcare responsibilities (Mowbray, Oyserman, Bybee, MacFarlane, & Rueda-Riedle, in press).

Numerous studies have identified problematic outcomes for the offspring of parents with mental illness; most have studied infants and preschool children (Oyserman & Mowbray, see Children, Parents with Mental Illness: Childhood). For school age children and adolescents, maternal depressive mood correlates consistently with behavior problems and lower levels of social competence (Thomas, Forehand, & Neighbors, 1995; mean age of children, 13.1 years). Concerning academic and cognitive outcomes, results are more complex. Arbelle et al. (1997) found offspring (median age 16–17) of parents with schizophrenia performed significantly worse on a cognitive battery than children of parents with other mental illnesses or having no mental illness. But other studies find either no significant impairments for children of parents with mental illness or mediating relationships; for example, in one study, the relationship between maternal mental illness and self-perception of scholastic ability in children (mean age 10.11 years) was mediated by children's perceptions of emotional distress in their mothers (Scherer, Melloh, Buyck, Anderson, & Foster, 1996). Where gender differences do occur, they favor male children; that is, girls are more often adversely affected by having a mother with a mental illness than are boys (Oyserman et al., 2000), although results are inconsistent and not examined often enough.

It might be expected that families with a parent with a serious mental illness would have access to services necessary for identified and emergent needs. Unfortunately, this seems not to be the case. According to our own research and that of others, few mental health treatment programs or practitioners address the parenting needs of their clients. Few state information services collect data about whether clients have children; clinical records of mental health agencies often fail to even note the existence of children for adult clients; and only a minority of mothers identify their therapist or case manager as someone who could give advice or support about being a mother (Mowbray, Schwartz, Bybee, Spang, Rueda-Riedle, & Oyserman, 2000).

THEORIES

This review adopts a bio-psychosocial perspective as most helpful in understanding the situation of children with a mentally ill parent. The biological aspect of this perspective is well established; multiple research methods have documented that for many mental illness diagnoses "heredity—that is, genes—plays a role in the transmission of vulnerability... from generation to generation" (US DHHS, 1999, p. 53). However, multiple environmental factors affect the extent to which genetic predispositions are expressed. In this regard, ecological theory seems most applicable to conducting comprehensive research on outcomes for children with mentally ill parents (Dulmus & Rapp-Paglicci, 2000). Bronfenbrenner (1979) conceptualized environmental influences on development as emanating from four domains: micro-, meso-, exo-, and macro-systems. Outcomes reflect the influences of these domains, as well as interactions between characteristics of the individual and of each domain. Thus, concerning children with mentally ill parents, research has focused most attention on the microsystem of parent-child interactions being influenced (negatively) by parental mental illness, the particular mechanisms through which this occurs, and, to a limited extent, the ways in which child characteristics (such as age or gender) may affect (moderate) this impact. Some research has also identified factors in the meso- and exo-systems that are relevant (such as marital discord or family functioning; Beardslee & Wheelock, 1994). Case studies have discussed how negative community and societal attitudes towards mental illness may affect children's adaptation and social integration (Marsh & Dickens, 1997). However, comprehensive research studies have not addressed these influences overall, nor studied their differential impact. The question we would like answered is: what characteristics of children and their contexts, including parents, families, peer interactions, community and societal influences, are the most prominent risk factors for negative outcomes?

RESEARCH

Biological Risk Factors

According to the recent report on mental health from the Surgeon General (US DHHS, 1999), biological factors (including genetics as well as early-onset abnormalities of the central nervous system) play a large part in the etiology of schizophrenia, bipolar disorder, social phobia, obsessive compulsive disorder, and Tourette's disorder (US DHHS, 1999, p. 129). However, heritability indices1 vary from estimates

