MENTAL HEATH PROBLEMS AND CHILD MALTREATMENT

Kathleen Coulborn Faller & Chyrell D. Bellamy

Introduction

Until the mid-50s, predominating practice was to hospitalize individuals with serious mental disorders, usually on a long-term basis. Professionals thought that people with mental illness were best served in psychiatric institutions. The 1950s brought the advent of the Community Mental Health Movement. Mental health professionals favoring community treatment were able to demonstrate both the negative effects of long term hospitalization and the capacity of individuals with mental illness to maintain themselves in the community, with short-term periods of hospitalization (Fairweather, 1969; Goldstein, 1987). These developments led to mass de-institutionalization of people with mental illness (Goldstein, 1987)

Before de-institutionalization, people hospitalized or in residential care because of mental illness generally did not have opportunities to become parents and if they did, their children were removed from their care. Presently, adults with mental health problems have more opportunities both for planned and unplanned parenthood.

Unhappily, the need for community-based services for people with mental illness has never achieved its promise. Although there are model programs, services are often less than ideal, and they are insufficient for the population requiring help. Programs also may not offer the full range of services needed, and many people needing these services “fall through the cracks”. Moreover, most programs for individuals with mental illness do not include services for their children.

There are other problems with service delivery in the mental health system. The failure to identify individuals with mental illness and failure to serve them adequately have been exacerbated by managed care, which has radically reduced the amount of time doctors spend with their patients (Frances & First, 1998). Minority populations are particularly likely to be under-served and inappropriately diagnosed (Snowden & Cheung, 199). As a consequence of resource deficiency and scarcity, individuals with mental illness may be inappropriately channeled into the criminal justice system or, in some instances, into the social service system. Minorities with mental illness are at special risk for becoming involved with the criminal justice system, when their problems are ones of mental illness. These larger issues must be take into account when considering the interface between parental mental health problems and child welfare issues.

The proportion of maltreating parents found to also have mental health problems varies from 20 to 70 percent, depending upon the source of the sample of maltreating parents being studied (Bland & Orn, 1986; Dubowitz, 1995; Dubowitz et al., 1996; Nelson et al., 1994; Whipple & Wilson, 1996). It is likely that Child Protection workers under-identify parental mental health problems both because investigations by CPS generally do not include in depth assessments of parental functioning and because CPS workers usually

are not trained in identification of mental health problems. Children, whose parents have severe symptoms of mental illness and no available social supports, are likely to be placed in substitute care. Parents may further decompensate with their children's placement, and children may remain for long periods in care. Ultimately, individuals with mental illness may have their parental rights terminated and their children put up for adoption (Mowbray, 1995). Involuntary intervention by the child welfare system is especially likely when it is the mother who is mentally ill, since mothers tend to be the primary caretakers. Some research suggests that mothers presenting with severe mental illness are likely to be single parents (e.g. Mowbray et al., 1995).

The mental health problems found in parents who come to the attention of the child welfare system are various. However, the most common type of mental health problem appears to be some sort of personality disorder. Depression is also common, and less common are schizophrenia and manic depression. Current thinking is that the etiologies of schizophrenia, depression, and manic depression are substantially bio-chemical (American Psychiatric Association, 1994). Because of this, many adults with these sorts of mental illnesses can be treated with psychotropic medications and, with appropriate medication, may be able to care quite adequately for themselves and even for their children. In contrast, propensity to develop personality disorders is thought to be affected by temperament, which is genetic, but to derive substantially from life experiences or socialization (Frances & First, 1998). Although some persons with personality disorders will be helped by medication, medications do not have the same level of utility with personality disorders as with depression, manic depression, and schizophrenia.

When mental health services are provided to parents, rehabilitation focuses on assisting the adult in self care and independent functioning. However, when adults with mental health problems are also parents, their illness can also impede their ability to provide appropriate child care, an issue that may go unnoticed and/or unaddressed by mental health specialists. Parenting inadequacies are viewed as a "social services" problem, rather than a mental health problem. This is especially likely to be the response when children are thought to be too young to benefit from therapeutic intervention.

Descriptions of mental health problems that are common among maltreating parents.

Professionals who encounter parents with mental illness need to understand each mental health problem and its implications for parenting. In this article, mental health problems most likely to be found in parents who come to the attention of the child welfare system will be described, and the implications of these conditions for parenting will be discussed.

The discussion of mental health diagnoses that follows will include those most likely to be found among parents who experience significant problems in parenting. Thus, this will not be an exhaustive description of all psychiatric problems. For a complete description of psychiatric disorders and their diagnostic criteria, refer to the American Psychiatric Association's Diagnostic and Statistical Manual (1994). The goal of this section is to

acquaint professionals with the characteristics and indicators of these mental health problems so they can be identified in parents.

Personality disorders:

Overall the proportion of the population in the United States with a personality disorder is 10% (Goldberg, 1998). However, they are much more common among parents who come to the attention of the child welfare system (e.g. Famularo, Kinscherff, & Fenton, 1992). Personality disorders may also be exacerbated by the sorts of crises that bring parents to the attention of social welfare, mental health, and justice systems (D&S Associates, 1997).

Unlike psychoses and major depression, personality disorders do not carry a mental disorder diagnosis. Because of this, they are often regarded as less severe than mental disorders. In addition, as a rule, they do not result in periodic or repeated psychiatric hospitalization. However, because of the specific deficits that characterize personality disorders and because of their lifelong nature, having a parent with a personality disorder can be much more detrimental to a child than having a parent with a mental disorder, which is usually more episodic.

Personality disorders are so called because they are a core component of the individual's personality, or style of perceiving and reacting to the world, as opposed to a transitory reaction to circumstances or an episodic dysfunction. Their origin is thought to be partly a function of temperament, which is genetic, and partly derived from environmental experiences, such as the lack of appropriate nurturing and/or trauma during early childhood (Frances & First, 1998). In addition, a characteristic of persons with personality disorders is to regard problems they experience as mostly externally caused, rather than their fault. As a rule, they do not wish to change, but rather they wish others or the situation to change to make them feel better.

