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Mental health services have generally ignored the parenting needs of women with serious mental illness. This chapter identifies the parenting risks and strengths that these women display, as well as the opportunities available to psychologists to play a key role in improving mother and child outcomes.

Mothers with Serious Mental Illness

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We're related to each other in ways we never fully understand, maybe hardly understand at all. He was always the real reason for coming out of the hospital. To have let him grow up alone would have been *really* wrong. . . . I haven't been carrying him at all. He's been carrying *me!*

Pirsig (1974, p. 409)

In the first half of the twentieth century, individuals with serious mental illness often spent most of their lives confined in institutions. Deinstitutionalization and the wider availability of community-based treatments produced many ramifications for consumers, families, service providers, and society at large. Often noted are the burdens placed on families to care for ill relatives, increased homelessness as individuals with mental illness were no longer housed by the state, transinstitutionalization (discharging older adults with mental illness into nursing homes), and criminalization (numerous individuals with mental illness allegedly sent to jail for status offenses or minor crimes). The policy and practice changes developed to address or prevent these problems have included family education and support services, increased residential options (independent and dependent living) with housing supports provided, stricter laws and procedures governing Medicare reimbursements for skilled nursing home care, jail diversion programs, and education and training (supported employment and supported education)

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through psychosocial rehabilitation, and vocational rehabilitation programs, designed to move more individuals into self-sufficiency.

What is seldom recognized are the implications of deinstitutionalization for marriage, childbearing, and the parenting roles of individuals with serious mental illness. Indeed, although a substantial body of literature addresses the problems of children whose parents have a psychiatric disability, there are relatively few research data available, especially with diverse populations, on the number and characteristics of parents with mental illness, their strengths and deficits, and how these factors affect parenting quality. Nor is there much documentation or shared knowledge among mental health researchers or practitioners. When Daphna Oyserman and I undertook our first grant application to the National Institute of Mental Health, “Women with a Serious Mental Illness: Coping with Parenthood,” we received mixed responses. Some colleagues reacted with disbelief that this was even a population for us to study: “Do female mental patients have children? Can they keep them?” On the other hand were responses like, “Why study mentally ill women with children? How is their situation different from that of any other low-income, urban sample of mothers?”

The gaps in our professional research and practice knowledge base concerning the interrelationships between parenting and mental illness are such that one might find a deeper understanding in humanities and literature, exemplified by the quotation from *Zen and the Art of Motorcycle Maintenance* at the beginning of this chapter. *Zen* is a narrative of a motorcycle adventure undertaken by the main character and his son. Although we are given hints throughout the story, we do not learn until the end of the book that this father has been seriously mentally ill and previously institutionalized; he has consciously suppressed these experiences. However, in the last chapter, the father realizes that his previous belief—that *he* was supporting his son, Chris—was wrong, and it is the other way around: that it is *his* role as a parent and *his* contacts with his son that have supported him in recovery from mental illness.

In this chapter, we seek to correct some of the deficiencies in the professional literature on parenting and mental illness concerning the demographics of parents with a mental illness, the risk factors and supports they experience, their parenting attitudes and behaviors, and what predicts parenting outcomes. The information presented comes from the available literature and our ongoing study of women with serious mental illness who are mothers. We put special emphasis on our own findings for several reasons, including the fact that we are proud of the quality and completeness of the data; we know the effort in time and resources required to assemble this database, and we are consequently motivated to see its findings used. Equally important, we believe that this is the largest U.S. longitudinal study undertaken of mothering among women with mental illness, recruited from the public sector, an especially important point, since it means that this sample has much diversity and differs substantially from many other studies, which have typically involved samples overrepresenting women who are

married, white, or middle income (see, for example, Oyserman, Mowbray, Allen-Meares, and Firminger, 2000).

