Life Circumstances of Mothers with Serious Mental Illnesses

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Individuals with a severe mental illness now have greater opportunities to pursue normal adult roles, including parenting. The research reported involved 379 women carrying out parenting responsibilities, recruited from the public mental health system in an urban area. The sample displayed great heterogeneity in educational levels, number of children, number of fathers for their children, and family living arrangements, except that most women were very poor. These women faced many significant stresses: living alone with their children, significant child behavior problems, and financial worries. Still, most of the women endorsed the significance of motherhood in their lives. Inattention by most mental health providers to parenting issues leaves many important needs unmet and is likely to have adverse consequences for these women and their children. Implications for psychosocial rehabilitation practice are discussed.

"For some persons with mental illness, parenthood can potentially overcome the major problems of isolation, identity confusion, and stigma that are associated with long-term mental illness. By becoming a parent, one can travel from outcast to a valued and honored status." (Apfel & Handel, 1993)

Introduction

Deinstitutionalization shifted the focus of mental health care from institutions to the community. One of the rarely acknowledged corollaries of this policy change is the increased likelihood of parenthood. Since nearly all adults with a severe and persistent mental illness now spend the majority of their time in the community, they are usually capable of and interested in pursuing normal adult roles, which obviously include having intimate relationships and bearing children (Apfel & Handel, 1993). However, the ramifications of this shift toward parenting have not had a noticeable impact on mental health practice. While mental health programs are addressing needs for housing and work, they are far behind in responding to consumers' needs with regard to functioning in parental roles (Nicholson & Blanch, 1994; Sands, 1995). For example, according to several studies, a ma-

jority of psychiatric clinical records do not address the whereabouts or the status of patients' children (55%: DeChillo, Matorin, & Hallahan, 1987; 81%: Zemencuk, Rogosch, & Mowbray, 1995). Less than one-third of state mental health authorities collect even basic data on their clients' parenting status (Nicholson, Geller, Fisher, & Dion, 1993).

In contrast, research indicates that many persons with mental illness do have children: women with mental illness have normal fertility rates and bear an average or above average number of children (Buckley, Buchanan, Schulz, & Tamminga, 1996; Saugstad, 1989). We also know that 10–15% of pregnant women develop a mental illness postpartum (Oates, 1989). As in the general population, the vast majority of persons with mental illness who are identified as parents are women (Nicholson, Nason, Calabresi, & Yando, 1999); women with mental illness are more likely to marry than men (NIMH, 1986) and less likely to be childless (Saugstad, 1989). Data are less clear concerning the extent to which persons with a mental illness are functioning in parental roles. Thus, Schwab, Clark, and Drake (1991) reported that 25% of a small sample with dual diagnosis were parents. However, Blanch and Purcell (1993) found 69% of women with a mental illness in New York City shelters had children, but only about 9% of female clients receiving intensive case management services in New York State were custodial parents of children under 18, and about 10% of clients with a mental illness in supported housing had sole or joint custody of children. A Massachusetts statewide study of adults with a serious mental illness (White, Nicholson, Fisher, & Geller, 1995) found 9% of women were primary caretakers for minor children; but in a large Boston outpatient clinic, among adult female clients actively receiving case management services, 46% were mothers (Nicholson et al., 1999).

Though estimates of prevalence vary widely, even the lowest of these rates would indicate that parenting is a substantial issue that needs to be addressed among adults with a mental illness. Other research also corroborates this need. That is, women with a mental illness who are mothers are parenting in high risk conditions: they are more likely to be single mothers, to begin childbearing early, to live in poverty, and to experience family strife and victimization (Belle, 1990; Downey & Coyne, 1990; Nicholson, Sweeney, & Geller, 1998; Olson & Banyard, 1993; Wang & Goldschmidt, 1994). Furthermore, the children of parents with a mental illness are at increased risk of both being placed in alternative settings such as foster care (Oyserman, Benbishty, & Ben Rabi, 1992) and exhibiting behavior problems (Ghodsian, Zajicek, & Wolkind, 1984) and psychiatric disorders of their own (Jacobsen, Miller, & Kirkwood, 1997).