Since families and parents who come to the attention of the child welfare system are usually reported by someone other than themselves--a professional, relative, neighbor, or friend--it is common for parents' initial reaction to be that the problem comes from outside themselves. In addition, families and individuals who are involved with social service systems experience many environmental crises and problems, such as poverty, homelessness, unemployment, violence, and accidents. Consequently, it is important to examine carefully whether the parent's sense of problems as being externally derived has a genuine basis. It may take several contacts with the parent before the service provider can determine whether the situation is one in which problems are primarily externally caused or one in which the parent plays a key role.

However, the following are illustrative of reactions that should alert professionals to the possibility or even likelihood of a personality disorder. A child has been injured, but all the parent is concerned about is who reported him/her. Similarly, if the parent's primary concern is to get their own needs met, especially if these are inconsequential, and they cannot think about the child's needs as separate from their own, the professional should be consider a possible diagnosis of personality disorder.

The etiology of personality disorders is thought to be problematic early life experience. Persons who develop them may be rejected by their caretakers or not nurtured during their infancy and childhood. They may have experienced physical abuse, sexual abuse, neglect or other traumatic experiences. Not all traumatic experiences that contribute to personality disorders derive from bad parenting. A child who has frequent hospitalizations during her/his first years of life or a child whose parent dies, when the child is very young, may develop a personality disorder. Moreover, some adults with personality disorders do not describe bad parenting or severe trauma during their childhoods.

Nevertheless, the common path to personality disorders is thought to be the following. Because of early traumatic experiences, individuals who develop personality disorders learn that the world is not a safe place where they can depend upon adults to care for them. They fail to develop trust in others because their experience teaches them other people can't be relied upon. Their capacities for close relationships are thereby impaired. They tend both to lack skills in nurturing or showing affection and to have unmet needs for nurturing, themselves. The patterns of behavior they display as adults often reflect efforts to get needs, that were not satisfied in childhood, met as adults. Thus, if they develop primary relationships, they are unlikely to be based upon genuine caring and may not be reciprocal. If they also have children who require care, they can experience severe conflicts of interest, between their needs and their children's needs.

Of course many people experience adverse circumstances during childhood and do not develop personality disorders. Individuals may suffer deprivation and trauma but nevertheless become intact, caring, and competent adults. Differences in outcomes from early trauma may reflect individual constitutional differences, the balance between adverse and enhancing childhood experiences, or the influence of a key relationship, with a caretaker or mentor, whose influence overshadows the negative ones in the child's life.

The diagnosis of personality disorder is usually not made until late adolescence. Because personality disorders represent lifelong patterns of behavior, they are very difficult to change. Furthermore, whatever change the parent achieves is likely to be modest. However, personality disorders vary in severity. This means that many parents with personality traits, or with mild or moderate disorders, can be worked with so they can provide adequately for their children.

Below will be described the personality disorders most commonly found in adults with parenting problems. Although these are described as if they are discrete entities, individuals may possess characteristics of more than one type of personality disorder, and therefore it may be difficult to classify a parent. Exact classification will be less important than noting their characteristics and their implications for parenting.

Dependent personality disorder. Parents with dependent personalities who come to the attention of the child welfare system are more likely to be women. These adults

have a great deal of difficulty functioning autonomously. They present as immature and ask for both psychological support and services. Their demands are excessive, and they may not respect agency and personal boundaries. Nevertheless, these adults make professionals, their family, and friends feel as if they have not given enough. Individuals with dependent personalities may try to get others to take over their responsibilities and make decisions for them. If professionals or their friends and family displease them or try to set limits on their dependency, these individuals become emotionally distraught, angry, and rejecting.

It should be evident that individuals with dependent personality disorder will be considerably challenged by the role of parent. Their goal is to get someone to take care of them rather than caring for and nurturing a child. Their children may be neglected both physically and emotionally. Role reversal is likely to characterize their relationships with children.

Case example. *Sally is a 30 year old woman married to a used car salesman. She has a son, David, 5, and a daughter, Sarah, 3, by her husband, and an older daughter, Melodie, 10, who was born out of wedlock. Sally came to the attention of Protective Services when Melodie reported that her stepfather had sexually abused her. Sally appeared and behaved much younger than her age. She appeared more distraught over the fact that her husband had to move out of the home than over the sexual abuse of Melodie. Sally had never lived on her own.*

In a family evaluation, Sally acknowledged that she had seen her husband slam Melodie's head against a concrete wall, but said Melodie was unmanageable. Besides, she said she was afraid if she intervened, her husband would hurt her, too. The family evaluation revealed Sarah had also been sexually abused, and David had seen abuse of both girls and reported it to Sally. Sally denied any knowledge of the sexual abuse or that David had told her about it.

Extensive services were provided to support Sally. She received Family Preservation Services, which involved a family worker helping her in a variety of ways on a daily basis, 24 hour availability of that worker, and financial support. Sally made extensive use of Family Preservation, calling the worker most evenings with a series of personal crises. Sarah was placed in daycare. Sally was enrolled in parenting classes, but she missed over half the sessions. All family members were referred to therapy. Sally attended group therapy for mothers of abused children regularly, but alienated the other group members because she monopolized the group. Despite all the efforts to help her, Sally was highly critical of the services she received.