1 Heritability indices reflect the estimated proportion of the phenotypic variance that is genetically determined. However, this is the estimate of genetic contribution in the population, not in each individual; and the partitioning of variance is specific to the particular trait, population, and environment. Further, heritability does not indicate what proportion of the trait is genetic, only what proportion of the variation in the trait is genetic. Finally, a trait can be genetically transmitted in a population but this does not necessarily mean that group differences in the trait are genetic in origin (Carr, 2001; Schelonka, 1999).
of 80 percent for bipolar disorder, 75 percent for schizophrenia, to 34–48 percent for depression (Rutter, Silberg, O’Connor, & Siminoff, 1999). As summarized by Downey and Coyne (1990), research studies on parents referred for depression indicate that their children are six times more likely to receive a diagnosis of major affective disorder than are children without an affectively ill parent. For these and other mental illness diagnoses, the likelihood of the identified patient’s first-degree relatives also having a diagnosis reflects genetic contributions, but environmental circumstances are necessary to trigger genetic vulnerabilities. A number of epidemiological studies have found high rates of diagnosis in children of mentally ill parents, but the diagnoses are not necessarily the same as their parents’. For example, schizophrenia has a high concordance rate, but schizoaffective and bipolar disorders do not (Erlenmeyer-Kimling et al., 1997). Rutter and Quinton (1984) concluded that the association between parental and child mental disorders is environmentally mediated rather than genetically determined.

## Parenting Problems

This summary of what is known about parenting problems draws from a more extensive literature review on parenting among mothers with a serious mental illness (Oyserman et al., 2000). That review covered parents of children from infancy to adolescence, and examined results from small clinical studies, as well as from larger and more diverse field studies. Unfortunately, a minority of published studies involves school age or adolescent children. Nevertheless, the studies available did show that, in comparison to non-mentally ill parents, mothers with schizophrenia or other psychotic disorders and mothers with unipolar depression have less encouraging parenting behaviors (Scherer et al., 1996), are less positive and more critical, and show less task-oriented behavior (Gordon, Burge, Hammen, & Adrian, 1989). Existing literature does not provide an adequate basis to determine differential effects of specific diagnoses. Studies do indicate that the current community functioning and symptomatology of mothers with mental illness have significant effects on parenting variables, such as the quality of the mother–child relationship, affective problems in family interactions, and children’s task persistence (Hammen, Adrian, Gordon, & Jaenicke, 1987). Children’s self-reports, gathered through qualitative research, indicate that their mothers are often inconsistent and unpredictable (Cowling, 1999).

A few qualitative studies have identified the parenting strengths of women with severe mental illness, presenting evidence that parenting can have positive and motivating effects upon the mothers. In these studies, mothers with serious mental illness articulated the significance of having children, its positive contribution to recovery, and their struggles to maintain custody (Nicholson, Sweeney, & Geller, 1998).

## Contextual Factors

While studies have clearly established parenting difficulties among mothers with mental illness, research has not determined the separate effects of common confounding risk factors. For example, marital discord and social isolation are common for seriously mentally ill mothers and their children, as are conflicts with extended family. Some research indicates that adults with depression tend to marry spouses with psychiatric illness, a history of psychopathology, and/or substance abuse. Mothers with a mental illness are also likely to have more stressful lives, including past experiences of physical and sexual abuse. Multiple hospitalizations and the chronicity of mental health problems affect mothers’ relationships with children and contribute to marital break-ups. Furthermore, all these factors are likely to interact and exacerbate overall family functioning; thus, marital discord contributes to negative interactions with children for depressed mothers, child behavior disturbances relate to mothers’ more distant and withdrawn behaviors, and children with externalizing disorders have fewer and less positive interactions with mentally ill mothers (Oyserman et al., 2000).

Narratives from now-adult children of mentally ill parents describe other risk factors. Risks for children include role reversals (children taking care of parents) and heightened anxieties about whether they will inherit their parents’ mental illness. More generally, risks may be due to a decrease in family social life and loss of “normal” family activities (e.g., outings and fun things to do), with concomitant instability, chaos, crises, and household disarray. Also periods of neglect, either relative or statutorily defined, and inconsistent parenting caused by separations when mothers are hospitalized (Bararkin & Greenberg, 1996) have been cited. These strains deplete family energies, leaving caretakers less able to help children with tasks that they must accomplish developmentally, and less capable of providing love, guidance, or supervision (Marsh & Dickens, 1997). Children may respond by feeling resentful and rejecting, increasing the likelihood of family burnout (Harfield, 1996).