Despite the likelihood of parenting for women with a mental illness and its associated risks, the amount of descriptive research on this topic remains limited. Only a few studies have reported on the childcare responsibilities of parents with mental illness; with the exception of case studies and law reviews, only four articles were identified on custody loss, and they reported percentages of women who lost custody ranging from 28% to 60% (Bazar, 1990; Coverdale & Aruffo, 1989; Miller & Finnerty, 1996; Test, Burke, & Wallisch, 1990). Research addressing parenting attitudes of mothers with a mental illness is also limited, as most studies have focused on their children (DeChillo et al., 1987; Sands, 1995). To the extent that mothers have been the subject of research, studies have considered mainly mothers of infants and toddlers (Oyserman, Mowbray, Allen-Meares, & Firminger, 2000).

Some recent reports have addressed parenting issues for women with a mental illness by taking more of an applied focus, examining service implications and the perspectives of the mothers themselves (Miller & Finnerty, 1996; Mowbray, Oyserman, & Ross, 1995; Nicholson et al., 1998; Sands, 1995; Wang & Goldschmidt, 1994; Zemencuk et al., 1995). While these articles have contributed to our understanding, methodological problems raise questions as to their applicability to the overall population of mothers with a serious mental illness. Many of the studies have used small, primarily middle class convenience samples with mostly Caucasian women—unrepresentative of clients seen in public mental health systems. In this article, we report descriptive, baseline findings from an NIMH-funded, longitudinal study of a large sample of primarily minority women from an urban area who are mothers and who have a serious mental illness.

The purpose of this article is to increase the knowledge of mental health practitioners concerning the life situation of mothers with a serious mental illness. We examine the generalizability of conclusions from previous smaller, primarily qualitative studies, to a larger sample of women that better represent individuals who were served by public mental health systems in urban areas. We utilize a framework provided by Wang and Goldschmidt (1994), describing the women's family and living situations, their condition and the condition of their children, and the women's parenting attitudes. The discussion focuses on the implications of these findings for psychiatric rehabilitation practice and the need for increased attention to the parenting role.

METHODS

Sample

The criteria for study inclusion were women between 18 and 55 years of age, with a serious mental illness (duration greater than a year; diagnoses primarily of schizophrenia, major affective disorder, or bipolar disorder, that was causing major dysfunction in one or more life areas). All participants had to have care responsibilities for at least one child between the ages of four and 16. Three hundred seventy-nine women were recruited from 12 community mental health (CMH) agencies and three inpatient psychiatric units in southeast Michigan. Participants were 60% African-American, 29% Caucasian, 8% Hispanic, and 3% other. Except for an over-representation of Hispanics (which was done on purpose to allow separate examination of this subgroup), the demographics mirrored the composition of the population in treatment in the public mental health system from the catchment area, according to statistics produced by the local community mental health board. The women in our study represented a wide range of educational levels, with 40% having some college or beyond, 25% a high school diploma/GED, and 35% less than a high school education. Participants' median age was 36.2 years.

Recruitment and Interviewing

Names of eligible women were obtained from mental health agencies through case-manager referrals and record searches. At three of the larger CMHCs, where recruitment utilized management information system-generated lists, it was possible to calculate the percentage of all female clients (aged 18-55) who had dependent children. Overall, the lists contained 1315 women, of whom 33.5% ($N = 441$) had minor children as dependents. Percentages at individual agencies were 42.3%, 28.2%, and 35%, comparable to the higher rates found for community-based samples in previous research.

To enroll clients in the study, eligible women were contacted either by project staff members or by their CMH case-managers. Women in inpatient units were recruited on the wards and interviewed 30 days later. Out of a total of 484 eligible women identified from CMHCs or inpatient units, 59 (12%) declined and 46 (10%) could not be contacted or scheduled.