In the MOMS study (our nickname for the NIMH grant on Coping with Motherhood),¹ women were recruited from community mental health centers (CMHCs) and hospitals serving public patients in metropolitan Detroit. The following criteria were used for including women in the study: ages between eighteen and fifty-five, with a serious mental illness (duration greater than a year; diagnoses primarily of schizophrenia, major affective disorder, or bipolar disorder; and causing major dysfunction in one or more life areas), and having care responsibilities for at least one child between the ages of four and sixteen. Participants were 60 percent African American, 29 percent Caucasian, 8 percent Hispanic, and 3 percent other racial and ethnic groups. Except for an overrepresentation of Hispanics (which was purposeful, to allow separate examination of data from this subgroup), the demographics mirrored the composition of the population in treatment in 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 percent having some college or beyond, 25 percent a high school diploma or general equivalency diploma, and 35 percent less than a high school education. Participants' median age was 36.2 years. Out of 484 eligible women identified from CMHCs or inpatient units, 59 (12 percent) refused and 46 (10 percent) could not be contacted or scheduled, resulting in a baseline sample size of 379. These women were given a Diagnostic Interview Schedule (NIMH, 1980) by trained interviewers and also interviewed about their demographics, including living arrangements, clinical history, symptoms, and community functioning, as well as their parenting attitudes, behaviors, and beliefs.

Parenting and Mental Illness: Demographic Data

The research indicates that many persons with mental illness have children. Women with mental illness have normal fertility rates and bear an average or above-average number of children (Saugstad, 1989; Buckley, Buchanan, Schulz, and Tamminga, 1996); reports range from 1.9 to 2.4 children (1.9, Wang and Goldschmidt, 1994; 2.0, Caton, Cournos, Felix, and Wyatt, 1998; 2.1, Zemencuk, Rogosch, and Mowbray, 1995; 2.2, Nicholson, Sweeney, and Geller, 1998a; 2.4, Nicholson, Nason, Calabresi, and Yando, 1999). In the MOMS study, the 379 women in our sample were mothers of 1,082 children, or a median of three children per mother. Research indicates that the vast majority of persons with mental illness who are identified as parents are women (Nicholson, Nason, Calabresi, and Yando, 1999); women with mental illness are more likely to marry than men (National Institute of Mental Health, 1986) and are less likely to be childless (Saugstad, 1989). Ten to 15 percent of pregnant women develop a mental illness postpartum (Downey and Coyne, 1990; Oates, 1988).

Data are less clear concerning the extent to which women with mental illness who are mothers are carrying out parenting responsibilities. Reported estimates are that 9 percent of females receive intensive case management services, 10 percent of women are in mental health–supported housing (Blanch and Purcell, 1993), 25 percent are dually diagnosed clients (Schwab, Clark, and Drake, 1991), 32.5 percent are Assertive Community Treatment clients (Test, Burke, and Wallisch, 1990), and 46 percent of adult females are receiving routine case management (White, Nicholson, Fisher, and Geller, 1995). In the MOMS study, we calculated that about one-third of a possible 1,315 women, listed in the management information systems of the three largest agencies, had minor children as dependents (Mowbray and others, 2000b). Although these estimates of prevalence vary widely, even the lowest of these rates would indicate that parenting is a substantial issue that needs to be addressed for women with mental illness. It is also not clear the extent to which mothers with serious mental illness lose custody of their children, with reported lifetime rates ranging from 28 percent to 60 percent (Miller and Finnerty, 1996; Bazar, 1990; Coverdale and Aruffo, 1989; Test, Burke, and Wallisch, 1990). Analyses of some court decisions concerning termination of parental rights for women with serious mental illness suggest that these women may experience discrimination (“Termination of Parental Rights,” 1985, 1986a, 1986b), and according to some state statutes, custody can be lost through diagnosis of mental illness per se, absent any allegations of abuse or neglect. In any case, custody concerns figure prominently for mothers with mental illness (Cook and Steigman, 2000).

Risk Factors and Lack of Support for Parenting

As is the case for many persons with psychiatric disabilities (Rogler, 1996), mothers with long-term mental illness are usually poor (Goodman and Johnson, 1986). In our MOMS study, more than two-thirds were living below the poverty line, 78 percent were currently unemployed (Mowbray and others, 2000a), 41 percent received federal welfare assistance (Aid to Families with Dependent Children/Temporary Assistance to Needy Families), and 48 percent were on Supplemental Security Income or Social Security Disability Income. Not surprisingly, 57 percent of these mothers were not satisfied with their financial situation. The income levels of these women were substantially lower than those of other adults living in the same census tracts (Mowbray and others, 2000b).

