

# INSIDE A FAMILY UNDER PRESSURE

## The Impact of Parental Mental Illness on the Family



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# **What is this booklet?**

## **Where did it come from?**

### **How do I use it?**

This document was initially prepared as a “take away” booklet to supplement and resource workers from across sectors participating in a training workshop *Working with families under pressure - the impact of mental illness on the family*. This activity was part of Ruah COPMI (Children of Parents with Mental Illness) project funded by the Commonwealth Department of Family and Community Services under the Stronger Families and Communities Strategy 2003 to 2006.

The WA COPMI Project direction, as cross-sectoral work towards changes in systems and services, was shaped by Pathways to Resilience - WA Office of Mental Health (Smith, W. & Nicholls, D.S. 2002)

The workshops were developed in partnership with the WA COPMI project State- wide Steering Committee to support the implementation of a ‘draft working interagency protocol to enhance outcomes for COPMI’ and their families. The protocol trial commenced in April 2004. The protocol is between:

- Division of Mental Health, Department of Health
- Child and Community Services, Department of Health
- Department for Community Development
- Department of Justice
- Department of Education
- Disability Services Commission
- Drug and Alcohol Office
- Department of Housing and Works.

The protocol was designed as a central platform in a strategy to improve outcomes for children of parents with a mental illness by:

- Increasing awareness of the vulnerability of this group of children and families across all health and human service WA State Government Departments.
- Providing a framework for policy and procedural review within and between each department to support practice, staff recruitment, training and orientation.
- Improving mental health literacy across sectors.
- Laying the foundations for collaborative practice with families and across services and sectors.

Research for this workshop series included extensive literature reviews and action research processes to establish the knowledge, skill and practice issues and constraints that each service sector faced in delivering flexible and responsive services. Building on the specialised skill and knowledge sets in each sector to enable collaborative working relationships and improve workforce capacity at direct service delivery, middle and senior management,

is central to the design. The workshops are always offered to local or regional cross sector groups and are enriched by the depth and diversity of skill and experience offered by different sectors and various professional orientations.

This document is offered as a way of assisting workers' understanding and awareness of the ways in which mental illness may affect each individual in the family, particularly children, and the family as a whole. Although we are confident that it will be useful to the reader it is not able to capture or replace the experiences offered in a workshop.

It does not provide all the answers but hopefully does provide some beginning points. It may help you to know what questions to ask.

***The Impact of Mental Illness on the Family***

was produced by the

Ruah COPMI project

(Children of Parents with Mental Illness)

as a resource to accompany the first of a series of cross-sectoral workshops on various aspects of working with members of families with dependent children where one or both parents has a mental illness.

A deliberate strategy for delivering the COPMI workshops has been to invite workers from a range of agencies (some with a primary focus on children, (child health, education) others specialising in working with the adults, (adult mental health, corrective services), and others who see the whole family as their client, to each session. As the work with COPMI families often requires input from a range of agencies, it is crucial for workers to develop common understandings and an appreciation of the roles and skills available in other services.

This booklet contains information that workers from a range of roles and professional backgrounds may find useful when working with COPMI families.

It is not intended to provide solutions or a recipe for doing the work, but shows how the parent's mental illness can affect the parent, the child or children and the parenting. A strengths' perspective and focus on resilience (of all family members and of the family as a unit) underpins the information provided.

The information will be more useful to readers if it is used in conjunction with strategies to broaden your local networks working with COPMI families, and explore some service delivery strategies with them.



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**Aim: To identify the impact of parental mental illness on the family, from a strengths-based perspective**

**Objectives:**

1. To discuss a family model
2. To examine family relationship issues
3. To identify supports and constraints to resilience of a parent with mental illness
4. To identify supports and constraints to child's resilience
5. To discuss impact of parental mental illness on children's resilience within a child development framework
6. To examine the impact of parental mental illness on parenting
7. To explore strategies for supporting families' resilience
8. To identify cultural factors affecting mental health treatment and parenting.

## Introduction

*It goes back to my childhood. My mum was never diagnosed but her behaviour was erratic and crazy. After she died I found out she'd been involved in psychiatric stuff, but that had all been hidden. She used to get hysterical, we never knew when she was going to explode, we had to tippytoes around her.*

*Then it became transgenerational – I could see her behaviour in myself but didn't know what was wrong with her so didn't know what was wrong with me. I was lucky though, I've never been in hospital, have never been so unwell I couldn't look after the kids.*

*The big difference between myself and my kids as parents is that I had nobody to take my kids, which meant they had no space from me either. They had no other way of knowing what was normal and what wasn't normal. No opportunity to weigh up my parenting behaviour against someone else's. My grandkids come and stay, and they have the ability to reality-test with me: "my mum's in a shitty with me" and explore what that could be about and what to do about it. My kids internalised it all, now one of my kids, I can see how much she's taken on of me, so depressed and negative.*

(Bella, mother and grandmother, November 2003)

In the early 80s I was an unmarried mum. I was interviewed by a psychiatrist, and because I was "Miss," was dumped in RPH and drugged, not even asked about kid/s. Everyone needs to be asked that question about kids.

It made me anxious, made me worse, knowing my daughter didn't know where I was. Nobody was listening to me, even though I was trying to express myself. It wasn't until eventually I was able to explain to a friend two days later that anyone took any notice.

(Mother, speaking in consumer forum, October 2003.)

### ***The importance of COPMI work***

Research has shown that there is a strong link between the mental illness of parents and a range of difficulties experienced by their children. Adverse outcomes ranging from developmental difficulties and delays to behavioural problems and even the development of mental illness have been reported for children of parents with mental illness (COPMI). These difficulties, however, are not inevitable. Factors have been identified that increase the resilience of children and families, and thus reduce the risk of adverse outcomes.

Clearly it is important to reduce the risks and increase the resilience of this group of children. Equally clearly, it is not possible to make interventions for the children's benefit in isolation from their families. There is an interaction between the needs of the children and the parents, and other family members. The mental illness can affect the parent and the parenting and therefore the child. The child can have an effect on the parent and the mental illness, positive or negative or a mixture. Thus anyone who is primarily working with the parent needs to be aware that the children are an important factor in the parent's context and well-being, and anyone who is primarily working with children must take into account the way parents are affecting the child's circumstances. A family-sensitive approach is important in both instances.

The WA COPMI project, a Commonwealth and State collaboration to improve service access and circumstances for this group of children, models the approach that is needed at a service delivery level. It has emphasised the need for cross-agency collaboration at both service-delivery and senior management levels, and has involved substantial input from a non-government agency (Ruah Community Services) and from consumer and carer representatives. Consumer and regional service provider forums have been held in an attempt to identify the important issues. Workforce development and protocol materials developed by the project are designed to address many of these issues. They also aim to promote cross-agency links and break down the "silo mentality" which has in the past reduced agencies' ability to work collaboratively.

One goal of these workshops is to encourage the interaction and exchange of information between workers within a region whose work may be with the same families, albeit from different perspectives or with different service goals. The provision of information is also important, but is by no means intended to be comprehensive. It is hoped that this forum will allow workers to share some of their own expertise and ingenuity in a collaborative way.

### ***The extent of the issue***

Until recently, there has been a dearth of statistical information on the incidence of adult psychiatric patients who also have dependent children. Falkov, in a review of studies estimating this incidence, comments that there could be anywhere from 20% to a third or even half of adults known to adult mental health services who have dependent children, but that little is known about the extent and nature of the children's needs. This range of estimates only includes those who have at some point been involved with mental health services – other studies indicate that there are more parents with mental health issues who are not necessarily receiving treatment<sup>1</sup>.

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<sup>1</sup>Falkov, A (ed.) (1998) *Crossing Bridges: Training Resources for Working with Mentally Ill Parents and their Children – Reader for Managers, Practitioners and Trainers*. Brighton: Pavilion Publishing; 9-12.

Most of the statistical information that is available seems to define children of a parent with mental illness as children who are living with that parent. There appears to be no information about non-custodial parents, who may still have some degree of contact with the child/ren and who may still strongly desire to carry out a parenting role. The parent's absence may have as much of an impact as his/her presence, depending on the way the custodial parent or others explain it and how the child understands it.

Based on census and epidemiological data, it is suggested that there are 27,000 children of mentally ill parents in Australia. This estimate is based on the number of women aged 20-45, the incidence and age of onset of schizophrenia and affective disorders, and data on the proportion of women with these disorders who have children.<sup>2</sup> Again, this estimate only includes mothers living with their children – there are also fathers with mental illness who are living with dependent children, and mothers and fathers with mental illness who temporarily or permanently are not living with their children. This group may not reach the statistics, but will still present with similar issues and concerns.

Daryl Mayberry et al VicHealth report 2006<sup>3</sup> describes those families with children at highest risk of poor outcomes as those where a parent has a high degree of disability associated with the mental illness; where the family experiences marital conflict, family violence and/or separation and divorce; and sole parenting without social supports and connections. These most vulnerable families are those most likely to be receiving services from the adult mental health service system.

### ***Achieving common ground among workers***

In the service provider forums, workers identified that a key difficulty in working collaboratively was workers' lack of familiarity with the language, assessment strategies and client acceptance criteria used by people from other agencies. A number of commonly used terms may be understood in different ways if some workers are using a legal or policy-related definition and others are operating from everyday (culturally-based) assumptions about their meaning. Clashes or misunderstandings can occur as a result of these different definitions for common words. Workshop participants will be asked to negotiate a mutually acceptable definition for each of the following terms:

- Family
- Mental illness
- Adequate or appropriate parenting
- Child at risk
- Early intervention

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<sup>2</sup>Cowling V (1996) "Effectively meeting the support needs of families with dependent children where the parent has a mental illness." AIFS conference paper: 3.

<sup>3</sup> Mayberry D, VicHealth Report 2006

Time is allowed in this session for people from the different agencies to network informally and perhaps discuss ways collaboration can be enhanced between workers. This may involve informal discussion of what you can and cannot ask each other to assist with. The last workshop of this series addresses collaborative practice specifically. It provides an opportunity to develop our understanding of what is involved in collaboration and ways to develop working partnerships specifically in relation to COPMI families.

### ***Early intervention***

The National Mental Health Plan 2003-2008 asserts: "Endeavouring to prevent mental health problems, mental illness and suicide involves understanding the factors that heighten the risk of these occurring and the factors that are protective against them, identifying the groups and individuals who can potentially benefit from interventions, and developing, disseminating and implementing effective interventions across the lifespan"<sup>4</sup>. Because COPMI have a heightened risk of a range of problems, they can benefit from early interventions.

The WA Statewide Strategic Committee (SSC) on COPMI promotes the importance of family-sensitive work to support children of parents with a mental illness. This involves both recognising the issues the children may be facing and supporting their ability to manage, and recognising and supporting the adults' role as parents not just as patients. The WA SSC advocates a prevention, early intervention approach to working with these families, with the rationale that accurate assessment and early support may prevent serious issues from arising later.

The model below presents a continuum of care showing the spectrum of interventions available for improving mental health<sup>5</sup>. It was designed to represent interventions for people at risk of or experiencing mental illness. The WA COPMI SSC has adapted it to indicate interventions for COPMI. Because they are at risk of a range of social and medical problems, including mental illness, terms such as 'case identification' and 'treatment' may not always be the most appropriate.

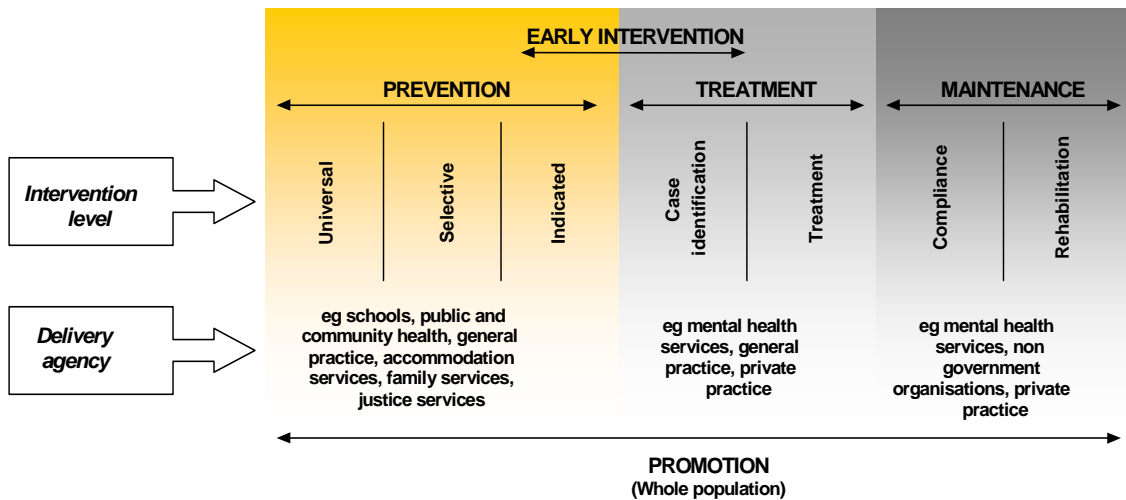
Our focus is on the selective and indicated prevention activities (explained in the table overleaf) as well as case identification in the scope of early intervention. Case identification involves the early identification of children at risk. Interventions aim to promote optimism, resilience and social and

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<sup>4</sup> Australian Health Ministers. (2003) *National Mental Health Plan 2003-2008*. Canberra: Australian Government:18.

<sup>5</sup> Munoz, Rf, Mrazek, PJ and Hagerty, RJ (1996) Institute of Medicine report on prevention of mental disorders: Summary and commentary' in *American Psychology*, Nov 51(11), pp 116-122. Cited & modified in Office of Mental Health, Department of Health, Government of Western Australia (2002) *Mental Health Promotion and Illness Prevention Policy*

emotional wellbeing and to reduce the impact of risk factors for these children<sup>6</sup>.



