Families Affected by Parental Mental Illness: A Multiperspective Account of Issues and Interventions

Andrea Reupert, PhD and Darryl Maybery, PhD
Charles Stuart University

A multiperspective account of the issues and subsequent interventions for families affected by parental mental illness is reviewed in this article, including those involving the children, the parent with mental illness, other family members, agencies, and society in general. An overview of various issues and interventions for families affected by parental mental illness is seen as potentially useful for practitioners and program developers as well as providing a resource bank for systematic evaluation, research, and policy.

Keywords: parental mental illness, interventions, children, evaluation, families

Families affected by parental mental illness are among the most vulnerable in our community. Such families are more likely to experience social isolation, financial hardship, and marital discord, with increased risks for children, genetically, psychologically, and environmentally (Beardslee, Versage & Gladstone, 1998). Mental illness often refers to a wide range of psychiatric symptoms that persist over time and are functionally disabling in living skills, social interactions, family relationships, jobs, and/or education (Johnson, 1997), and in this article, encompasses conditions such as schizophrenia, major depression and anxiety, and bipolar disorder.

Over the last decade, an increased awareness of the needs of families affected by parental mental illness has resulted in the development of various interventions and programs (Cowling, 2004). Such strategies are most often directed to meeting the unmet needs of the child (e.g., averting risk, developing resilience) or the parent with the mental illness (e.g., their mental health concerns, parenting responsibilities) rather than incorporate the needs of the family as a whole. In addition, to the best of our knowledge, no standards or guidelines for the types of programs best suited to such families has been presented.

One partial step toward evidence-based practice is to identify the range of issues and subsequent possible interventions for such families that are currently available in the literature. Toward this end, a review of the literature for each of the stakeholders is presented. Although various interventions are highlighted, we make no claims for best practice. Instead the aim of this review is, first, to highlight the issues generally associated with families affected by parental mental illness and second, to present examples of interventions currently offered. The model that informs this overview is based on a clinician's perspective, as it focuses primarily on the issues for parents and children. At the same time, the importance of the broader social context in which parenting takes place is acknowledged in the final section.

An overview of the issues and subsequent interventions for families affected by parental mental illness may provide a start to developing a resource bank from which evidence-based practices might be systematically drawn and evaluated. In addition, a summary that encapsulates all members of the family as well as emphasizing an integrated, organizational approach underscores the need for holistic practices when working with such families, rather than focusing on only the children or the mentally ill parent. Consequently, the issues and interventions for the various key stakeholders is presented including; the children, the parent with the mental illness, the remaining family (e.g., other parent, siblings, extended family), the family as a whole, the various agencies that work with such families as well as society as a whole. Table 1 briefly summarizes these issues and interventions, as outlined in detail below.

The Child

Although all children require nurturance and physical care, the child of a parent with a mental illness may experience a home environment different from many other children. Falkov (2004) summarized this environment when he wrote that "children whose parents are mentally ill live with the symptoms, behaviors and expressions of mental illness. They see it and feel it" (p. 55). The environment of children with a mentally ill parent might at times, be chaotic and threatening, particularly if the child is included in the parental delusional behavior (Jacobsen & Miller, 1998), though depressed parents might be physically but not emotionally available to their children (Oyserman, Mowbray, Allen-Meares, & Firminger, 2000). It has been estimated that there are approximately 21% to 23% children living in households where at least one parent has a mental illness (Maybery, Reupert, Patrick, Goodyear & Crase, 2005).

Parental mental illness places children at a significantly greater risk of having lower social, psychological, and physical health than

Table 1
Possible Issues and Interventions for Stakeholders Affected by Parental Mental Illness

Target group	Possible issues	Intervention strategies
Child	Attachment problems leading to relationship issues in child and adulthood.	Provide children with ongoing opportunities to relate closely to consistent, healthy, and supportive others, from within the family (i.e., siblings, parents, extended family members) as well as outside the family (e.g., friends of the family, peers).
	Transport, accommodation, and domestic issues when parent is unwell or hospitalized.	Family friendly hospital facilities; practical support for transport and domestic issues; alternative or assisted stay at home accommodation.
	Maladaptive coping styles.	Provide opportunities to learn and practice adaptive problem solving strategies.
	Misconceptions about parent's mental illness.	Provide ongoing opportunities for child to express themselves about illness; provide age appropriate education about parental mental illness and mental illness generally.
	Young people assuming onerous caring responsibilities for parent and/or siblings.	Provide education about as well as adequate respite for care giving.
Parent with the mental illness	Managing the parent's mental illness.	Appropriate, sensitive, and timely assessment, intervention, and rehabilitation; ensure that rehabilitation acknowledges and includes children and parenting role.
	Assuming parental responsibilities.	Provide appropriate parent role models, education about attachment, connectedness, and specific and individualized parenting topics, according to need; ensure that practical support is available, for example, having childcare when the parent is very ill or hospitalized.
	Identifying and accessing emotional and social support.	Rehabilitation needs to identify and develop an individual's community and family support networks.
Other family members/family as a unit	Family stress associated with caring for a mentally ill parent.	Provide psychological and practical support, education and respite for carers.
	Low family cohesion and poor communication.	Family based intervention and attachment programs.
Human service and mental health agencies	Fragmented and uncoordinated services.	Organizational commitment to share information within and across services; policy responses that consider the family context of clients.
	Inadequate worker skills regarding families affected by parental mental illness; workers knowledge is often negative, reactive, and/or deficit based.	Further training and education regarding the issues of families affected by mental illness.
Society	Social, political, and economic barriers that exclude families from an acceptable quality of life; stigma and stereotypes towards those with a mental illness and their families.	Government policies and programs that support and encourage supportive communities and the inclusion of those with a mental illness; ongoing psychoeducation and public programs targeting stigma and stereotypes across the community, including the media.

children in families not affected by mental illness. Current research consistently shows a higher rate of behavioral, developmental, and emotional problems in such children compared with those in the general community (Beardslee et al., 1998; Cicchetti, Rogosch & Toth, 1998; Klimes-Dougan et al., 1999; Oyserman et al., 2000), with long-term effects including social and occupational dysfunction (Shiner & Marmorstein, 1998). In addition, several studies report increased rates of psychiatric disorders in children from homes with affectively ill parents, compared to children with nonill parents, on both genetic and environmental grounds (Beardslee, Keller, & Seifer, 1996; Hammen, 1991; Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997).