Mothers with mental illness are more often divorced or never married, raising their children as single parents (Cohn and others, 1986; Downey and Coyne, 1990; Mowbray, Oyserman, and Ross, 1995; Rogosch, Mowbray, and Bogat, 1992). In the MOMS study, only 40 percent of participants were currently married or living with a partner; the remainder were equally likely to be never married or previously married (Mowbray and others, 2000b). Even

those women with a mental illness who are married often experience marital conflict (Cox, Puckering, Pound, and Mills, 1987; Downey and Coyne, 1990; Krener, Simmons, Hansen, and Treat, 1989) and are more likely to marry a spouse with a psychiatric disorder (Keitner and Miller, 1990; Lancaster, 1999; Rutter and Quinton, 1984). When depressed persons have psychiatrically disturbed spouses, their own symptoms are more severe, and marital disturbance is more likely (Puckering, 1989; Quinton, Rutter, and Liddle, 1984).

Social support for mothers with mental illness is problematic in a number of other ways. Support or assistance received from the fathers of their children is typically low (Mowbray, Oyserman, and Ross, 1995). Conflicts with extended family are reportedly common (Nicholson, Sweeney, and Geller, 1998b), as is social isolation (Cox, Puckering, Pound, and Mills, 1987; Downey and Coyne, 1990). In the MOMS study population, the average number of supporters in women's social networks was significantly lower than that of a less disabled mental health population but comparable to that of other disadvantaged women (Mowbray and others, 2000a). The stress of parenting under conditions of poverty, social isolation, and marital discord is known to decrease sensitive and responsive parenting behaviors (Miller-Loncar, Landry, Smith, and Swank, 1997) and increase risks for negative outcomes in children (Davies and Windle, 1997; Hops and others, 1987), likely causing further stress and symptomatology for mothers.

Women with a mental illness also tend to live in adverse physical environments. Pregnant women with severe mental illness were often undomiciled or homeless according to several research studies (Miller, 1990; Rudolph and others, 1990), and in qualitative research, these mothers have reported difficulty finding acceptable housing for themselves and their children (Sands, 1995). MOMS study participants reported mixed feelings about their neighbors and neighborhood safety, appearance, and cleanliness, rating their neighborhoods substantially lower than did a comparable national sample (Mowbray and others, 2000b).

Besides these stressors from living arrangements and relationships, mothers with serious mental illness are subject to stressful life histories and current living circumstances. Research on incidence rates of childhood abuse demonstrates a significantly higher occurrence among women with mental illness compared to the general adult female population (Siegel and others, 1987). Incidence of childhood sexual assault reported by female psychiatric patients ranges from 20 to 51 percent in inpatient settings and 22 to 54 percent in outpatient settings, compared to 6 to 15 percent for the general population (Bifulco, Brown, and Adler, 1991).

Mothers with mental illness also experience more negative recent life events (Webster-Stratton and Hammond, 1988). In the MOMS study, half or more of the respondents reported experiencing the following in the previous twelve months: a psychiatric crisis, major money crisis, or the death of a close friend or relative. Furthermore, more than one-third reported major

separations from their children or a serious illness or injury to themselves, and one in seven reported being physically or sexually assaulted (Mowbray and others, 2000a). Participants in the MOMS study had significantly worse health status than a comparable sample of women who were aged eighteen to forty-five, of lower economic status, and living in a midwestern city (Mowbray and others, 2000a).