Economic factors are also likely to significantly affect families; nearly all individuals with a serious mental illness, especially women, are living in poverty and at risk for chronic economic hardships. Lack of social support is another risk factor because adults with serious mental illness consistently have smaller social networks than the general population (Mowbray, Schwartz et al., 2000). Culture can interact with mental illness symptoms to affect labeling and treatment. For
example, gender and race/ethnicity influence the reliability and stability of diagnoses (Nathan & Langenbucher, 1999; Prudo & Blum, 1987); in particular, African Americans with affective disorders are significantly more likely than Caucasians to be mis-diagnosed with schizophrenia-spectrum disorders, especially paranoia (Whaley, 1998).

Although not systematically examined in research, studies on risk factors, stigma and discrimination experienced from neighbors and others in the community, as well as rejection and abandonment by extended family and family friends are frequently reported by adults who grew up with a mentally ill parent (Marsh & Dickens, 1997). These adult children report losing friends, being afraid or ashamed to return home, feeling different, and feeling that they came from a “defective” family. School age and adolescence are particularly critical, as children report that it is the time when they realize that their family is different (Cowlino, 1999).

Thus correlations between maternal mental illness, parenting, and children’s outcomes, may be due to a direct effect of mental illness, but are also likely to be due, in part, to the many other social and economic hardships associated with mental illness—hardships that can interfere with important developmental opportunities. These effects seem particularly significant for school age children and adolescents, as they establish their own identity, sense of competence, networks of social support, and autonomy in their communities.

Unfortunately, very little research has attempted to disentangle the direct effects of maternal psychiatric variables, such as diagnosis, symptom severity, duration and chronicity of mental illness, or community functioning, from social/ contextual variables that negatively affect mothers and their children, such as poverty, single parenting, social support. Mowbray, Oyserman, Bybee, and MacFarlane (2000) found that controlling for demographic variables, mothers’ diagnosis made independent, but small contributions to explaining variability in parenting; mothers’ symptomatology and community functioning had much stronger effects. Some research has begun to investigate the pathways through which maternal diagnoses or symptoms affect child and adolescent outcomes. For example, Davies and Windle (1997), found that family discord was a strong mediator of the relationship between maternal depressive symptoms and children’s conduct disturbances and depressive symptoms, at least for girls.

STRAATEGIES THAT WORK

Only one of the identified programs has undergone any rigorous evaluation: “Preventive Intervention for Families with Depression.” For this program, Beardslee, Salt, Versage, Gladstone, Wright, and Rothberg (1997) utilized an experimental design, with random assignment to a clinician-facilitated (active treatment) or lecture-based intervention (quasi-control) condition. Eligible families, recruited from a large health maintenance organization, included at least one parent who experienced an episode of affective disorder and one child between ages 8 and 15 who had never been treated for affective disorder. The purpose of the intervention was to decrease the effect of family and marital risk factors, encourage the promotion of resiliency in children through enhanced parental and family functioning, and prevent the onset of depression and other mental health problems. The clinician-facilitated (active) condition involved 6–10 sessions, starting with an assessment of all family members. It included individual sessions with parents, an individual session with each child and one or two family meetings, along with an information packet about depression. The program had a strong cognitive orientation, with a goal of increasing all family members’ understanding of the illness experience, increasing adults’ understanding of their children’s perspective, and helping parents to promote children’s ability to cope with

STRAATEGIES: OVERVIEW

There is a disturbing lack of research addressing the needs of school aged and adolescent children of mentally ill parents. This gap is surprising given the long history of attributing children’s mental disturbances to parental influences (e.g., the “schizophrenogenic” mother) and the acknowledged potency of parental psychopathology as a risk factor for child/adolescent mental illness. Most existing research has focused on epidemiology, but additional research of that type is likely to provide diminishing returns. More helpful to the development of effective prevention interventions would be studies addressing: “What is the best way to intervene with these children and their families?” Answers to this question would assist in developing and testing the effectiveness of alternative approaches, including early preventive interventions with children, parents, families, and broader support systems, as well as in identifying the critical components of these interventions.