An important issue often discussed in association with parental mental illness is the attachment bond between parent and child. Attachment theory is based on the premise that an infant's first attachment experience (usually his or her mother) profoundly shapes the child's cognitive and emotional development (Bowlby, 1969, 1988) as well as present and future relationships (Karen, 1998). A parent, who responds sensitively and consistently to a child's needs, sends messages that build a sense of security and self-identity (Howes, 1999). Sometimes, however, because of a parent's mental illness (or for other reasons, such as addiction),

instead of sensitive, responsive nurturing, an infant may face inconsistency and/or neglect. Such parental cues often lead to various attachment problems in adult relationships (Karen, 1998; Mickelson, Kessler, & Shaver, 1997).

Closely related to the concept of attachment is the broader term, *connectedness*, which according to Lee, Draper, and Lee (2001) encompasses an individual's various caring and supportive relationships. Masten and colleagues (1988) found that social and emotional connections with others were a significant moderator on the effects of a variety of disadvantages, including parental mental illness. For instance, Rutter (1979) showed that a positive relationship with at least one parent, especially during infancy and early childhood, is a protective factor for children's psychological health. Howes (1999) argued that children have the potential to form many different kinds of relationships, whereas Harrison (2003) emphasized the role of child care workers and teachers in a child's social network. Siblings within families that experience disadvantage also have the potential to provide support to each other (Widmer & Weiss, 2000). Children themselves identified that having a friend at school is important for someone to talk to and rely on for support (Fudge & Mason, 2004; Maybery, Ling, Szakacs & Reupert, 2005). Overall, such research indicates that if

or when the primary adult is not able to appropriately support the child, meaningful social and emotional connections, from within and outside of the family, might be effectively made elsewhere.

In addition to social and emotional support, practical assistance is also important. Children report that one of the most stressful times for them is when a parent is hospitalized or experiencing an acute phase of their illness (Fudge & Mason, 2004; Maybery, Ling, et al., 2005). Maybery, Ling, and Szakacs (2002) found that during a parent's hospitalization, the level of risk for children is heightened when there is no other parent or relative to look after the children, particularly in single parent families (where the mentally ill parent is the sole parent). In such times, young people report problems accessing transport to go to visit a parent in the hospital, limited finances, the separation from their siblings (e.g., while in foster care), and the often-unfriendly nature of the hospital environment (Maybery et al., 2002).

Assuming the domestic and emotional responsibilities for their mentally ill parent and/or younger siblings is another issue for young people, particularly in single parent families (Aldridge & Becker, 2003). Such caregiving has been associated with limiting young people's recreation, friendships, educational achievement, and personal growth (Atkin, 1992). Recently there has been a growing recognition that some degree of caring in childhood is normal and encouraged as a part of "healthy" child development; that the experience of caring can be positive (for instance in developing closer family ties and encouraging independence) and that the division between caring and being cared for is not always clear, given the reciprocity of support and guidance that occurs between many children and their ill parent (Aldridge & Becker, 1999; Morris, 1993). Nonetheless, because respite care has generally been underdeveloped for people with mental health issues (Atkin, 1992) caregiving can become quite onerous. In addition, although young carers may take on substantial care responsibilities within their families, they are rarely consulted by professionals about their parent's needs and their own needs as children and carers (Aldridge & Becker, 2003).

Other problems identified in children whose parents have a mental illness are maladaptive coping strategies. Maybery and colleagues (2002) found that many children adopted maladaptive coping styles when their parent was ill, such as withdrawing, avoiding, and distancing. Folkman et al. (1991) found that the long term overuse of emotion-focused activities (such as those illustrated above) can be maladaptive and consequently highlighted the need to develop problem-focused activities that aim to change the environment or oneself in relation to it.

Devlin and O'Brien (1999) found that children tend to form misconceptions about their parent's mental illness, and recommended ongoing, age appropriate information. Falkov (2004) suggested that younger children might simply need to learn what a mental illness is and what to do when "mommy" is unwell whereas Hay (2004) pointed out that it might be important to present to adolescents the prodromal signs and degree of "inheritability" of the mental illness. Falkov suggested that it is important for children to express themselves and their fears about parental mental illness as part of an ongoing process, rather than as a one time event. Many children reported wanting to hear this information from their parents themselves (Fudge & Mason, 2004), although Falkov pointed out that it is everyone's responsibility including mental health practitioners to talk about a parent's mental illness.

Based on the issues raised above, there appears to be a number of important intervention strategies when working with children whose parent has a mental illness. In the first instance, children whose parents have a mental illness need, like all children, appropriate physical and emotional care. More specific, as attachment bonds might be problematic with the mentally ill parent, children require the opportunity to develop and enhance meaningful social and emotional connections from within and outside of the family. Practical support is important, particularly in times of high need (such as a parent being hospitalized), and include allowing the children to have regular access to the parent in the hospital and having a family member (i.e., other parent, "aunty") or trusted friend living in the family home for the duration of hospitalization. Some children also need to learn and practice effective, problem-focused coping strategies. Respite from onerous caregiving is also required. Children whose parents have a mental illness need to be provided with age-appropriate information and education about their genetic disposition to mental illness, mental illness generally, and their parent's mental illness in particular (Falkov, 2004). Various programs have been developed for this target group with various aims including: providing age appropriate education about mental illness, increasing self-esteem and problem focused coping,; and reducing feelings of isolation (Maybery, Reupert, & Goodyear, 2006; Orel, Groves, & Shannon, 2003; Pitman & Matthey, 2004).

