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# RESOURCES AND SUPPORTS FOR MOTHERS WITH SEVERE MENTAL ILLNESS

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*Over the past 20 years, community mental health services have enabled individuals with severe mental illness (SMI) to spend more time in the community and to have greater opportunities to face normal developmental life tasks. Currently, women with SMI appear to be as likely to have children as women in the general population. Although these mothers tend to be single parents, often live in inadequate housing, have small social networks, and lack social and emotional supports, they have received little treatment attention. This article presents a systematic review of literature published in the past decade that describes interventions for mothers with SMI. These interventions are critiqued, and implications for future interventions are drawn using a psychiatric rehabilitation framework.*

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## **Key Words**

community-based programs  
literature review  
mental illness  
mother-child relations  
psychiatric rehabilitation

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Severe mental illness (SMI) refers to long-term and persistent disorders such as schizophrenia or major affective disorders that disrupt capacities to carry out primary aspects of daily life (Dennis, Buckner, Lipton, & Levine, 1991; Gonzales, Kelly, Mowbray, Hays, & Snowden, 1991). Over the past 20 years, the goal of community mental health services has been to enable individuals with SMI to spend more time in the community and thus to have greater opportunities to develop personal skills necessary for coping with life tasks. Psychosocial rehabilitation can be used within the community mental health rubric to address this goal. It involves development of both specific individual skills and environmental resources to assist individuals with SMI in functioning successfully in the environments of their choice with a minimum of ongoing professional intervention (Farkas & Anthony, 1989). Theoretically, psychosocial rehabilitation can encompass any of the wide variety of domains in which individuals with SMI may choose to function.

Unfortunately, community-based interventions are often conceptualized as dealing with a clientele for whom gender and socioeconomic issues are unimportant (see, for example, Bachrach & Nadelson, 1988; Mowbray & Benedek, 1988; Mowbray, Herman, & Hazel, 1992). Yet services to those with SMI must be sensitive to the individual characteristics of clients if they are to truly meet their environmental and social needs (Gonzales et al., 1991). When treatment is generic, it may de facto be more appropriate for men than for women and for those in dominant rather than subordinate positions. Psychosocial rehabilitation techniques have concentrated primarily on vocational rehabilitation, with some consideration given to educational environments and housing or living arrangements. Only peripheral attention has been given to social relationships such as friendship, and rehabilitation needs in intimate or parenting relationships have been all but ignored. Indeed, the assumption present in the major text describing psychiatric rehabilitation is that the clientele of concern are younger adults, with family of origin being their only kinship bonds (Farkas & Anthony, 1989).

This article reviews programs for mothers with SMI described in the published literature from 1983 to 1992, reviewing what is

currently being tried and with what effect. These programs are then assessed against a psychosocial rehabilitation perspective: the extent to which they focus simultaneously on developing needed skills and on ensuring supportive environments. From this review and assessment, we suggest improvements in service delivery to mothers with SMI. Ten articles describing interventions were reviewed. Diagnostic criteria change with time, are not completely reliable, and may be culturally biased. In spite of these difficulties, every attempt was made to include all studies describing programs for mothers with SMI and to exclude studies in which diagnoses were other than SMI. Some of the problems of the vagaries of diagnoses were ameliorated by focusing only on research conducted within the past decade. We made no attempt to second-guess the authors of the studies and report findings and samples as described.

Attention to parenting, of course, is a gender-tied issue. Childbirth, child care, and child rearing are life tasks that have traditionally been the concern and almost exclusive responsibility of women. Among people identified as severely mentally ill, the gender differential is even more striking: Studies have repeatedly found that much greater proportions of women than men with SMI are married or have been married and have children (Mowbray et al., 1992; Rogosch, 1987). The inattention to parenting issues in the psychosocial rehabilitation literature corresponds to a more general lack of knowledge concerning the specific treatment needs of women with SMI (Bachrach & Nadelson, 1988; Mowbray & Benedek, 1988; Mowbray et al., 1992). Thus, it is not surprising that relatively little is known about interventions focused on the severely mentally ill mother-child dyad or on the mother and child in the larger family context.