Pertaining to such research, some prevention approaches for school age and adolescent offspring of mentally ill parents have still been developed. Through literature reviews, searches of conference presentations, and networking with other researchers, we were able to identify seven programs that provide services to the target group.2

2 Primary 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, both of whom have been funded to identify and document the operations of model programs serving mothers with mental illness and their children.
the illness and to move on with their lives. In the lecture condition, families received the same packet of information and attended two 1-hr lectures, followed by brief question and answer periods.

Beardslee, Salt, Versage, Gladstone, Wright, and Rothenberg (1997) reported the follow-up results for 37 families served, 18 months after the initial intervention. Independent raters documented significant improvements for all families in number of positive changes in behaviors and attitudes, global benefits, self-understanding, and the family's focus on their children. Additionally, families in the clinician-facilitated (vs. lecture) condition reported significantly more satisfaction and more benefits from the intervention. However, no data were reported on differential outcomes for children.

**STRATEGIES THAT MIGHT WORK**

Table 1 summarizes information for all the relevant programs identified in the literature, their locations and descriptions. Listed programs are located all over the United States, Canada, Australia and Israel, suggesting recognition of this problem in diverse societies. Interestingly, we identified urban programs serving mothers with serious mental illness and their infants and/or young children, but programs for families with older children are primarily located in rural or suburban areas. Possibly, urban services put less emphasis on mental health and more on behavioral problems: Mracek and Haggerty (1994) found no prevention programs for adolescents focused on preventing depression or schizophrenia. All the programs for adolescents they identified involve preventing substance abuse or conduct disorder.

The programs described in Table 1 are extremely heterogeneous. Some are add-ons to existing services provided to the parent with a mental illness, offering parenting support and/or training, such as Beardslee et al. (1997) or Lifequest. Some are comprehensive, offering services that the parents’ mental health agency should provide, at least for a limited period of time, such as crisis intervention, coordination of needed services, housing availability, family reunification services (FSS in Iowa City and the Invisible Children’s Program in Goshen, New York). Several of the programs were for children only, utilizing a group support model (Group intervention—Tel Aviv: Kids Link—Vancouver, Champs and Kids with Confidence—Victoria, Australia).

**STRATEGIES THAT DO NOT WORK**

The lack of comprehensive research on intervention models and their components precludes a definitive answer to this question. However, some research reviews have offered some speculation. While the specifics vary, the overall answer is that a “one size fits all” prevention approach for families with a mentally ill parent should be avoided. Thus, Downey and Coyne (1990), presenting an integrative review of research on children of depressed parents, concluded “adequate explanatory models must incorporate considerable complexity” (p. 68). They note the importance of reciprocal influences between mothers and children and the significance of the family context. Obviously, race/ethnicity, class, and culture need attention in all family treatment and prevention programs (Corcoran, 2000)—but perhaps even more so where mental illness is involved, since its labeling, acceptance, treatment, and recovery definitions are extremely culture-bound.

At a minimum, these considerations imply first, that the target of prevention efforts should be the entire family—not just children and not just parents. Second, interventions should be individualized, or alternative models should be available. Thus, while some parents may need parent training, others have this knowledge and would find such services boring, irrelevant, or insulting. However, these families may need assistance in budgeting or in accessing additional resources, so they can do the best job they can with what they have available. Finally, although one would hope that this would not need to be said, based on our accumulated research knowledge, interventions must avoid blaming mothers with mental illness for their children’s problems. Downey and Coyne (1990) remarked that they found “a distinct and consistent, even if unintentional, ‘mother-bashing’ quality to much of this body of work” (p. 72). From a prevention perspective, capitalizing on family strengths not just weaknesses should enhance willingness to stay involved in services.

