Addressing the needs of children of parents with a mental illness: Current approaches

ABSTRACT

Children of parents with a mental illness have been identified as vulnerable to experiencing a variety of psychosocial effects arising from the impact of parental mental illness. Many children do not however, experience difficulties as a result of their parent’s mental illness and are able to thrive despite what may be an adverse situation. Until recently there has been a lack of adequate service provision in Australia for these children and their families. Recent government initiatives have led to greater awareness and recognition of the needs of children whose parents have a mental illness, and key principles and actions have been developed to assist health services to adequately care for them. The aim of this paper is to overview the risk and protective factors that may impact on the psychosocial health of children of parents with a mental illness, and provide some strategies that nurses in a range of health settings may use to assist families where parents have a mental illness.

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INTRODUCTION

My mum had depression. During my Grade 2 year it was bad, 'cause I didn’t really know what was going on … The best thing for me was learning that I wasn’t the only kid that this happened to … so I guess what I’ve learned from this is that not everything can go the way we want it to. (Alice, 2004: 1)

Since the 1920s there has been extensive empirical research and review literature on the varying effects of parental mental illness on children. Until more recent times however, there has been limited recognition of their needs in terms of service provision. In Australia the National Inquiry into the Human Rights of People with Mental Illness in 1993 highlighted the harmful impact that parental mental illness may have on the child and other members of the family. The Inquiry outlined the serious disadvantages these children may face, and recognized the lack of effective prevention and intervention strategies in place to support the family’s functioning (Burdekin, Guilfoyle & Hall, 1993).

More recently, the Children of Parents Affected by a Mental Illness Scoping Project (Australian Infant Child Adolescent and Family Mental Health Association, AICAFMHA, 2001) was conducted under the Mental Health Promotion & Prevention National Action Plan (1999) in order to ascertain the current responses in Australia to the issues facing both children and their families. In a more positive light, the findings revealed an emerging awareness of the needs of this group, and a growing movement to effectively respond to their needs. Further to this, in 2002 the Children of Parents with a Mental Illness (COPMI) National Initiative was conducted, where widespread consumer, carer, service provider and expert consultation resulted in the recent release of the Principles and Actions for Services and People Working with Children of Parents with a Mental Illness document (AICAFMHA, 2004). After many years of apparent invisibility, research-based evidence as well as information from parents, children, adult children and health professionals working directly with families affected by parental mental illness, has served to bring about well-deserved recognition of, and attention to, this large group of potentially vulnerable Australian children.

The purpose of this paper is to review the context within which parental mental illness may arise and the interaction between major risk and protective factors that affect psychosocial outcomes for children of parents with a mental illness, so as to provide an understanding for nurses of the key issues. The most effective current strategies to address the needs of this group of children are outlined so that nurses’ knowledge and awareness of the needs of these children and their families is enhanced, and effective interventions to meet their needs may be incorporated into nursing practice.

Context of parental mental illness

It is commonly acknowledged that between one in four to five, or twenty to twenty five percent of Australians, experience some form of mental illness in their lifetime (McDermott & Carter, 1995; SANE Australia, 1998; Commonwealth Department of Health & Aged Care & Australian Institute of Health & Welfare, 1999). The terms mental illness and mental health problem cover a broad spectrum of diagnostic nomenclature including anxiety, personality, cognitive, mood, and psychotic disorders. In terms of serious mental illness, around three percent of the population will develop a major psychotic disorder such as Schizophrenia or Bipolar Affective Disorder (SANE Australia, 1998). Approximately equal numbers of men and women experience the illness of schizophrenia (Bennett & Fossey, 2001), although women are more likely than men to experience affective disorders such as depression (Harvey, Meadows & Singh, 2001).

It has been reported that women with men-
tal illness are more often parents than males with mental illness, being up to twice as likely to report having children as men, and also being more likely than men to have custody of their children (Caton et al, 1999; Hearle, 1999). This may account for the significant amount of research that has focused exclusively on the mother with regard to the impact of parental mental illness on the child (e.g. Grunebaum, Cohler, Kauffman & Gallant, 1978; Cannon et al, 1994; Klimes-Dougan & Bolger, 1998). Other key studies, although including both genders in their sampling, have also found that parent participants were more often women with mental illness than men (Rutter, 1966; Grunebaum & Cohler, 1983; Jablensky et al, 1999).

