Psychological Disability and Parenting

Dr C.J. Lennings, University of Sydney

The following review discusses issues associated with parental psychopathology, chiefly depression, and the risks that flow from parental psychopathology for children. It reports on a methodology for expanding current parenting assessments in cases where psychopathology is alleged, and reviews a case study to illustrate the patenting assessment methodology.

Currently, there is a belief that children are susceptible to greater distress if their parents have some kind of psychopathological disorder (Bosco, Renk, Dinger, Epstein & Phares[1], 2003; Markus[2] et al., 2003). For instance Keltikangas-Jarvien, Kivimaki & Keskivaara (2003) found that hostile parenting practices in childhood still exerted effects on self-esteem of these children as adults. Kane and Garber[3] (2004) report that maternal depression is positively associated with higher rates of internalising and externalising disorders in their children and increases the likelihood of irritable conflict between children and mothers. Their study also identified similar effects for fathers. Weissman et al[4]., (2004) report that depressed mothers (after controlling for other comorbid conditions) were three times more likely to report psychosocial and behavioural disturbance in their children than non-depressed mothers. Clark-Stewart[5] et al., 2003 found that parents who themselves had poor psychological adjustment tended to attribute to their children poorer psychological adjustment. Bell et al., report a large Canadian study in which parents with dysthymia were more likely to report having a

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[1] Bosco, G. L., Renk, K., Dinger, T. M., Epstein, M. K., & Phares, V. (2003) The connections between adolescent's perceptions of parents, parental psychological symptoms and adolescent functioning. *Applied Developmental Psychopathology, 24*, 179 – 200.

[2] Markus, M. T., Lindhour, I. E., Boer, F., Hoogendijk, T. H., Arrindell, W. A. (2003) Factors of perceived parenting rearing styles: the EMBU-C examined in a sample of Dutch primary school children. *Personality and Individual Differences, 34*, 503-519.

[3] Kane, P., & Garber, J. (2004) The relationship among depression in fathers, children's psychopathology, and father-child conflict. A meta-analysis. *Clinical Psychology Review, 24*, 339-360.

[4] Weissman, M.M., Feder, A., Pilowsky, D. J., Olfson, M., Fuentes, M., Blanco, C., Lantigua, R., Gameroff, M. G., and Shea, S. (2004) Depressed mothers coming to primary care: Maternal reports of problems in their children,. *Jnl of Affective Disorders, 79*, 93-100.

[5] Clarke-Stewart, K. A., Allhusen, V. D., McDowell, D. J., Thelen, L., & Call, J. D. (2003) Identifying psychological problems in young children: How do mothers compare with child psychiatrists? *Applied Developmental Psychology, 23*, 589-624.

child with a diagnosed psychiatric condition than parents without dysthymia (Bell[6] et al., 2004). Dysthymia is a less obvious, but in some ways a more pernicious form of depression in which symptoms tended to be long lasting, but muted, and often the condition goes undiagnosed until some life stressor exacerbates the disorder.

However, Turner[7] et al., 2003 reveal that simply having a disorder does not necessarily mean a poor parenting climate exists. The issue is multidimensional and simply finding high levels of psychopathology in and of themselves should not necessarily lead to a judgment of risk of abuse.

Depression & Parenting. Depression is a function of common emotional experiences in our society. The impact of loss and the expression of grief, and the increasingly recognised incidence of post-partum depression are two such manifestations of depression. For instance, post-partum depression has been diagnosed in between 10% and 20% of women within three months following childbirth (Matthey et al., 2004). If untreated, approximately 30% to 50% of those women will remain depressed at 1 year post-partum.

In general most studies indicate that depression has about twice the prevalence in the adult population for females than for males (Kane & Garber, 2004). In addition adults under the age of 45 have higher rates of depression than do older adults, indicating depression is most likely to occur at a time when an adult is young enough to have dependent children.

Depression appears to be a moderately common correlate of parenting, especially among women with sample studies revealing high rates of depression in mothers of young children (ranging from 27% to 42%). Numerous reasons may account for such high rates, but obviously parenting young children can be a strain in and of itself. Naerde et al[8]., (2002) identify that the logistics of child care and balancing child care with work commitments explain much of the relationship between the first

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[6] Bell, B., Chalkin, L. etal., 2004. Burden of dysthymia and comorbid illness in adults in a Canadian primary care setting: High rates of psychiatric illness in the offspring. *Journal of Affective Disorders, 78*, 73-80

[7] Turner, S. M., Beidal, D.C., Roberson-Nay, R., & Tervo, K. (2003) Parenting behaviours in parents with anxiety disorders. *Behaviour Research and Therapy, 41*, 541-554.