**SYNTHESIS**

Despite the heterogeneity of available models, program descriptions and summative reviews (Cook & Steigman, 2000) present some common, important ingredients for interventions that are successful in preventing mental health and other problems in school-age and adolescent children of parents with mental illness. Following a prevention framework, interventions must minimize risks and maximize protective factors; this means minimizing family dysfunction and maximizing the child’s support system and his/her own competencies. Whether the program provides direct services or coordinates and links with other services, prevention activities must have a multiple focus on parents, family, and children. With regard to parents, prevention efforts need to ensure that the parent with a mental illness remains as healthy as possible, minimizing negative effects on parenting. Family members need support and education about
## Table 1. Programs for Parents with Mental Illness and/or Their School Age/Adolescent Children

<table>
<thead>
<tr>
<th>Program</th>
<th>Focus/goals</th>
<th>Children</th>
<th>Parents</th>
<th>Services/methods</th>
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<tr>
<td>Preventive interventions for families with depression (Beardslee et al., 1997)</td>
<td>Project aims to decrease impact of parental illness on family functioning and promote changes in parental behavior and attitudes that would result in fostering resiliency in children</td>
<td>Ages 8–15 (X = 12)</td>
<td>Mean age = 42.9 N = 37 families; 29 dual-parent families; 8 single parents. All single parents were mothers White middle-class</td>
<td>A clinician-facilitated group intervention was designed to prevent childhood depression and related problems through decreasing the impact of related risk factors and encouraging resiliency-promoting behaviors and attitudes</td>
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<tr>
<td>Short-term group therapy for children of mentally ill parents (Finzi &amp; Stange, 1997)</td>
<td>Group therapy intervention aimed at creating support systems for improving children’s coping mechanisms and adjustment via positive peer experiences, and assisting in rehabilitation of damaged interpersonal skills and self-concept.</td>
<td>Ages 9–12 15 boys and girls</td>
<td>11 families referred by local general practitioners</td>
<td>Traditional aspects of activity group therapy with special activities and dramatic games through which children could express inner world fantasies and fears and real world distress, become aware of and learn new coping strategies in a safe, accepting atmosphere</td>
</tr>
<tr>
<td>The family support services program, Iowa City, Iowa (J. Cook, personal communication, 2000)</td>
<td>Reduce hospitalizations by coordination of treatment services; reduce out-of-home placements of children; bridge gap between mental health and child welfare</td>
<td>Ages 0–18</td>
<td>Most are single-parent and impoverished, with little or no family support 95% White, 2% African American, 2% Latino, 1% Native American (1997)</td>
<td>Crisis intervention 24 hr/day, 7 days/week teaching decision-making, problem-solving skills, and helping with child management. Teaching children about parent’s mental illness and assisting in preparations for hospitalization. Families engage in self-assessment, strengths identification, family goal-setting, and establishment of formal/informal supports</td>
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<tr>
<td>The invisible children’s program, Goshen, NY (J. Nicholson, personal communication, 2000)</td>
<td>First priority is to empower parent to be a role model. Provide guidance to help develop quality way of life; support to avoid separation of parent(s) and child; prevent child(ren) from repeated foster care; preservation of family</td>
<td>Ages 0–12</td>
<td>Voluntary, self-referred clients 60% White, 40% African American (1997)</td>
<td>Quality housing to keep families together; 17 apartments and 24 hr case management provided. Respite care, job training, and safety planning. Art therapy for children. Children educated about their parents’ disorders</td>
</tr>
<tr>
<td>Lifequest Services, Wasilla, Alaska (J. Cook, personal communication, 2000)</td>
<td>Large, diverse, community-oriented mental health services agency</td>
<td>Ages 0–18</td>
<td>Mothers w/parental role impairment, homeless. Mostly White, small percentage Native American, African American (1997)</td>
<td>Clinical, emergency, rehabilitation, medical, residential, and prevention/early intervention/community education services, including supported housing and home-based services</td>
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<tr>
<td>Kids in control, Vancouver, British Columbia, Canada (J. Cook, personal communication, 2000)</td>
<td>Psycho-educational support group program for children/adolescents. Promotes children’s development of healthy coping skills</td>
<td>Young children to early adolescents</td>
<td>Adults with serious mental illness</td>
<td>Group runs once/year in four BC communities. and consists of 1.5 hr sessions once/week for 4 weeks. Group members given opportunity to work with and develop weekly themes through use of different arts, crafts, and interactive game activities</td>
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<tr>
<td>Southern partnership project—&quot;Listen to the Children,&quot; Victoria, Australia (Cowling, 1999)</td>
<td>Develop 4 inter-agency networks to more effectively meet the needs of families. Facilitate collaborative and cooperative links among service providers to ensure children are identified and receive support and parents feel entitled to ask for help in caring for children; develop prevention and early intervention programs for children</td>
<td>Dependent children, all ages</td>
<td>Adults with serious mental illness</td>
<td>Regional level; questionnaire for service providers; reference group initiatives—identified shortcomings of Dept of Human Services data collection forms re service provision to families. Network level: lobbying workshops on understanding effects of MI on parents and parenting; service development—a planned support program for parents</td>
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mental illness. Children need their own sources of support and advocacy, and help understanding their parent’s mental illness and their own independence from it.