Treatment Availability

Accessible and appropriate mental health services should ameliorate the effects of these risk factors. Unfortunately, needed mental health services are often not available to adults with serious mental illness. Nationally, mental health service as a percentage of health care expenditures has recently been declining; historically, services to persons with serious mental illness have been inadequately funded and insufficiently available (Mechanic and McAlpine, 1999). The mental health services that are provided often decontextualize individuals with serious mental illness from their environments, seeing only “patients” and not people. So, for example, histories of current or past sexual abuse among women with serious mental illness are seldom explored by mental health professionals (Jacobson and Richardson, 1987). According to a New York statewide task force, mental health providers generally view service recipients as patients rather than as family members or parents (Blanch, Nicholson, and Purcell, 1994). It is thus not surprising that parenting and child care concerns are usually ignored by mental health providers who are working with adults with serious mental illness. That is, the extent to which women enrolled in ongoing mental health interventions typically receive treatment that addresses or even considers their needs as mothers or the needs of their children appears to be minimal. For example, 44 percent of psychiatric inpatient records at a private teaching hospital did not indicate whether the patient had children; when parenthood was documented, the whereabouts of children was recorded in only 20 percent of cases, and children were contacted in only 32 percent of cases (DeChillo, Matorin, and Hallahan, 1987). In a state psychiatric hospital study, only 19 percent of records of mothers mentioned the woman’s children. Few state information systems even collect data about whether mentally ill patients have young children (Nicholson, Geller, Fisher, and Dion, 1993). And this situation is not confined to American psychiatry: in a Danish study, 40 percent of psychiatric inpatients had never received professional help related to their children, despite the fact that child psychiatrists who were reviewing records found “reason for concern” in regard to 77 percent of these children. Contrary to prevalent assumptions, 80 percent of these parents when interviewed said they would not be afraid to ask for help; only 10 percent mentioned fear of the authorities as a basis for their reluctance to seek assistance (Wang and Goldschmidt, 1996).

Not only are risks for mother and child often ignored by mental health professionals, but women with a serious mental illness may receive more services to help them cope with daily living tasks when they do not have children or child care responsibilities than when they do. Thus, it has recently been argued that in Great Britain, sheltered living environments (such as group homes) are provided only to women not caring for children; women with children must either make it on their own or lose custody of their child (Perkins, 1992). We were unable to find any published evaluation of an ongoing program in the United States that provides a sheltered living environment for mothers with mental illness and their children. Cook and Steigman (2000) have recently described supported housing and residential programming specifically designed for consumer parents. A number of specialized outpatient programs supporting mothers with serious mental illness have also been reported (Cohler and Musick, 1983; Cook and Steigman, 2000; Gonzales and others, 1991; Oates, 1988; Stott and others, 1984; Tableman, 1987; Waldo, Roath, Levine, and Freedman, 1987), although their numbers are limited. Unfortunately, available evaluations document high dropout rates in long-term programs, and studies using careful research designs have been unable to document improved outcomes resulting from such programs (Oyserman, Mowbray, and Zemencuk, 1994).

In the MOMS study, the vast majority of participants (96 percent) reported having used some type of mental health services during the past three months—typically outpatient or case management. Overall, mental health services were seen as “somewhat helpful” by participants. However, on a specific item concerning how much their mental health services helped with the problems of being a parent, women’s responses were significantly lower, on average, than for the other eight scale items. Furthermore, when asked to whom they would turn for support and advice about being a mother, only about 20 percent of respondents listed a mental health provider (Mowbray and others, 2000a). Approximately half of the respondents provided an answer to an open-ended question about additional mental health services they needed. Responses mentioned by 25 percent or more included more control over therapy, availability of group therapy and self-help, child care and help with transportation, more financial resources, and skill training in parenting or household management. In another small, qualitative study, mothers with mental illness mentioned the need for assistance in financial and household management (Mowbray, Oyserman, and Ross, 1995). A Danish study of psychiatric inpatients found that about one-third expressed a need for additional assistance with their children, mainly involving accessing child psychotherapy, relationships with foster care families, assistance with improving parenting competence, and practical help at home. Many of these patients emphasized the importance of offering help at an early stage and of involving the whole family in better understanding the parent’s mental illness (Wang and Goldschmidt, 1996).