PREVENTIVE INTERVENTION TYPE <sup>7</sup>	TARGET	EXAMPLE
<b>Universal</b>	Whole population	<ul style="list-style-type: none"> <li>▪ Immunisation</li> <li>▪ Prevention of smoking</li> </ul>
<b>Selective</b>	Sub-groups of the population who are currently asymptomatic but are at higher than average risk of illness	<ul style="list-style-type: none"> <li>▪ Annual mammograms for women with family history of breast cancer</li> <li>▪ Screening strategy for children of parents with mental illness</li> </ul>
<b>Indicated</b>	Individuals who are known to be at high risk of a specific disorder	<ul style="list-style-type: none"> <li>▪ People with subclinical symptoms that indicate a risk for serious psychosis</li> </ul>

It may appear that shifting to an early intervention approach adds extra work to already busy workloads. The experience of the Reorientation of Services Project<sup>8</sup> shows that some strategies of changing ways of working to incorporate early intervention approaches, rather than adding early intervention work as a discrete extra, have been successful. One example given was of teachers changing their approach to the work they were already doing on mental health promotion with children rather than adding extra work. Informal processes of building interagency links through key people were also seen as a slow but effective way of improving the success of referrals.

<sup>6</sup> Mental Health Promotion and Illness Prevention Policy

<sup>7</sup> Edwards J and McGorry PD (2002) *Implementing Early Intervention in Psychosis*. London, Martin Dunitz.

<sup>8</sup> Ratnaïke D & Parnham J (2002) "Reorientation of Services Toward Early Intervention in Mental Health: Brief Report". *Australian e-Journal for the Advancement of Mental Health*. 1(2):

## ***Stigma***

Stigma compounds the struggle for parents with mental illness to meet their needs. Even their own families may act towards them in ways that are belittling and humiliating. Research into the stigma associated with mental illness has shown that mental health workers and the general public ascribe the following characteristics to people with mental illness: “unpredictable; irresponsible; socially undesirable; immature; confused; irrational; aggressive”.<sup>9</sup>

Before they became ill, people with a mental illness too were likely to have assumed certain things about people with this type of illness. No matter how good the psycho-education they are given by the treating team (if any is given), those assumptions are unlikely to just disappear once these people make the transition from members of the public to patients. So they may be grappling internally with their own stigma, leading them to attribute a lot of negative characteristics to themselves. If they receive stigmatising responses from people around them too, this can only work to reinforce the low opinion they may be developing about themselves.

It is unfortunate that in the research cited above, mental health professionals are included in the group of people who characterised people with mental illness in that way. Their knowledge and experience should lead them to a more balanced view of those who experience mental illness. However, professionals whose primary focus is not mental illness may find that their lack of mental health knowledge or experience may lead them to behave in a stigmatising way by:

- assuming that mental illness always means bad parenting
- assuming that if a person has an illness they are always ill
- focusing on the person’s vulnerabilities and not acknowledging or working with the strengths.

It is important that a complete assessment is made before it is assumed that the person’s mental illness is impacting on their ability to interact as a reasoning adult who is capable of making sensible decisions in relation to the welfare of their children.

## ***Culture***

Culture is often assumed to relate to ethnicity, and so when talking about cultural diversity in Australia, the tendency is to concentrate on issues relevant to indigenous Australians and those from ethnic groups or from a background where a language other than English is spoken. Participation in groups determined by social class, religion, sexual orientation, gender and disability may also be considered to be cultural membership, and of course

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<sup>9</sup>Bakshi L, Rooney R & O’Neil K. 1999. *Reducing Stigma about Mental Health in Transcultural Settings: A Guide*. Australian Transcultural Mental Health Network, Melbourne.

these further divisions occur both within mainstream culture and within ethnic or indigenous groupings. Acknowledging that a person speaks a language other than English at home is important. It is also important to recognise that their values, personal identity and family structure may be shaped by the culture in which they have been raised, and that these are not homogeneous within linguistic groupings<sup>10</sup>.

Beliefs that would usually be considered delusional if expressed by a white, English-speaking Australian may be appropriate within an indigenous or migrant person's culture of origin, or within some sections of that culture. Behaviour, too, sometimes has a cultural rather than a psychiatric explanation. Refugees in particular may well have experienced war or related traumatic events, to which paranoid or otherwise bizarre behaviour may have been an adaptive response. Even if that behaviour is now excessive or irrelevant, the context in which it developed was real, and the experience validated.

Explanatory models for behaviour that WA's Mental Health Act defines as mental illness will vary in different cultures. The way in which the person or family engages with treatment will reflect the explanatory model and cultural expectations regarding the purpose and status of treatment. Parenting, too, is perceived differently across cultures. What constitutes a family, and the respective roles of family members, may also be different from the family dynamics the worker is used to. In some CALD and indigenous communities, the family structure and roles may be a strong protective factor for both the mentally ill parent and the child/ren, ensuring that supports or foster carers are available.

Families from CALD communities tend to have a lower voluntary use of specialist mental health services than the rest of the community, and shorter face-to-face contacts with service providers. Medication tends to be the predominant treatment, even where a "talking" therapeutic intervention is indicated. Often a bilingual GP is their main contact for mental health support.<sup>11</sup>

CALD families may have little awareness of what services are available for their support, or may be (or assume they are) ineligible to use them. Their experiences in their country of origin may lead them to be highly suspicious of government agencies. Conscious efforts may need to be made by agencies to ensure that they are accessible and known to CALD communities.

In many CALD families a physical explanation may be given for emotional problems or behavioral changes, in others there may be attribution to spiritual

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<sup>10</sup>Finley, L (1997) "The Multiple Effects of Culture and Ethnicity on Psychiatric Disability" in Spaniol L, Gagne C and Koehler M (eds) *Psychological and Social Aspects of Psychiatric Disability*. Boston University, Boston: 497-510.

<sup>11</sup> Mental Health Division (December 2001) *A Transculturally Orientated Mental Health Service for Western Australia*. Mental Health Division, Department of Health, Western Australia:4

factors. The family may, on the other hand, recognise that mental illness is involved but isolate themselves because of the stigma of mental illness and their fear of ostracism from their community. Members of CALD communities may believe that a mentally ill family member is the family's responsibility, and thus not seek help from services available in the wider community even when the burden is great<sup>12</sup>. For some, the burden may in fact be greater if they do seek professional help, because of their expectation that members of their own community will consider them "weak" and incapable of fulfilling their family obligations. The guilt and shame this entails may well increase the mental health issues within the family system rather than reducing them.

Aboriginal families too may have other explanations for what is causing the unusual behaviour that determine how temporary or permanent the condition is likely to be, and whether an intervention is necessary or likely to work. There may also be higher tolerance for unusual behaviour or a perception that it is the family's role to take care of the mentally ill person. There has been enough historical evidence to convince many Aboriginal families that government agencies are not to be trusted. Many admissions to psychiatric hospitals are delayed until the person is floridly unwell (with possibly all the above reasons contributing to this delay), leading to involuntary admissions involving shameful scenes with police and ambulance, and thus perpetuating this fear of the system.

The type of questioning that is normal in psychiatry is quite different from normal ways of conversing between Aboriginal people, and attempts to look at issues from the perspective of the individual may be seen as inappropriate or simplistic. For example, the presenting symptoms of one Aboriginal person may well be an indicator of unresolved conflicts within the extended family or community of that person, and until these issues are addressed at the appropriate level the stress to the individual will remain<sup>13</sup>.

Children from CALD families (particularly those with limited English or with obviously foreign appearance) and indigenous families may already be struggling to feel as if they belong, and may have already found that their visible or audible difference is treated with suspicion. Their task of attempting to reconcile their parents' culture with the one in which they are currently living is already a difficult one. The desire to belong may give them very strong motivation to hide any further evidence of difference, such as a parent with a mental illness. Family members may exert pressure to keep family business secret. Workers and others may interpret behaviour with which the children attempt to manage their world in stereotypical ways ("typical overachieving Asian student"; "typical Aboriginal kid wagging school and drinking") and thus dismiss it rather than seeing it as a possible indicator of

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<sup>12</sup>Kokanovic R, Petersen A, Hansen S and Mitchell V (2001) "On having 'mental illness' in the family: Caregiving in immigrant communities" *Synergy*, Autumn.

<sup>13</sup> Reser JP (1991) "Aboriginal Mental Health: Conflicting Cultural Perspectives" in Reid J & Trompf P (eds) *The Health of Aboriginal Australia*. Harcourt Brace Jovanovich, Sydney: 233.

difficulties at home. Assessing the children's psychosocial adjustment needs to take into account cultural variables: how do their self esteem and self-concept, their attitude towards autonomy and achievement compare with others from their own culture, and how much are they affected by the way they compare themselves with mainstream norms?<sup>14</sup>

Questions for workers to think about when working with CALD and Aboriginal children whose parent/s experience mental illness include:

- ◆ How are settlement, assimilation, historical or immigration issues impacting on the child and on the family (eg poverty, racism, uncertain status, self esteem, isolation, mistrust, lack of access to or knowledge of rights and services etc)?
- ◆ Are the children accepting the parent's beliefs even though they recognise the difference from other people's belief, because they assume the difference is cultural?
- ◆ Is there conflict or tension within the family due to children and parents having different rates of acculturation and therefore different understandings of culture-specific and psychiatric explanations of the illness and treatment?
- ◆ Is the family from a collectivist culture where the stigma of the parent's illness may attach to the children to an extent where friendships, status and marriage prospects are compromised? Are the children being expected to collude with family attempts to hide the parent's illness as a result?
- ◆ Is the child carrying the hopes of his/her elders as a member of a generation that may be able to overcome the adversity of the past in the old country? How is the child able to cope with the burden of expectations on them, and have those burdens increased because of extra responsibilities related to the parent's illness?
- ◆ Did the child have exposure to trauma of his/her own to deal with, that perhaps is not being addressed due to the family being preoccupied with or distracted by the parents' issues? What is the family or community doing to assist the child's resilience in the face of their own or their parent's trauma?

Effective work can be done with CALD or indigenous families if the worker or service investigates:

- ◆ What the person's mental illness means to the person and to the family or community with whom they are interacting – what they call the problem, whether they think this is the problem, what they think caused it (one

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<sup>14</sup>Personal communication, Dr Bernadette Wright, Deputy Head, West Australian Transcultural Mental Health Centre, 2004.

cause or many causes; physical issues, energy imbalances, supernatural or spiritual causes) and why it is affecting them at this particular time<sup>15</sup>

- ◆ what the person and their family imagine treatment will do to or for them (eg in many cultures counselling would be expected to provide advice, not to assist an individual to seek their own solutions)
- ◆ what the culture or community expects of them as a parent
- ◆ where their roles fit within the family structure
- ◆ how well the person understands English and whether an interpreter is needed (the person may cope well with everyday conversation but anxiety or unfamiliar concepts and systems may make it more difficult to talk with a professional)
- ◆ if an interpreter is required, what language and/or dialect is relevant
- ◆ whether the gender or age of the worker is important<sup>16</sup>
- ◆ whether there are traditional forms of healing that the person with the illness and/or their family considers appropriate or necessary, and whether these strategies can be used either in conjunction with or instead of the treatments that would usually be prescribed<sup>17</sup>
- ◆ whether it is normal or acceptable within the culture of origin to problem-solve on an individual level, or to self-disclose about emotional issues – it may be considered more appropriate to work through a senior family member before, instead of or as well as working directly with the individual. Some questions that a worker may ask as a matter of course may require self-disclosure to an extent that is unacceptable within the culture.

If the person comes from a culture with which the worker is unfamiliar, the use of a cultural consultant (preferably not from the person's family – they may have other agendas) may be useful as a way to supplement or cross-check information initially gained from the client about these issues.

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<sup>15</sup> Coffey G and Fromhold W (2004) "Cultural Considerations in Understanding Parents with Mental Illness and their Children" in Cowling v (ed) *Children of Parents with Mental Illness 2: Personal and Clinical Perspectives*. ACER Press, Melbourne:167-190.

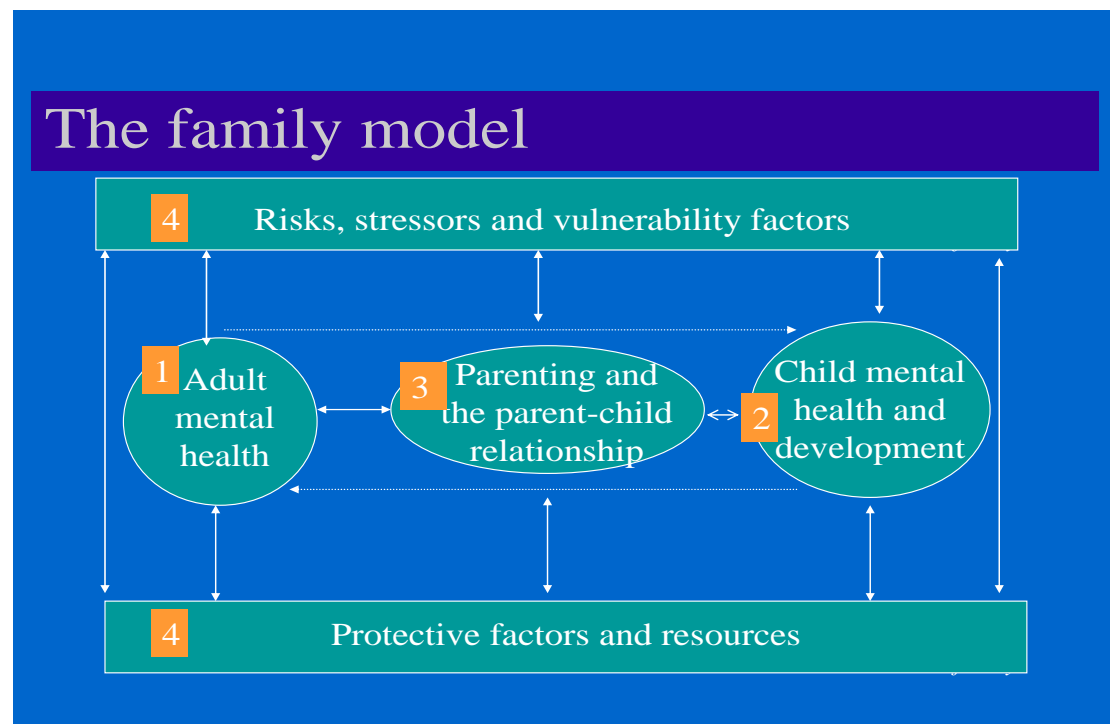
<sup>16</sup> Minas H (2001) "Communication with people from non-English-speaking backgrounds" in Meadows G and Singh B (eds) *Mental Health in Australia: Collaborative Community Practice*. Oxford University Press, Melbourne: 227.