Furthermore, in surveying the situation of chronically mentally ill women, Gonzales et al. (1991) noted that women are more subject to the strains of poverty, discrimination, and victimization than are men, and these stressors and ongoing strains are relevant to the high incidence of mental illness among women. Yet several record review studies indicated that children are rarely mentioned at all in treatment plans for mothers with SMI. DeChillo, Matorin, and Hallahan (1987) found that only 44 percent of charts recorded whether patients had children; Rogosch (1987) found that in only 19 percent of the records of severely mentally ill women with young children were these children ever mentioned. The lack of focus in the psychosocial rehabilitation or mental health treatment literature may stem from an underlying assumption that

if the mother is not able to take care of the child unassisted, the child should be removed from the home, or that such women should not have children at all.

By focusing on psychiatric disabilities and parenting for women only, we do not mean to contribute to the prevalent disregard of fathers' impact on their children. Rather, it has been established that few males with SMI are married, and even fewer have responsibilities for children. In contrast, women with SMI have normal fertility rates; usually either they are single parents or the fathers of their children are not severely mentally ill. Thus, we feel that the focus on mothers is justified.

The acuity of the need for interventions to help women with SMI is highlighted in a case study describing a mother and the course of an intervention aimed at helping her to parent her daughter (Gross, 1984). The mother had already lost custody of four children. The child in question was her fifth, born in her current marriage. Both mother and father were severely mentally ill; both had alcohol abuse problems; and both came from backgrounds involving alcoholism, physical abuse, and neglect. Neither had completed high school. In spite of intensive work involving family and individual therapy as well as a therapeutic nursery for the child, the mother had her child placed in foster care when the therapist was on a week-long vacation. This was the child's third foster placement. The parents finally decided to terminate their parental rights and allow the child to be adopted.

The case brings into sharp relief the multiple strains on mothers with SMI who not only have a mental illness but also lack resources in almost all other domains. Programs often focus on development of a secure attachment relationship for the mother-child dyad to help the mother foster the child's socioemotional and cognitive development. But as the case history suggests, the mothers sometimes lack the ability to sustain such a relationship over time without nurturance from others. Unfortunately, the therapist may be the only individual available to provide such support. Even a week's break in this nurturing may prove too stressful.

This case description also highlights the need to focus on both the mother and her child and to take into account the natural environment of the family unit. When intervention efforts focus on either the child or the mother outside of the home environment, difficulties are likely to arise. Experience suggests that parental cooperation is hard to elicit in programs designed to help children only (Stott, Musick, Clark, & Cohler, 1984; Stott et al., 1984). Because inpatient psychiatric treatment of a mother

disrupts her marital and family relationships, interventions logically should also focus on strengthening the family and preventing hospitalization.

## FINDINGS

Intervention programs for mothers with SMI and their children have used residential and hospital settings, day treatment settings, and outreach approaches. Residential and hospital settings, termed "mother-baby units," have served women with infants exclusively, and the other models have accommodated a wider age range of children. Details on the studies reviewed can be found in Table 1.

### Mother-Baby Units

Our review indicates that published English language reports of mother-baby psychiatric units in the past 10 years are all from the United Kingdom and Australia. A few mother-baby units were opened in the United States in the late 1960s; however, it appears that mother-baby units never gained much recognition or acceptance here (Stewart, 1989). The reasons for this are open to speculation and may include costs (estimated at three times that for mother-only admissions), staff anxiety over infant welfare, difficulty in finding staff trained to care for psychiatric adult patients and infants, lack of documentation of program effectiveness, or conflicts and treatment problems produced when staff must recommend that infants be removed (Buist, Dennerstein, & Burrows, 1990; Crossling, Brooker, & McGrath, 1988; Stewart, 1989). It is also possible that introduction of the programs in the United States after the beginning of the deinstitutionalization and normalization movements, as well as heightened economic pressures to reduce hospital length of stay, meant that these programs never really had a chance to take root. An exception to this trend is the opening of a mother-baby unit at a private psychiatric hospital in Boston (personal communication with J. Nicholson, assistant professor, University of Massachusetts Medical School, November 9, 1992). It may be that for the patient population that uses this service, needs outweigh cost considerations.