At-Risk Parenting

According to our recent review (Oyserman, Mowbray, Allen-Meares, and Firminger, 2000), research studies have consistently found that with children aged preschool and older, mothers with a serious mental illness, in comparison to non-mentally ill mothers, are significantly less emotionally available, less reciprocal, less involved, less positive (Musick and others, 1984; Stott and others, 1984), less encouraging (Scherer and others, 1996), less affectionate and responsive (Goodman and Brumley, 1990), less able to differentiate their own needs from those of the child (Cohler and others, 1980), and more disorganized and inconsistent (Davenport, Zahn-Waxler, Adland, and Mayfield, 1984).

Maternal mental illness is clearly a risk factor for children. Children whose mothers have a long-term, serious mental illness are at increased risk of being placed in alternative settings such as foster care (Oyserman, Benishti, and Ben Rabi, 1992), and in their lifetimes, from one-third to more than half of these children will themselves have a diagnosable disorder (Amminger and others, 1999; Jacobsen, Miller, and Kirkwood, 1997; Waters and Marchenko-Bouer, 1980). Early childhood and early to mid-adolescence appear to be the ages of heightened risk, according to Beardslee and Wheelock (1994). These authors note the lack of attention to treatment or prevention services for children of depressed parents.

In the MOMS study, we asked mothers to complete a Child Behavior Checklist (Achenbach and Edelbrock, 1983) on a target child, typically one of school age. Age-adjusted comparisons showed that scores of all groups of children differed significantly from those of a normative sample. Furthermore, the overall behavioral problems of girls as well as the internalizing behavior problems of boys were comparable to those of clinical samples (Mowbray and others, 2000b).

Some of the association between the psychiatric problems of mothers and their children may reflect the heritability of major mental illnesses (estimated at 80 percent for bipolar disorder, 34 to 48 percent for depression, and 75 percent for schizophrenia; Rutter, Silberg, O'Connor, and Siminoff, 1999). However, according to other research, mental illness in offspring reflects significantly less adequate parenting skills and behaviors in these mothers compared to those of non-mentally ill mothers (Oyserman, Mowbray, Allen-Meares, and Firminger, 2000). Our own research suggests a limited relationship between mothers' diagnoses and parenting variables; contextual factors and mothers' current symptomatology and functioning play a much larger role.

Many existing studies of the parenting of women with serious mental illness display serious gaps. Consistently this research has employed a deficit perspective, examining only mothers' problems, not their strengths. Data are collected from mental health providers, clinical records, behavioral observations, or quantified self-report questionnaires, with only lim-

ited options for describing positive parenting. Positive parenting is more likely to emerge from qualitative assessments of how women feel about children and the mothering role, which allow women's answers and perspectives to emerge rather than being fit into investigator-predetermined, deficit, and problem-oriented categories. Finally, the research has been extremely limited in its efforts to examine systematically the effects of environmental factors like economic levels, social support, or culture on parenting outcomes. This is a severe limitation, since mental illness covaries significantly with numerous socioeconomic factors that also predict problematic parenting, such as poverty level, stressful life events, single parenthood, isolation, and lack of support (Oyserman, Mowbray, Allen-Meares, and Firminger, 2000).

Parenting: The Mothers' Perspective

In the MOMS project, we attempted to correct for some of the deficiencies in previous studies. Thus, we included a number of different ways to ask women about their orientation to parenting. We asked mothers in the study about the importance of the parenting role in comparison to other adult roles. We found that their ratings of the parenting role item averaged at the upper end of the scale—the highest mean and the lowest variance of all eleven family, personal, and social or work roles rated, indicating its primacy in women's self-perceptions. Women also reported high parenting satisfaction (averaging nearly 4, on a 5-point scale); parenting stress (Parenting Stress Index, Abidin, 1990) was reported at midrange on average (Mowbray and others, 2000b).