Measures

Trained interviewers administered a comprehensive two-part interview, 7 to 10 days apart. In Part I, women were asked about their children (ages, gender, and living arrangements) and the composition of the household. They were also asked about their educational levels, their current and past employment status, income level and source, and they completed a Financial Worries Scale (8 items, yes-no scale, Cronbach's $\alpha = .80$) (Mowbray, et al., 1999). Participants were also administered (a) the Colorado Symptom Index (Shern, et al., 1994) (14 items, 5-point frequency scale, $\alpha = .90$); (b) the Drug Abuse Screening Test, or DAST (Skinner, 1982), adapted to be more appropriate for women; (c) the Self-Report Community Functioning Scale (Bybee, Mowbray, & Cohen, 1994), adapted from a case manager-report format (Bybee, Mowbray, & McCrohan, 1995) (17 items covering activities of daily living and interpersonal relations with level of difficulty rated on a 5-point scale, $\alpha = .83$); (d) seven items from Lehman's Quality of Life Interview (Lehman, Ward, & Linn, 1982; Lehman, 1988, 1991) on neighborhood safety (rated 1-7, $\alpha = .86$); (e) the Behavior Problems section of the Child Behavior Checklist (Achenbach & Edelbrock, 1983), including externalizing and internalizing behaviors (rated 0–2; α's = .90 and .88, respectively); (f) questions about CMH services and services needed; (g) an open-ended question, "What are the changes motherhood has made in your life?" with responses coded into categories developed by project staff members ($\kappa = .62$ to 1.00); and (h) the Role Importance Scale, adapted from Holmberg, Markus, Herzog, and Franz (1996), to assess the personal significance of different roles, including being a mother (11 items, rated 1 to 5). Part II included the affective disorder and schizophrenia modules of the DIS (Robins, Helzer, Croughan, & Ratcliff, 1981); and sections on drug and alcohol use from the *Addiction Severity Index* (ASI) (McLellan, Luborsky, Woody, & O'Brien, 1980).

RESULTS

Family and living arrangements. Data on the women's economic status, family composition, and the composition of their households are presented in Table 1, with additional detail provided below. The economic status of the study participants was very low, despite the diversity of their educational levels. The majority of the sample fell below the poverty line and indicated dissatisfaction with their financial situations. Most of the women derived income from SSI/SSDI and food stamps, but a substantial number were on AFDC. Relatively few women received income from their spouses or partner's wages, child support, or help from family or friends. Median income from the latter two sources amounted to only $200 and $150 a month, respectively. Though less than a quarter of mothers were currently working, more than 90% reported having a work history. The time working at their longest steady job ranged from one month to more than 20 years (median = 3 years). The median Hollingshead rating (Hollingshead, 1975) of the women's

current or last job was 3.5 (semi-skilled to skilled). In terms of activity besides working, a few of the mothers were involved with school or college or volunteering. Nearly all reported housekeeping activity.

The quality of the neighborhood in which the mothers were currently living was rated at about mid-scale, indicating that, on average, women have mixed feelings about neighbors and neighborhood safety, appearance, and cleanliness.

Concerning marital status, more than 40% of the women were currently married or living with a partner, while the remainder were equally likely to have never been married or previously married. In terms of living arrangements, nearly half of our mothers lived by themselves with their minor children. Only about a third lived with a domestic partner and children, and about one in seven lived with extended family and children. Five percent of the study participants did not live with their children, although they did have childcare responsibilities at least one day a week. White women were more likely to be living with domestic partners and children, whereas African-American mothers more often lived alone with their children, or with their parents or other extended family ($\chi^2 = 35.98$, $df = 12$, $p < .00$). The average number of children per mother was 2.85, but ranged from one to nine. Altogether, the mothers had 1082 children. About 15% of the children were 21 and over, and the modal category was elementary school age (median age = 11). About half (48%) of the women indicated there was one father for all their children; the other half identified from one to nine fathers. The vast majority of the mothers' minor children lived with them. Children who didn't live with their mothers were mostly with fathers (35.4%) or grandmothers (23.2%);

Table 1—Family and Living Situations of Mothers with a Serious Mental Illness (N = 379)