The Parent With a Mental Illness

Nicholson, Biebel, Kinden, Henry, and Stier (2001) pointed out that the needs of parents affected by mental illness are generic to all parents as well as specific to their illness. The main issues for mentally ill parents center on their capacity and motivation for managing their mental illness and at the same time assuming parenting responsibilities. Risley-Curtiss, Stromwall, Trueet Hunt, and Teska (2004) found that with appropriate diagnosis, support, treatment, and medication, most people with a serious mental illness experience widespread improvement in many areas including parenting behaviors. However, they also found that many people have difficulty adhering to treatment, the most common reasons being the sometimes "trial and error" approach of many drug treatments and the often debilitating effect of many psychotropic drugs (such as lethargy and blunting).

Parents with a mental illness require support and sometimes guidance in their parenting behaviors. Although it is important to note that the effects of the mental illness are compounded by other factors such as poverty and social isolation, Oyserman et al. (2000) found that mothers with a serious mental illness have significantly less adequate parenting skills than mothers who do not have a mental illness. For instance, depressed mothers are less likely to be emotionally available and affectionate (Hammen, 1991) and parents with schizophrenia may have unusual or inappropriate affective responses to their children (Jacobsen, Miller, & Kirkwood, 1997). However, Rogosch, Mowbray, and Bogat (1992) found that not all parents with mental illness display the same degree of parenting difficulty; those with more severe and chronic disturbance were associated with less sensitive and competent parenting behaviors than parents with less debilitating disturbances. Similarly, Mowbray, Oyserman, Bybee, and MacFarlane (2002) established that a specific diagnosis is neither an independent nor useful predictor for parenting problems or strengths. Instead, Mowbray et

al. showed that current symptomatology and community networking was more indicative of parenting capacity and consequently stressed the need for quality treatment for clients with a mental illness and the enhancement of existing community supports.

Although there are many parenting programs in the community, Ackerson (2003a) argued that these typically fail to address the specific needs of parents with a mental illness. Thomas and Kalucy (2002, 2003) showed that problems with motivation and stigma may impede parents' attendance or, if attendance occurs, many parenting programs generally do not address a mentally ill parent's needs. Underscoring the importance of providing specific parenting training, Ackerson found that most mothers saw themselves as lax or permissive, rather than harsh or punitive. Similarly, many parents report being worried about the impact of their illness on their children and often prioritize their child's needs ahead of their own (Nicholson, Sweeney, & Geller, 1998a). Even though some clients might exhibit problematic parenting behaviors, many are open to interventions that enhance their parenting capacity and sense of maternal self-competence (Oyserman et al., 2000). Generally, mothers are more likely to be effective when given the opportunity to take on responsibilities (Gopfert, Webster, Pollard, & Nelki, 1996) and many consider parenting to be just as important as employment (Mowbray, Oyserman, & Ross, 1995) and a valued role in their lives (Nicholson et al., 1998a).

Although the cyclical nature of mental illness might mean a temporary inability to care for their children, parenting behaviors need not necessarily be the focus of intervention. Ackerson (2003a; 2003b) observed that the literature on mentally ill parents focuses on a parent's pathology and not on the strengths parents bring to manage their illness and to care for their children, nor their potential parenting capability if their mental illness was properly managed. A serious mental illness can adversely affect an individual's ability to parent, but it is possible, if provided with adequate resources, that many individuals with a serious mental illness are able to successfully care for their children. Mullick, Miller, and Jacobsen (2001) suggested, "Parents within any given diagnostic category can have parenting skills ranging from excellent to maltreating" (p. 489). Rather than dysfunctional parenting behaviors, Ackerson (2003a) found that many parents with a mental illness regarded the bond between themselves and their children as especially strong and close. Although cautioning issues regarding enmeshment, Ackerson asserted that many parents with a mental illness had close, mutually interdependent relationships with their children.

Rather than considering parenting as a hindrance, Ackerson (2003b) found that mentally ill parents were more highly motivated to continue rehabilitation programs compared to clients who were not parents. Mentally ill mothers report that looking after children is rewarding and central to their lives, even though the demands of parenting are considerable (Mowbray, Oyserman, Zemencuk & Ross, 1995). White, Nicholson, Fisher, and Geller (1995) suggested that assuming a caretaking role may enhance a mother's motivation to remain in treatment.

Similarly, Caton, Cournos, and Dominguez (1999) found that mothers with schizophrenia were more likely to have had better premorbid social adjustment than schizophrenic women who were not mothers. In addition, Wang and Goldschmidt (1996) found that psychiatric patients wanted family focused interventions rather than focusing solely on themselves as the identified patient. Thus, rather than being a hindrance, assuming parenting responsibilities

might significantly assist in the rehabilitation and treatment for the parent with the mental illness, highlighting the importance in incorporating a parent's caretaker responsibilities into his or her treatment plan.