Coadmission of mothers with SMI and their infants was first initiated in London in the 1950s. The three rationales for coadmission are as follows: (1) Coadmission allows continuing mother-infant contact, obviating the deleterious effects of separation on bonding; (2) coadmission permits continuity in primary caregiving; and (3) coadmission enables staff to assess the patient's mothering abilities and to help develop needed skills and confidence (Melhuish, Gambles, & Kumar, 1988).

Mothers who require psychiatric hospitalization are admitted to these units with their infants, who are maintained in a nursery on the psychiatric ward and may or may not sleep with their mothers at night (Crossling et al., 1988). Reported hospital stays were approximately eight weeks in length (Buist et al., 1990; Stewart, 1989). Programs reported served severely disturbed mothers with chronic histories. However, patient demographics suggest an atypical population with more affective disorders represented (Stewart, 1989) and a higher percentage of patients married (Buist et al., 1990) or living with the infant's father than expected in the overall female population with SMI (Stewart, 1989).

Hospital programs expected mothers to spend time caring for and interacting with their infants and structured time for them to do so. In this way, staff assessed mothering strengths and problems; acted as role models; and provided supervision, training, or guidance in deficit areas. These programs also provided opportunities for family (especially father) involvement with the mother-child dyad as well as for the establishment of connections to community social services agencies, mental health providers, and mutual support groups.

No reports presented well-controlled evaluations of the effectiveness of any mother-baby unit. Stewart (1989) contrasted a treatment group with a comparison group and found all of the former and less than half of the latter caring for their children two years after discharge. However, it is likely that significant selection factors were operating; comparison group mothers had refused joint admission, were more often single parents, and were diagnosed with more personality disorders and substance abuse problems. In general, outcomes reported in the literature indicated that recovery from a psychotic episode was associated with improved interaction with the infant and greater caregiving abilities, even for thought-disordered and delusional patients (Buist et al., 1990; Stewart, 1989; Thiels & Kumar, 1987), perhaps with the exception of a small group of chronic schizophrenic patients (Crossling et al., 1988). Of course, it cannot be determined whether the results would have been the same with a regular psychiatric hospitalization.

Perhaps as a result of staff vigilance, admitted babies reportedly did well—there were no instances of severe illness or injury (Stewart, 1989). The Australian unit (Buist et al., 1990) reported some negative reaction from patients and staff. In particular, patients not admitted with an infant resented the attention demanded by babies, and staff may have preferred to care for the babies themselves rather than

**Table 1. Summary of Research Studies Cited**

Authors <sup>a</sup>	Sample Population	Database	Diagnoses	Ages of Children
Buist, Dennerstein, and Burrows (1990)	N = 47 mothers (three admitted twice), 44 infants Age range: 19–40 years 74% married	Admissions to a mother–baby unit in a psychiatric hospital in Australia over a 51-month period	38.3% major depression <sup>b</sup> 29.8% schizophreniform disorder 17.1% schizophrenia 8.5% bipolar disorder 4.2% anxiety disorder 2.1% deferred	6.7 to 16.5 weeks postpartum
Crossling, Brooker, and McGrath (1988)	Mothers with babies younger than 1 year	Information not provided	Development of psychiatric illness within 12 months of childbirth Preexisting mental illness that relapses during the puerperium Preexisting mental illness and ongoing symptoms Nonpsychotic mothers whose difficulties in the relationship with their babies gave rise to significant psychiatric symptoms	To 1 year postpartum
DeChillo, Matorin, and Hallahan (1987)	N = 121 charts (55% female) Mean age: 37 years 32% married; 31% single; 36% separated, divorced, or widowed 84% white SES: 46% I or II, 16% III, 3% IV 27% unemployed or on public assistance No. of children in household: 66% none or not noted, 17% one, 13% two, 3% three or four	Chart review of inpatient psychiatric service	55% major affective disorder; 16% schizophrenic; 12% substance abuse; 5% schizoaffective or atypical psychosis; 11% organic mental disorder, personality disorder anxiety, or adjustment disorder	34% noted the existence of a child younger than 19 years in the nuclear family of the patient

(continued)