The general incidence of children whose parents have a mental illness has been difficult to identify (AICAFMHA, 2001). As Cowling (1999) recognized, in Australia data on the incidence of adult psychiatric clients who are parents is not regularly collected. Estimates must therefore be made from epidemiological or census data. Cowling (1999) calculated that roughly 27,000 Australian children may be affected by their mothers’ mental illness. Various Australian surveys have found between twenty-nine to thirty-five percent of clients of mental health services are women with one or more dependent children (Cowling, 1999; Hearle et al, 1999; Farrell et al, 1999). The number of children affected by their father’s mental illness is not known, although as Devlin & O’Brien (1999) point out, there are potentially very large numbers of children from combined parental illness who may be at risk. One estimate suggests that up to 50 in every 100 clients with a mental illness are mothers or fathers with a mental illness who are living with dependent children (Gopfert, Webster & Seeman, 1996). Clearly, there are significant numbers of young children who are living with parents who suffer mental illness. The following discussion explores the risk and protective factors that may variously impact on these children and result in a range of outcomes.

**DIALECTICS OF RISK, VULNERABILITY AND PROTECTION**

For the child, the impact of parental mental illness may range from short-term traumatisation, through to domination of the child’s early life experience. (Clausen & Huffine, 1979: 183)

There has been a large volume of literature and research into factors that may either increase the risk of negative psychosocial outcomes for children of parents with mental illness, or protect against the risks. The term ‘risk’ can be defined as individual or environmental factors that increase a child’s vulnerability to experiencing negative developmental outcomes (Beardslee et al, 1983; Kostelny & Garbarino, 1994). Protective factors on the other hand, are seen as those that positively mediate the effects of risk, decreasing the likelihood of negative outcome. Researchers have conceptualized the notions of risk and protection in terms of parental mental illness in a variety of ways. Shih (1995) for instance, put forward the view that risk and protection could be considered through the metaphor of the coin, protective factors constituting the reverse side of risk. It is important to note however that both these groups of factors may exert influences that are independent of each other (Garmezy, 1987; Rutter, 1988).

An analysis of the interrelationship between the two groups of factors considered as being potentially risk and/or protective reveals they can be viewed as being in a dialectical relationship, where they are inter-related. From this perspective the factors that may be either risk or protective of the child from the effects of parental mental illness include as follows; individual factors, family factors, parental functioning and parenting, and social and environmental factors. As may be seen in the following discus-
sion, each factor can be either protective or risk in a dynamic dialectic depending on context, interaction with other factors, and relative strength and influence.

**Risk factors**

It has been well recognised that children of parents with a mental illness have a greater individual risk of developing a mental disorder than children of mentally well parents (Landau et al, 1972; Beardslee, Bemporad, Keller & Klerman, 1983; Rutter & Quinton, 1984). In terms of genetic predisposition for instance, the child has a 10–16% chance of developing schizophrenia or another psychotic disorder (Sameroff, Barocas & Seifer, 1984; Worgland, Weeks & Janes, 1987; Gottesman, 1991). If both parents have a psychosis, the risk rises to around 40% (Grunebaum & Cohler, 1983). Beardslee et al (1983), in a review of the literature, also report high rates of impairment in children of parents with an affective disorder.

Other individual risk factors linked to the development of adverse psychosocial outcomes for COPMI include a younger age at time of parental illness, male gender, ‘difficult’ temperament, low self-esteem, lower level of intelligence, birth defects, medical illness, and learning disabilities (Rutter, 1988; LaRoche, 1989; Brooks, 1994). The age between 6 months to 4 years has been found to be most vulnerable period for stressful events, and in general, the younger the age the greater the impact of parental mental illness (Anthony, 1969; Rutter, 1988). In terms of gender and stress, boys have been found in general to be more vulnerable to developing adverse responses than girls (Rutter, 1988). Self-esteem has also been a key component in determining risk (Marsh, 1996). Children with low self-esteem have been found to use counter-productive coping behaviors such as denying, bullying or giving up which are used to escape from challenging situations rather than adapting to them (Brooks, 1994).