Emotional and social supports are particularly important for parents with a mental illness. Cochran and Brasard (as cited in Rogosch et al., 1992) described how social support networks provide various types of assistance for all parents, such as role modeling, providing emotional support, companionship, and practical assistance. Accordingly, Rogsoch and colleagues demonstrated that the presence and strength of mentally ill mothers' current supportive relationships predicted adaptive parenting attitudes. Ackerson (2003a) found that those parents with a strong social support network, such as family, friends, or church, coped better with crises than those who were socially isolated. Such support was especially critical when alternative care was needed, such as when the parent was hospitalized or very unwell (Ackerson, 2003a). In comparison, parents who did not have such support were more likely to have lost custody of their children (Ackerson, 2003a). However, as parents with a mental illness are more likely to be living without partners (White et al., 1995) and marital discord is more common among families in which a parent has a mental illness (Downey & Coyne, 1990), the need for parents to find support from his or her extended family and the wider community is further emphasized.

The Family

As well as the mentally ill parent and his or her children, other family members also need to be acknowledged. Nicholson, Sweeney, and Geller (1998b) found that caregiver responsibilities often fall on mentally ill parents' spouses or partners (if present) and/or extended family members, particularly children's grandparents and older children. However, they also found that although the partner and other relatives might be useful to the mentally ill parent (e.g., by assisting in household tasks and child care) they may also become a source of stress, by taking over a parent's responsibilities without consulting the parent (Nicholson et al., 1998b). In addition, Merikangas, Prusoff, and Weissman (1988) showed depression in one parent is frequently associated with depression and other psychopathology in the other parent. Such literature mirrors other caretaker research (e.g., Nankervis, Bloch, Murphy, & Herrman, 1997) that highlights the stress of family caregiving, the psychological and physical needs of caregivers and the subsequent importance of respite and caregiver education in how to best support themselves and the mentally ill parent.

Among families with depression or schizophrenia, Warner, Mufson, and Weissman, (1995) showed lower family cohesion and poorer communication as more prevalent than in families without a diagnosable disorder. Similarly, Dickstein et al. (1998) found that family unit functioning based on domains such as task accomplishment, communication, roles, affect management, interpersonal involvement, and behavior control, was less healthy in families with maternal mental illness compared with families with no maternal mental illness. Such research suggests that the family unit has specific needs over and above individual parent–child or spousal relationships. When working with at risk families, Marvin and Stewart (1990) argued that rather than focus on the parent–child dyad, the interaction style of the family unit needs to be the

focus of the intervention. Marvin and Stewart (as cited in Bowlby, 1969) argued that within each family there exists a variety of relationship networks or subgroups (such as the child–mother, child–father, mother–father, and mother–child–father, between children, and among the extended family) as well as an overarching "working model," or shared expectations and plans regarding attachment and caregiving behavior. The idea of an overarching working model means that the family as a whole system needs to be the focus of intervention, for families experiencing problems in attachment. Focusing also on the broader family dynamic, Hammen (1991) found that the parenting patterns established by depressed mothers might be learned by their children, who in turn, parent in much the same way, thereby maintaining negative interactional patterns across generations.

However, although much attachment theory appears to encourage a holistic approach to intervention, most attachment programs focus on selective subgroups within the family unit. Robinson (2002) argued that most attachment programs tend to focus on the parent's and/or infant's interactive behaviors and on their representation of the child–parent relationship rather than the interaction patterns between the various familial networks and the broader, everyday functioning of the family unit. Several studies (Egeland & Erickson, 1993; van Ijzendoorn, Juffer, & Duyvesteyn, 1995) have shown that although many attachment interventions do enhance maternal sensitivity, they are not always successful at changing the child or infant's attachment organization or classification. This means that although most attachment programs are effective in enhancing a parent's ability to interpret children's cues, they tend to be less effective at changing the quality of the child's attachment pattern. This might be due, in part; to Dickstein's et al. (1998) suggestion that families affected by parental illness face increased rigidity within and among family subsystems, despite reasonably healthy other subsystems that might exist between a parent and a child. Family therapy might be an alternative intervention for this target group (Sved-Williams, 2004) although the Circle of Security project (Marvin, Cooper, Hoffman, & Powell, 2002) focuses on attachment issues between family members through the generations with promising results.

Another promising intervention has been developed by Beardslee and colleagues (Beardslee, Gladstone, Wright, & Cooper, 2003; Beardslee, Versage, et al., 1997; Beardslee, Wright, et al., 1997), for families and their children aged 8 to 15 years, in which at least one parent had experienced a recent episode of affective disorder. Using two different approaches (either lecture or clinician-facilitated intervention) but with similar content, the programs were designed to provide information about mood disorders to parents, to enhance parents' skill in communicating information to their children, and to open dialogue within families about the effects of parental depression. After 2½ years of enrollment children reported greater understanding of parental affective disorder and better adaptive functioning. Parents reported increased marital support and improved knowledge and communication about mental illness, indicating strong overall support for this family based approach.

Another issue for families affected by parental mental illness is that they are more likely to experience crises, such as the hospitalization of a parent, or an acute mental illness episode. The exposure to any critical incident has the potential to generate anxiety, stress, and hurt to the individuals involved and although the strain is particularly felt in the time just after the incident occurs, it may endure for a lengthy period (Wilson & Raphael, 1993). As prior planning is the key to optimum management of a critical incident in any setting (Kirkland & Maybery, 2000) it is important for all members of a family to plan for future episodes of hospitalization or periods of illness. An example of one such approach is the "Supporting Our Family" kit developed by Children of Mentally Ill Consumers and available from http://www.howstat.com/comic/. This crisis plan invites family members to nominate a contact person if a parent is ill or in the hospital whom each child might stay with, who needs to be told if the child is staying somewhere else and so on.