**Table 1. Continued**

Authors <sup>a</sup>	Sample Population	Database	Diagnoses	Ages of Children
Gross (1984)	Case study: Age 38, married, did not complete high school	Agency providing intervention program to help mothers and their children develop a mutually satisfying relationship through treatment of the mother, the child, and the dyad	Schizophrenia with recurrent episodes of anxiety, paranoia, and hallucinations	Young children
Musick, Stott, Spencer, Goldman, and Cohler (1984)	Mentally ill mothers and their children	Information not provided	Information not provided	Younger than 5 years
Oates (1988)	N = 31	Presented to psychiatric services in Nottinghamshire, Great Britain	8 mania 2 schizophreniform 2 mixed affective psychosis 8 depressive psychosis 1 schizoaffective 1 manic-depressive psychosis	Preschool-age children or younger
Stewart (1989)	N = 32 joint admissions with infant N = 26 mother-only admissions	Admissions to a Canadian general hospital psychiatric unit that has occasional mother-infant admissions	Mother-infant admissions: <sup>b</sup> 56.3% major affective disorder 28.1% schizophrenia/schizophreniform 9.4% atypical psychosis 3.1% anxiety disorder 3.1% mental retardation	7 to 10 months postpartum
Tableman (1987)	Mothers diagnosed with a mental illness, 17 years or older, pregnant or with child from infant to 3 years Mothers needing a structured day program	Information not provided	Information not provided	Infant to 3 years

Thiels and Kumar (1987)	<p>N = 26                  Age range: 19 to 37 years                  Mean age: 28 years                  Age range of infants: 1 to 52 weeks                  Mean age of infants: 9.5 weeks</p>	Admissions to a mother-baby unit	<p>46% schizophrenic psychoses                  27% affective psychosis                  23% neurotic disorders                  4% drug-induced psychosis</p>	To one year postpartum
Waldo, Roath, Levine, and Freedman (1987)	<p>N = 31 (25 attended regularly for 6 months)                  Age range: 19 to 45 years                  Mean age: 26.7 years                  48 children (from 25 women)                  Age range of children: birth to 27 years                  Each mother had at least one preschool child</p>	Patients registered with a mental health clinic or a private psychiatrist	Schizophrenia	Through pre-school age

NOTE: SES = socioeconomic status.

<sup>a</sup>Information on programs for mothers with SMI were sought from PsycLIT, Medline, Wilson Indexes, and Dissertation Abstracts Ondisc databases for the years 1983 to 1992. A full listing of the 61 terms and term combinations describing interventions is available from the authors.

<sup>b</sup>Diagnosis made by consultant psychiatrist according to DSM-III (American Psychiatric Association, 1980).

develop the patients' mothering abilities. However, overall the authors felt that the advantages of having babies on the ward outweighed any disadvantages.

When considering the psychosocial rehabilitation framework, psychiatric hospital units providing simultaneous care for mothers and their infants use one of the framework's major methodologies—a skill development approach. The focus is on staff role modeling or teaching the patient how to understand, relate to, and care for her infant directly. The approach also involves environmental modification; the patient and child are hospitalized together to maintain the mother-child dyad. Rather than being taught mothering skills in the abstract, the mother can practice them under staff guidance. However, as in any inpatient context, attention to environmental modification is necessarily limited. What needs to be done to support the mother in her posthospital living arrangement and other environmental modifications cannot be addressed directly in the hospital. Perhaps hospital-based interventions are successful because they address a very select group of patients whose posthospital environments are supportive, for example, middle-class women, perhaps experiencing their first psychiatric episode, who have a spouse present. Despite the positive benefits of providing intensive skill-building experiences, mother-baby hospital units may have limited applicability or usefulness once women return to their community environments.

#### **Integrated Mother-Baby Units and In-Home Care**

Oates (1988) described the development of an integrated community-oriented service for women with severe postnatal mental illness in the Nottinghamshire Health District in Great Britain. The program was based on the knowledge and expertise gained from the local mother-baby psychiatric unit. A needs analysis found that 25 percent of women between ages 16 and 50 who required psychiatric care in the district had children younger than five and that women who needed care in the first year after childbirth were more severely mentally ill than the men presenting for care during the same time period. These findings underscored the importance of community care and the possible impact of maternal illness on the family unit.