Shortly before the criminal prosecution of Sally's husband was to take place, Melodie recanted the sexual abuse allegation. Sally and the children were referred back to the family evaluator. Melodie told the evaluator that her mother had tied her to a chair, and her mother and the other two children had circled around her pointing fingers at her and shouting "liar, liar". Melodie stated eventually she said she had lied. Then her mother took her to the prosecutor so she could tell him she had lied. However, Melodie told the evaluator her allegation was not a lie; her stepfather had sexually abused her. When Sally was asked about what Melodie said, she said she knew her husband had not sexually abused the children because he told her so and that Melodie is a mean child. She said she had to tie Melodie to the chair to get her to tell

the truth. She also said she cannot handle the children without her husband. If he can't come back home, then the children should go to foster care.

Antisocial personality disorder. Caretakers with antisocial personality disorder who come to the attention of the child welfare system are more likely to be men. Other terms used for persons with antisocial personality disorder are sociopath or psychopath. Individuals with extreme forms of antisocial personality disorder have virtually no conscience. Their goal is to satisfy their own needs, even at the expense of others. They may even take pleasure in harming others. They limit their antisocial behavior to avoid getting caught, not because they care if they hurt others or break the law. They have no empathy, and think that people who are concerned for the well-being of others and who obey society's rules are "stupid". However, some persons with anti-social personality disorder are quite charming and charismatic. The goal of their engaging behavior, however, is to manipulate others for their own ends. Although people may engage in transgressions for a variety of reasons, an indicator of possible personality disorder is a history of criminal acts and/or violence.

It should be evident that adults with antisocial personality disorder are very poor candidates for parenthood. They will exploit, manipulate, and harm children. They have little or no regard for the needs of children. They do not care if they hurt them and often feel it is their right to do whatever they want to their children. Children engaging in developmentally normal behaviors, such as crying, are at grave risk if they irritate a caretaker with antisocial personality disorder. Some sex offenders and sadistic abusers have antisocial personality disorder.

Case example. Marie has two children by her husband, Jonathan, Alan, 8, and Jonathan, Jr., two months. In addition, she had two teenage boys, Sam, 13, and Daniel, 14, by two different men. Marie describes Jonathan as cruel and abusive to her and her children.

The family first came to the attention of Protective Services when Alan was 4. Marie reported her husband to Child Protective Services, stating he had beaten the boys with chains. When the Protective Services worker made a home visit to investigate the report, Jonathan was home. He brought all the family members into the living room, sat Alan on his lap, and voluntarily talked to the worker. The worker found Jonathan to be very cooperative and engaging and Marie to be sullen. The worker took each of the boys into their bedroom and questioned them about their mother's allegation that Jonathan had beaten them with chains. Each boy denied that this had happened. When the worker interviewed Jonathan alone, he said that Marie had emotional problems and sometimes said things that weren't true. He said he is strict but not abusive. Jonathan also said he had once been fired from a job for a fight, but it was the other man's fault. Otherwise he is a good citizen. Marie would not talk to the worker alone. When the worker checked other records, he did find Marie had a history of mental health problems. He also found Jonathan had been charged with assault in a bar on one occasion, but the charge had been dropped. The worker denied the case.

Shortly after Jonathan, Jr. was born, Marie fled the home to a domestic violence shelter. Jonathan hired a private detective, who found her. Jonathan came to the shelter with a shot gun and was arrested. At that time, the following history was revealed. Marie said she finally

left because Jonathan had tried to smother Jonathan, Jr. with a pillow. The child was crying and keeping Marie from attending to her husband's needs. She grabbed the pillow off of Jonathan, Jr.'s face, and her husband hit her in the face, knocking her front teeth out. He told her Jonathan, Jr., was his child, and he could do what he wanted to him, including kill him. She reported marital rape and numerous beatings of herself and her children. She said people who know Jonathan are afraid of him because he was violent and has guns.

The two older boys said their stepfather has a whole arsenal. Both reported he would take them to a building he owned, make them kneel, put a rifle to their head, and sodomize them. If they were uncooperative, he would hit them in the head with the gun butt. They also reported the previously alleged beating with chains. However, both boys were afraid to testify because they knew their stepfather would kill them.

Borderline personality disorder (BPD). Adults with borderline personality disorder who come into contact with the child welfare system are more likely to be women. Research indicates that there is a very high correlation between borderline personality disorder and serious early trauma, particularly child sexual abuse (Brown & Anderson, 1991; Famularo, Kinscherff, & Fenton, 1992). The central characteristic of BPD is highly unstable interpersonal relationships. An individual with BPD may idealize a person, including a professional, and then suddenly switch and vilify that person or hate him/her. The relationships of individuals with BPD are characterized by "splitting"; that is they see individuals as all good or all bad, and often they designate one professional as the good one and another as the bad one. They do the same thing within their families. They are often intensely and inappropriately angry. Individuals with BPD also experience a sense of "emptiness" and low self esteem. Because of this, at times, they may appear quite depressed. Their behavior can be impulsive, self destructive, and manipulative. They are sometimes suicidal and harm themselves. Suicidal behavior can be calculated to manipulate others. They may also have brief (a few days) psychotic episodes.

Because of their volatility, unreasonable anger, impulsiveness, and self-destructive behavior, adults with BPD are generally not stable and consistently nurturing parents. They may at one point engage in model parenting, but then neglect or scapegoat their children. Children of parents with BPD may experience parenting as a roller coaster. They never know what will happen next. Being a child of a parent with BPD can also be very frightening because of the parent's self destructive and sometimes suicidal behavior. In the worst case, the child may be the one to rescue the parent from a suicide attempt.

Case example. Leah is an attractive mother of three girls, Megan, 5, and Crystal and Carol, twins, age 2. However, Leah is very difficult to deal with. She can be unreasonable, angry, and extremely demanding. A few minutes later, she is depressed and tearful.

She reports a history of sexual abuse by her brother and her father. She says as a child, she told her mother and her mother did not believe her. She says she hates her family and will have nothing to do with them.