Human Service and Mental Health Agencies

Many agencies, which work with families affected by parental mental illness, tend to have a singular and/or negative focus when defining their client base. In addition, many human and health agency workers do not have the training and knowledge to work effectively with such families. In a survey of programs across North America, Nicholson et al. (2001) found that many organizations are often fragmented and uncoordinated, so that they tend to focus only on the client (either the "child" or "adult"), and do not consider a client's environment (such as his or her school or family base) and/or contextual demands (such as parenting responsibilities). Nicholson et al. pointed out that program eligibility requirements may limit participation to eligible adults or children but not both, as is generally needed for families affected by parental mental illness.

When reviewing adult and child services in Europe, Hetherington and Baistow (2001) stressed the importance of informal communication between agencies, though at the same time highlighted time and geographic difficulties in doing so. Fleck-Henderson (2000) used the term *seeing double* to describe how workers are being asked to simultaneously recognize and work with the needs of adult clients and of their children, though Cousins (2004) pointed out that this might not be possible for all workers, for both personal and professional reasons, particularly for child protection workers. Mowbray et al. (2000) found that although parents identified their mental health provider as a source of support, only 20% of parents listed their provider as someone who could provide assistance in being a mother, perhaps because of mothers' concerns about losing custody of their children.

Many government departments have consequently recommended that mental health agencies be encouraged to take a leadership role in developing community linkages for example, in Australia (Commonwealth Department of Health & Aged Care, 2000). Accordingly, collaboration between and within organizations is vital, for example, if child protection workers are called for suspected cases of abuse they may need to work closely with adult mental health workers to best work with the parent. Hetherington and Baistow (2001) suggested that adult mental health services need to, as part of their standard intake practice, record whether patients are parents, the ages of children, and who is caring for them. The rationale for this assessment would be for adult mental health services to then offer assistance to parents in their responsibilities as primary caregivers (Hetherington & Baistow, 2001). Falkov's (1998) training resource, *Crossing Bridges*, is designed to encourage interagency collaboration across specialist areas, by

covering information on adult mental health, parenting, the parent–child relationship, and child development.

As well as organizational barriers, many human and health agency workers do not have the skills and knowledge to identify, refer, and/or intervene appropriately with different family members. Bibou-Nakou (2004) found that although many teachers in Greece acknowledged that supporting children whose parents had a mental illness were a part of their responsibilities, they did not feel that they had adequate training and knowledge to do this. Similarly, although many of their clients are parents, Maybery and Reupert (2006) found that adult mental health workers lack the knowledge, skills, and resources (including time) to work with their clients on parenting issues.

Ackerson (2003b) suggested that many human and health agency workers often take a problem and deficit focus approach when working with clients, and as Nicholson et al. (2001) noted, their services are often only available when parents or children have a diagnosable problem or after abuse or neglect has been identified. A preventative stance is not often assumed. Ackerson (2003a) suggested that rather than focus on parents' deficits, workers need to acknowledge the cyclical nature of mental illness, and an individual's parenting strengths. This might also lessen the stigma often associated with seeking treatment for many parents.

A Broader Focus

The discriminatory economic and social barriers that prevent the mentally ill from securing an acceptable quality of life also need to be addressed. Having a mental disorder often leads to a *snowball effect*, as other problems follow, including unemployment, isolation, and poverty. In teasing out impacting variables for at risk children, Rutter (1981) found that the direct effects of parental illness was less influential than the social adversity usually associated with mental illness. From this perspective, many of the problems experienced by families affected by parental mental illness are more the result of society and governments' failure to provide effective and enabling services, than the mental illness per se. Accordingly, maladaptive coping might instead be constructed as a, "personal, individualized solution to structural social problems" (Lawrence, 1992, p.45). In this way, rather than only focus on the problems within families affected by parental mental illness, we need to also address the failure of governments and society to enable the mentally ill to have independence, freedom from discrimination, and full family functioning.

The stigma associated with mental illness is a problem, as many mothers report being reluctant to discuss their parenting role, for fear of losing access to their children (Ackerson, 2003a; Mowbray, Oyserman, Zemencuk, & Ross, 1995). The stigma associated with mental illness is entrenched; North Americans rated leprosy and mental illness as two of the worst things that can happen to anyone (National Institute of Mental Health, 1986). Finally, the association of mental illness with violence and child abuse, in the media and the community, has increased in recent years (Fraser, 1994; Nicholson et al., 1998b).

The way that mental illness is socially constructed needs to be changed, to encourage understanding, respect, and inclusion for families in this situation. One way of doing this is through the collective political power of the mental health survivor; for example, the Pandora Foundation in the Netherlands (see http://www.stitchingpandora.nl/bymysite.v3/id/D37CAFDF-4912-42FD-9845-DA5FCD1032BB) involves service users to influence policy and to provide information, advice, support, education, and press releases. Another approach comes from Byrne (2000), who presented a practical model of stigma management aimed at various target groups, through consultation and flexible public education programs that take place over time.

Implications for Policy, Training, and Practice

Policymakers need to assume a preventative focus and address the societal and economic barriers that create the distress experienced by many families affected by parental mental illness. At the same time, practitioners and program developers need to consider not only on the child or the parent with the mental illness, but recognize that families affected by parental mental illness require multiple foci and interventions (see Table 1). This has implications for how service providers are trained and also practice; for instance, adult mental health workers need to understand, and work with, the parenting context in which some of their clients live in. Similarly, child protection workers need to understand how parental mental illness might impact on parenting capacity, in both useful and negative ways. In terms of practice, it is imperative to have a family focus in identification (e.g., asking mentally ill clients, "Do you have dependent children?") as well as intervention. Given that parental mental illness places children at greater risk of overall well-being, it is important that intervention has a preventative focus (e.g., teaching children adaptive problem-focused coping and helping families develop their crisis plans for possible future crises). A multifaceted approach is required that acknowledges all stakeholders, including the child, the parent, the family, and agencies, and society as a whole (see Table 1 for further examples of policy, training, and practice).