Minimizing Risks

1. *Keeping the Parent with Mental Illness Healthy.* The identified consumer in the family must receive appropriate, state of the art mental health and rehabilitation services. This usually means psychiatric diagnostic assessments and medication, rehabilitative assistance through recovery counseling, and psycho-education targeted on consumers’ understanding their disorder and making necessary lifestyle changes to maximize functioning. Usually case management services are necessary to assure that services are coordinated, available, accessible, and acceptable. This may require making funding arrangements, identifying programs to meet special needs (e.g., for those with English as a second language, or with a physical disability), finding programs acceptable to the individual’s cultural values, or accessing services provided through other agencies, like supported education or vocational rehabilitation. Case management is often necessary to help families meet basic needs such as housing that is affordable, safe, and appropriate for children, and funds for food, clothing, and children’s developmental needs. Programs should build on the newly found recognition that child rearing is a significant role for parents with mental illness and one that often can serve as the foundation for a parent’s recovery (Cook & Steigman, 2000).

2. *Maintaining a Functioning Family System.* As parents are working on their own recovery, the family system needs to provide assistance and also needs help meeting needs of each individual adult family member. All family members must understand that psychiatric disorders are real illnesses—not disorders of character or morality. Families often need assistance in how they communicate about mental illness, because keeping this problem a family secret usually exacerbates functioning difficulties. Families also need proboscil that there is a stable back-up for their parent with mental illness. Psycho-education programs, developed primarily for families where an adult child has a mental illness, can be adapted to families in which a parent has mental illness.

3. *Minimizing Crises, Family Disruptions and Child Placements.* Mental health treatments, psychiatric rehabilitation and case management services should help minimize the likelihood of serious problems that require hospitalizations. Suicide attempts, extremely bizarre behaviors, or interpersonal violence are problems that disrupt family functioning and children’s need for stability, cause parental separations that disturb parenting continuity, heighten children’s anxieties and fears, and may produce trauma and other stresses. Because psychiatric disorders are illnesses with variable courses, procedures for early intervention and for immediate and sensitive crisis resolution must be in place to handle serious problems when they do arise. These procedures need to take into account the care of children when the main caregiving parent is in the hospital. Because many mothers with mental illness are not married and live alone with their children, lack of advance planning is likely to result in child welfare placement that may be difficult to reverse, even when the mother is subsequently released and stabilized. To avoid such placements, some states and advocacy groups have information available on how to establish temporary custody arrangements in advance or execute advance directives specifying childcare arrangements and the authority of the temporary care provider when the parent is unavailable.