She was married for five years, and she and her husband constantly fought. Neighbors called the police on more than one occasion. Leah said they couldn't live with each other and

couldn't live without each other. They both were hospitalized for attempted suicide. Their lives became even more stressed after the twins were born because the twins had spina bifida. Leah blamed her husband and he blamed her for their defects. When the twins had been in the home for three months, her husband was successful at committing suicide. One night he asphyxiated himself in the garage with carbon monoxide by leaving the car motor on. Leah was furious at him for killing himself and, at his funeral, said he was a coward. Thereafter his family refused to have anything to do with her and blamed her for his suicide.

Social agencies responded to Leah's' plight with many supportive services. Leah received disability benefits for the children and had a home help who came in to assist her with the children several hours a day. However, Leah fought with these service providers and usually they did not last more than a few weeks. Leah also found a charity that was willing to buy her a car so she could transport her children. She got the hospital to give her children special wheel chairs.

She had a therapist, whom she saw twice a week. She had a consistently positive relationship with her therapist, but the therapist never confronted Leah, never set limits on her behavior, and never placed any demands on Leah. The therapist, a psychiatrist, gave Leah whatever medication Leah thought she needed.

Leah had been employed as an office administrator, and her boss arranged for her to have extended sick leave to care for her children. He confided in the child protection worker that this was a good solution for his business. Leah was very talented and efficient, but was very hard to work with.

Despite all the services Leah had, she became overwhelmed and depressed. Finally she called her child protection worker and said that she was about to kill herself and all three children. When the worker arrived with the police, Leah said she was "over it", and they should "get lost". The children were removed anyway. Leah was furious.

In her supervised visits, which occurred after the children were removed, the following observations were made of her relationships with her children. Megan appeared to be a parental child, assisting with the twins. She was also hypervigilant, always on guard for changes in her mother's moods. Leah was at times very demonstrative in her affection toward her children. Megan was quick to respond when Leah was nurturing, but the twins were less capable because of their impairments. Leah made marked demands on the twins. For example, she would bring juice for them to the visits. But she would make them crawl (they could not walk) across the room to get their juice. She would then try to make them sit up and hold the juice in order to be allowed to drink it. When questioned about this, she said that this was for the best. She would make sure they had the skills to function on their own. She would not always be around to look out for them.

Narcissistic personality disorder. Individuals with narcissistic personality disorder are markedly self-absorbed and convey a sense of entitlement. They may also be grandiose, thinking themselves to be very important even though their accomplishments in life are modest. They lack empathy for others but have exaggerated concern for themselves and how the behavior of others and events affect them. Persons with narcissistic personality disorder expect the world to revolve around them. They are likely

to be critical of others and to have the capacity to discern other's weaknesses. However, they lack the capacity to be self critical.

Because of the self-centeredness of individuals with narcissistic personality disorder, they are problematic parents. Their children are seen by them as an extension of themselves. That is children exist to reflect positively on the parent, to give the parent an opportunity to "show off", and to satisfy the needs of the parent. Children are not seen as having their own needs or wishes. Men who sexually abuse children may have narcissistic personality disorders.

Case example. John was accused of sexually abusing his six year old daughter. When he was evaluated to investigate that allegation, he talked a great deal about himself. He said he was an engineer and was very successful in the business community, but it turned out that he had taken some engineering classes in community college and had a number of low skilled jobs. He said his family name was important in the community, and therefore this allegation must be dealt with discretely. His father was a retired laborer and his mother worked as a cook in a nursing home.

He said when he had met his wife, she was beautiful, and they had a big wedding. He brought the pictures of the wedding to show the evaluator. However, he said the evaluator could tell by comparing the pictures to how his wife looked now, that she had "let herself go" and he didn't find her attractive anymore. He said he meets many women through his work who think he has a great personality, but he has stayed loyal to his wife. He was irate that his "reward for this was to be accused by her of sexual abuse of my daughter".

In describing his daughter, he said that she is beautiful and reminds him of his wife when they first met. He said he loves doing things with her. They watch football games together on TV. He teaches her all the names of the teams and players, and she brings him beer and popcorn. He takes his daughter out to dinner when his wife has to work, and she has perfect manners. However, he did not know the name of school she was attending or the name of her teacher. He was sure she was doing "real good" in school because he taught her the alphabet and to spell her name even before she went to school.

Depression

There are a number of types of depression. Like personality disorders, depression will be discussed selectively. The goal of this section is to help professionals differentiate between depression ("the blues"), as an appropriate reaction to circumstances, and clinical or major depression that is likely to significantly impair functioning and parenting.

Adjustment disorder with depressed mood. Depression is a fairly common response to certain life circumstances. In fact, most people have some periods of depression in response to specific situations and stressful life events. This type of depression usually has its onset within three weeks of the stressor and ends within six months of the termination of the stressor.

Persons who come to the attention of the child welfare system and other social agencies are more likely to experience depression than those in the general population. Commonly

they have experienced many stresses, such as poverty, unemployment, homelessness, illness, and loss of loved ones, which are overwhelming and consequently depressing. It may be difficult to apply guidelines for judging whether their depression is reactive to stressors because parents in the child welfare system tend to experience one crisis after another. Thus, they do not have an opportunity to rebound from one stress before another is upon them. Their experiences of constant life crises may lead to chronic depression, making it difficult for them to cope with life generally and to care for children. Parents with depression are especially at risk for inability to care for their children when they lack resources and social supports.

Major depression. Major depression is found in between 3 and 5 percent of the general population. The lifetime risk for major depression is greater (5-25%), and twice as common in women than men (Goldberg, 1998). Professionals should be concerned about possible major depression if the parent is extremely depressed for more than two weeks, especially if there has been no identifiable cause for the depression. Other warning signals are that the parent feels they are utterly worthless, is guilt-ridden, and/or derives no pleasure from life. Additional signs include sleep problems, especially early morning waking, but also trouble falling asleep and staying asleep. Adults with major depression also may complain of always being tired and may report changes in appetite, typically loss of appetite and often weight loss. They may appear markedly sad or exhibit signs of agitation, such as wringing their hands, sighing, or pacing the floor. Persons with major depression report they cannot concentrate. Finally they are likely to be suicidal.