<sup>17</sup> Mental Health Division (December 2001) *A Transculturally Orientated Mental Health Service for Western Australia*. Mental Health Division, Department of Health, Western Australia:9

## The family model<sup>18</sup>

*For the purposes of exploring the issues for families in which a parent experiences mental illness, this booklet is divided into sections that explore components of the family model illustrated below. There are sections on adult mental health, child mental health and development, and parenting and the parent-child relationship.*

*Readers are encouraged to think about the aspects of the model that are not explicitly discussed in this booklet. Think, in each family situation you encounter, about the arrows in the diagram. How does each component impact on the others? How do the risks, stressors and vulnerability factors of each family member interact with the protective factors and resources available to each of them?*



Within the family system it can be seen that:

- parental mental illness affects children (1-2)
- mental illness can affect parenting and the parent-child relationship (1-3)
- parenthood can precipitate and influence mental illness (3-1)
- children's mental health and development needs have an impact on parental mental health (2-1)

<sup>18</sup> Falkov A (ed) 1998. *Crossing Bridges: Training resources for working with mentally ill parents and their children*. Department of Health, Brighton: 29.

The family model attempts to show how interaction between adult mental health issues, the child and parenting issues is complex and multidirectional<sup>19</sup>. It also indicates that both risk factors and protective factors have their impact on what occurs within the family, and need to be considered. The example below is another attempt to illustrate the complexity and multi-directionality even in one interaction. Over time, of course, it can only become more complex as the child's behaviour impacts on the mother's mental health, the mother's mental health impacts on her parenting, and the mother's mental state and style of parenting affect the child's behaviour.

*Bill, a 14-year-old, comes home from school and demands money from his mother, Jane, to buy CDs. When she tells him she doesn't have the money he shouts at her, calls her a loony, and threatens to wreck the house if she doesn't find some cash. Jane suffers from depression and feels unable to cope with the shouting and threats. Initially she phones her ex-partner, James, to seek either assistance to control Bill or the money. When James tells her impatiently that it's all her fault and she can deal with the consequences herself, she gives Bill part of the rent money, then retreats to bed and cries. Over time, Bill discovers that threats and shouting are a good way of getting from Jane what she might not normally give him, and starts using the same bullying tactics with younger children at school. Jane continues to want to abdicate from the whole situation, particularly since she can no longer manage the budget and fears eviction if she cannot replace the rent money extorted from her by Bill.*

The focus of the COPMI initiative is on what can be done to increase the resilience of the children. At the same time it is acknowledged that the parents (both the one with the mental illness and, if available, the one without) are in most instances the obvious people to be assisting their children. So it is important to think about

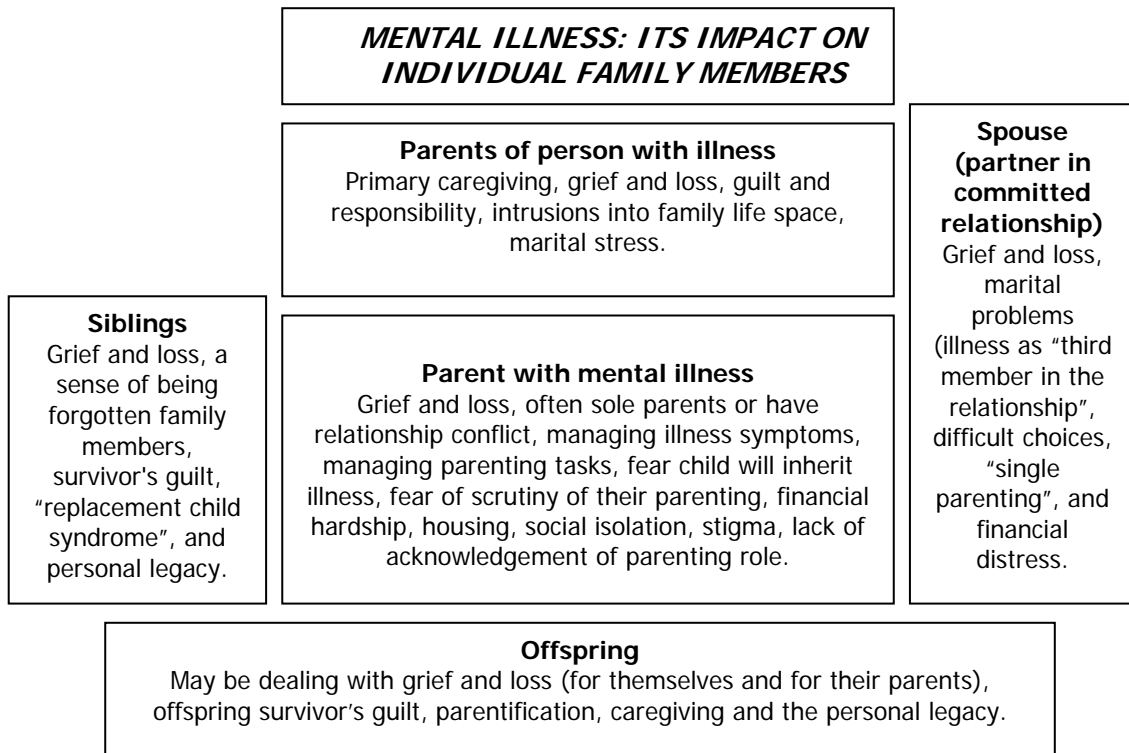
- ◆ what may be difficult for the children, how that can be overcome and what strengths and resources they can access to do that, and
- ◆ what difficulties the parents themselves are experiencing, that may be preventing them from being aware of or supplying what the children need, and what strengths or resources they can draw on to overcome those difficulties.

This booklet discusses the impact of mental illness on the parent with the illness, the child and the parenting. It does not go into any detail about the other parent, or other members of the extended family. They too, however, are affected by the illness, and may be a resource in assisting the children to develop resilience. Their concerns will be discussed further in later workshops (Awkward COPMI Conversations and Collaborative Practice). A brief synopsis

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<sup>19</sup> Goodman SH and Gotlib IH "Risk for psychopathology in the children of depressed mothers: a developmental model for understanding mechanisms of transmission" *Psychological Review* 1999, 106(3): 458-90.

of the kinds of impacts experienced by three generations of a family in which mental illness is a factor is shown below.



Also not discussed further in this booklet, but in need of consideration, are the foster parents who provide short-term or long-term homes for the children when their biological parents are unable to manage. In many cases it is grandparents who take on this role, often by default (not knowing of any better alternative) rather than from any desire to commit themselves to another unspecified period of responsibility for children. Grandparents as foster carers are reported to experience a number of difficulties. The unexpected financial burden, their own health concerns or physical frailty impacting on childcaring (especially if they are elderly), and compassion fatigue from dealing with the parent's illness as well as his/her children (particularly if problematic substance use or aggression have been involved) are a few of these. They and other foster parents also have the difficulty of not being provided with much information about the parent's illness, not knowing what impact it is likely to have had on the children, and perhaps most importantly how they can assist the children.

## Adult mental health

### *What it's like for a parent with mental illness*

The mental illness itself is only one of the factors impacting on the parent with mental illness. There is also a range of social and economic factors, associated with their illness, which will have an impact on both their own wellbeing and their ability to parent.

#### The effects of the illness

Clearly mental illness has different effects on individuals depending on their diagnosis, their resilience and supports, other stressors in their lives, and their attitude to the illness. The following are some of the ways in which the mental illness may impact on a person's ability to carry out everyday activities, including parenting functions:

- Positive symptoms – Hallucinations and/or delusions can cause people to behave in ways that others around them find inexplicable or peculiar. These symptoms may lead to conflict with others, or withdrawal from and fear of others, or perhaps to attempts to enlist others in the same beliefs. They may preoccupy a person to the extent that normal daily activities (housework, paid work, keeping the baby clean and fed, managing household finances, shopping, washing clothes, eating, or sleeping) are ignored or disrupted. Positive symptoms are only present in psychosis.
- Apathy – This may occur as a symptom of the illness (for instance as a part of the reduced activity of depression or as a negative symptom of psychosis) but may also be a side effect of the medication taken to treat the illness. Apathy reduces a person's inclination to take action on duties or pleasures they would normally be involved in. Playing or doing homework with children may become too much of a bother. This is often interpreted by family members as laziness, and can lead to considerable resentment.
- Tiredness and desire to sleep – Again this may be a symptom of the illness or a result of the medication. Many consumers report frustration with treating teams' and others' lack of understanding of this symptom. They comment on how difficult it is to carry out everyday responsibilities when it feels almost impossible to wake up in the morning, and when there are times throughout the day when there is an overwhelming desire to sleep<sup>20</sup>. It does not help when other people are assuming they are being lazy and just need to get themselves motivated.
- Anxiety – In some instances anxiety is the main feature of the illness (present in anxiety disorders and some forms of depression). It may instead be a response to some of the positive symptoms of a psychotic

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<sup>20</sup> Consumer interviews, October 2003.

illness (for example paranoid delusions may lead a person to feel anxious about going outside because of an expected attack by an enemy).

- Lack of acknowledgement of the illness – Some disorders are characterised by a lack of insight, in which the person is absorbed into their version of reality and does not acknowledge that what is being experienced is as a result of illness. In other situations the person may accept that they have a mental illness, but do not want to admit this to anyone else because of the fear of consequences (social or otherwise) if they do so. Conflict may arise as the person with the illness and the people around them express different interpretations of what is going on.
- Impaired cognition and decision making – For many people who experience mental illness, these impairments are not present all the time, but may be a feature of acute episodes. The person may experience negative consequences of decisions they have made while unwell. Another frustrating feature is that they may be expected (by friends and family as well as service delivery staff) to have equally suspect judgement or cognitive functioning when they are well.

### Socioeconomic context

Having an ongoing mental illness or one involving a number of episodes of acute illness leads to socioeconomic consequences. Stigma may affect relationships both within and outside the family. Relationships may break down as partners find it difficult to cope with changes in behaviour, energy levels, moods, and contribution to household chores and activities. Employment status may change as the person's ability to cope with their job is compromised. The result is that a large number of parents experiencing mental illness are reliant on a pension for their income – either because of being a single parent or because of inability to maintain employment as a result of their illness. Many (but importantly, not all) of these single parents are women, and thus may experience the double stigma of both mental illness and single motherhood. Poverty leads to a number of other consequences that also impact on both the experience of illness and the parenting role:

- Housing concerns: Difficulty with accessing or maintaining decent affordable housing in an area close to their networks. This may also include difficulty in negotiating with the housing provider regarding issues such as problems with rent or the need for maintenance or repairs. Lack of organisation (often a symptom of mental illness) may mean that the house is not cleaned or tidied to a standard required by the owner. Hospitalisations may put the housing in jeopardy if there is nobody left to maintain the property while the person is in hospital.
- Adequate transportation: The affordable housing is not always located close to public transport. It may be difficult to access the local mental

health clinic or other medical services by public transport. If changes of bus or train are required it may become too expensive to make the trip. One consumer commented that it was easier to do without some types of food and use a taxi to get to the shops than to try and get onto a bus with a stroller, an infant and a few bags of shopping<sup>21</sup>. Private transport is almost impossible to purchase, maintain and run if the person's sole income is the pension (consumers with cars have reported that budgeting for petrol is a weekly struggle, with choices needing to be made between essential and desirable trips).

- Nutrition: On a restricted income with a number of competing demands on one's income, producing nutritionally balanced and appetising meals is a challenge for many parents. If the illness affects energy and motivation, then the food also needs to be quickly and easily prepared. Many antipsychotic and antidepressant medications can also lead to rapid and considerable weight gain, so some parents may also be facing the challenge of preparing food which satisfies the children, satisfies their own increased desire for food, but helps them resist that tendency to weight gain.
- Childcare: Childcare provides both respite for the parent, and an alternative view of the world for the children, and thus can be valuable to both. Parents who do not have family support may have great difficulty accessing childcare either because of lack of money to pay for it, or because of lack of inclination or ability to maintain the social relationships necessary with more informal childcare arrangements.
- Gender differences: Research shows that while a minority of men with a serious mental illness marry (31-46%), a majority of women do (55-75%), and it has been postulated that for men marriage serves a protective function while for women the marriage may not affect their health so positively. Of course marriage is not a requirement for cohabitation or producing children, but the figures are reflected to some extent in the greater number of women with mental illness who are living with their children. However, it is important to be aware that men with mental illness may also be fathers, whether or not they are living with their children, or may have a parenting role with a partner's children.
- Domestic violence: Women with mental illness appear to suffer a higher incidence of domestic violence and/or sexual abuse than do other women<sup>22</sup>, and this occurs sometimes as a precipitating factor for illness and sometimes as a consequence of it. They may also be the perpetrators of the violence, either towards their partner or child/ren. This conflict in intimate relationships may lead to difficulties in maintaining a safe

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<sup>21</sup>Ruah Inreach Families Service (2003) Action Research, consumer feedback report.