Review literature and research on family risk factors has also noted an association between a greater risk for the child, and marital conflict, high levels of chronic family stress, difficulty with communication, discordant family environment, and overall reduction in effective family functioning (LaRoche, 1989; Kaslow, Gray Deering & Racusin, 1994; Inoff-Germain et al, 1997). Parenting plays a significant role in terms of risk. A secure attachment between mother and child may be impaired by the mother’s mental illness. In a relatively small comparison study with forty five first-time mothers and their children, divided into three groups where two of the groups were mothers with schizophrenia or depression, and with one a control group, D’Angelo (1986) sought to identify whether the use of the standard ‘Strange Situation’ attachment procedure, rated by observers, would result in differences in attachment responses between the groups. Results from the standard ‘Strange Situation” procedure were compared with the abbreviated version of the procedure. Children of mothers with depression and schizophrenia in this study were found to experience higher levels of anxious attachment with the standard procedure; however the abbreviated version found significantly more ratings of secure attachment for the children of mothers with schizophrenia or depression. These findings therefore indicated a possible over-identification of secure attachment with these mothers, and use of the abbreviated version of this procedure required further investigation (D’Angelo, 1986). Other research however, has found that separation of mother/caregiver and child through hospitalization has been associated with impaired attachment (Rutter, 1972; Hall, 1996). Repeated separations and loss of the caregiver relationship and secure attachment have been found to have harmful consequences, contributing to the child’s potential difficulty in developing healthy relationships with others (Rutter, 1972).

The parent’s most recent overall level of func-
tioning has also been associated with the risk of children’s behavioral problems (Inoff-Germain et al., 1997). Parental hostility, irritability and/or aggression toward the child can be more important in terms of risk than the disorder itself (Rutter & Quinton, 1984). In a critical review of research evidence for a relationship between child maltreatment/abuse and parental mental disorder, Tomison (1996) found that although it has been recognised there is a relationship between the two, there was inadequate research data to clearly define the causative link (Tomison, 1996). There are however, numerous documentations of negative and sometimes abusive parenting practices including violence and homicide, by persons who have a mental illness – particularly those that have chronic and/or psychotic disorder (Anthony, 1986; Buist, 1998; Devlin & O’Brien, 1999). Further, the impairment of the parent through illness/substance abuse may lead to a role reversal where the child assumes adult functioning, ‘parentification’ – which may also be considered a form of maltreatment. Neglect of the child can also be evident when parents are unwell and/or experience a lack of motivation as a result of their illness, resulting in insufficient supervision, inability to plan activities and lack of emotional availability and interaction, which may increase the risk of danger for the child (Devlin & O’Brien, 1999; Thomas & Kalucy, 2003).

It is important to note that not all parents with a mental illness are ineffective, inconsistent or abusive in their parenting. As stated, no causal connection has been found between harmful or uniform parenting practices and parental mental illness (Silverman, 1989; Jacobsen & Miller, 1998). Many mentally ill parents are competent and caring parents with warm relationships with their children, although this is variable (Inoff-Germain et al., 1997; Nicholson et al., 1998). Indeed, it is recognized there may even be a reciprocal effect where problems experienced by the child can negatively impact on the parent’s mental health, and that parenting itself may not have a positive impact on the course of the parent’s illness (Rutter & Quinton, 1984; Nicholson et al., 1998; Caton et al., 1999).