A person's first major depressive episode is likely to occur during adolescence. Untreated, major depression is likely to resolve in 6 to 9 months, but for some people, it may last years. About half of individuals who experience one major depressive episode will have another one, and the more episodes a person has, the greater the risk of another one (Goldberg, 1998).

Depression with psychotic features (Psychotic depression). Some individuals become psychotically depressed. Psychotic depression is characterized by hearing voices, that is auditory hallucinations, and delusions, that is having ideas that have no basis in reality. The voices may be telling the person they are despicable, worthless, or guilty, or the voices may tell the person to kill him/herself. Delusions may involve beliefs that the person has committed some terrible crime and needs to be severely punished, that they have some terrible disease or illness, when they do not, that nothing whatsoever is worthwhile, or a cataclysmic disaster is about to strike.

Being seriously depressed makes it difficult to get things done, including caring for children, resulting in physical neglect. Research indicates that depressed parents may foster depression in their children (Melhuish, Gambles, & Kumar,). Severe depression may also result in emotional neglect of children. Moreover, parents with severe or psychotic depression may commit suicide. Consequences of suicide for children are dire. Parental suicide is psychologically traumatic, and its effect may be exacerbated by

placement of the child. Making the right placement choice and providing mental health services for the child of a parent who has suicided are of utmost importance.

Case example. *Mary lost custody of her four children after Terry, their father, was incarcerated. Despite the fact he sold and used drugs, Mary had stayed with him because she loved him and could not manage the children by herself. With Terry's incarceration, Mary's depression became worse, and she could not get herself out of bed and could not cope with the children. On one occasion, her four year old was found wandering the streets. On another occasion, he also went to school to find his 13 year old sister to come home and take care of their mother and the children.*

Mary appeared to be extremely sad and her speech was characterized by long pauses. She sat slumped in her chair. She described first feeling depressed at 15. The depression started when she had a fight with her father, who was very strict, and he pulled her earrings off, tearing her ear lobes. She did not receive medication at that time. She left home when she was 16 and soon developed a relationship with Terry. About a year later, she had to be hospitalized because she was "sick". She said she became so depressed she didn't know how she was going to get through the day, she couldn't sleep, and she didn't eat. She had sex but got no pleasure out of it. The doctors put her on medication and she began feeling better.

However, she soon learned that she was pregnant. She was happy about the pregnancy, but worried about the effect of her medication. She decided to stop taking the medication until after the baby was born. She said she was "OK" until the baby was born, but then she "got sick" again. She was re-started on medication and felt better, but was "sad" because she had to stop nursing the baby.

The history over the next 12 years was similar, with Mary taking medication and doing better. However, then she would stop the medication because she was again pregnant, because she couldn't tolerate the medication's side effects, or because she no longer felt medicine was effective. Altogether she had had five hospitalizations and several periods when she was so depressed she spent a lot of time in bed. Because of Terry's drug use and dealing, there were other crises in her life. He had been arrested several times, and they had fled to avoid authorities. These crises often exacerbated Mary's illness.

Manic depression. Bi-polar disorder or manic depression occurs in less than 1% of the population and usually first appears during adolescence. Although manic depression is found equally among men and women, cases that come to the attention of the child welfare system are more likely to involve men (Goldberg, 1998).

Earlier the characteristics of depression and its impact on parenting were discussed. Mania is characterized by unusual expansiveness, elevated mood, and/or irritability. Specifically, during manic periods individuals may demonstrate grandiosity, decreased need for sleep, pressured speech (talking non-stop), flight of ideas (racing thoughts that are hard to follow), distractibility, increased work, social, or sexual activity, and activities that represent very poor judgment, for example spending sprees, gambling, and wild investment schemes. Sometimes these characteristics reach psychotic proportions, during which the person has delusions or auditory hallucinations. Persons who have one manic episode are at increased risk for subsequent episodes.

The erratic behavior caused by manic depression can have problematic implications for parenting. For a child, having a parent whose behavior can vary so dramatically makes it difficult to establish consistent relationships. Moreover, risk taking during mania may endanger children. Finally people with manic-depressive illness often need hospitalization and therefore are unavailable for periods of time to their children. Children may need to be placed into care, if there is no alternative caretaker available.

Case example. *Jeremy is the single parent father of two boys, Ian, 8, and Richard, 10. He was successful in gaining custody of his boys when the parents divorced. His ex-wife was in school and, at the time, he was a successful salesman. Now the mother sees little of the boys.*

Ian told his school counselor that he is worried about his dad. For a while, his dad seemed really down, and wasn't going to work regularly. Now he's up at all hours of the night and gone sometimes for a really long time. When he is at home, he talks non-stop, either on the phone or to the boys. Sometimes he doesn't make sense. Ian thinks his dad is drinking too much and that he is spending money he shouldn't. He took the money out of Ian's savings account to buy some stocks. His dad also bounced some checks. His dad hasn't bought groceries for quite a while, and when the boys ask him about it, he says he'll get to it, but he has more important things to worry about. The previous night Ian and Richard went next door to the neighbors to borrow eggs for supper.

When the counselor reviewed Ian's school record, there was a note in it indicating that before the parents' divorce, Jeremy had been hospitalized for manic depression. After consulting with the school principal, the counselor made a referral to child protective services.