Oates (1988) described interventions for 31 women during the study year who presented for care with a diagnosis of affective disorder or schizophrenia. To be included in the program, the women had to live within a 20-minute car ride of the hospital. They had to be diagnosed as not suicidal, and they had to have a reliable adult living in the home to take on care in the evenings. No specific inclusion or ex-

clusion criteria relating to the child's age were discussed, although it appears that all were younger than preschool. In-home care was provided by community psychiatric nurses, a social worker, a psychologist, and three psychiatrists.

At the most-intense level of intervention, a nurse spent eight hours each day in the mother's home, and a psychiatrist visited the home on alternate days. Nurses stayed in the home until relieved by a reliable family member who slept in the home with the mother and infant. At the second level of intensity, the nurse visited the home twice daily, spending at least two hours each visit. During her absence, a family member, trained volunteer, or other health professional was in the home. The psychiatrist visited the home twice a week. At the least-intensive phase, the community nurse visited the home every other day, alternating her care with family members and other health professionals. The psychiatrist visited the home weekly.

Most mothers began the intervention with an inpatient admission of one week to one month on the mother-baby unit and then received outpatient care for one to three months. According to the author, the course of the illness episode did not appear to be shorter than it would have been with traditional care. However, mothers were able to continue caring for their children and to remain in their home, an important outcome of the program according to Oates (1988).

Because skill development activities occurred both in the hospital and at home, this integrated program appeared likely to be better equipped to work on the environmental modification issues important within a psychosocial perspective. Intervention provided support and training in the client's natural environment as part of the home visits of the psychiatric nurse or psychiatrist. Yet the environmental focus appeared limited. Environmental supports outside the home were not considered, and treatment did not include development of natural support systems to provide informational, emotional, or instrumental assistance after the crisis. Apparently neither family dynamics nor the role of the live-in family member was a treatment focus. The interventions appeared to focus primarily on supporting the mother's efforts to care for the child on her own. The applicability of this modality is limited to those who have a reliable live-in family member.

#### **Home-Care Programs**

Concern about follow-up after inpatient stays and continuity of care in the community motivated development of the Home Care Program in Chicago; this program involved weekly, at-home, two-hour

visits by a trained psychiatric nurse or social worker, who worked intensively with the mother regarding the conflicts she experienced in her roles as wife, homemaker, and mother (Cohler & Musick, 1983; Musick, Stott, Spencer, Goldman, & Cohler, 1984). Child care, parenting, and family problems were targeted and community referrals made as needed to meet the family's physical and health needs, the mother's psychiatric needs, and the child's emotional and educational needs.

A project with similar goals was set up at Thresholds, a psychological rehabilitation agency in Chicago (Cohler & Musick, 1983; Musick et al., 1984). Here, women and their children attended an intensive center-based program three to five days a week, with home visits at least monthly. Clinical and therapeutic or rehabilitative services were provided. Services available included group sessions that were educational, clinical, and support focused (for example, stress management, household management, child development); a nursery and child care setting to provide a stable daytime environment; caregiving adults and growth-enhancing activities; child care workers who modeled caregiving activities for the mothers in the nursery; and periodic assessments of the child's development.

The program also provided transportation to and from the agency, on-site snacks and lunch times for the mothers and children to be together, and videotaping of mother-child interactions to provide feedback. The program structure provided the mothers with assistance in crisis intervention, alleviating the problems brought on by economic deficits and psychiatric illness; supportive treatment for better parenting; and insight therapy to resolve issues that interfered with parenting.

In a comparison research study of the Thresholds versus Home Care programs in Chicago, women were recruited from inpatient psychiatric clinics and private practices of mental health professionals (Cohler & Musick, 1983; Musick et al., 1984). To participate, a woman had to be at least 18 years old; have a child younger than five; have a diagnosis of psychosis; and have no history of drug addiction, alcoholism, or mental retardation. Mothers were assigned to one of the two programs randomly, subject to geographic constraints. The attrition rate was 51 percent from time of initial contact ( $n = 83$ ) to the one-year posttest ( $n = 42$ ). The authors suggested that one reason for the high attrition rate was the high rate at which mothers lost custody of their children.