### Process by which parental mental illness affects children

A number of empirical studies have found that in respect to the development of psychosocial impairment and/or mental disorders in children of the mentally ill, the main risk has been from psychosocial disturbance in the family and/or an unsettled living situation, rather than from parental mental illness itself. The chronic symptoms of mental illness may still however, have an influence (El-Guebaly & Offord, 1980; Rutter & Quinton, 1984; Cantwell & Baker, 1984; Kraemer Tebes et al, 2001; Ahern, 2003). As Hindle (1998) recognised, a linear model of causation oversimplifies the complexity of the situation. The mental health problems of one person do not as such, cause disturbance in the children. It has further been argued that it is difficult to separate the direct effects of parental mental illness, including suicidal tendencies and homicidal delusion, from the indirect effects of marital disharmony, separation due to hospitalisation, unemployment, impaired parenting, disrupted parent–child bond, and social disadvantage, as they may be synergistic (Anthony, 1986; Dunn, 1993; Cowling et al, 1995; Hall, 1996).

In 1984 Rutter and Quinton conducted a pivotal study, which laid the groundwork for many subsequent investigations, to identify the process by which a parent’s mental illness might lead to disorder in the child. They conducted one of the relatively few prospective studies on COPMI, which over four years followed a representative sample of 137 patients who had children under the age of fifteen, and had been newly referred for psychiatric services. The children were followed through yearly teacher questionnaires, and yearly, standardised interviews were conducted both simultaneously and
separately with the patients/parents and their spouses. The results were compared with those of a control group in the general population who had ten-year-old children.

Major findings by Rutter and Quinton (1984) included an increased rate of emotional and behavioral disturbances and significantly greater risk of developing a mental illness during childhood for these children, and a high level of marital discord between parents. Just as significantly Rutter and Quinton also found that approximately one third of the children did not suffer any form of disturbance, and that the major risk for COPMI was not from the parental mental illness, but from associated psychosocial disturbances such as marital discord and disturbed family relationships.

Outcomes for the child who experiences parental mental illness

Children and adolescents may develop a number of disorders and/or psychosocial problems as a result of their parent’s mental illness. 25–50% of children will experience some disorder or problem during their childhood and/or adolescence (Worland, Weeks & Janes, 1987). Research has however; consistently revealed little correlation between the type of parental mental illness and the type of disorder the child may develop (Cantwell & Baker, 1984; Rutter & Quinton, 1984). Significant large-scale follow-up and/or prospective studies by Rutter and Quinton (1984), Parnas et al. (1993) and Higgins et al. (1997), have added to understanding of the effects of parental mental illness on children. Findings included that children of these parents may develop a variety of psychiatric diagnoses, and that these tend to be the more serious and persistent mental disorders. They include schizophrenia (particularly paranoid), schizoaffective disorders, schizoaffective psychosis, schizotypal, paranoid and schizoid personality disorders, major depression, substance abuse and dependence, post-traumatic stress disorder, phobias, non-psychotic mood disorder and atypical psychosis.

The child’s psychosocial functioning may also be adversely affected by parental mental illness. Children of parents with mental illness have been found to have higher rates of academic problems, peer interaction problems, and school discipline problems than children of non-mentally ill parents (Billings & Moos, 1983). Children’s capacity to form interpersonal relationships has also been linked with parental mental illness (Grunebaum & Cohler, 1983). Children of mentally ill parents have additionally been found to have an increased suicide rate, related to the genetic and psychosocial stresses of their parent’s illness, feelings of fear, a sense of isolation, and often significant responsibility and burden through for example, parentification (Anthony, 1986; Drake, Racusin & Murphy, 1990; Rossow & Lauritzen, 2001).