Schizophrenia. The lifetime prevalence rate for schizophrenia in the general population is 1 percent. It is equally common in men and women. The core of schizophrenia is being out of touch with reality in a manner that affects most aspects of functioning. Characteristics of schizophrenia are found in other mental disorders as well. For example, some of its symptoms are the same as those for psychotic depression, and it may take mental health professionals a period of time to sort out whether a person has psychotic depression or schizophrenia. Like psychotic depression, symptoms of schizophrenia include hallucinations and delusions, but additional "crazy" thoughts as well. In terms of thought content, people with schizophrenia may think that they are under the control of outside forces, that people can hear their thoughts without these thoughts being voiced, or that thoughts are being inserted into their heads. In term of actual speech, their talk may evidence loose associations (connections between topics are hard to follow). Alternatively, they may appear to lose the capacity for abstract thought and become extremely concrete or literal. Sometimes what they say is characterized by invented words or neologisms. They may parrot statements of others, which is called echolalia. People with schizophrenia also tend to have fundamental problems is their interpersonal relationships. They do not develop close relationships, and they may be withdrawn and isolated. They also typically present with flat affect. Often a red flag for the onset of its more severe symptoms is neglect of self care, such as bathing, dress, and grooming.

Symptoms of schizophrenia usually begin during adolescence. There may be a slow decline in functioning or a dramatic break. Often the first indication of schizophrenia is withdrawal and cutting off of relationships, which is later followed by more bizarre or florid symptoms, such as delusions and hearing voices. The typical pattern is a series of breaks with acute and florid symptoms, followed by some recovery. However, with each break, the recovery is less complete and the period between breaks may become shorter. Moreover, some adults suffer from chronic schizophrenia, characterized by ongoing psychotic process and lack of relatedness.

As already noted, schizophrenia tends to affect most aspects of the individual's functioning: work, interpersonal relationships, and parenting. Research on parents with schizophrenia, who want to be good mothers, indicates that they can sustain appropriate interaction with their children for short periods of time, but not on a consistent basis over time (Cohler & Musick, 1983). Children, whose mothers have schizophrenia but who are motivated to parent, may have patterns of withdrawal or may be emotionally overreactive (Melhuish, Gambles, & Kumar, 1988). Moreover, parents with schizophrenia may not be available to their children because of repeated hospitalizations. A family history of schizophrenia, acute onset, later onset, adequate functioning before the first breakdown, and good family support are associated with a better prognosis (Goldberg, 1998). Persons whose schizophrenia has these characteristics are likely to respond to medication and are more likely to be self and otherwise motivated to follow through on treatment.

Case example. *This case example involves an African-American family. Chris is the father of Barbie, 5, and the stepfather of Solomon, 10. His wife, Sonja, left him, taking the children with her, and went to her mother's because Chris's behavior. According to her, he had always been hard to communicate with, but now he was acting "weird". He had quit his job because he said that other employees had been trying to steal his thoughts and ideas and were talking about him. He then stopped bathing and spent the day in his pajamas. He had strange thoughts. For example, he thought there were poisons in the neighborhood, and he put bundles of little items, which he called totems in various parts of the house to counteract the poisons. He thought one side of his body was dead and decaying from the poisons and the other side was alive. He did not allow Barbie to go to day care because he thought she would be poisoned there. At one point, Chris had said that he should probably kill them all so the poisons didn't kill them. Sonja was afraid to involve authorities because she and her family are African American. She thought they would just lock Chris up, without figuring out what was wrong with him, and she would never see him again.*

After the family had been at the grandmother's a few days, Barbie began talking about her father getting "bugs and maggots" out of her "vaginata" with his fingers and having her get maggots off his "peanuts" (penis). At the grandmother's insistence, protective services was called. The worker interviewed Barbie and determined that Chris had been sexually abusing her. The worker went with the police to interview Chris. Chris said that he knew they were coming and that he had been praying to the four corners. He stood up and bowed in each of four directions. He said something they couldn't understand and told them he was speaking in tongues and Swahili.

Impact on parenting

Research and clinical investigation into the impact of mental health problems on parenting has been not focused on parents with personality disorders, which appear to be the most common mental health diagnoses of parents who enter the child welfare system. Rather research addresses the impact of schizophrenia, depression, and bi-polar disorders on parenting (e.g. Cohler & Musick, 1983).

Moreover, the research into parental mental health problems has largely explored the developmental effects, that is the impact on children's cognitive development, mood, and interpersonal relationships from having parents with mental illness. In these studies, the more severe the parental psychopathology, the more impaired the children (Beardmore, Edwards, & Warren, 1997; Cohler & Musick, 1983). Only recently have studies begun to examine risk for overt child maltreatment by parents with mental health problems. The more subtle developmental impacts are important to consider in policy and practice with parents with mental illness and their children. However, these effects generally are not grounds for involuntary intervention into the lives of families. Thus, for the child welfare system to become involved with families there must be potential or actual child maltreatment, as well as concerns about developmental risk to the children.

In addition, the targeted parent in most of the research on mentally ill parents has been the mother (e.g. Goodman & Brumley, 1990; Melhuish, Gambles, & Kumar, 1988; Mowbray, Oyserman, Zemencuk, & Ross, 1995). Since mothers are generally the primary caretakers, their capacity to relate and respond to children is arguably more central to children's development. Similarly, when a mother is hospitalized (because of mental illness), it usually disrupts parenting more than when a father is hospitalized. However, when the issue or risk is the more overt forms of child maltreatment, maternal and paternal caretakers pose equal risk to children.

Factors that can potentially mediate the impact of mental illness

Every situation involving a child of a parent with mental illness needs to be evaluated on its own merits for the severity of the mental illness, overall parental functioning, co-existing problems (e.g. domestic violence, substance use), the parents' view of the mental illness, and the availability of social supports and resources.

Severity. Severe mental illness is characterized by early onset (usually during adolescence or before), significant periods of dysfunction, and frequent hospitalizations of the parent. When these characteristics are found, then the likelihood of adequate parenting is markedly diminished. Conversely, later onset, fewer periods of dysfunction, and infrequent or no hospitalizations increase the chances the parent will be able to care for the child. As noted earlier, severity of personality disorders are evaluated somewhat differently. Personality disorders should be assessed in terms of the seriousness and frequency of parental behavior problems and the extent of the parent's inability to consider the needs of others, especially those who are dependent upon them.