<sup>22</sup> Mowbray CT, Oyserman D, Lutz C and Purnell R (1997) "Women: The Ignored Majority" in Spaniol L, Gagne C and Koehler M (eds) *Psychological and Social Aspects of Psychiatric Disability*. Boston University, Boston:171-194.

environment for children, or to the children witnessing violence. Exposure to parental hostility and discord between parents has been shown to have a strong negative impact on children from a very early age, although there have been few studies that have explored family violence involving a mentally ill parent and dependent children<sup>23</sup>. Where a parent has dual diagnosis of alcohol abuse and personality disorder or depression, it has also been shown that there is a higher risk of the children being physically abused<sup>24</sup>.

- Isolation from support networks: This can occur for a number of reasons. The stigma may lead to ostracism by family or community members. The burden of caring may overwhelm some family members, who may avoid the person for that reason. Some friends and relatives may not wish to deal with positive symptoms and some of the behaviour resulting from them. Some of the consequences of some kinds of mental illness (such as poor grooming, reduced motivation, flattened emotional response and slower speech) can be more detrimental to maintaining relationships than positive psychotic symptoms<sup>25</sup>. The person may choose to isolate him/herself from networks as a result of perceived slights by friends or relatives, or from a reduced desire to interact (possibly symptomatic of the illness), or shame related to the stigma of the illness. This can sometimes leave children with few adult role models other than the parent with the mental illness, a factor which can impact on their resilience. It also leaves parents with few avenues for respite at times when their parenting responsibilities become too much for them.
- Fear: Parents who have a mental illness may choose to not take advantage of support services because of the fear that they will be assumed to be incompetent parents and their children taken away<sup>26</sup>. The fear can be reinforced by the stories of other consumers.

### ***Developmental context***

Before moving to concentrate on the impact of mental illness on dependent children specifically, it is worth taking a moment to consider how one person's illness can affect not only their lifespan development, but also that of other members of the family. There can be an impact from the time or attention taken up by the illness, the confusion resulting from the illness, and the tendency for some family members to have their needs overlooked while the

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<sup>23</sup> Falkov A (ed) 1998. *Crossing Bridges: Training resources for working with mentally ill parents and their children*. Department of Health, Brighton: 35.

<sup>24</sup> Bland R & Orn H (1986) "Family Violence and Psychiatric Disorder", *Canadian Journal of Psychiatry*, 31(2): 129-37.

<sup>25</sup> Hamilton, NG, Ponzoha, CA, Cutler DL and Weigel RM (1989) "Social networks and negative versus positive symptoms of schizophrenia". *Schizophrenia Bulletin*, 16 (1): 157-164.

<sup>26</sup> Pietsch J and Cuff R (1995) *The CHAMP Project. Hidden Children: Families caught between two systems*. Mental Health Research Institute of Victoria, Parkville, p14.

illness is taking centre stage within the family. It may be helpful in understanding what the person's illness means to the family to consider:

- What life plans have the family or individual members had to cancel, postpone or alter?
- What are the family's needs in relation to the client's progression through the stages of illness and recovery?

The impact will depend on individual resilience and how much involvement each family member has with the person with the illness, but also on each individual's location in the lifespan, and what developmental phases or tasks may be interrupted or affected by the illness.

### Developmental phases and tasks

<p><b>INFANCY/TODDLERHOOD (0-2)</b> survival, attachment, basic trust recognition of consequences, use of symbols, exploration, socialisation and start of language development.</p>	<p><b>YOUNG ADULTHOOD</b> intimacy, marriage, partnership, parenthood vocational commitment</p>
<p><b>PRESCHOOL (3-5)</b> cognitive, social, emotional and behavioural development socialisation, identification, gender identity, self-concept</p>	<p><b>MIDDLE ADULTHOOD</b> renegotiation of commitments launching of children</p>
<p><b>MIDDLE CHILDHOOD (6-12)</b> academic adjustment peer relations</p>	<p><b>LATE ADULTHOOD</b> retirement, financial security loss of intimate relationships personal illness and mortality life review, grandparenthood</p>
<p><b>ADOLESCENCE (12-18)</b> identity, sexuality career plans, separation</p>	

Note: the approximate ages suggested above for these developmental phases may vary among individuals. In different cultural and socioeconomic contexts some phases may be truncated or extended in comparison with others.

## Child mental health and development

### *Impact of parental mental illness on children*

*"She was manic, delusional, needed to make phone calls to the Prime Minister and the Pope. I was feeling `this is weird, this isn't my mum, I'm having to be the mum here, locking away the phone so she can't make those phone calls"*  
(Female, now adult, then year 8)

*"When I came back from school, dinner was 2 fish cakes on a plate. They were hard. I don't think we got breakfast. We'd leave her howling like a dog, come home to her howling like a dog"*  
(Female, now adult, then primary school age)

Some children of parents with mental illness manage very well developmentally, mentally and emotionally. Compared with the general population, however, this group can be considered an at-risk group and have been shown to display increased rates of the following:

#### Rates of mental health diagnoses, particularly depression

A complex interplay of genetic and environmental factors is involved in how the increased risk of mental illness in children of parents with mental illness will manifest in any individual child. The vulnerability may be to the specific mental illness experienced by the parent or to any related disorder, and a range of protective factors can mitigate the genetic risk. Another factor it is important to consider is that advances in psychiatric treatment have improved the prognosis for people with mental illness compared with sufferers of the same illness 20 years ago. There is every chance that this will continue, and if children of people who are currently mentally ill do become unwell themselves, the course of their illness may have much less impact on their lives than what their parent experienced.<sup>27</sup>

Research shows that maternal stress and anxiety during pregnancy are transmitted to the foetus, and "the long-term neurodevelopmental effects on the infant ... may include an increased predisposition to later depression"<sup>28</sup>. Vulnerability to later illness may also arise from birth complications or lower birth weight.

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<sup>27</sup>Hay D (2003) "Understanding and Explaining the Genetics of Mental Illness" in Cowling V (ed) *Children of Parents with Mental Illness*. ACER, Melbourne

<sup>28</sup> Glover V "Maternal stress or anxiety in pregnancy and emotional development of the child" *British Journal of Psychiatry* (1997), 171, 105-106.

Rutter and Quinton<sup>29</sup> showed that among the children of consecutive new psychiatric patients, a third showed a persistent psychiatric disorder, a third had transient psychiatric difficulties, and a third showed no emotional or behavioural disturbance. Frequently the children were diagnosed with conduct disorders, which are among the most persistent and most difficult to treat of psychiatric disorders in children. A control group showed comparable rates of transient disturbance but half the frequency of persistent disturbance.

### Psychosocial stress

As has been discussed earlier, mental illness is often associated with a range of other psychosocial risk factors, such as poverty, isolation, unemployment, substance use and domestic violence, all of which can impact on the children. This is particularly relevant where there is an absence of structure, stability and organisation in the home as a result of the parent's illness<sup>30</sup>.

### Learning difficulties, emotional and/or behavioural problems

Maternal anxiety or stress throughout pregnancy is linked with low birth weight, which is a risk factor for a number of later health issues including possibly mental health issues<sup>31</sup>. Research has shown a strong connection between antenatal maternal anxiety and behavioural/emotional problems in the children, and indicates that this could be a direct effect of the mother's mood on fetal brain development<sup>32</sup>. Untreated depression during pregnancy has greater adverse effects on the child's cognitive and language achievement than does the exposure to antidepressants, with the clinical factors (effects in utero, number of depressive episodes after birth, use of antidepressants) appearing to affect outcomes more than external environmental factors<sup>33</sup>.

There is another body of evidence indicating that it is not necessarily the parent's mental illness or its symptoms affecting the children, but rather the psychosocial factors associated with it<sup>34</sup>. Such factors as poverty, family conflict, disruptions in schooling and the shift to alternative care that accompany the parent's hospitalisations may be the source of the children's

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<sup>29</sup>Rutter M & Quinton D (1984) "Parental Psychiatric Disorder: Effects on Children". *Psychological Medicine*, 14, 853-880.

<sup>30</sup>Vanharen J, Laroche C, Heyman M, Massabki A & Colle L (1993) "Have the invisible children become visible?" *Canadian Journal of Psychiatry*, 38.

<sup>31</sup>Gitau R, Fisk N and Glover V "Maternal Stress in Pregnancy and its Effect on the Human Foetus: An Overview of Research Findings". *Stress*, V4: 195-203.

<sup>32</sup>O'Connor T, Heron J, Golding J, Beveridge M and Glover V "Maternal antenatal anxiety and children's behavioural/emotional problems at 4 years". *British Journal of Psychiatry* (2002), 180, 502-508.

<sup>33</sup>Nulman I, Rovet J, Stewart D, Wolpin J, Pace-Asciak P, Shuhaiber S, Koren G. "Child Development Following Exposure to Tricyclic Antidepressants or Fluoxetine Throughout Fetal Life: A Prospective, Controlled Study. *American Journal of Psychiatry* 2002, 159: 1889-1895.

<sup>34</sup>Rutter M & Quinton D (1984) "Parental Psychiatric Disorder: Effects on Children". *Psychological Medicine*, 14, 853-880.

behavioural, learning and emotional difficulties<sup>35</sup>. Whatever the aetiology, persistent emotional and behavioural difficulties for children are at least twice as common, and attention deficit or behavioural disorders are more frequent in children of mentally ill parents than in other children. Up to 50% of these children will be vulnerable to emotional disturbance in adulthood, perhaps requiring psychiatric intervention<sup>36</sup>.

### Antisocial behaviours

Risk of antisocial behaviours is highest in children who have been exposed to multiple risk factors over a long period, such as parental personality disorder, hostility to the child and marital disharmony, three factors which often coexist in a family<sup>37</sup>. Childhood antisocial behaviour in a minority of cases may develop into adult antisocial personality disorder, usually in instances where there has been inadequate parenting and separation through foster care<sup>38</sup>.

### Suicidal behaviour

Mental illness within the family, particularly if it involves parental suicidal behaviour, personality disorder, or problematic substance use, is one of the risk factors for pre-adolescent suicide. Other risk factors include any prior suicidal ideation or attempts by the child, or mood disorder (in the child). Family discord including physical or sexual abuse of the child, and events leading to family instability such as moves, death, and the illness of significant carers may result in children's suicidal behaviour. Suicidal behaviour is as much attributable to the psychosocial environment in which the family lives as to direct results of the parent's illness behaviour.<sup>39</sup>.

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<sup>35</sup> Silverman MM (1989) "Children of psychiatrically ill parents: a prevention perspective. *Hospital and Community Psychiatry*, 40, 1257-1265.

<sup>36</sup> Pietsch J and Cuff R (1995) *Hidden Children: Families caught between two systems. An interim report: developing programs for dependent children who have a parent/s with a serious mental illness*. The Mental Health Research Institute of Victoria, Parkville: 3.

<sup>37</sup> Hall A (1996) "Parental Psychiatric Disorder and the Developing Child" in Gopfert M, Webster J and Seeman M (eds) *Parental Psychiatric Disorder: Distressed parents and their families*. Cambridge: Cambridge University Press.

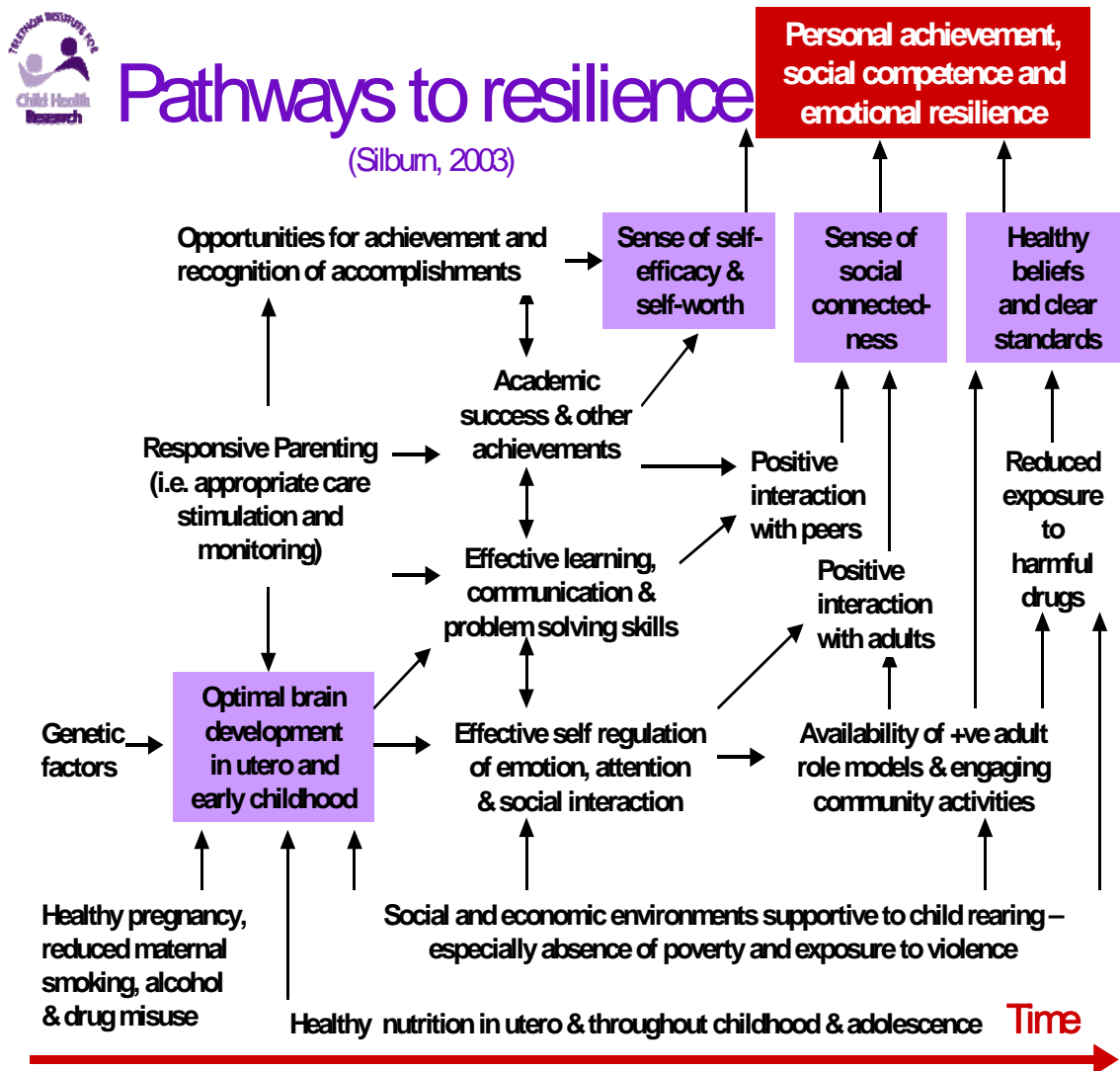
<sup>38</sup> Zeitlin H (1986) cited in Hall A (1996) *op cit*.