To get additional information on the participants' perspectives, each woman was asked a series of six open-ended questions concerning the advantages and disadvantages of motherhood, something that made her feel really good or really bad about being a mother, changes in her life brought on by motherhood, and what about being a mother was most important to her. These answers were coded into categories that encompassed six domains: personal benefits and personally rewarding aspects of motherhood (for example, having children means there is someone to help you and keep you company); personal stress due to parenting (for example, being a mother means being worried about what may happen to the child); motherhood as providing support and developmental context for the child (for example, being a mother means cleaning and cooking for a child and giving him or her love); the child as a burden (for example, being a mother means suffering through children's tantrums and bad behavior); motherhood as a valued social role (for example, being a mother means sharing holidays and other times with family and friends and feeling fulfilled as a woman); and mental illness as an aspect of motherhood (for example, being a mother means being careful with medication and staying in treatment because of children).

For nearly all participants, motherhood involved a focus on the child, and children were primarily perceived as a resource—a source of emotional support and positive self-feelings. Motherhood and being a parent are clearly central and important roles to many of the mothers in the study. In the words of one mother, “Motherhood has fulfilled my life. I don’t know what I’d do without my kids. That’s the God’s honest truth. I don’t know what I’d do without my kids.” Over 90 percent of mothers mentioned provision of care and support to their children and the personal benefits of motherhood, and almost three-fourths of women saw motherhood as an important social role. In addition, though, about half described motherhood in terms of the burden of child rearing, and about 30 percent of mothers mentioned dealing with their mental illness. Motherhood was a source of personal stress for most.

Thus, to these women with mental illness, motherhood is simultaneously critical to personal happiness and also a source of everyday psychological distress; it means both the provision and the receipt of love and support and is a social role that carries status in society. On a day-to-day basis, motherhood means shared experiences and provides a reason to stop personally destructive behavior and to deal with one’s mental illness. But motherhood is also perceived as a constraint, a role that takes away personal freedom—one that exacerbates feelings of inadequacy and lack of control. Finally, for many mothers, motherhood carries with it straining economically and forces them to deal with stressful child-rearing and discipline issues.

These results parallel those from other recent research, identifying the positive and motivating effects of parenting for individuals with psychiatric disabilities. In these smaller, qualitative studies, mothers with serious mental illness have identified motherhood as a central force for keeping them involved in treatment, a key outlet for expression of feelings of care and concern, and a valued, normative social role (Mowbray, Oyserman, and Ross, 1995; Nicholson, Sweeney, and Geller, 1998a; Perkins, 1992; Sands, 1995).

Predictors of Parenting Attitudes and Behaviors

Research is quite consistent concerning the problematic outcomes for children of mothers with mental illness and the fact that these mothers are significantly different compared to non-mentally ill mothers on their positive parenting attitudes and behaviors. Many factors in the mothers’ clinical histories have been proposed to account for these differences. Studies have, in fact, found significant relationships between parenting measures and diagnosis (for example, Downey and Coyne, 1990; Hammen, 1997), current severity of disorder (Radke-Yarrow, Nottelmann, Belmont, and Welsh, 1993; Frankel and Harmon, 1996), and chronicity (Gross, 1983; Rogosch, Mowbray, and Bogat, 1992). However, so far nothing in the published literature has identified the inde-

pendent effects of each of these clinical history variables (diagnosis, symptom severity, chronicity) or their effects independent of co-occurring conditions.

Since clinical characteristics of mothers with serious mental illness are so heterogeneous and vary by demographic variables such as poverty status, research on parenting outcomes should use multivariate techniques with covariate control variables to address this complexity. A few studies have done this. Gordon and others (1989), through a series of hierarchical regression analyses, established that chronic stress was a significant and independent predictor of maternal communication quality above and beyond the contribution of current symptoms. Hamilton, Jones, and Hammen (1993) reported that high levels of chronic stress, lower rates of positive life events, and single parenthood were significant predictors of affective style for mothers with mental illness. Once these variables were taken into account, maternal diagnostic status was not a significant predictor. Finally, a longitudinal study of mothers from an inner London borough found little evidence of maternal depression predicting child behavior problems after differences in socioenvironmental stressors (such as overcrowding) were taken into account (Ghodsian, Zajicek, and Wolkind, 1984).