VARIABLE	DESCRIPTIVE STATISTICS % (n) OR MEAN (SD)	
Total Monthly Family Income		
Median	$ 929	
25th percentile	$ 687	
75th percentile	$1310	
% Below the Poverty Line[1]	68.1%	
Satisfaction with Family's Financial Situation:		
Not very or not at all satisfied	57%	(215)
Income Source[2,3]:		
AFDC	41.3%	(93)
SSI/SSDI	58.0%	(131)
Child support	20.4%	(46)
Food stamps	55.8%	(126)
Help from family/friends	19.8%	(43)
Spouse/partner's wages	20.4%	(46)
Productive Activity:		
Working full-time	11.3%	(43)
Working part-time	10.6%	(40)
School or college	10.8%	(41)
Volunteer activity	20.6%	(78)
Keeping house	91.0%	(343)
Quality of Neighborhood [4]	Mean = 4.38	(1.23)
Marital Status:		
Married	29.0%	(110)
Not married, living with a partner	12.4%	(47)
Separated/widowed/divorced	27.7%	(105)
Never married	30.6%	(116)
Living with:		
Minor children (under 21) only	48.8%	(185)
Husband/partner/boyfriend and minor children	31.9%	(121)
Extended family and minor children	14.2%	(54)
Alone (no other adults or children)	5.0% (19)	
Total Number of Children	Mean = 2.85	(1.51)
Percent of minor children	85.5%	(925)
Percent of adult children (18 and older)	14.5%	(157)
Percent of Minor Children Who Live with Mother	82.2%	(697)

[1] Adjusted for family size, to include spouse or partner and number of children dependent on participant in the household, based on US Census Bureau specification of poverty thresholds in 1996.
[2] Based on N of 226; questions not asked in early interviews.
[3] Respondents could select multiple categories.
[4] From Lehman's Quality of Life Interview (31-33), on a scale of 1-7, where 1 = terrible, 7 = delighted.

Table 2—Clinical Characteristics of Participants (N = 379)

VARIABLE	DESCRIPTIVE STATISTICS % (n) OR MEAN (SD)	
DIS Diagnosis:		
Schizophrenia	10.4%	(35)
Schizoaffective	10.1%	(34)
Major depression	39.8%	(134)
Major depression with psychotic features	11.9%	(40)
Bipolar disorder	12.2%	(41)
Bipolar disorder with psychotic features	15.7%	(53)
Age[1]	Mean = 26.7 range 3–54	(8.20)
Self-Report Lifetime Hospitalizations	Mdn = 2.0	
Hospitalized in Past Year for Psychiatric Problems?	31.9%	(N = 121)
Above DAST Cutoff Score for Alcohol/Drug Use[2]	36.7%	(N =139)
ASI Alcohol Composite Score[3]	Mean = .082	(0.13)
ASI Drug Composite Score[3]	Mean = .030	(0.06)
Colorado Symptom Index[4]	Mean = 2.77	(0.83)
Self-Report Community Functioning Scale score[5]	Mean = 3.36	(0.56)
Global Quality of Life[6]	Mean = 4.27	(1.30)

[1] Based on first hospitalization; for those women who reported no hospitalizations, age at which she first saw a psychiatrist or other mental health professional, or age of worst symptom experience from the DIS, N = 377
[2] Based on the DAST (30); cutoff scores of 5 or above, items indicating past or current problems
[3] From the Addiction Severity Index (37).
[4] 14 items, range 1–5, with 5 = most severe, Shern et al. (29).
[5] 17 items, ratings from 1–5 with 5 = more functional (42).
[6] A single item (How do you feel about life as a whole?) repeated at end of questionnaire. From Lehman's Quality of Life Interview (31-33), on a scale of 1–7, where 1 = terrible, 7 = delighted.

about 10% each were in juvenile justice facilities or foster care.