<sup>39</sup> Pfeffer C (2000) "Suicidal Behaviour in Children: an Emphasis on Developmental Influences" in Hawton K and van Heeringen K (eds) *The International Handbook of Suicide and Attempted Suicide*. John Wiley & Sons, New York:237-248.

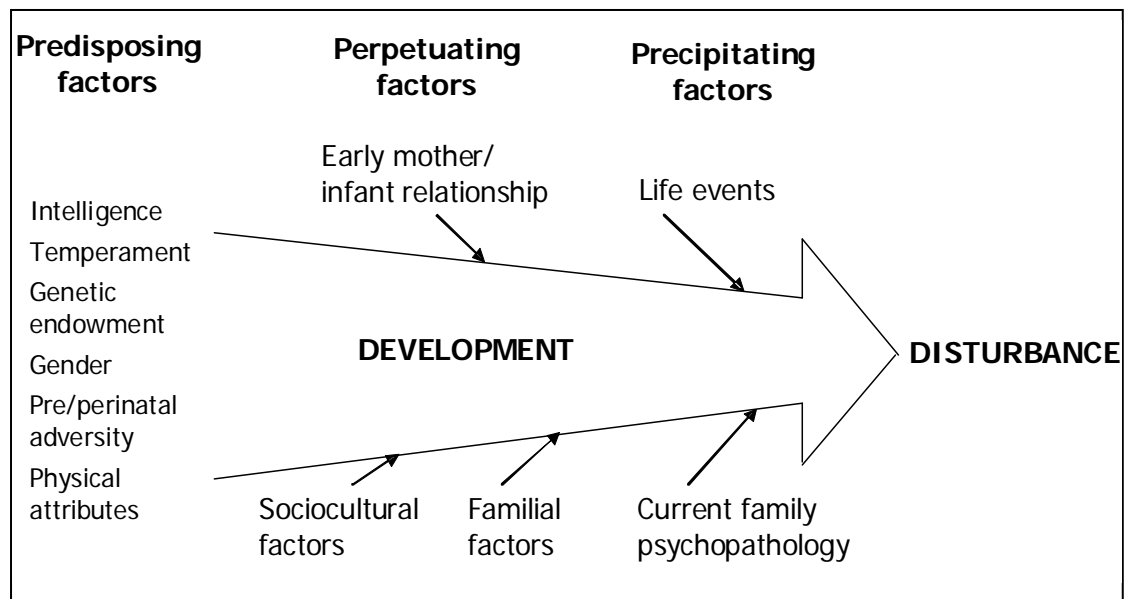
## Resilience factors

These are the factors that have been shown to contribute to a resilient child<sup>40</sup>. Absence or disruption of any of these factors may reduce resilience, although as the diagram shows, factors do not operate in a linear fashion. If one step on the path is blocked, a child has options that enable a happy ending despite that obstacle.

The factors that can contribute to disturbance and reduced resilience are shown in the developmental model overleaf. Protective factors (those which promote resilience) are not shown in this model.



<sup>40</sup> New directions in Australian suicide prevention. Invited keynote address to the 1st Asia-Pacific Injury Prevention Conference & 6th National Conference on Injury Prevention and Control, Fremantle, Western Australia, 16-18 March 2003.



*Developmental model*

### ***How parental mental illness affects attachment***

The attachments infants and toddlers develop with their primary parent figure form the template for the ways they later deal with relationships and with the tension between dependence and independence. Secure attachments are an important factor in resilience.

Normally if a person wants to reduce distress or feel emotional closeness, they attract that closeness by a repertoire of behaviours they learned in childhood:

- ◆ Behaving in a socially appealing manner (as babies they smiled and laughed)
- ◆ Sending out distress signals to invite attention and concern (as babies they cried)
- ◆ Actively approaching and seeking out others (as babies they reached out for their mother, or followed her around)<sup>41</sup>.

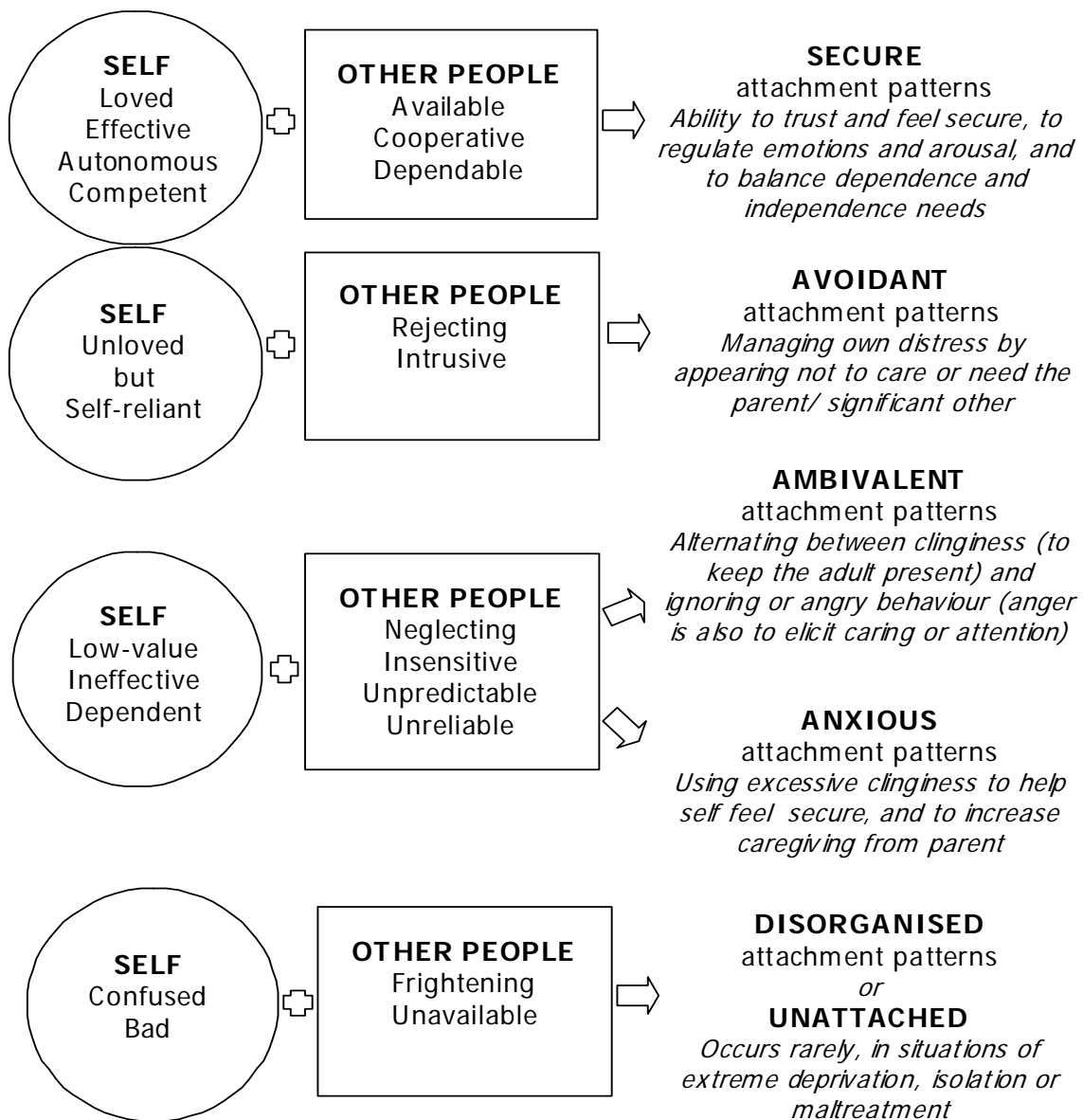
If a parent is for some reason unavailable for several weeks or more, and other satisfactory attachment figures cannot be found, a small child may develop insecure attachment patterns such as those in the diagram overleaf. Parental unavailability may be due to actual separation for some reason (such as hospitalisation of either parent or child). But it may also take the form of emotional absence, where the adult is not responsive to the child's expressed needs. Mental illness can be one reason for this. A depressed or delusional parent (or a highly disorganised one) may become emotionally unavailable to the child if all their energy is being focussed on their own concerns. This

<sup>41</sup> Howe D, M Brandon, Hinings D and Schofiel G (1999) *Attachment Theory, Child Maltreatment and Family Support*. Macmillan, London: 15.

inattention may be mitigated where the other parent or a grandparent can step in to take over (or share) the role of attachment figure. If other family members, however, are overwhelmed with the disruptions to the family caused by one parent's illness, they too may feel unable to be emotionally present for the child.

The attachment disturbances described below are a result of both internal processes (perceptions of self) and environmental factors (how others have behaved towards the child).

### HOW INTERNAL MODELS AFFECT ATTACHMENT PATTERNS



Adapted from  
 Howe, Brandon, Hinings and Schofield (1999) *Attachment Theory, Child Maltreatment and Family Support*. MacMillan, London: 25; and  
 Archer, C (1999) *First Steps in Parenting the Child Who Hurts: Tiddlers and Toddlers*. Jessica Kingsley Publishers, London and Philadelphia: 37-39.

Parental mental illness often leads to situations in which physical or emotional absence of a caregiver may occur for extended periods of time, and for that reason may make a child vulnerable to attachment disturbances. If the child is very young (under 3 years old) when the first separations from an attachment figure occur, or if there are several separations in which the parent is replaced by different carers each time, the child's vulnerability may be increased. If the child is unable to access good-quality social interaction and thus is unable to learn how to behave socially, the vulnerability may be compounded by the child's decreased ability to form positive supportive relationships.

There are, however, factors that can protect the child's resilience. Protective factors within the infant (temperament, intelligence or skill in self-regulation) or within the environment (other adults who are supportive of either the parent or the child) can mitigate the risk. Children who avoid frequent changes of carers may manage to preserve secure attachments. Those who have positive relationships outside the family and are able to recognise that the parent is ill may succeed in protecting their self-esteem. Those who have already developed secure attachments before they encounter the parent's illness may already have a strong enough sense of self to help them manage any separation or emotional distance.

<b>Impact of parental depression on children according to age/developmental stage<sup>42</sup></b>			
<b>AGE/DEVELOPMENTAL STAGE OF CHILD</b>			
<b>Infant</b>	<b>Toddler</b>	<b>Primary school</b>	<b>Adolescent</b>
Disordered attachment relationships Less responsive and spontaneous More withdrawn and apathetic "Fussy" Cognitive impairment (esp. male infants)	Less content, more distressed Less persistent in completing tasks More sensitive More anxious or avoidant behaviour More compassion (role reversal) More behavioural problems (more demanding) Developmental delays (eg language)	Lower self-esteem Greater rates of emotional and behavioural problems (eg depression, conduct disorder) More somatic complaints (eg stomach aches, headaches) More anxious and less confident Poorer concentration and attention span Underachievement at school Less competent peer relationships More conflict in family relationships	Lower self-confidence More socially isolated More care responsibilities (eg for parent or siblings, chores) Conflict in relationships (family, peer) Poorer academic performance More behavioural and emotional disorders (depression, anxiety, conduct disorder, substance misuse) Less supervision and greater rates of dangerous, illegal activities Self-harm

<sup>42</sup> Falkov A (ed) 1998. *Crossing Bridges: Training resources for working with mentally ill parents and their children*. Department of Health, Brighton: 58.