In our own research, we have found that positive parenting attitudes and viewing the child as a burden (variables obtained through scaling of responses from the meaning of motherhood questions) were both significant predictors of scores on Parental Nurturance (subscale of the Block Child Rearing Practices Scale; Rickel and Biasatti, 1982) and the Parenting Stress Index (Abidin, 1990). These dimensions of the meaning of motherhood are in turn predicted by variables such as the extent of daily hassles, community functioning, having a substance abuse history, and number of people available for social support (Oyserman, Bybee, Mowbray, and Kahng, 2000). The results suggest that women's parenting practices can be affected by their attitudes toward their children and seeing themselves as efficacious parents. Parenting practices are also affected by the context in which women live—the extent of hassles and economic stressors versus available social support. These are all variables that may be affected by treatment and prevention interventions, many of which have been developed, evaluated, and disseminated by psychologists.

Roles for Psychologists in Improving Services to Mothers with Serious Mental Illness

In other reports (Mowbray, Oyserman, Lutz, and Purnell, 1997; Oyserman, Mowbray, Allen-Meares, and Firminger, 2000), we have identified a number of service implications based on our own results and those reported in the literature. Intervention strategies noted include education and building awareness in clinicians, parenting assessments, and special programs developed for psychiatric consumers who are mothers. These recommended service activities follow.

- Educating clinicians to the likelihood that women with a serious mental illness have or will have children, and that parenthood needs to be an important component of treatment planning and case management services from their initiation. Psychologists have already demonstrated with diverse subgroups of non-mentally ill parents that children play an important role in adult social status and meaningfulness of women's lives. Psychologists need to be involved in services to persons with psychiatric disabilities and share these same conclusions with providers. Joanne Nicholson, a psychologist in the Department of Psychiatry at University of Massachusetts Medical School, is forging new awareness of parenting issues for adults with serious mental illness through her Parenting Options Project. In collaboration with the Massachusetts Department of Mental Health and funded through the National Institute on Disability and Rehabilitation Research, this project is developing resources for these parents, conducting workshops for service providers, and supporting the development of specialized services for parents statewide and at select clubhouse locations.

- Offering relevant periodic assessments of children in response to mothers' concerns and in order to determine changing needs for parenting resources and supports. The particular focus of each assessment will be individually based but could include, for example, testing and observation of children's attachment, social skills, and early signs and symptoms of mental and emotional disorders. For the mothers, as part of annual treatment planning, assessments of parenting should be offered, to include parenting stress, skills, and knowledge; attitudes and feelings toward nurturing and discipline of children; and parenting style. Assessments should also include mothers' past and current histories of experiencing interpersonal violence; separations from their children and their parents; available social support and parenting role models; living arrangements; negative life events; and chronic stressors—factors that can affect positive parenting and have often been identified as problematic for women with serious mental illness. The mother's situation regarding these variables is likely to affect her ability to parent significantly and the type of interventions that are warranted.

Psychologists are well trained in assessments of children and adults. They need to be aware of factors that are specifically relevant to women with mental illnesses (such as current or past histories of physical and sexual assault) and ensure that their skills also encompass assessment of these contextual and external circumstances. Nicholson, through the Parenting Options Project, has developed an assessment of parenting strengths and needs specifically designed with and for parents with severe mental illness (Cook and Steigman, 2000).

- Offering education and skill training for all female consumers who are parents. Many research reports, from clinician judgments and based on stated preferences of consumers, are converging in the need for mothers with mental illness to increase their skills in household and money management, because finances often put them below the poverty level and eco-

conomic problems can create extreme financial stress, especially when they have to deny children's requests. Many mothers with mental illness have also mentioned their difficulties in determining whether, how, and when to provide information about their mental illness to their children and other family members. Some research suggests that children who understand and accept the parent's mental illness as separate from their own functioning have fewer problems (Beardslee and Podorefsky, 1988). Thus, psychiatric rehabilitation programs should consistently incorporate this information in service delivery.

Psychologists have particular skills and experience in developing interventions on coping and problem solving, particularly for disadvantaged populations. Thus, their backgrounds would enable them to make contributions in this development area, as well as to train staff to implement such educational interventions. To be most effective, the development of parenting interventions must meaningfully involve consumers who are parents: "Nothing about us without us."