Protection against problems arising from parental mental illness

The literature discussed so far has revealed a dominant thread where problematic and negative effects for the child have been considered to result from the biopsychosocial effects of parental mental illness. Indeed, it is only through unexpected research discoveries in the 1960s and 1970s of children who were functioning well that there came an awareness that not all children were negatively affected by their parent’s illness, and would not necessarily go on to develop future psychosocial problems (Feldman, Stiffman & Jung, 1987; Silverman, 1989). Various terms were developed to describe this group of children who became of increasing interest to researchers. These include the ‘invulnerable’ (Anthony & Koupernik, 1974; Garmezy, 1974), or ‘superkids’ (Kauffman et al, 1979). The terms described children who were considered to be outstanding and functioned even more successfully than those who had parents without mental illness (Grunebaum & Cohler, 1983). The con-
cept of ‘exceptional’ children, whilst intriguing, has subsequently been viewed as misleading in that the ability of the child to avoid risk associated with parental mental illness was found to fluctuate. A developmental progression could occur, where vulnerabilities and/or further strengths emerged in the child according to changes in life circumstances (Rutter, 1985; Feldman et al, 1987; Luthar et al, 2000a). Subsequent to these discoveries, the concept of ‘invulnerability’ has developed to the more relative one of ‘resilience’ (Rutter, 1985; Luthar et al, 2000a). Further to this, resilience itself has been proposed to exist in varying degrees within a spectrum of successful outcome (Osborn, 1990).

**Becoming resilient**

Although it has not been prominent until more recently, the concept of resilience has been present in the literature for more than thirty years. As illuminated in the previous section, the literature discussing the effects of parental mental illness on the child played a significant role in the emergence of childhood resilience as a theoretical topic of discourse (Luthar et al, 2000a). Garmezy (1983) for instance, found there were children who seemed to thrive even in the face of severe stress. This finding illustrates an important facet of resilience research in that it has been concerned not only with the absence of dysfunction, but also with exploring the dimension of wellness itself (Luthar et al, 2000b). This reflected in an important change in research focus where parental mental illness was recognised as by no means indicative of future difficulties for the child.

There have been a number of operational definitions of resilience over time. Resilience has been described as an ability to rebound from adversity and overcome difficult circumstances in one’s life (Marsh et al, 1996). Resilience has also been viewed in terms of two major concepts, those of competence and vulnerability. Children who were vulnerable due to risk yet achieved ‘competence’ have been deemed resilient (Osborn, 1990). More recently resilience has been viewed as a complex cultural construct that involved the dynamic interaction between individual or family maintenance of positive adaptation despite experience(s) of considerable adversity (Luthar et al, 2000a; Marmion & Joyce, 2001; Deveson, 2003). This definition notably includes the concept of the family as a group, rather than just the individual, as having the ability to demonstrate resilience.

**Protective factors and resilience**

Protective factors are seen as influences that are able to modify, alter or improve an individual’s response to an external risk that may have otherwise predisposed them to a negative outcome. Protective factors are not however; always pleasant or positive characteristics or experiences and can include a personal quality such as gender, or an experience such as preventative interventions (Rutter, 1985). In terms of parental mental illness, protective factors are the specific resources the child may have or experience that can support them in developing and maintaining resilience (Brooks, 1994).

A number of protective factors have been specifically considered to mediate the more negative effects of environmental stress including that of parental mental illness (Rutter & Quinton, 1984; Thompson & Calkins, 1996). These can be separated into internal factors within the child and external resources accessed by the child that support the development and maintenance of the construct of resilience. Internal factors that have been found by empirical research to provide protection against adversity and strengthen resilience include higher intelligence, a belief in their own effectiveness (internal locus of control), ability to be autonomous, being optimistic, having a low risk or ‘easy’ temperament, using effective communication and problem-solving, having a sense of humour, involvement in social activi-
ties and commitment to relationships with others, having a special interest or hobby, having high self-esteem and positive self-concept, substantial self-understanding, and the ability to manage emotional regulation (Rutter & Quinton, 1984; Luthar & Zigler, 1991; Werner, 1995; Fonagy et al, 1994; Seligman, 1996; Thompson & Calkins, 1996; McGrath, 2001).

External protective factors include those within the family and in the community that may enhance the child’s resilience such as a positive relationship with a caregiver, positive sibling relationships and support, reading and interest in literature, use of music, and support and positive feedback from other adults (Kauffman et al, 1979; Silverman, 1989; Werner, 1995; Inoff-Germain et al, 1997). The opportunity to establish a close bond with a competent and emotionally stable person, particularly a schoolteacher, has been considered an important protective factor for many resilient children. The development of positive emotional bonds with other adults throughout development has been found to provide the child with caring role models who reinforced the child’s competencies and affirmed their intrinsic worth (Kauffman et al, 1979; Anthony, 1987).