## IMPACT OF MENTAL ILLNESS, SUBSTANCE USE AND DOMESTIC VIOLENCE ON CHILDREN<sup>43</sup>

<b>CHILDREN 0-2 YEARS</b>	
<b>Basic tasks: survival, attachment, basic trust.</b>	
<b>Key problems</b>	<b>Protective factors</b>
<ul style="list-style-type: none"> <li>◆ Neurological and physical damage to baby may result from untreated mental illness, violence or substance use in pregnancy</li> <li>◆ Physical and emotional neglect of babies may damage their health</li> <li>◆ The child's health problems may be exacerbated by living in an impoverished physical environment</li> <li>◆ Cognitive development of the infant may be delayed through parents' inconsistent, under-stimulating and neglecting behaviour</li> <li>◆ Children may fail to develop a positive identity because they are rejected and uncertain of who they are</li> <li>◆ Babies suffering withdrawal symptoms from fetal addiction may be difficult to manage</li> <li>◆ A lack of commitment and increased unhappiness, tension and irritability in parents may result in inappropriate responses which lead to faulty attachment</li> </ul>	<ul style="list-style-type: none"> <li>◆ The presence of an alternative or supplementary caring adult who can respond to the developmental needs of babies</li> <li>◆ Sufficient income support and good physical standards in the home</li> <li>◆ Regular supportive help from primary health care team and social services, including consistent day care</li> <li>◆ An alternative, safe and supportive residence for mothers subject to violence and the threat of violence</li> <li>◆ Skilled pre-pregnancy counselling for mothers with known mental illness, and appropriate support and treatment of the illness during pregnancy<sup>44</sup></li> </ul>

<sup>43</sup> Adapted from Cleaver H, Unell I, Aldgate J (1999) *Children's Needs- Parenting Capacity: The impact of parental mental illness, problem alcohol and drug use, and domestic violence on children's development*. The Stationery Office, London. 47-98; Stoppard M (1995) *Complete Baby and Child Care*. Viking, Ringwood, Victoria.

<sup>44</sup> Personal communication, Dr Jon Rampono

## CHILDREN 3-5 YEARS

**Basic tasks: cognitive, social, emotional and behavioural development  
Socialisation, language development, identification, gender identity, self concept**

Key problems	Protective factors
<ul style="list-style-type: none"> <li>◆ Children may be placed in physical danger by parents whose capacity to care is limited by mental illness, excessive substance use, or domestic violence</li> <li>◆ Children may have their physical needs neglected, for example, may be unfed or unwashed</li> <li>◆ Children may be subjected to direct physical violence by their parents</li> <li>◆ Cognitive development may be delayed through lack of stimulation, disorganisation and failure to attend pre-school facilities</li> <li>◆ Attachment may be damaged by inconsistent parenting</li> <li>◆ Children may learn inappropriate behavioural responses through witnessing domestic violence</li> <li>◆ When parents' behaviour is unpredictable and frightening children may display emotional symptoms similar to those of post-traumatic stress disorder</li> <li>◆ Children may take on responsibilities beyond their years because of parental incapacity</li> <li>◆ Children may be at risk because they are unable to tell anyone about their distress</li> </ul>	<ul style="list-style-type: none"> <li>◆ The presence of an alternative, consistent caring adult who can respond to the cognitive and emotional needs of the child</li> <li>◆ Sufficient income support and good physical standards in the home</li> <li>◆ Regular supportive help from primary health care team and social services, including consistent day care, respite care, accommodation and family assistance</li> <li>◆ Regular attendance at pre-school facilities</li> <li>◆ An alternative, safe and supportive residence for mothers subject to violence and the threat of violence</li> </ul>

## CHILDREN 5-9 YEARS

### Basic tasks: academic adjustment, peer relationships

Key problems	Protective factors
<ul style="list-style-type: none"> <li>◆ Possible increased risk of physical injury, symptoms of extreme anxiety and fear</li> <li>◆ Academic attainment may be negatively affected, or there may be problematic behaviour at school</li> <li>◆ Identity, age and gender may affect outcomes. Boys more quickly exhibit problematic behaviour but girls are also affected if parental problems continue</li> <li>◆ Children may develop poor self-esteem, and may blame themselves for their parents' problems</li> <li>◆ Inconsistent parental behaviour may cause anxiety and faulty attachments</li> <li>◆ Children may fear hostility or self-harm from parents</li> <li>◆ Unplanned separation can cause distress and disrupt education and friendship patterns</li> <li>◆ Children may feel embarrassment or shame over parent's behaviour, and in consequence may curtail friendships and social interaction</li> <li>◆ Children may take on too much responsibility for themselves, their parents and younger siblings</li> </ul>	<ul style="list-style-type: none"> <li>◆ Cognitive ability to rationalise parent's behaviour in terms of illness, and thus accept and cope with it</li> <li>◆ The presence of an alternative, consistent, caring adult who can respond to the cognitive and emotional needs of children</li> <li>◆ Sufficient income support and good physical standards in the home</li> <li>◆ Regular supportive help from a primary health care team and social services, including respite care and accommodation</li> <li>◆ Regular attendance at school, and at school health screening</li> <li>◆ Sympathetic, empathic and vigilant teachers</li> <li>◆ An alternative, safe and supportive residence for mothers subject to domestic violence</li> <li>◆ A supportive older sibling, a friend, or social networks outside the family (especially a sympathetic adult of the same sex)</li> <li>◆ Belonging to organised out-of-school activities, including homework clubs</li> <li>◆ Being taught different ways of coping and being sufficiently confident to know what to do when parents are incapacitated</li> <li>◆ Ability to separate, either psychologically or physically from the stressful factor</li> </ul>

<b>CHILDREN 10-14 YEARS</b>	
<b>Basic tasks: identity, sexuality</b>	
<b>Key problems</b>	<b>Protective factors</b>
<ul style="list-style-type: none"> <li>◆ Coping with puberty without support</li> <li>◆ Increased risk of psychological problems</li> <li>◆ Fear of being hurt</li> <li>◆ Increased risk of actual injury</li> <li>◆ Anxiety about how to compensate for physical neglect</li> <li>◆ Education suffers because of difficulty concentrating</li> <li>◆ School performance may be below expected ability</li> <li>◆ Children may miss school because of looking after parents or siblings</li> <li>◆ Children reject their families and have low self-esteem</li> <li>◆ Children are cautious of exposing family life to outside scrutiny</li> <li>◆ Friendships are restricted</li> <li>◆ Children fear the family will be broken up</li> <li>◆ Children feel isolated and have no one to turn to</li> <li>◆ Children are at increased risk of emotional disturbance and conduct disorders</li> <li>◆ An increased risk of sexual abuse in adolescent boys</li> <li>◆ Problems of being a young carer increase</li> <li>◆ Children may be in denial of their own needs and feelings</li> </ul>	<ul style="list-style-type: none"> <li>◆ Sufficient income support and good physical standards in the home</li> <li>◆ Practical and domestic help</li> <li>◆ Regular medical and dental checks, and factual information about puberty, sex and contraception</li> <li>◆ Regular attendance at school</li> <li>◆ Sympathetic, empathic and vigilant teachers</li> <li>◆ Belonging to organised out-of-school activities, including homework clubs</li> <li>◆ A mentor or trusted adult with whom the child is able to discuss sensitive issues, and/or an adult who assumes the role of champion for the child</li> <li>◆ A mutual friend</li> <li>◆ A range of coping strategies, and confidence to know what to do when parents are incapacitated, including contact details for relevant professionals and who to contact if there is a crisis regarding the parent</li> <li>◆ An ability to separate, either psychologically or physically, from the stressful situation</li> <li>◆ Unstigmatised support from relevant professionals, and acknowledgement of the child's caring role and responsibilities within the family</li> <li>◆ An alternative, safe and supportive residence for mothers and children subject to domestic violence</li> </ul>

## YOUNG PEOPLE 15-18 YEARS

### Basic tasks: identity, sexuality, career plans, separation

Key problems	Protective factors
<ul style="list-style-type: none"> <li>◆ Teenagers with inappropriate role models</li> <li>◆ At greater risk of accidents</li> <li>◆ May have problems related to sexual relationships</li> <li>◆ May fail to achieve their potential</li> <li>◆ Are at increased risk of school exclusion</li> <li>◆ Poor life chances due to exclusion and poor school attainment</li> <li>◆ Low self-esteem as a consequence of inconsistent parenting</li> <li>◆ Increased isolation from both friends and adults outside the family</li> <li>◆ Teenagers may use aggression inappropriately to solve problems</li> <li>◆ Emotional problems may result from self-blame and guilt, and lead to increased risk of suicidal behaviour, and vulnerability to crime</li> <li>◆ Teenagers' own needs may be sacrificed to meet the needs of their parents</li> </ul>	<ul style="list-style-type: none"> <li>◆ Sufficient income support and good physical standards in the home</li> <li>◆ Practical and domestic help</li> <li>◆ Regular medical and dental checks</li> <li>◆ Factual information about sex and contraception</li> <li>◆ Regular attendance at school or further education</li> <li>◆ Sympathetic, empathic and vigilant teachers</li> <li>◆ For those no longer in full time education, a job</li> <li>◆ A trusted adult with whom the young person is able to discuss sensitive issues.</li> <li>◆ An adult to act as champion for the child</li> <li>◆ A mutual friend</li> <li>◆ A range of coping strategies, and confidence to know what to do when parents are incapacitated, including contact details for relevant professionals and who to contact if there is a crisis regarding the parent</li> <li>◆ An ability to separate, either psychologically or physically, from the stressful situation</li> <li>◆ When young people act as carers, and experience a degree of satisfaction and control this may act as a protective factor</li> <li>◆ Unstigmatised support from relevant professionals recognising the role of the young carer</li> <li>◆ An alternative, safe and supportive residence for young people subject to domestic violence</li> </ul>

## ***Common themes for COPMI***

### Self-blame - belief that their own behaviour causes parent's illness

Children may examine the information available to them and come to the conclusion without assistance that their parent's illness is their (the child's) fault, either just by being born, or because of naughty behaviour. Parents or others may reinforce the message by commenting that behaving in particular ways might make the parent sick. A study by Dunn<sup>45</sup> identified a complex mix of loyalty and guilt experienced by children of mentally ill mothers. Loyalty can lead to difficulties for the child as the desire to escape the erratic or difficult environment of the unwell parent conflicts with love for that parent and desire to protect or nurture her. The child may feel guilty because of a perception that s/he is to blame for the parent's illness, or because s/he wants to leave home thus abandoning the unwell parent, or even because the child has been able to achieve more than the sick parent.

***It is important to note that part of being loyal to the parent may involve keeping the illness secret from outsiders. The child may feel very uncomfortable if asked to disclose "family business" because of a perception (or past experience) that it may result in being separated from the parent<sup>46</sup>.***

### Caregiving for the affected relative/s

Children of mentally ill parents report an increased sense that they need to take care of their parent. This may involve taking over a number of household tasks that the adult feels unable to complete, at other times it may be the emotional needs of the parent that the child attempts to meet. Sometimes it is almost as if there is competition for the child role.

*After Dad disappeared [presumed dead] I became the surrogate father to my five adopted siblings. This wasn't a total shock to me. When he'd been well, Dad and I had been quite close. But then during the years when he was working two jobs and we hardly saw him, I was already taking on a parent role with the younger kids. As he got more seriously depressed he became more distant emotionally anyway<sup>47</sup>.*

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<sup>45</sup>Dunn B (1997) "Growing up with a psychotic mother: a retrospective study" in Spaniol L, Gagne C and Koehler M (eds) *Psychological and Social Aspects of Psychiatric Disability*. Boston University, Boston: 323-332.

<sup>46</sup> Absler D (1999) "Talking with Children about Their Parent's Mental Illness or Mental Health Problem" in Cowling V (ed) *Children of Parents with Mental Illness*. ACER, Melbourne.

<sup>47</sup> Jack, adult COPMI, now a parent who suffers from depression himself.

*My brother was doing TEE, Dad was working, so I took on the role of cooking, cleaning. A friend's mum helped with the ironing etc. I got a D for cooking at that time (the teacher acknowledged it was mostly because I mucked around in class) and I ended up joking with my dad and my brother "I hope my cooking wasn't that bad." We could all laugh about it<sup>48</sup>.*

*I became the perfect child to spare my parents more grief. I was forced to become responsible. In many ways it forced me to accomplish things in my life I might not otherwise have done. But I have spent my life trying to run away from this problem. Feeling guilty and helpless, the unending sorrow for not being able to help. I have not felt entitled to be happy most of my adult life<sup>49</sup>.*

### Family disruption

Mental illness is often a catalyst for relationship breakdown. The parents may stay together in a state of chronic conflict, or may separate. Either way, there is impact on the children. As in relationship conflicts where mental illness is not a factor, one parent may try to recruit the children's support for their point of view or "side." If one of the parents has a mental illness, recruitment by the "well" parent may involve stereotyping and offensive insults related to mental illness, with the child also responding to the parent in that way. The ill parent, on the other hand, may try to convince the child to collude with delusional agendas.

Consumers (at consumer forums and 1:1 interviews) commented:

*Anything I did was put down to "going off." "If you people would pull yourselves together..." It's very painful when family members mimic or laugh at mental illness. The kids were taught by their dad to laugh at my illness<sup>50</sup>.*

*My breakdown happened a long time ago, and my wife was advised to take the kids and leave. Difficult for her to cope with the kids and support me under treatment at the same time. Humour at the expense of mentally ill people is hurtful to my wife. That attitude gets perpetuated through generations – the kids pick it up and replicate it<sup>51</sup>.*

Family disruption may involve the children "walking on eggshells" to try to avoid explosions from the mentally ill parent during acute episodes. It may

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<sup>48</sup> Jennifer, adult COPMI who has not experienced mental illness herself

<sup>49</sup> Family member, cited in Marsh DT (2000) "Meeting the Needs of Young Family Members" in Spaniol L, Zipple A, Marsh D and Finley L (eds) *The Role of the Family in Psychiatric Rehabilitation: A workbook*. Center for Psychiatric Rehabilitation, Boston University:75.

<sup>50</sup> Female consumer, Consumer forum, Perth, October 2003.