Co-existing problems. In addition, the parent's mental health problems must be examined in the broader family context. If there is only one parent with mental illness in a

two parent household, the probability of the child being adequately cared for may be much better. Unfortunately, the parent may not only have a mental health problem, but may also have a substance abuse problem. This dual diagnosis is found fairly frequently among parents reported to child protection agencies for child maltreatment. Parents with mental illness may also attract partners with problems in functioning, including, mental illness, histories of violence, and problems with substance abuse. Finally, children may also have problems. Because of the interactive nature of parent-child relationships, children whose parents have mental illness may develop significant difficulties of their own. In these instances, caretaking expectations for the parents become even greater, but parents, because of their own illness, are less likely to be able to meet them.

Acceptance of the problem. Persons with mental illness have a variety of responses to their problem. Parents with depression are probably the most likely to readily accept their diagnosis, to comply with interventions, and to experience recovery. Interventions include taking prescribed medication and learning to manage symptoms using cognitive behavioral techniques. Acceptance is greater for persons who have had three or more depressive episodes.

For persons with schizophrenia and manic depression, because of the cyclical nature of both of these illnesses, acceptance of mental illness and adherence to medication may require a longer process (Bellamy, 1999). Acceptance of illness means understanding that they must take medication in order to manage more severe symptoms. Most medications have side effects, especially psychotropic medications. Moreover, it may take up to a year for effective medications and appropriate dosage to be established. These problems may lead to inconsistency in taking medications (Frances & First, 1998; p. 141). Parenting functions may be seriously compromised when symptoms of mental illness are severe, the parent does not acknowledge the illness and its impact, and the parent does not consistently take medications.

Personality disorders pose some special difficulties related to acceptance by the parent of his/her limitations. Individuals with personality disorders experience less personal discomfort than those with the other mental health problems discussed here. As already noted, a core feature of personality disorders in that adults who have them see the problem not within themselves but caused by external circumstances and the behavior of others. Because they usually don't think there is anything wrong with them, it is hard to get them to accept that their parenting is inadequate. And, as mentioned earlier, these mental health difficulties do not usually respond to medication. They generally require extended therapy and prognosis is usually modest to poor.

Social supports and "burn out". Social supports may be informal, that is comprised of friends, neighbors, and relatives, or formal, that is composed of professionals and social agencies, or some combination of these two types of supports. Persons with mental health problems who have good social supports will fare better as parents than those who do not have supports or whose supportive network consists of other dysfunctional individuals.

However, even with appropriate social supports, the parent with mental health problems must be willing to accede parenting and other responsibilities to social network resources and persons. Moreover, it is often difficult for family and friends to repeatedly deal with someone they care about who has mental health problems. That person may become irrational, combative, and bizarre, while at the same time being dependent on family and friends. Furthermore, trying to assist parents with personality disorders may be especially stressful because they take advantage of members of their social network. Thus, parents with mental health problems may "burn out" their social supports over time. Finally, professionals who work with parents with mental health problems are not immune to burn-out. They too can become disillusioned and overwhelmed. As a consequence, professionals may withdraw services, when services appear ineffective or to have been misused, or they may transfer the case to another service provider.

Specific impacts of caretaker mental health problems on children.
The relationship of parental mental health problems to child maltreatment can be subdivided into three categories: 1. Difficulties around the peri-natal period, 2. Difficulties with the specific tasks of parenting, 3. Problems associated with parental absence. Each of these will be discussed in greater detail.

Parents with mental health problems may have special difficulty pre-natally, during childbirth, and during the postpartum period. In addition, because of their inordinate dependency on their caretakers and their unformed personalities, children may be especially vulnerable during this time period.

1. Parents with mental disorders may be vulnerable to unwanted pregnancy. Women with severe mental illness are at increased risk for unwanted sexual encounters (Brown, 1997). They may find themselves in situations where they are not able to control their sexual contacts, contraception use, and access to abortion. Therefore, they may give birth to unplanned and/or unwanted children. Some women with severe mental disorders may not even be sufficiently in touch with reality to realize they are pregnant.

2. Mental health problems may impede the likelihood parents will seek and receive pre-natal care (neglect). Mothers with personality disorders may be preoccupied with their own well-being to the point they do not attend to that of the fetus. Mothers who are depressed may be immobilized. Mothers with psychotic disorders may be in psychotic denial of the pregnancy. Moreover, they may not be aware of the importance of seeking pre-natal care that both takes into account their mental illness and protects the fetus from the potential harmful effects of psychotropic medications.

3. Parents with personality disorders may see the child as someone who will prevent them getting their psychological needs met. They may experience a child as a competitor for scarce resources of nurturing. Moreover, because of their lack

of nurturing skills, adults with personality disorders will be poorly equipped to care sensitively for a child. They may be overwhelmed by the task of caring for an infant. These responses to the demands of parenting may cause them to either abuse or neglect their children

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4. Mothers with personality disorders may have children in order to get their needs for nurturing met. Thus, they have a child so that they have someone to “love” them and in some instances to take care of them. Since children are not responsible for meeting the needs of parents, these children may disappoint their parents. When this happens, the parent may physically or emotionally abuse or neglect the child.

5. Pregnancy and the post-partum periods are times of vulnerability for mothers with mental health problems. However, mothers with a prior history of mental illness may be better prepared for the impact of pregnancy on their mental health. Mothers with or without a prior history may suffer from post partum psychosis or depression. Many women suffer post partum blues, but about 10% of mothers become clinically depressed, and .1% become psychotically depressed. Depression, especially if untreated, can negatively impact upon the parent-child relationship. Thus, it can result in emotional neglect of the child. Of mothers who suffer post partum depression, 30-50% will become depressed after a subsequent child birth (Goldberg, 1998). Moreover, mothers with post-partum psychotic depression are at risk for suicide and may harm their children.