Mothers who remained in the Thresholds or Home Care programs showed significant improve-

ment in adjustment to work and parenting roles and in cognitive performance. Children in both programs showed improvements over time in developmental and cognitive measures, social competence, and adaptive skills. No significant differences were found between the two treatment groups on any of the maternal measures. Both programs had a positive impact on those who received the interventions, and despite program differences, they were not distinguishable in terms of measured outcomes.

Tableman (1987) described Detroit's Loving Attachment of Mothers and Babies (LAMB) program, which targeted severely disordered schizophrenic and depressed mothers of very young children. It was modeled after the mother-child program at Thresholds. For the child, the program sought to minimize the deleterious effects of parental disorder, to stabilize caregiving, and to facilitate normal cognitive and socioemotional development. For the mother, the LAMB program attempted to reduce rehospitalization and to increase competence as a parent (Cohler & Musick, 1983; Gonzales et al., 1991). Service delivery objectives focused on increasing attachment between mother and child; facilitating appropriate child care practices; reducing the mother's psychological distress, social isolation, and environmental stress; increasing social support; maintaining physical health; and dealing with other problems facing the child. The evaluation of the LAMB program in Detroit is still under way (Gonzales et al., 1991).

Similar in goals yet less intense in structure is the Denver Mothers' and Children's Project (Waldo, Roath, Levine, & Freedman, 1987). The program focused on teaching mothering skills to schizophrenic mothers, monitoring the developmental progress of their children, and providing early intervention when needed. Mothers had to be diagnosed as schizophrenic and had to have a preschool child with whom they had an ongoing relationship. The children lived at home or in a temporary foster home, and the mothers received ongoing care from a community mental health clinic or private therapist. Mothers were visited once at home for an assessment and then met with their children once a week for 2½ hours at a local church. There they played with their children under the guidance of a child development expert. Children then played in a therapeutic nursery setting while mothers either discussed problems with staff and other mothers or met privately with the child development expert. Mothers were also involved in a therapeutic group to discuss parenting, with specific group direction determined by the mothers.



Waldo and his colleagues (1987) reported that over the five-year period from 1982 to 1987, 52 women applied to the project and 31 were accepted. Those who were refused either did not have preschool children, were not confirmed to have a diagnosis of schizophrenia, or were currently being investigated for life-threatening child abuse. Of the women accepted, 25 participated regularly for at least six months. An evaluation of these mothers showed that fewer children entered foster care while their mothers participated in the program and that the mothers were more likely to continue with their own treatment, resulting in almost no psychiatric hospitalizations. This program appears to have helped women on specific issues of parenting when they were concurrently receiving treatment for other life problems as well as their mental illness. However, the Denver Mothers and Children's Project appears to have focused on mothers who were better educated and more highly functioning than the mothers in the programs previously described. Those programs involved intensive effort and human resources to reach out to women who were difficult to serve and often drop out of longer-term programs.

The community-based home-care programs described addressed environmental and contextual issues of mothers and their children and were therefore closer to the psychosocial rehabilitation framework than inpatient programs. The interventions attempted to help the mothers build a social support system, including other clients, and tried to provide referrals to outside resources that could address the family's needs. Mothers and their children appeared to improve with treatment, although documentation is limited. This may be a function of weak or nonexistent research designs used for evaluation. However, the fact that so many women with SMI drop out of these mothering programs and the selectivity in program entry standards strongly suggest that an exclusive and nonrepresentative group was being served. As a result, we question the generalizability of these interventions. Furthermore, a major focus of these programs was improvement of the mother's parenting skills and knowledge about child development. Less attention was given to socioeconomic context, barriers that constrained effective parenting or program participation, or modification of the mother's formal and informal environments. Such contextual issues may include need for assistance in finding better housing to accommodate a child (in terms of interior space, outdoor safety, play space, transportation access, and so on) or in arranging for increased housekeeping or child care assistance.