<sup>51</sup> Male consumer, Consumers' forum, Perth, October 2003.

mean that while the parent is ill some of the children's activities are put on hold either so care can be given to the parent (eg hospital visits) or because the parent cannot manage. It may include changes to routine, to standards of cleanliness, and to how family members interact with each other. Homework or after-school activities may be neglected because the family's energy is focussed on the ill parent. Interaction between family members may be characterised by hostility, lack of warmth, or tension, with little sense of togetherness. Disruption may be as extreme as domestic violence, separation, or the children being considered at risk and placed in foster care. A parent's hospitalisation can disrupt household routines, with the child not only experiencing the loss of the separation from the affected parent, but often also the fear that the parent may not return.<sup>52</sup>

### Need for information and debriefing

Children who are not given explanations of why the parent is behaving in a way that is puzzling or unlike the behaviour of other people's parents will make up their own explanations. These may be self-blaming ("Mum/Dad is behaving like that because I'm bad") or upsetting in other ways ("s/he hates me"). They need age-appropriate explanations of the questions that concern them about the parent's behaviour, and someone with whom they can talk through fears, guilt and confusion. The parent may not feel confident, comfortable or willing to give that explanation. The child may feel it is disloyal to speak of his/her own needs, or believe that the parent would not cope with the added burden. It may help for the parent to be coached or supported to have these difficult conversations with the child. Otherwise the child may seek support from another trusted adult.

Several adults whose childhood was spent with a parent with mental illness mentioned concerns they felt about whether they too would experience mental illness when they grew up. Some said they had even wondered whether the risk of passing a genetic vulnerability to their own children meant they should consider not having biological offspring<sup>53</sup>.

### Having a mentally ill parent can make you stronger

While children of a parent with mental illness may be at risk of some adverse consequences, and thus should have access to extra supports that can help minimise those risks, there are many children who are resilient and show no major ill-effects. Resilience is the ability to bounce back from adversity. That is, it can only be shown to exist if there has been adversity to bounce back from. Some children who have grown up with mentally ill parents believe their experiences have helped them become better human beings. They specify that overcoming adversity has made them stronger. They talk of stronger

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<sup>52</sup> Thomas L and Kalucy R "Parents with mental illness: A qualitative study of the effects on their families" *Journal of Family Studies, Vol 8, No 1, April 2002: 38-52.*

<sup>53</sup> Consumer forum and individual interviews, Perth, October and November 2003.

bonds within the family, or believe they are more compassionate and more competent as a result of their experiences with a parent with mental illness.

The impact of the parent’s mental illness depends partly on the child’s perception or interpretation of what is happening. For example, one child who is expected to take on a quasi-parental role with younger siblings may resent the role and wish for a “real childhood,” whereas another child in the same position may feel gratified at having a useful role in which s/he can genuinely help the family.

Returning to the theme of resilience raised earlier, evidence shows certain factors to have enabled some children with a parent with mental illness to avoid negative consequences. These are summarised in the table below<sup>54</sup>.

## What makes a resilient child

<p><b>INDIVIDUAL CHARACTERISTICS</b></p> <ul style="list-style-type: none"> <li>• Able to resist over-involvement and over-identification with affected parent</li> <li>• Able to sustain independence and psychological separation from the illness</li> <li>• Low risk temperament (positive mood, high regularity, malleable, fastidious)</li> <li>• Intellectual and social competence</li> <li>• Interest in finding out about illness</li> </ul>	<p><b>FAMILY ENVIRONMENT</b></p> <ul style="list-style-type: none"> <li>• No serious discord</li> <li>• Good parenting skills</li> <li>• Good relationship with one or more parents</li> <li>• Supportive “non-affected” parent</li> <li>• No other psychosocial adversity</li> <li>• Intact family</li> <li>• Warm and emotionally supportive family environment</li> </ul>
<p><b>PARENTAL DISORDER</b></p> <ul style="list-style-type: none"> <li>• Brief or transient (not chronic)</li> <li>• Comparatively mild disorder</li> <li>• Does not involve child in symptomatology</li> </ul>	<p><b>SOCIAL ENVIRONMENT</b></p> <ul style="list-style-type: none"> <li>• Good relationship with appropriate role model outside of family</li> <li>• Good peer relationships</li> <li>• Involvement in compensatory social activities</li> <li>• Presence of extended support system</li> </ul>

<sup>54</sup> This table was adapted from the “Wheel of Fortune” (no reference available) which is based on evidence such as Rutter (1989) “International continuities and discontinuities in serious parenting difficulties” in Cicchetti and Carlson (eds) *Child Maltreatment*. Cambridge University Press; Garmezy (1991) Resilience in children’s adaptation to negative life events and stressed environments. *Pediatric Annals*, 20 (9), 459-466; Shure, M.B. & Spivak, G. (1988). Interpersonal cognitive problem solving. In R.H. Price, E.L. Cowen, R.P. Lorion, and J. Ramos-McKay (Eds). *Fourteen ounces of prevention: A casebook for practitioners*. (pp. 69-82). Washington, DC: American Psychological Association; Fisher & Kokes (1987) *Competent Children at Risk: A Study of Well-functioning Offspring of Disturbed Parents* in Anthony and Cohler (eds) *The Invulnerable Child*. New York, Guilford Press.

## Parenting and the parent-child relationship

Being a parent is an important life role that is highly valued by adults in our society, and within many cultures is considered to be one of the roles that defines adulthood. People with mental illness tend to parent at the same rate as members of the general public and can be highly motivated to fulfil that role<sup>55</sup>.

Mental illness can have an impact on a person's ability to carry out the functions of a parent and can sometimes make those tasks more difficult, but it does not prevent a person from parenting. With appropriate supports to enhance their resilience, parents with mental illness can be caring and effective parents.

### *The impact of parenting on mental illness*

The interaction between parenting and mental illness is a complex one, and goes in both directions. Being a parent can affect the mental illness in a number of ways:

- ◆ Giving birth or commencing child rearing may trigger the onset of illness for parents who are vulnerable. Postnatal depression and psychosis are examples affecting mothers, but fathers may also become ill as a result of the stress and role changes around the time of the birth of a child.
- ◆ The ongoing stress of parenting can worsen a pre-existing illness, particularly if there is not much support for the parents. This may be exacerbated if the child exhibits developmental or behavioural problems, or has a hostile or stigmatising response to the parent's mental illness.
- ◆ Parents with mental illness may feel added pressure to "measure up," sometimes to unrealistic standards. This may be because they are aware that child protection issues have already been raised and they are under scrutiny by the Department for Community Development, or because they fear that this scrutiny is an inevitable consequence of their illness. Parents talk about "giving 110%", trying to be super mum or dad, or fearing that even normal naughtiness in their children will be perceived as evidence of their own inadequacy as parents because of the mental illness.
- ◆ Parents may avoid hospitalisation for their illness even when necessary because they do not know what will happen to their children while they are in hospital.

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<sup>55</sup>Supporting Families with Parental Mental Illness Provincial Working Group (2002) *Supporting Families with Parental Mental Illness: A Community Education and Development Workshop. Community Mental Health Services and Ministry of Children and Family Development, British Columbia: 77.*

- ◆ A child may (consciously or unconsciously) reinforce particular behaviours that are not necessarily in the parent's best interests because there are payoffs for the child. For instance, a parent who becomes very affectionate and attentive to the child when intoxicated or on the way towards mania may be encouraged by the child's positive response to that behaviour to pursue the state in which it happens (ie neglect to take mood stabilisers, or continue substance use).

However, parenting can also contribute to recovery by providing

- ◆ a source of motivation to manage one's illness
- ◆ a source of daily and ongoing structure, and
- ◆ a sense of identity and status apart from being only "a person with a mental illness"<sup>56</sup>.

### ***The impact of mental illness on parenting***

*DCD had tried to get me to sign the kids over to them, but I wouldn't, even when I was really sick I was stubborn. If they'd been made wards it would've been a hell of a fight to get them back. My daughter has been home 16 months. It was very hard to start with. The first 6 weeks at the new school she was saying "I hate mum, I don't want to be here, she made me move in with her." If we'd had more time together it would have been easier. You tell me what having two kids full time then back to 4 hours a week does to you. It tears your heart out. The kids don't understand. She loves it at home now.*

*The social worker near my home now wants DCD involved again, because I have a mental illness. Schizophrenia + kids = DCD. She has contacted my psychiatrist expressing concerns about my ability to parent.*

*(Karen, mum of 2, at time of interview reunited with one child, second child about to return to her care)*

*When my kids got to toddler age, my parenting was quite erratic. I'd tell the doctor "I'm scared I'm going to hit my kids" and he'd give me an injection and valium and say "don't worry, people who think they're going to never do."*

*(Bella, mum of 5, depression that at the time was undiagnosed)*

*She's not just had the immediate family, but several other ersatz parents who have been very closely involved.... Her best friends' parents would also take on a parenting role. Often she had no clothes, no shoes, no money, no food, and the friends' parents would arrange that for her."*

*(Jill, mum of mixed-step family: her child, partner's child, and their child)*

<sup>56</sup> Supporting Families with Parental Mental Illness Provincial Working Group (2002) *Supporting Families with Parental Mental Illness: A Community Education and Development Workshop. Community Mental Health Services and Ministry of Children and Family Development, British Columbia.*

A parent's mental illness does not automatically have a negative impact on the parent-child relationship, nor does it always imply an inability to parent. It is also not usually the only factor that is affecting the children, and thus the successful treatment of the mental illness is not necessarily enough to ensure that the children have a safe or emotionally nurturing environment.

Recovery from illness may not always be accompanied by a return to "good enough" parenting. This may be because of the way in which recovery is defined (well enough to leave hospital, particularly when there is considerable pressure for beds, might not necessarily mean well enough to fulfil usual roles outside the hospital). Even if the parent returns home in a state of mental health that is optimal for them, there may still be issues such as poverty, isolation, domestic violence, insecure housing or co-morbidity, all of which will affect their capacity to parent. Because of this, any assessment of parenting needs to focus on parental behaviours that affect the child, not on the diagnostic symptoms alone.

<b><i>Behaviour arising from mental illness that may affect parenting</i></b>		
	<b>Changed behaviour:</b>	<b>Effect on child:</b>
<b>Mood:</b> Elevated, depressed, irritable, agitated, or frequently changing and unpredictable, suicidal	<ul style="list-style-type: none"> <li>◆ Parent's waking time and bedtime alters</li> <li>◆ Energy levels and motivation alter</li> <li>◆ Style of interaction – impatient, avoidant, enthusiastic, unpredictable</li> <li>◆ Preoccupation with suicidal thoughts or negative ruminations</li> </ul>	<ul style="list-style-type: none"> <li>◆ Being woken unusually early or late, affecting their own sleep requirements, performance and moods</li> <li>◆ Receiving more or less attention than usual, routine tasks (meal preparation, lifts to school, help with homework, feeding, bathing, nappy changing) being ignored, poorly done or not completed</li> <li>◆ Interaction style affecting the child's self-esteem, language acquisition, anxiety, social skills, and personal safety (perceived or actual). Discipline may be excessive, inadequate or variable</li> <li>◆ Child may take or be given role as parent's emotional support</li> <li>◆ If the parent suicides, the child will need to deal with grief and possible self-blame. The parent may kill the child and then suicide</li> </ul>
<b>Perception and thought content:</b> Hallucinations, delusions, paranoia	<ul style="list-style-type: none"> <li>◆ Unusual levels of fear, suspicion or anger</li> <li>◆ Actions based on delusion eg refusal to eat particular foods because they may be poisoned, bizarre behaviour, violence to self or others</li> <li>◆ Moods may be responding more to the delusion or hallucination than to observable external events</li> </ul>	<ul style="list-style-type: none"> <li>◆ "walking on eggshells", fear of provoking a verbal or physical outburst, fear that parent will suicide or self-harm, perhaps as a result of child's behaviour</li> <li>◆ nutrition, sleep, hygiene, homework, and other routines may be affected</li> <li>◆ absence from school or other activities to caretake for the parent</li> <li>◆ child may avoid social interaction because of shame or stigma related to parent's behaviour, or guilt at leaving parent alone</li> <li>◆ child may be persuaded that colluding in parent's delusional beliefs is a demonstration of love, and experience difficulty reconciling the version of reality s/he perceives and the parent's version</li> <li>◆ child may feature in the parent's hallucinations or delusions, and be at risk of violence or even homicide</li> </ul>

<b><i>Behaviour arising from mental illness that may affect parenting</i></b>		
	<b>Changed behaviour:</b>	<b>Effect on child:</b>
<b>Memory</b>	<ul style="list-style-type: none"> <li>◆ May be permanent as a result of head injury or prolonged substance use</li> <li>◆ May be temporary, secondary to ECT, intoxication, or acute illness such as depression or psychosis</li> </ul>	<ul style="list-style-type: none"> <li>◆ Child may feel need to take on age-inappropriate responsibility to remind parent of tasks, appointments etc</li> <li>◆ Important events in the child's life (school, health, social) may be forgotten</li> <li>◆ Routine may be disturbed</li> </ul>
<b>Organisation</b>	<ul style="list-style-type: none"> <li>◆ Disorganised (major tasks such as food preparation, bills, clothes washing not attended to on time)</li> <li>◆ Chaotic (housing problems, frequent relocations, schooling disruptions)</li> <li>◆ Obsessional routines may lead to tension and rigidity within the family system</li> </ul>	<ul style="list-style-type: none"> <li>◆ Disorganisation may result in uncertainty, anger, neglect which can cause emotional harm or affect the child's health. Child may respond by taking on a parent role to try and establish or restore routine</li> <li>◆ Chaotic parenting may affect the child's health (due to substandard housing, neglect or poor nutrition), and lead to difficulty developing peer relationships, uncertainty, anger, behavioural or emotional disturbances</li> <li>◆ Obsessional routines may mean the child's initiative is stifled because s/he is not offered choices. The child may be tense and/or angry if over organised</li> </ul>
<b>Confidence</b>	<ul style="list-style-type: none"> <li>◆ Unwilling to trust own abilities, fearful of making the wrong decision</li> <li>◆ Exaggerated belief in own abilities, leading to making inappropriate decisions</li> </ul>	<ul style="list-style-type: none"> <li>◆ Frustration at and critical of parent not making decisions or putting them off. Child may make own decisions. Parent may ask child for advice on adult issues</li> <li>◆ Inappropriate decisions may affect child's safety, self esteem, academic achievement</li> </ul>
<b>Sociability</b>	<ul style="list-style-type: none"> <li>◆ Withdrawn. Uncomfortable in crowds or with a group of people, may suffer anxiety or panic attacks</li> <li>◆ When meets someone conversation is hard to initiate or continue</li> <li>◆ Extremely sociable and vivacious, friendly to anyone, poor boundaries</li> </ul>	<ul style="list-style-type: none"> <li>◆ Reduced network for the child to call on in a crisis</li> <li>◆ Poor modelling of social interaction skills, possible transmission of social anxiety to the child</li> <li>◆ Parent's absorption in social interaction to the neglect of the child, possible exposure to risky situations or abusive individuals</li> </ul>

The above table does not constitute a complete list of behaviours that affect parenting. The child is not always negatively affected by the behaviours. For example, a parent in the early stages of mania may have more time than usual to play with a child, and may relate in a joyful and affectionate manner that the child finds affirming and enjoyable.