Condition of the mothers. Information about mothers' clinical characteristics and functioning is contained in Table 2. Schizophrenia and schizoaffective disorders each made up 10% of the diagnoses; bipolar disorder made up a somewhat higher percentage, as did bipolar disorder with psychotic features. The modal diagnosis was major depression, with another 12% having diagnoses of depression with psychotic features. The average age of onset for psychiatric problems was mid-twenties, but ranged from age 3 to 54. The median number of lifetime hospitalizations was 2.0, but the distribution was wide and positively skewed, with a mean of 4.24. The average number of hospitalizations over the duration of the women's mental illness was .47, or one every other year. In the year before the interview, about one-third of the women had been hospitalized for a psychiatric problem.

In terms of lifetime drug or alcohol use, more than a third of the women scored above the cutoff point on the DAST, implying past or current substance abuse. Alcohol (44.2%), cocaine (24.4%), and marijuana (11%) were identified as the substances most disruptive to women's lives. Other drugs were listed, but none by 10% or more of women. Composite scores on the ASI for current alcohol and drug use were both quite low. In the past 30 days, the substances reportedly used by the highest number of women were alcohol (22% reported drinking enough to get a buzz) and marijuana (used by 10.5%).

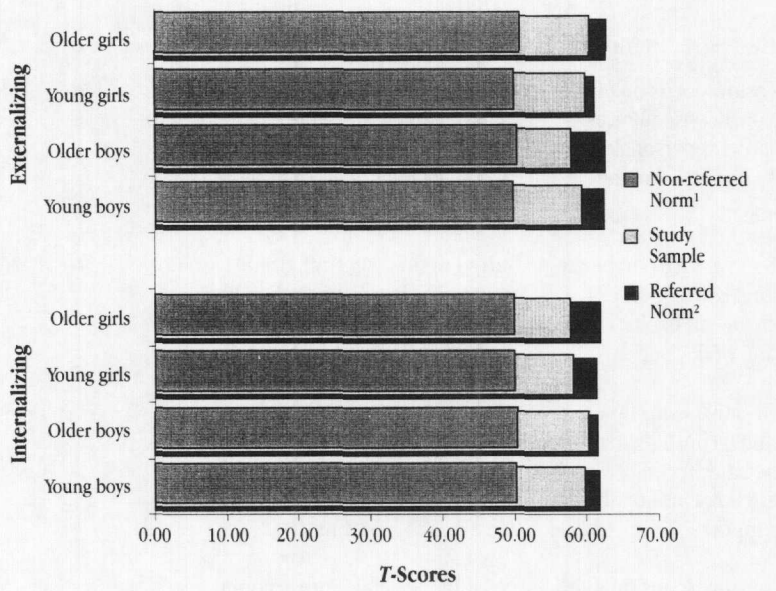
Current symptomatology on the Colorado Symptom Index was about at mid-range on average, indicating symptom occurrence several times a month or less. Similarly, women's responses on the Self-Report Community Functioning Scale were indicative of independent functioning in most areas, but needing a lot of help. The mean Global Quality of Life Score for women in our sample was somewhat above mid-range.

Children's behavior problems. Graphical portrayal of the children's scores on the CBCL sections can be found in Figure 1, in comparison to non-referred (normative) and referred (clinical) samples (Achenbach & Edelbrock, 1983). The mid-point of the T-score bandwidth for sample children reaches the 98th percentile of the published clinical cut point of 70; 17.2% of sample children were above this clinical cut point. There were no significant age or gender differences in behavior problem scores.

Study means of the internalizing and externalizing broad-band scales of the Child Behavior Checklist (Achenbach, 1991) were compared with both referred and non-referred standardized norms using the Independent groups t-test assuming unequal group variances (Kanji, 1999). This was done within age (3–11 and 12–17) by gender groups, necessitating a total of 16 t-tests. We

held the family-wise error at .05 by Bonferroni-adjusting the four comparisons made within each age by gender subgroup. Findings show that sample means were significantly higher than the non-referred normative means on both internalizing and externalizing scales, across all four age by gender groups. However, only two out of eight comparisons with the referred norms yielded significantly lower scores: the externalizing scores for both the younger and older boys. This indicates that both age groups of girls were not significantly different from the internalizing or externalizing referred standardized means, nor did either age group of boys differ on internalizing scores; i.e., internalizing scores for both boys and girls were at clinical levels, as were the externalizing scores for girls.