Werner (1995), in a major longitudinal study on resilience in children, followed 698 children in Kauai over three decades from the prenatal period through to birth and ages one, two, ten, eighteen and thirty two. In monitoring the children’s biological and psychosocial risk factors, protective factors and stressful life events, Werner and her associates found that thirty percent of the children were considered high risk due to factors such as parental mental illness and poverty. Her findings however, reinforced previously cited literature in that parental mental illness and other risks did not necessarily determine future problems; as one third of these children who were considered to be high risk went on to develop into competent and confident adults. They were able to overcome their difficulties in adulthood by participation with external supportive influences such as supportive friends, marital partners, church involvement, and educational programs such as community colleges and voluntary military service. Rutter (1993) supports that these turning points in a person’s life can enable them to change to a more positive course, due to the benefits and resilience the experiences may bring.

**ADDRESSING THE NEEDS OF CHILDREN OF PARENTS WITH A MENTAL ILLNESS: PRIORITIES SERVICE PROVISION**

The previous overview of the needs of children of parents with a mental illness has revealed a number of key areas for health services to address. This group of children is relatively easily identified and due to the benefits of protective factors and enhancement of resilience is therefore likely to respond well to prevention and early intervention strategies (AICAFMHA, 2001). The challenges for service provision include the need to strengthen and support children and their families so that protective factors are facilitated and contribute to both children’s and their parent’s mental health, and the need to identify and reduce risk factors in the parents with a mental illness, along with those in the family and wider community, so that children’s well-being is enhanced (AICAFMHA, 2004). Effective strategies may be grouped according to three levels of intervention: policy and service level changes, support for the family, and support for the child (AICAFMHA, 2001).

The guiding principles for service provision in the recently launched ‘Principles and Actions for Services and People Working with Children of Parents with a Mental Illness’ are:

- Recognition of children’s rights to, for instance, the support, protection and care that is needed for their well-being
- That parents and families have rights, responsibilities, roles and diverse backgrounds and needs.
That people with a mental illness have both rights and responsibilities as stated in the Australian Ministers’ Mental Health Statement of Rights and responsibilities (1995), and the United Nations Principles on the Protection of People with a Mental Illness (1992)

• Promotion of mental health, prevention of disorder and early intervention play a vital role with those who demonstrate signs or symptoms of mental health problems
• Collaboration and empowerment of children and their families is the responsibility of many sectors and human services
• Quality and effectiveness are important goals for research, service provision, workforce development and education for families where a parent has a mental illness.
  (AICAFMHA, 2004).

Specific strategies that have been recommended as helpful for both children and their families include:
• Family-focused assessment and management of inpatient and community mental health clients; ie: identification of dependent children, their needs and risk levels through improved intake and assessment procedures, and data-gathering
• Education of parent and child(ren) on the mental illness, including heredity risks, medications, the course of illness, and stigma
• Development of resilience/coping skills through social skills training, problem-solving skills training and decreasing parentification of the child
• Increased community & school-based education and promotion of tolerance for mental illness
• Validation and support of the parenting role, eg peer-support groups, home-based training, development of parenting skills, and family friendly mental health services
• Provision of specialised services such as mother–baby inpatient and day services, supported accommodation, and dedicated COPMI programs/services
• Provision of parent support groups, and child/peer support groups: see the following website for examples of specific COPMI groups and services available in Australia: http://www.copmi.net.au/common/services.html
• Planned care, provision of respite services, assistance with housing, health and vocational training for parents and families.
  (AICAFHMA, 2001)

Other strategies for health services recommended by recent research are to include the whole family in care and management (Fudge et al, 2004), perform early assessment of both the child and the parent’s and child’s relationship (Ahern, 2003), and undertake assessment and support of the child-care and domestic capacities of the parent (Thomas & Kalucy, 2003).