4. *Parenting Assistance.* Many adults with mental illness were functioning successfully as parents before the onset of their disorder. However, those adults who experienced an early onset of mental illness may need considerable education and training in parenting skills. All families with a mentally ill parent should be involved in an assessment of strengths and weaknesses that gives the identified parent–patient the opportunity to voice his/her concerns and needs. Based on the assessment, parents should have available any needed education and training about child and adolescent development, group support and mentoring from other parents with mental illness (which also helps with problem-solving and communication issues), and parent skill training (which can be provided through in-home services or by role-modeling of other parent support group members). Mental health and rehabilitation staff and/or client case managers will need to involve themselves in parenting issues by including parenting goals in individual treatment plans. Parents will often need assistance and advocacy support to deal with other agencies, such as child welfare services with regard to TANF payments or abuse/neglect allegations, schools regarding children’s academic or behavior problems, and children’s health providers.
Maximizing Protective Factors

1. Supportive Adults in the Child/Adolescent's Life. Research literature and self-reports of children with a mentally ill parent confirm the importance of the child having alternative caretakers or other supportive adults that they trust and feel they can rely on. Supportive adults can provide consistent, warm, and affectionate relationships and a source for building the child's self esteem and his/her sense of independence and accomplishment (Cowling, 1999). If the child does not have rapport with adults in the family system, prevention programs should help build such connections (e.g., with a coach, teacher, religious or youth group leader, a neighbor, etc.) and this adult support person should be invited to attend family support activities so that he/she has an understanding of mental illness and of the family situation.

2. Peer Support for Children/Adolescents. A number of programs include peer support groups for children, composed of a small group whose parents all have a mental illness. Peer groups serve the significant function of helping children believe (rather than just hearing or being told) that their problems are not unique. This experience can help decrease stigma and shame experienced, increase social connectedness, provide opportunities to help others, and give some children opportunities to practice interpersonal skills that may be under-developed because of social isolation and discrimination.

3. Child/Adolescent Understanding and Competence. Many self-reports from adult children who experienced parental mental illness emphasize the importance of their understanding and believing that they are not responsible for parental behavior and outcomes and therefore do not need to compensate—by being "good" or filling adult roles—and that their own outcomes are separate from their parents'. Thus, children/adolescents individually or through group support need to hear these messages clearly and repeatedly. Their own competence and autonomy need to be enhanced and promoted to reduce guilt, anxiety, and fear and the stress these produce, especially because these stresses, themselves, can increase risk of mental and emotional problems.

4. Early Identification of Child Problems and Ready Access to Child and Family Mental Health Services. Even if all the above critical ingredients are available to a family, child/adolescent problems may develop as a result of genetic, constitutional, or other biological bases of mental illness as well as psychosocial factors such as maternal prenatal stress, poverty, or exposure to external toxins experienced in urban areas (accidents, crime, and the like). Parents, family members, and the child's adult support/advocate need education and awareness for early identification of such problems. Case managers, mental health staff and rehabilitation workers all need to be tuned in and responsive to early warning signs of child disorders. Baranakin and Greenberg (1996) recommend that all children of parents with serious mental illnesses be given annual "check-ups," much as is the case when parents have other chronic disorders with a genetic basis (e.g., diabetes). We now know that many serious mental illnesses have a long prodromal period, and that early interventions can markedly decrease the likelihood of relapse and disability throughout life. Agency procedures must facilitate rapid response and integrated treatments for parent and child.

Thus, prevention programs targeting children/adolescents of mentally ill parents need to have many components and work effectively with other services utilized or needed by families, in a wrap-around fashion, where meeting family needs is more important than the administrative procedures of various funding sources. It would seem that most often, child/adolescent prevention services should be associated with the parent's mental health or rehabilitation provider. This contrasts with many traditional school-based child/adolescent prevention programs that target at-risk groups such as children of divorce, and children coping with grief and mourning. Because creating an understanding and a supportive context is central to prevention with school age and adolescent children of parents with mental illness, school-based services would be inappropriate because of the stigma of being the child of a mentally ill parent and the discrimination likely directed at group members. An exception might be Student Assistance Programs (SAP), which operate much like Employee Assistance Programs in industry; that is, schools provide information to help students realize that they may have a problem and then self-refer or obtain referral for confidential treatment and assessment. It is up to the SAP to identify the risk factors contributing to problems and to address them (Dupont, 1997). A similar approach is used with children from families with addictions and could potentially be applied to other family-based problems like parental mental illness, since family dysfunction is often similar under both sets of risk factors.

References