Figure 1 — CBCL Scores of Study Participants' Children



Note: Young = Ages 3 to 11; Older = Age 12 to 17
[1] All study sample means were significantly higher than non-referred means
[2] The externalizing scores for both younger and older boys were the only two means significantly lower than the referred normative means.

Parenting. The average age when women had their first child was 21.79 years of age. Most women were mothers before experiencing the onset of mental illness (63.7%; although many women had additional children after the mental illness began). The average rating for the parenting item on the Role Importance Scale was 4.72 on a 5-point scale, the highest mean and the lowest variance of all of the 11 family, personal, social, or work roles rated, indicating its primacy in women's self-perceptions. When asked how much of the help provided through mental health services related to parenting needs, 43% of the women said that they received such service "not at all" or "a little." Yet nearly 20% of women stated that there were services they wanted but were not receiving—most frequently describing a need for control over therapy and a need for parenting skill training or support.

Table 3 presents women's answers to the open-ended question, "What changes has motherhood brought to your life?" Nearly half of the women gave an answer describing positive emotional consequences of being a mother, such as a sense of personal worth and accomplishment. More than one-fifth mentioned positive behavioral consequences of motherhood, such as giving up drugs or ending bad relationships. Another 6.5% of women depicted positive effects in dealing with their own mental illness, and about 10% described enhancements of their status or social roles. In contrast, less than 10% of mothers presented angry or globally negative responses. Much more common were specific negative responses reflective of the situation of low-income mothers. For example, about one-fifth discussed their worries about children; a quarter mentioned concrete changes like loss of freedom or financial problems; and about 10% reported restrictions on career/life choices.

Discussion

This study was able to identify a large number of women from the public mental health system in an urban area who were parenting their children. Compared to descriptions in previous reports with smaller clinical samples, our results show some similarities and some differences. In comparison to the more qualitative studies (e.g., Nicholson et al., 1998), ours included a much larger percentage of non-Caucasian women who were mothers (71% vs.16.7%). The average age of our sample was similar to the average age reported in two studies (White et al., 1995; Nicholson et al., 1998), but older than that reported in three others (Sands, 1995; Zemencuk et al., 1995; Nicholson et al., 1993). The number of "never married" women in this sample is much higher than in previous studies (White et al., 1995;

Table 3—Responses to the Open-Ended Question: "What Changes Has Motherhood Brought to Your Life?"[1]

Response category[2]	Examples	*N*	%
Positive focus on emotional consequences – sense of personal worth & accomplishment	Feeling proud; a blessing; it is everything I need to be happy; something to live for; more purpose; enhances my life; helps me not give up; more responsible; maturity; happiness	174	45.8%
Positive focus on behavioral consequences – change in habits, cessation of deviance	I used to do drug stuff, drink a lot, not anymore; I was in bad relationships	79	20.8%
Negative focus on emotional consequences – negative feelings v/v self-esteem, emotional support	More depressed, angry and pissed off; stopped caring about a lot of things; wish I never had kids; I don't know what it is to be a child; I don't know what it is to have fun	34	9.0%
Negative focus on motherhood – loss of freedom and free time, financial problems	Need to take child into account; just having to care for two extra bodies; have more things to do; you can't go anyplace; it slowed me down; your time is limited; can't just pick up and go; more dependent on others financially	98	25.8%
Focus on child/ren and emotional consequences	Worries; scared, really scared; scared about kids and drugs and alcohol	73	19.2%
Focus on social context – status/social role enhancements	I feel realized or fulfilled as a woman; being a good wife and mother; became an adult; became a mother, that changed others' views	41	10.7%
Focus on social context – career / life choices	Staying at home; not being able to work	41	10.7%
Focus on social context – positive effects on social relations, social activities	Instead of being by myself, I am with them; because of them I socialize; keeps me from being alone; I have company	22	5.8%
Positive consequences of understanding or dealing with a mental illness	I have to be careful with my medication; for my kids, now I try to make sure I go to therapy	25	6.5%

[1] Frequencies are number and percentage of respondents with at least one instance of the category in their overall response, $N = 379$.
[2] Categories used by less than 5% of respondents are not listed in the table.