The aim of this article was to present the varied and interrelated issues for families affected by parental mental illness, rather than focusing on one part of family, such as the child or the mentally ill parent. To conclude, one study found that children whose parent has a mental illness have different opinions to "what helps", compared to parents and agency workers (Maybery, Ling, et al., 2005). Consequently, as well as training and practice, research also needs to take a multiperspective approach, and identify all key stakeholders' perspectives on issues and needs.

References

Ackerson, B. J. (2003a). Coping with the dual demands of severe mental illness and parenting: The parents' perspective. *Families in Society, 84,* 109–119.

Ackerson, B. J. (2003b). Parents with serious and persistent mental illness: Issues in assessment and services. *Social Work, 48,* 187–195.

Aldridge, J., & Becker, S. (1999). Children as carers: The impact of parental illness and disability on children's caring roles. *Journal of Family Therapy, 21,* 303–320.

Aldridge, J., & Becker, S. (2003). *Children caring for parents with mental illness: Perspectives of young carers, parents and professionals.* Bristol, England: Policy.

Atkin, K. (1992). Similarities and differences between informal carers. In J. Twigg (Ed.), *Carers: Research and practice* (pp. 30–58). London: Her Majesty's Stationery Office.

Beardslee, W. R., Gladstone, T. R. G., Wright, E. J., & Cooper, A. B.

(2003). A family-based approach to the prevention of depressive symptoms in children at risk: Evidence of parental and child change. *Pediatrics, 112,* 119–131.

Beardslee, W. R., Keller, M. B., & Seifer, R. (1996). Prediction of adolescent affective disorder: Effects of prior parental affective disorders and child psychopathology. *Journal of the American Academy of Child & Adolescent Psychiatry, 35,* 279–288.

Beardslee, W. R., Versage, E. M., & Gladstone, T. R. (1998). Children of affectively ill parents: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry, 37,* 1134–1141.

Beardslee, W. R., Versage, E. M., Wright, E. J., Salt, P., Rothberg, P. C., Drezner, K., et al. (1997). Examination of preventive interventions for families with depression: Evidence of change. *Development and Psychopathology, 9,* 109–130.

Beardslee, W. R., Wright, E. J., Salt, P., Drezner, K., Gladstone, T. R. G., Versage, E. M., et al. (1997). Examination of children's responses to two preventive intervention strategies over time. *Child & Adolescent Psychiatry, 36,* 196–204.

Bibou-Nakou, I. (2004). Helping teachers to help children living with a mentally ill parent. *School Psychology International, 25,* 42–58.

Bowlby, J. A. (1969). *Attachment and loss: Vol. 1.* New York: Basic Books.

Bowlby, J. A. (1988). *A secure base.* New York: Basic Books.

Brotman, B. E., & Weisz, J. R. (1988). How to feel better when it feels bad: Children's perspectives on coping with everyday stress. *Developmental Psychology, 24,* 247–253.

Byrne, P. (2000). Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment, 6,* 65–72.

Caton, C. L., Cournos, F., & Dominguez, B. (1999). Parenting and adjustment in schizophrenia. *Psychiatric Services, 50,* 239–243.

Cicchetti, D., Rogosch, F. A., & Toth, S. L. (1998). Maternal depressive disorder and contextual risk: Contributions to the development of attachment insecurity and behavior problems in toddlerhood. *Development and Psychopathology, 10,* 283–300.

Commonwealth Department of Health and Aged Care. (2000). National action plan for promotion, prevention and early intervention for mental health 2000. A joint commonwealth, state and territory initiative under the second national mental health plan. Canberra, Australia: Public Affairs, Parliamentary and Access Branch.

Cousins, C. (2004). When is it serious enough? The protection of children of parents with a mental health problem, tough decisions and avoiding a "martyred" child. *Australian e-Journal for the Advancement of Mental Health 3*(2). Retrieved October 2005 from www.auseinet.com/journal/vol3iss2/cousins.pdf

Cowling, V. (Ed.). (2004). *Children of parents with mental illness 2: Personal and clinical perspectives.* Melbourne, Australia: Australian Council of Education Research.

Devlin, J. M., & O'Brien, L. M. (1999). Children of parents with mental illness: 1: An overview from a nursing perspective. *Australian and New Zealand Journal of Mental Health Nursing, 8,* 19–29.

Dickstein, S., Seifer, R., Hayden, L. C., Schiller, M., Sameroff, A. J., Keitner, et al. (1998). Levels of family assessment 2: Impact of maternal psychopathology on family functioning, *Journal of Family Psychology, 12,* 23–40.

Downey, G., & Coyne, J. C. (1990). Children of depressed parents: An integrative review. *Psychological Bulletin, 108,* 50–76.

Egeland, B., & Erickson, M. F. (1993). Attachment theory and findings: Implications for prevention and intervention. In S. Kramer & H. Parens (Eds.), *Prevention in mental health: Now, tomorrow, ever* (pp. 21–50). Northvale, NJ: Aronson.

Falkov, A. (Ed.). (1998). *Crossing bridges: Training resources for working with mentally ill parents and their children. Reader for managers, practitioners and trainers.* East Sussex, England: Pavilion.

Falkov, A. (2004). Talking with children whose parents experience mental illness. In V. Cowling (Ed.), *Children of parents with mental illness 2: Personal and clinical perspectives* (pp. 41–56). Melbourne, Australia: Australian Council of Education Research.

Fleck-Henderson, A. (2000). Domestic violence in the child protection system: Seeing double. *Children and Youth Services Review, 22,* 333–354.