A contextual focus would lead to increased attention to such issues as the adequacy of the social, emotional, and informational support systems the mother has both to meet her own social and emotional needs and to carry out her role as caretaker. A related concern within such a framework is the response of significant others to the woman's parenting status and psychiatric disabilities and the ways in which this response affects the woman and her child. Participant feedback from clients of the Thresholds program indicates that mutual support was one of the major perceived benefits and reinforces the importance of contextual issues (Musick et al., 1984).

## DISCUSSION

As the social work community becomes more sensitive to the diverse needs of individuals with SMI, a focus on vocational rehabilitation will no longer be sufficient. Although even basic information on mothers with SMI is scarce, mental illness appears to have little impact on fertility or the likelihood of having children (Mowbray, Zemencuk, & Oyserman, 1993; Oyserman et al., 1992). Yet our literature search identified relatively few programs that target severely mentally ill mothers and their children. Evaluations of these programs are inadequate; even so, it appears that concern about program coverage and outcomes is warranted. An assessment of available interventions from a psychosocial rehabilitation perspective revealed that although all had some components of the framework, none fully reflected its principles. Of particular concern are the following three components of the psychosocial rehabilitation framework:

1. assessment of the mother's environment: Environmental deficits may be critical as mothers with SMI tend to be single parents, often live in inadequate housing, have limited social networks, and lack social and emotional supports (McNeil, Kaij, & Malmquist-Larsson, 1983; Miller, Resnick, Williams, & Bloom, 1990; Rogosch, 1987; Rudolph, Larson, Sweeny, Hough, & Arorian, 1990).
2. assessment of the mother's strengths: The reports reviewed failed to describe mothers' competencies or to attend to the meaning of parenting for the women themselves. The adult development literature discusses the positive aspects of parenting, not just the burdens (for example, Oyserman et al., 1993). The psychosocial rehabilitation literature has provided anecdotal reports of the rewards and enhanced competencies that people with SMI experience related to having children (Schwab,

Clark, & Drake, 1991). For normalized outcomes to occur, assessments must be informed by this perspective.

3. assessment of barriers to program participation and attainment of parenting goals: Such assessment was lacking in the programs described. Many programs did not report addressing issues beyond the mother-child dyad or the home. Yet lack of attention to barriers is likely to contribute directly to the bias, selectivity, and high dropout rates programs experience. For example, mothers and members of their families may be reluctant to request parenting assistance for fear that such requests will increase scrutiny by child welfare agencies and thus increase the likelihood of having the children taken away from them. Additionally, more attention to what the mothers feel they want and need may increase the relevance of interventions to the women targeted for participation and therefore their initial and continuing involvement.

These assessments need to be integrated and developed into a comprehensive plan containing interventions that build on existing strengths and produce improvements in skills and knowledge within a strengthened social context. Where possible, in vivo environmental modification of family functioning; mothers' social, economic, and other supports; and child care and living arrangements should be program components.

Social workers aware of the gaps in current specialized programs for mothers with SMI can use their knowledge to advocate for new service development. Where service development opportunities are limited, social workers can use these suggestions for assessment and treatment planning to improve their own practice. At the most basic level, social workers need to be aware of the parenting demands that their clients with SMI face and how clients feel about their family situations. The ecological perspective that characterizes social work practice should complement a psychosocial rehabilitation framework to improve outcomes for seriously mentally ill women and their children.

## CONCLUSION

Following a psychosocial rehabilitation perspective, there is no reason to assume that women with SMI cannot function as mothers. Severely mentally ill women with children should be able to meet their rehabilitation goals—including parenting—when provided with the appropriate rehabilitation assistance. Interventions that address parenting as a re-

habilitation goal must concentrate equally on modifications of environments and social-structural contexts that support mothers and individual skill and knowledge development, acknowledging the mother's strengths and her choices about parenting.

Individuals with SMI are likely to live with families and to raise families of their own. If social workers do not provide assistance in this process, the profession is not truly meeting these women's needs. Social workers should assess the needs of mothers with SMI using objective standards. They should also consider the mothers' perspective on their problems, including a determination of the extent to which improved parenting is among their rehabilitation goals. Intervention approaches for severely mentally ill mothers and their children based on such assessments would be in the spirit of true psychosocial rehabilitation. **HSW**

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