Nicholson et al., 1998), probably reflecting other demographic differences. While other research has similarly reported that nearly half of mothers with a mental illness are single parents (Nicholson et al., 1998; Wang & Goldschmidt, 1994), by collecting data on living arrangements, we have also determined that most of these single mothers live alone with their minor children (49%), but one-seventh live with extended family and/or adult children. This distinction is important for planning the type and focus of intervention services needed (for example, in-home parenting interventions versus education and support for the child's other caretakers).

Compared to women described in other studies, these women's clinical situations appeared similar in terms of diagnoses (mainly affective disorders, Nicholson et al., 1998); average age of onset (mid-twenties, Caton, Cournos, Felix & Wyatt, 1998), and duration of mental disorder (modal value of 10 years, Wang & Goldschmidt, 1994). However, mothers in this study had a higher number of children than reported in other contemporary studies (1.9: Wang & Goldschmidt, 1994; 2.0: Caton et al., 1998; 2.1: Zemencuk et al., 1995; 2.2: Nicholson et al., 1998; 2.4: Nicholson et al., 1999)—perhaps because our sample was community- rather than inpatient-based and recruited from an urban area. Compared to other research, our sample also had a higher number of mothers whose children were living with them; for example, a study of women with schizophrenia-spectrum disorders from an urban public system reported nearly half had children living in foster care (Miller & Finnerty, 1996). This, no doubt, reflects the recruiting bias of the present study; that is, when recruited for the study, mothers had to have at least some care responsibilities for their minor children. However, longitudinal data collection will enable us to see if the parenting situation of these mothers continues.

In terms of stress and social support, our sample appears to be living under very difficult circumstances. Many are faced with stressful life situations—cur-

rent psychiatric crises and hospitalizations, and past histories of drug and alcohol abuse. In terms of the environments in which they are living, the ratings they give to their neighborhoods are somewhat lower than the mean neighborhood ratings from women with serious mental illness aged 36-45 reported by Lehman, Slaughter, and Myers (1992) in another sample (mean rating = 4.76), and substantially lower than the quality of neighborhood ratings from a national sample (mean rating = 5.2) (Lehman et al., 1982). However, our data seem congruent with qualitative research reports indicating that mothers with serious mental illness have difficulty finding suitable housing (Sands, 1995).

Another aspect of stress experienced by these mothers has to do with their children. Our CBCL data indicate that according to mothers' perceptions, their children's behavior is significantly more problematic than that of the test-maker's normative sample. In fact, with one exception, the amount of behavior problems reported for these children does not differ significantly from that found in a child clinical sample. The exception, externalizing behavior in boys, is not surprising since one would expect that boys in treatment would have extremely high levels of externalizing symptoms (i.e., boys with externalizing symptoms that high would undoubtedly be brought to the attention of authorities and put into treatment). Reports of mental health and behavioral problems in children whose parents have a mental illness is consistent with a large body of literature (see for example, Ghodsian, Zajicek, & Wolkind, 1984; Scherer, Melloh, Buyck, Anderson, & Foster, 1996).

One of the striking findings of this research is the heterogeneity of our sample of mothers—in terms of their educational backgrounds, the number of children they have, the children's ages, the number of fathers for these children, family living arrangements, and marital status. Previously reported data from small samples were unable to capture this range of differences, heightening the utility of information collection from larger, more representative samples. Such heterogeneity is probably more representative of the actual service variations that PSR providers must address.