Implications for nurses
Nurses from a variety of practice areas may engage in providing care for children and families where a parent has a mental illness. Those working in areas such as child and adolescent mental health services, paediatric settings, adult mental health services, and women’s health/perinatal services are particularly likely to work with parents with mental illness and/or their children.

Attention to, and awareness of children whose parents have a mental illness is a fundamental strategy for all nurses. The current focus on a supportive and empowering approach to children and families, the benefits of early assessment and intervention, and provision of practical and timely interventions highlights the important role nurses can play in many areas of health care. Garley et al (1997) suggest that the potential effect parental mental illness may have on the child means it is particularly important nurses broaden their practice to incorporate primary prevention strategies into their work.
This may include for instance the regular provision of both support groups and psychoeducational groups for children of parents with a mental illness. The promotion of mental health in families may be seen as an essential role for nurses in child and youth, adult mental health, and women’s health services. Devlin & O’Brien (1999) highlight that nurses are also uniquely positioned to assess the needs of the children and their families so that potential and actual problems may be identified and interventions put in place to limit their impact.

Blair (2004), a psychiatric mental health nurse and adult child of a parent with mental illness, recommends that those working with children of parents with mental illness attend to specific areas when identifying a child of a parent with mental illness. These include referral to support agencies, COPMI support groups, counselors, literature and videos on issues pertinent to children of parents with mental illness. As Blair identifies, facilitating the child’s contact with support enhances universality – knowing that they are not alone and others also share the same issues and/or difficulties. This is a benefit all health professionals can offer to the child, regardless of their expertise or health setting. Dunn (1993) suggests that in all strategies used to support families with a mentally ill parent, health professionals need to be aware of the potential loyalty conflicts that may be engendered by the interventions, and the guilt that may be felt by the children. As many children of mentally ill parents are also in a caregiving role with their parent, the likelihood of parentification means there is a need for nurses to work directly with the parents to strengthen their caregiving and parenting capacity. One of the most useful strategies that nurses can use is to encourage the family to enlist the support of other adults such as friends who may provide emotional and practical support, particularly to the children. Thomas and Kalucy (2003) further suggest that practical support for parents in the form of assistance with daily living and domestic chores such as cooking and washing has been reported by parents to be of significant help in resuming their parenting role and relieving the burden on carers after an episode of illness.

Approaching the child and their family from a strengths perspective, which involves building on an individual’s/family’s strengths rather than focusing on deficits and vulnerabilities (AICAFMHA, 2004), is a further supportive strategy suggested by Blair (2004). This approach may diminish the stigma of mental illness that can impact on both the child and their family, and its use implies an understanding that children are by no means inevitably negatively affected by parental mental illness.

Specific interventions nurses can provide, especially for mothers with mental illness, include support to parents through assistance with practical issues such as breastfeeding and mother-craft skills, and strategies to enhance parenting skills such as helping parents ‘read’ and respond appropriately to their child’s signals for care and attention (Sved Williams, 2004). These interventions are important in facilitating a warm parent–child bond and attachment, which has previously been identified as an important protective/risk factor.

From a workforce development and training perspective it has been recommended that inclusion of information on the needs of COPMI and their families in undergraduate, postgraduate and in-service training and education for nurses would support improved outcomes (AICAFMHA, 2004).

In conclusion, children of parents with a mental illness may be vulnerable to experiencing higher rates of psychosocial disorder than the general population. It is important to note that with recognition of their needs, a focus on supporting the family as a whole, attention to primary prevention and early intervention, and the widespread provision of appropriate interventions and support, these children will not necessarily suffer adverse outcomes as a result of their parent’s mental illness. A dialectical
relationship between risk and protective factors suggests that the greater the focus on enhancing protective factors, the greater the chance of developing resilience in the child and their family. Nurses and other health professionals are in a key position to respond in a timely and effective way to the needs of children and families where a parent has a mental illness.

Endnote
1 As diagnostic criteria/nomenclature for many mental disorders has changed over time however, there is some difficulty in comparison of diagnoses in older studies, e.g., 1970s, to more recent ones from the 1990s & 2000s. Nevertheless, these are large-scale, pivotal international studies which span up to three decades.

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