- Ensuring availability of specialized individualized or group treatment for mothers and their families. Some women will need this more intensive form of service from their mental health agencies. Williams (1998) suggests providing joint parent-child therapy or psychoeducation for the entire family, to address the fact that children often feel ignorant about a parent's mental illness and mothers express difficulty in knowing how to discuss their mental illness with their children. Parent training has been frequently mentioned by mothers with mental illness in research and needs assessment studies. Parent support groups have been found to have significantly positive effects on the parenting of low-income women and other women with disadvantages. However, so that mothers can feel comfortable getting the help they need and discussing how to deal with their symptoms, such groups need to be exclusively for mothers with mental illness and within an agency or self-help setting. The use of generic parenting programs is not likely to be helpful due to the stigma still associated with mental illness.

Psychologists have conceptualized, developed, and researched a number of interventions for disadvantaged parents and their children. Taylor and Biglan (1998) reviewed published evidence on parenting interventions and concluded that behavioral family training is effective in improving child rearing in distressed families. Furthermore, for parents with additional issues, such as depression, training on child management strategies can be effectively enhanced by adding other components, such as training in personal and marital adjustment and self-control. Webster-Stratton has developed a comprehensive videotape-based parenting training that has proven effective in clinical treatment programs for families with conduct-disordered children and in community programs for at-risk families (Brestan and Eyberg, 1998; Taylor, Schmidt, Pepler, and Hodgins, 1998; Webster-Stratton and Herbert, 1994; Webster-Stratton and Hancock, 1998; Webster-Stratton and Taylor, 1998). The program's goals are strengthening parent competence, increasing

positive family support networks and school involvement, promoting child social competence, and decreasing child conduct problems. These goals are highly congruent with the needs expressed by mothers with serious mental illness and relevant to the problems identified by research on these families.

Taylor and Biglan (1998) noted that therapists using these approaches need to have a high level of clinical skill in order to make the process of therapy collaborative. Doctorate-level psychology training should be optimal for effectively delivering these services. However, psychologists will need to increase their involvement with mothers with mental illness in order to understand their perspective, so that these interventions can be appropriately modified for these mothers.

- Carrying out more high-quality and comprehensive research on mothers with serious mental illness, to identify specific capabilities and risk factors in mothers' parenting practices that relate directly to child outcomes, as well as the direct and mediating roles on parenting of the social and economic contexts in which these women live. More research is also needed on the effectiveness of various service alternatives in place or being developed to meet the needs of these mothers best. Other priorities for research include the effects of parental mental illness on children in different developmental stages (adolescence is particularly understudied), as well as the interaction between parenting characteristics and individual child characteristics and temperament.

Psychologists have played major roles in studying the parenting of other populations and in evaluating parenting interventions. Once they become more involved in practice and research with individuals who are mentally ill, they will find that existing skills readily apply. The conceptualizations of motherhood articulated by the women with serious mental illness in our study have much in common with the perspectives of other low-income and disadvantaged mothers.

Conclusion

Mothers with mental illness confront many challenges in living and in raising their children. Children of these mothers are at high risk for diagnosed mental illness, substance abuse, and other problems in coping and behavior. Nevertheless, the role of parent is an important one for most women with mental illness and offers significant rehabilitation potential and motivation for recovery. Despite the challenges and opportunities, these mothers and their children have been largely ignored by mental health service systems. This situation is extremely unfortunate, since effective models of service do exist that could be extremely helpful to families where parents have mental illness. Psychologists could play key roles in delivering such services. However, before this can happen, an awareness of the needs and intervention possibilities for persons with psychiatric disabilities needs to be communicated in psychology preservice training and professional training provided

through continuing-education seminars offered by the American Psychological Association, its state psychological associations, and individual colleges and universities. Without this push, psychologists will probably continue to avoid this client group, to the disadvantage of all. As self-help approaches and managed care oversight continue to decrease the marketplace for psychological services to less distressed populations, psychology needs to step up to the challenge of working with serious mental illness—for the benefit of the profession, adult consumers, and future generations of their children.

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