Despite diversity in educational attainments and family situations, the economic levels of these women are consistently very low, with more than two-thirds living below the poverty line, similar to most research on the relationship between poverty and mental illness. But in spite of poverty, their past, long-term psychiatric histories, the severity of psychiatric diagnoses, and current stresses, many women are experiencing only moderate levels of symptoms, currently functioning at an independent level—but needing a lot of help—which appears to be similar to mothers with a mental illness studied by Nicholson et al. (1998). One can only wonder how long these mothers may be able to continue at this level of functioning, however, given the at-risk circumstances in which most of them are living, the perceived behavior problems of their children, and the lack of attention paid to parenting by mental health providers. In an older sample with long-term schizophrenia diagnoses, Caton et al. (1998) concluded, "Parenthood was associated with better premorbid social adjustment, but it conferred no advantage in the long-term course of schizophrenia."

Concerning the meaning of motherhood, in comparison to other more qualitative, small sample studies (Sands, 1995), in this study, many of the mothers acknowledged past problems, described the positive impact of motherhood, and discussed their current needs for parenting assistance. But similar to the other studies (e.g., Miller & Finnerty, 1996), responses from the present research also strongly conveyed the personal significance of the parenting role through the structured as well as the open-ended questions on the importance of parenting compared to other roles, and how motherhood had changed their lives. This congruence of findings enhances the validity we can ascribe to the significance of parenting for women with a serious mental illness. Whereas other studies might be criticized for employing small and atypical samples, with women who perhaps participated because of their interest in parenting, the current study has a much larger number of participants, recruited in a more systematic and less biased fashion. Interestingly, in our sample, the positive aspects of motherhood seem to be even stronger, perhaps because we specifically asked women questions that elicited their parenting strengths, not just their problems. In fact, in terms of Global Quality of Life, these mothers' reports are higher on average than those reported for women with serious mental illness aged 36-45 (3.76, Lehman et al., 1992), but lower than that of a national sample of persons with low SES (5.1, Lehman et al., 1982).

Implications for Psychiatric Rehabilitation Services

PSR principles emphasize assistance to individuals in pursuing roles of their choosing. Clearly, parenting is a positive role, valued by many women with psychiatric disabilities. Thus, it is congruent with psychosocial rehabilitation practice to provide more services in relationship to parenting needs. Accordingly, we offer these recommendations, following from our findings and from other research reported in the literature:

1. Psychosocial assessments should include information collection on parenting status and meaning.
2. For individuals who are parents, service plans must include consideration of their concerns about parenting and about the welfare of children.
3. Consumers who are parents should be assured adequate access to transportation and childcare services, as necessary, to meet their rehabilitation objectives.
4. Case management must include attention to parenting concerns; such as, adequate parenting resources, respite services, resource and service needs of the children.
5. PSR services must provide adequate opportunities for parents to address parenting issues and concerns. This should include availability of parenting support groups, parent education and training, and education and support groups for children whose parents have a mental illness.
6. Furthermore, in mental health systems, children whose parents have psychiatric disabilities should be given priority for individual and family services. Specialized programming should be in place in all agencies to simultaneously serve mothers and their young children.

CONCLUSIONS

Our results substantiate the necessity of addressing parenting issues in mental health and psychiatric rehabilitation programming for women. As noted in the introductory quotation, parenting has powerful implications for positive rehabilitation outcomes: in this study, women described how motherhood had motivated changes in harmful behaviors. On the other hand, parenting for these women and their children involves risks that have equally powerful implications for long-term outcomes on their own and their children's functioning. One woman who was pressured into giving up custody of her two daughters wrote, "I think that if treatment providers had viewed my role as a mother as one of primary importance, my life might have turned out differently" (Fox, 1999). Because of the diversity of life circumstances for mothers with a serious mental illness (e.g., living arrangements, marital status, educational backgrounds, etc.), parenting concerns need to be addressed through individualized attention from case managers and therapists. However, since there are large numbers of women with a serious mental illness who are mothers, agencies should also offer diverse, group-based educational, training, and support programs for women and their family members. Finally, since the living arrangements for these mothers appear to vary by race or ethnicity, attention to cultural factors is a necessity.

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ENDNOTES

[1] These percentages have been corrected for ineligibles on the original MIS lists received from the CMHCs, listing all female clients with children; that is, for those women who could be contacted, interviewers identified about 18% for whom the MIS data was incorrect because women did not have children.