6. Parents with schizophrenia may suffer a psychotic break associated with the birth of a child. This is much more common in mothers than in fathers with schizophrenia. Their psychotic thought process may include hallucinations or delusions about the child, for example that the child is possessed by the devil or is harming the parent. Similarly, parents may hear voices that instruct them to do things to the child, such as kill the child. As a consequence, parents with these disturbed thought processes may kill or injure the child. If there are any indications of these sorts of thoughts the child should be moved to a safe place.

7. The psychiatric medications taken by women who are pregnant may endanger the fetus. If the parent does not notify his/her health care professional, the health care professional may unwittingly harm the fetus. Similarly out of ignorance, the mentally ill mother may endanger the fetus by continuing medication.

Ironically, concerned mothers with mental health problems may stop taking their medications during pregnancy to prevent birth defects. This increases parental risk for mental health “breakdowns”. As a consequence, some mothers may need to be hospitalized during their pregnancy. Moreover, some mothers with mental illness will not want to resume medications after birth because they want to breast feed.

These periods of serious and/or exacerbated mental illness during the peri-natal period may pose serious obstacles to bonding and attachment. The impact on the parent-child relationship can be long-term.

Parents with mental health problems may have difficulty with the ongoing expectations of parenting.

1. Parents with mental health problems may have unrealistic expectations for children's self control. This is a particular problem with parents with personality disorders, but can occur with psychosis. When the child is perceived as being disobedient, this misperception can lead to child abuse.

2. Parents with mental health problems may have unrealistic expectations for children's self care. Such unrealistic expectations may be found in depressed parents as well as parents with personality disorders. The resulting parenting style may constitute neglect. For example, a parent with dependent personality disorder may turn over to the oldest child in the family responsibilities for caring for younger children.

3. Parents with personality disorders may not perceive risk situations and may endanger their children. Because these parents were not protected when they were children, they often do not have the skills to protect their own children. For example, a parent who was sexually abused as a child may not perceive the risk of using her offender or another person with a sex offense history as a substitute caretaker.

4. Parents with borderline personality disorder or depression may engage in self destructive behaviors (e.g. suicide attempts and self injury). These behaviors are very traumatic to children (which could be defined as emotional abuse) and interfere with the parent's capacity to care for the child, resulting in neglect.

5. Parents with all the mental health problems described above--schizophrenia, bi-polar disorders, major affective disorders, and personality disorders, will have difficulty forming attachments to children (emotional neglect). The emotional bond between a parent and child is regarded as at the core of the motivation to provide consistent, ongoing care, even in the face of adversity and environmental stress.

6. Parents who have severe symptoms of depression may not be able to care for themselves or their children (physical and emotional neglect). Similarly parents whose schizophrenia is characterized by negative symptoms, such as social withdrawal and failure to care for themselves, will likely carry over these symptoms into their parenting and neglect their children.

7. Parents with bi-polar disorders, psychosis, and personality disorders may engage in behaviors that put their children at risk. Parents who are manic may squander resources leaving no money for the child's basic necessities. They may expose the child to individuals who are dangerous to them. Psychotic parents' delusions and hallucinations may cause risk to the child. For example, the parent may have a delusion that the family dwelling is contaminated or haunted. This can result in acts of exorcism that are dangerous to children. Parents with antisocial personality disorder, who engage in illegal acts or who have weapons, may put their children in harm's way.

8. Parents with psychosis may form delusions about their children that lead them to injure or kill them. Reference was made above to post partum psychotic process. Such delusions or auditory hallucinations may occur at other times as well. Some parents have persistent thought distortions about their children. The child may internalize these and come to accept the parent's delusions as reality-based. Thus, for example, a child may view him/herself as possessed by the devil.

Parents with mental health problems may be unavailable to their children. Their problems may result in physical absence from the family and children.

1. Parents may be absent because they are hospitalized. Although parents with schizophrenia, post-partum depression or psychosis, major or psychotic depression, and manic depressive illness are the most likely to be hospitalized, borderline personality disordered parents may also be hospitalized. The latter hospitalizations tend to be brief, but can be very disruptive to children. Arguably if they are brief but frequent and co-exist with the rapid fluctuations in behavior, they are more damaging to children than longer hospitalizations in which the child has an opportunity to adjust to an alternative caretaking arrangement.

2. Parents may be unavailable because their treatment is very consuming. The parent may need to go to day treatment or may be in therapy several days a week. Some programs require the parent be in residence, for example in a group home. If a parent has co-existing problems, such as medical problems or a substance abuse problem, he/she will likely spend even greater periods away from the child. All consuming programs are especially likely to interfere with the parental relationship with young children.

3. Parents may engage in activities that are criminal or bizarre and that result in incarceration. This is a greater problems with parents with personality disorders, especially anti-social personality disorder. However, it is becoming increasingly common for adults with mental illness to become involved with the criminal justice system, either because of failure to diagnose mental illness, the punitive approach of the particular community, the lack of needed medications and therapy, or the lack of available services to assist the individual in managing the mental illness.

Conclusion

The mental health conditions described in this article are to a substantial extent caused by biopsychosocial factors, that is bio-chemical factors and early life trauma. Professionals want to and should enhance the well-being and functioning of adults with these problems. At the same time, it is important to recognize that these impairments can affect their children, if they have children. Sometimes parental deficits can be compensated for, and the child can be appropriately raised in a home with a parent with mental health problems. Moreover, some parents with mental illness have strengths that clearly outweigh their weaknesses. Nevertheless, it is important to maintain child safety and well-being as primary and protect children from physical, sexual, and psychological harm. Children should not be sacrificed for their parents' well-being. Children represent society's future.

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