Folkman, S., Chesney, M., McKusick, L., Ironson, G., Johnson, D., & Coates, T. J. (1991). Translating coping theory into an intervention. In J. Eckenrode (Ed.), *The social context of coping* (pp. 239–260). New York: Plenum Press.

Fraser, M. E. (1994). Educating the public about mental illness: What will it take to get the job done? *Innovations and Research, 3,* 29–31.

Fudge, E., & Mason, P. (2004). Consulting with young people about service guidelines relating to parental mental illness. *Australian e-Journal for the Advancement of Mental Health,* 3(2). Retrieved October 2005 from www.auseinet.com/journal/vol3iss2/fudgemason.pdf

Gopfert, M., Webster, J., Pollard, J., & Nelki, S. (1996). The assessment and prediction of parenting capacity: A community-orientated approach. In M. Gopfert, J. Webster, & M. V. Seeman (Eds.), *Parental psychiatric disorder: Distressed parents and their families* (pp. 271–309). Cambridge, MA: Cambridge University Press.

Hammen, C. (1991). *Depression runs in families: The social context of risk and resilience in children of depressed mothers.* New York: Springer-Verlag.

Harrison, L. (2003). *Attachment: Building secure relationships in early childhood.* Canberra, Australia: Early Childhood Australia.

Hay, D. A. (2004). Understanding and explaining the genetics of mental illness. In V. Cowling (Ed.), *Children of parents with mental illness 2: Personal and clinical perspectives* (pp. 5–14). Melbourne, Australia: Australian Council of Education Research.

Hetherington, R., & Baistow, K. (2001). Supporting families with a mentally ill parent: European perspectives on interagency cooperation. *Child Abuse Review, 10,* 351–365.

Howes, C., (1999). Attachment relationships to multiple caregivers. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 671–687). New York: Guilford.

Jacobsen, T., & Miller, L. J. (1998). Mentally ill mothers who have killed: Three cases addressing the issue of future parenting capability. *Psychiatric Services, 49,* 650–657.

Jacobsen, T., Miller, L. J., & Kirkwood, K. P. (1997). Assessing parental competency in individuals with severe mental illness. A comprehensive service. *The Journal of Mental Health Administration, 24,* 189–199.

Johnson, D. L. (1997). Overview of severe mental illness. *Clinical Psychology Review, 17,* 247–257.

Karen, R. (1998). *Becoming attached. First relationships and how they shape our capacity to love.* New York: Oxford University Press.

Kirkland, R., & Maybery, D. J. (2000). Managing critical incidents in schools, planning your response. *Practising Administrator, 22*(3), 18–23.

Klimes-Dougan, B., Free, K., Ronsaville, D., Stilwell, J., Welsch, J. C., & Radke-Yarrow, M. (1999). Suicidal ideation and attempts: A longitudinal investigation of children of depressed and well mothers. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 651–659.

Lawrence, M. (1992). Women's psychology and feminist social work practice. In M. Langan & L. Day (Eds.), *Women, oppression and social work: Issues in anti-discriminatory practice* (pp. 32–47). London: Routledge.

Lee, R. M., Draper, M., & Lee, S. (2001). Social connectedness, dysfunctional interpersonal behaviors, and psychological distress: Testing a mediator model. *Journal of Counseling Psychology, 48,* 310–318.

Marvin, R., Cooper, G., Hoffman, K., & Powell, B. (2002). The circle of security project: Attachment-based intervention with caregiver pre-school child dyads. *Attachment and Human Development, 4*(1), 107–124.

Marvin, R. S., & Stewart, R. B. (1990). A family systems framework for the study of attachment. In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the pre-school years: Theory, research and innovation* (pp. 51–86). London: University of Chicago Press.

Masten, A. S., Garmezy, N., Tellegen, A., Pellegrini, D. S., Larkin, K., & Larsen, A. (1988). Competence and stress in school children: The moderating effects of individual and family qualities. *Journal of Child Psychology and Psychiatry, 29,* 745–764.

Maybery, D., Ling, L., & Szakacs, E. (2002). *The needs of children with parents who have a mental illness.* Wodonga, Australia: La Trobe University.

Maybery, D., Ling, L., Szakacs, E., & Reupert, A. (2005). Children of parents with mental illness: Perspectives of need. *Australian e-Journal for the Advancement of Mental Health,* 4(2). Retrieved December 2005 from www.auseinet.com/journal/vol4iss2/maybery.pdf

Maybery, D., & Reupert, A. (2006). Workforce capacity to respond to children whose parents have a mental illness. *Australian and New Zealand Journal of Psychiatry.*

Maybery, D., Reupert, A., & Goodyear, M. (2006). *Evaluation of a model of best practice for families who have a parent with a mental illness.* Unpublished evaluation report retrieved December 2006 from www.quantifyingconnections.com/COPMIpage.htm

Maybery, D., Reupert, A., Patrick, K., Goodyear, M., & Crase, L. (2005). *Report on children at risk in families affected by parental mental illness.* Retrieved June 1, 2006, from https://www.vichealth.vic.gov.au/assets/contentFiles/Research_Report_COPMI.pdf

Merikangas, K. R., Prusoff, B. A., & Weissman, M. M. (1988). Parental concordance for affective disorders: Psychotherapy in offspring. *Journal of Affective Disorders, 15,* 279–290.

Mickelson, K. D., Kessler, R. C., & Shaver, P. R. (1997). Adult attachment in a nationally representative sample. *Journal of Personality and Social Psychology, 73,* 1092–1106.

Morris, J. (1993). *Independent lives? Community care and disabled people.* Basingstoke, England: MacMillan.

Mowbray, C., Oyserman, D., Bybee, D., & MacFarlane, P. (2002). Parenting of mothers with a serious mental illness: Differential effects of diagnosis, clinical history and other mental health variables. *Social Work Journal, 26,* 225–241.