### ***Factors that affect the impact of parent's illness on parenting***

#### The child's developmental stage when first exposed to the parent's illness

Some studies have been unable to identify age or developmental effects of parental mental illness on children<sup>57</sup>. However, there are indications that exposure to parental mental illness and the resulting disruption may be more harmful to younger children. Some of the factors leading to the resilient child are established early in life and would be difficult to recuperate (such as optimal brain development in utero). One of the developmental tasks for 0-3-year-olds, for example, is the building of secure attachments. If a parent's

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<sup>57</sup>Nicholson J, Biebel K, Hinden B *Critical Issues for Parents with Mental Illness and their Families*.

illness leads to extended periods of physical or emotional absence from the child during this stage, it is possible that the child's ability to regulate emotions and interact socially can be compromised in a way that affects their further development. Maternal depression in infancy has been shown to have long-term effects on the child's physical and psychological health, behaviour and school performance<sup>58</sup>.

The charts on pages 26-30 that show Impact of Mental Illness, Substance Use and Domestic Violence on Children give some indication of what factors can lead to or prevent problems at different life stages.

### Child's involvement and exposure to parental symptoms

The amount of exposure to the parent's symptoms will depend on

- ◆ custody arrangements
- ◆ the age of the child when the parent first becomes ill, the frequency of relapses and the extent of recovery between episodes
- ◆ the amount of out-of-home activity the child has which reduces contact with the parent (school, pre-school or child care, homework classes, sport, social activities away from home)
- ◆ whether another adult is present within the home to explain or compensate for some symptoms (such as sedation, lack of motivation, lack of routine) and provide an alternative view to others (such as delusional material).

The child's involvement with the parent's symptoms is particularly worrying in two situations. In the first, the child closely identifies with the ill parent and becomes concerned that s/he too is beginning to show signs of the illness and may have inherited it from the ill parent. That is, the personality characteristics the child may share with the parent, or anxiety symptoms arising from concerns about the parent's illness, may be interpreted as permanent evidence of the child's mental illness. This situation may be inadvertently reinforced if the child notices the well-meaning concern of relatives and interprets that as confirmation of his/her own interpretation.

In the second situation, the child begins to identify with the parent's reality to the extent where parent and child may share a delusional system. This is known as folie a deux<sup>59</sup>. The child may feel considerable emotional pressure to accept the parent's internal view of reality even if conflicting external evidence is available. Even if the child does not entirely share the parent's delusion, confusion, cognitive and emotional difficulties may result from the mismatch between the child's and the parent's views of reality. This is

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<sup>58</sup>Puckering C (1989) "Maternal Depression". *Journal of Child Psychology and Psychiatry*. 30: 807-17.

<sup>59</sup>Hall A (1996) "Parental Disorder and the Developing Child" in Gopfert M, Webster J and Seeman M (eds) *Parental Psychiatric Disorder: Distressed parents and their families*. Cambridge : Cambridge University Press: 17-41.

exacerbated if the child does not have another trusted adult with whom to reality-test.

### Nature, severity and duration of the illness

Personality disorders and illnesses where violence or hostility are a feature tend to be associated with more serious risks to children. Multiple hospitalisations where the child is separated from the unwell parent frequently or for long periods can also have detrimental effects on the child, both emotionally and developmentally. This effect is mediated somewhat if the other parent is a strong positive influence during these difficult times. Different types of illnesses will have different impacts on the parent-child interaction and on other behaviour that affects the child, as has been shown above.

Exposure to bizarre behaviour associated with delusions or mania can be disturbing and confusing to children, or even dangerous in some instances, and can also lead to intense shame, social embarrassment and possible ostracism from peer groups.

### Comorbidity

Where the parent with the mental illness also has problematic substance use, or where the mental illness is accompanied by a personality disorder, outcomes may be worse for the child. There are higher levels of violence, child abuse and neglect in these families.

### Effects of treatment, including non-compliance

Effects of treatment may include reduction of the problematic symptoms, so that the parent no longer feels so depressed, or no longer feels the need to act on delusions. However, there may also be unwanted side effects of medication. Sedation, which is common with high doses of many antipsychotic, antispasmodic, anxiolytic and antidepressant drugs, may make it extremely difficult for a parent to carry out normal daily activities (such as wake up in time to prepare breakfast or get children to school). Children may be embarrassed or distressed to see their parents displaying other side effects, such as unusual stiff posture, weight gain or excessive salivation. Other forms of treatment, such as psychotherapy, may require time and monetary resources that impact on other household needs.

Non-compliance with medication, or the reduction in efficacy of medication due to substance use, can lead to the re-emergence of symptoms that family members had believed to be already in the past. If the relapse occurs slowly, there may be some time during which children give positive feedback for the parent to be unmedicated, as they gain benefits from the parent's reduced sedation and increased energy. Unfortunately, as the parent becomes more

involved with the illness, benefits for the child begin to be outweighed by the difficulties.

### Alterations in family structure or functioning

Marital disharmony is a source of distress to children, and may also increase the risk of disturbed child development. Disagreements about child care may lead to inconsistent decisions and poor limit setting. Other conflict between parents may result in reduced attention for the child, and poor role modelling of such important skills as conflict resolution, problem solving and household tasks. Older children may find marital disharmony distressing if they are particularly close to one parent and become involved in the arguments. They may take on a parental role with younger siblings to an extent where they find it difficult to continue with age-appropriate activities and behaviours (missing school to attend to infants or toddlers, or being unable to have a carefree fun childhood because of the weight of responsibility for siblings).

### Associated risk and protective factors

- ◆ Characteristics of the child - attractive and "easy" children may be less stressful to parent than those with health problems, unattractive appearance, or difficult behaviours. If the child is constantly sick or behaviourally problematic, crises with the child may precipitate crises in the parent's mental health and with some parents may lead to abuse or neglect of the child. Easy-going children, and those who can cope with and understand their parent's behaviour, are the most likely to be resilient.
- ◆ Access to a well adult as an alternate role model – if the other parent is a strong presence in the child's life, this can be beneficial to the child's development of a positive self-image and social skills. Other trusted adults, whether family members, family friends or people known from other aspects of the child's life, can be equally important in fulfilling some of the functions that would otherwise have been performed by the parent.
- ◆ Sufficient resources – resources required for effective parenting include not only the material resources which may be in short supply in some families with a mentally ill parent, but also people who can provide emotional support and the knowledge of how to access relevant services.
- ◆ Culture – the family's culture may be a risk or protective factor for parenting. In cultures where there are strong family connections, available respite carers and alternative role models for the child, it may be a protective factor. Where there are different levels of cultural integration between members of the family, or different understanding or acceptance of the parent's mental illness, it may make parenting more problematic.

## ***Impact of mental illness on parenting***



## Helping COPMI families

The family model shown on page 13 refers to a number of components within the family to be considered when determining what impact a parent's mental health has on the parent and the child. In this discussion we have looked at the impact of mental illness on a parent, on a child, and on how the child is parented. Readers are encouraged to note resources, capacities and strengths of families and family members, as well as their vulnerabilities and problems.

Remember that the interactions between various components in the family model are not simple or unidirectional. The way the mental illness impacts on the parent may affect the parenting style, which in turn influences the child's behaviour and emotional response, and this feeds back into how the parent parents. Similarly, the child's presentation (behaviour, appearance and personality) may affect the parent's style of interaction or parenting, and the effectiveness or otherwise of this may in turn impact on the amount of stress the parent experiences and thus perhaps on their mental health. The family situation becomes more complex again if more than one child is involved.

The other complexity this booklet has not addressed in detail is the impact on other people involved in the family situation. There has been reference to how the parent without the mental illness may be a resource for the mentally ill parent and/or the child, or an additional source of stress. Reference has also been made how other extended family members may have a positive or negative impact, and how the illness may affect them in turn, but again this has not been discussed in detail. Our focus has been the issues for the parent with the illness and the child or children.

The literature shows that children of parents with a mental illness can be at greater risk of a number of undesirable consequences than other children, but that many children are resilient and manage to cope well despite this vulnerability. As Silburn's Pathways to Resilience show, there are a number of factors that contribute to children's resilience. While some of those factors can be absent or negatively affected by a parent's mental illness, opportunities can often be made to compensate for these by providing other supports. The availability of positive adult role models, positive peer relationships and engaging community activities can be factors in any child developing resilience.

With COPMI, explanations of mental illness that help the child to make sense of the parent's behaviour in a way that protects the child's self esteem and their cognitive processing of the world can be vital. Poverty and violence are more likely to be factors in the life of a child with mentally ill parent/s than for other children. Interventions that give them opportunities the parents would not normally afford, or a sense of safety that is not often present, can provide an important alternative view of the world for these children. Many children with mentally ill parents can experience a sense of isolation, secrecy and stigma. There has been some success with peer groups which allow the

children to realise that they are not alone, it is not their fault, and there is an explanation for what is happening in their lives.

Mental illness does not stop people from parenting, and often does not stop them from parenting well. Having children is often one of the factors that assists a person to maintain wellness. There are situations in which the mental illness may impact badly on parenting or even lead to physical, emotional or sexual danger for the child. However, mental illness does not automatically make a person a bad parent. Even if during acute illness a parent behaves in a way that appears to have negative effects on the child, this behaviour may be totally absent when the person has recovered from that episode of illness.

In determining whether “good enough” parenting is present, assessment needs to take into account both strengths and vulnerabilities of the individuals and families involved, with decisions about interventions reflecting how things are both while the parent is acutely ill and when they are more well.

### ***Parenting and barriers to seeking help***

While the literature suggests that intervention in COPMI families may be a good way of preventing problems from arising for the children in later life, the parents may not be so convinced. From their point of view, there may be very good reasons for not seeking advice or assistance with parenting, or other forms of help for themselves or their children. Others may be desperate to obtain help, but unable to access it.

#### Personal barriers to help seeking in early stages of illness

- ◆ Stigma
- ◆ Fear of losing custody
- ◆ Misinformation about services
- ◆ Lack of insight
- ◆ Cultural reasons (eg fear of services, belief that it is family business)
- ◆ Parents postpone treatment because children’s short-term needs take priority

#### System-level barriers

- ◆ Low visibility of services
- ◆ Restrictive service mandates
- ◆ Reactive vs preventive orientation (ie the problem has to be serious to obtain intervention – it can be difficult to access help for relapse prevention)
- ◆ Long waiting lists for desired services

## In conclusion

Now that you have read through the information that supports the training package you may well be left with questions and issues that spring to mind. We hope you are asking questions like:

- How does all this affect the way I, my workplace, my agency goes about business?
- What other information or knowledge do I need to work out how to recognize and respond to the needs of children, well parents, grand parents, and the parent with the illness?
- Where does this fit in the services' mandate? Who can I seek information and consultation with?
- What flexibility do we have or would I like to see in services?
- What sort of relationships could I be developing with other services?
- Where are the barriers and opportunities to do things differently in the local service network?

The key points to remember are:

- Mental illness takes many shapes and forms. It affects people's ability to manage life roles and responsibilities in several ways:
  - Mood
  - Perception
  - Organization
  - Memory
  - Cognition
- Mental illness does not mean people cannot live meaningful productive lives
- Most families do very well when they:
  - Have good information about the illness
  - Have a supportive family and friendship networks
  - Have access to treatment, management and psychosocial supports
  - Have a parenting partnership and/ or support in the parenting role
  - Have access the supports and service they require (including housing, education, employment, recreation and cultural opportunities)
  - Talk together with their children about parental mental illness
  - Have proactive support to the parenting tasks including the exploration of the ways in which parenting affects their mental health and their mental health influences parenting
  - Are mindful of and have assistance with the developmental needs of their children

- Most workers and services support good outcomes for families and children when they:
  - Understand and support the family roles and responsibilities of the people they work with
  - Acknowledge the importance of the parenting role
  - Acknowledge parents/children's concerns and provide information, resources or appropriate referrals
  - Are trauma aware
  - Work together with other services to find flexible and timely responses.

*For more information:*

National COPMI Project website [www.copmi.net.au](http://www.copmi.net.au)



For more information about  
Ruah Community Services  
please see

**[www.ruah.com.au](http://www.ruah.com.au)**