Mowbray, C., Oyserman, D., & Ross, S. R. (1995). Parenting and the significance of children for women with a serious mental illness. *Mental Health Administration, 22,* 189–200.

Mowbray, C., Oyserman, D., Zemencuk, J. K., & Ross, S. R. (1995). Motherhood for women with serious mental illness: Pregnancy, childbirth, and the postpartum period. *American Journal of Orthopsychiatry,* 65(1), 21–38.

Mowbray, C., Schwartz, S., Bybee, D., Spang, J., Rueda-Riedle, A., & Oyserman, D. (2000). Mothers with a mental illness: Stressors and resources for parenting and living. *Families in Society, 81,* 118–129.

Mullick, M., Miller, L. J., & Jacobsen, T. (2001). Insight into mental illness and child maltreatment risk among mothers with major psychiatric disorders. *Psychiatric Services, 52,* 488–492.

Nankervis, J. M., Bloch, S., Murphy, B. M., & Herrman, H. E. (1997). A classification of family carers' problems as described by counsellors. *Journal of Family Studies, 3,* 169–182.

National Institute of Mental Health. (1986). *Combating the stigma of mental illness.* (DHHS Publication No. ADM 86–1470). Washington, DC: U.S. Government Printing Office.

Nicholson, J., Biebel, K., Kinden, B., Henry, A., & Stier, L. (2001). *Critical issues for parents with mental illness and their families.* Retrieved from http://www.mental heath. Org/publications/all/pubs/

Nicholson, J., Sweeney, E. M., & Geller, J. L. (1998a). Mothers with mental illness: 1. The competing demands of parenting and living with mental illness. *Psychiatric Services, 49,* 635–642.

Nicholson, J., Sweeney, E. M., & Geller, J. L. (1998b). Mothers with mental illness: 2. The competing demands of parenting and living with mental illness. *Psychiatric Services, 49,* 643–649.

Orel, N. A., Groves, P. A., & Shannon, L. (2003). Positive connections: A program for children who have a parent with a mental illness. *Child & Family Social Work, 8,* 113–122.

Oyserman, D., Mowbray, C. T., Allen-Meares, P., & Firminger, K. (2000). Parenting among mothers with a serious mental illness. *American Journal of Orthopsychiatry, 70,* 296–315.

Pitman, E., & Matthey, S. (2004). The SMILES program: A group program for children with mentally ill parents or siblings. *American Journal of Orthopsychiatry, 74,* 383–388.

Risley-Curtiss, C., Stromwall, L. K., Trueet Hunt, D., & Teska, J. (2004). Identifying and reducing barriers to reunification for seriously mentally ill parents involved in child welfare cases. *Families in Society, 85,* 107–119.

Robinson, J. R. (2002). Attachment, problems and disorders in infants and young children: Identification, assessment and intervention. *Infants and Young Children, 14,* 6–19.

Rogosch, F. A., Mowbray, C. T., & Bogat, G. A. (1992). Determinants of parenting attitudes in mothers with severe psychopathology. *Development and Psychopathology, 4,* 469–487.

Rutter, M. (1979). Protective factors in children's responses to stress and disadvantage. In M. W. Kent & J. E. Rolf (Eds.), *Social competence in children* (pp. 49–74). Hanover, NH: University Press of New England.

Rutter, M. (1981). *Maternal deprivation reassessed* (2nd ed.). Harmondsworth, England: Penguin.

Shiner, R. L., & Marmorstein, N. R. (1998). Family environments of adolescents with lifetime depression: Associations with maternal depression history. *Journal of the American Academy of Child and Adolescent Psychiatry, 37,* 1152–1160.

Sved-Williams, A. S. (2004). Infants of mothers with mental illness. In V. Cowling (Ed.), *Children of parents with mental illness 2: Personal and clinical perspectives* (pp. 17–40). Melbourne, Australia: Australian Council of Education Research.

Thomas, L. J., & Kalucy, R. S. (2002). Parents with mental illness: A qualitative study of the effects on their families. *Journal of Family Studies, 8,* 38–52.

Thomas, L. J., & Kalucy, R. (2003). Parents with mental illness: Lacking motivation to parent. *International Journal of Mental Health Nursing, 12,* 153–157.

van Ijzendoorn, M. H., Juffer, F., & Duyvesteyn, M. G. D. (1995). Breaking the intergenerational cycle of insecure attachment: A review of the effects of attachment- based interventions on maternal sensitivity and infant security. *Journal of Child Psychology and Psychiatry, 20,* 225–248.

Wang, A. R., & Goldschmidt, V. V. (1996). Interviews with psychiatric inpatients about professional intervention in regard to their children. *Acta Psychiatrica Scandinavia, 90,* 459–465.

Warner, V., Mufson, L., & Weissman, M. (1995). Offspring at high and low risk for depression and anxiety: Mechanisms of psychiatric disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 34,* 786–797.

Weissman, M. M., Warner, V., Wickramaratne, P., Moreau, D., & Olfson, M. (1997). Offspring of depressed parents: Ten years later. *Archive General Psychiatry, 54,* 932–940.

White, C. L., Nicholson, J., Fisher, W. H., & Geller, J. L. (1995). Mothers with severe mental illness caring for children. *Journal of Nervous and Mental Disease, 183,* 398–403.

Widmer, E. D., & Weiss, C. C. (2000). Do older siblings make a difference? The effects of elder sibling support and older sibling adjustment on the adjustment of socially disadvantaged adolescents. *Journal of Research on Adolescence, 10,* 1–27.

Wilson, J. P., & Raphael, B. (Eds.). (1993). *International handbook of traumatic stress syndromes.* New York: Plenum Press.