[8] Naerde, A., Tambs, K., Mathiesen, K. S., Delgard, O. S., & Samuelson, S. O. (2000) Symptoms of anxiety and depression among mothers of pre-school children: effect of chronic strain related to children and child care taking. *Journal of Affective Disorders, 58*, 181-199.

years of child birth and maternal depression. That is, the stress of being a parent itself is an issue. Similarly, the same research finds that a protective mechanism against depression was a supportive and open relationship with a spouse in the first years after child birth.

Weissman et al., (2004) argue that children of depressed parents have a three fold risk compared to non-depressed parents of themselves having depression. Typically, they report behavioural difficulties for such children emerge in pre-school, and, further, become complicated by emerging substance abuse (possibly as a form of self-medication) in adolescence. In their study of more than 1,000 mothers they found family conflict rates (compared to non-depressed controls) were 10 times greater, and yet the families had lower rates of professional involvement in helping them with their more difficult children.

Some research indicates that depression makes parents more critical of their children, more likely to be hostile in their interactions with children, and more likely to generate conflict (see Kane & Garber, 2004 for a review). Depressed parents may also experience affect restriction (narrowing repertoire of feeling akin to emotional numbness) or more volatile emotionality, thus creating conditions for failures of emotional regulation in their children. Sachs-Ericsson et al[9]., 2006 used the data base of the United States National Epidemiological Study (nearly 5877 people who received the psychosocial survey) people and reported in the incidence of various forms of abuse. They found that whilst less than 5% reported sexual abuse and less than 7% reported physical abuse, almost 30% reported significant verbal abuse from their parents. Interestingly, there were no gender differences for the report of verbal and physical abuse although more women than men reported sexual abuse as children.

Father-child conflict (particularly when linked with low socio-economic families in which greater use of coercive parenting strategies is found) is thought to be particularly salient for the development of delinquency in the child (Kane & Garber, 2004). It is thought that conflict might act as a mediator in children, increasing the likelihood of an externalising or internalising disorder. Hence, maternal (or paternal) depression may be a risk factor for childhood psychopathology. The same research quotes

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[9] Sachs-Ericsson, N, Verona, E., Joiner, T., & Preacher, K. J. (2006) Parental verbal abuse and the mediating role of self-criticism in adults internalising disorders. *Journal of Affective Disorders, in press.*

other studies suggesting that the likelihood a child will develop an externalising disorder is not only a function of parental depression, but also of marital conflict, suggesting a cumulative hypothesis in accounting for childhood psychopathology.

Haskett, Scott, Grant, Ward, & Robinson[10], 2003 conducted a study that helps integrate our understanding of the effect of parental psychopathology within parenting assessments. They tested a cognitive model of propensity to abuse. In their sample of 155 parents, they assessed 3 cognitive and 2 psychopathology factors associated with likelihood of being an abusive parent. Their findings, in brief were:

- high levels of generalised psychological distress (as assessed with the SCL-90R) was associated with poor parenting and that such distress was associated with more negative pattern of child related beliefs (children are intentionally naughty) and attitudes.
- Parents who had unrealistically high expectations of children's developmental level tended to see their children as having problematic behaviours as well as believing the children misbehaved in order to annoy them.
- A set of three "cognitive" factors appear important in assessing risk of abuse. These are unrealistically high parent expectations; the perception by parents that their own child was a "problem child" (e.g. in my clinical practice this accords with the attribution of ADD to their child); and the attribution of intent to their child (my child is deliberately naughty).

It is important to note that symptom clusters are not as important as the kind of cognitive distortions that might arise in vulnerable adult parents. Similarly many studies reveal the importance of substance abuse issues in leading to decisions about protection, and as predictors of abuse (Fuller & Wells[11], 2003; Kelley[12], 2003; Maluccio & Ainsworth[13], 2003). It may be the case that a parent may have depressive traits or sub-clinical manifestations of the disorder and it is unclear to what extent the severity of the disorder contributes to childhood psychopathology. For fathers, Kane and Garber

[10] Haskett, M. E. Scott, S. S., Grant, R., Ward, C. S., & Robinson, C. (2003) Child-related cognitions and affective functioning of physically abusive and comparison parents. *Child Abuse and Neglect, 27*, 663-686.
[11] Fuller, T. L., & Wells, S. J. (2003) Predicting maltreatment recurrence among CPS cases with Alcohol and Other Drug involvement. *Children and Youth Services Review, 25*, 553-569.
[12] Kelly, S. J. (2003) Invited commentary: Cumulative environmental risk in substance abusing women, parenting stress, child abuse potential and child development. *Child Abuse & Neglect, 27*, 993-995.
[13] Maluccio, A. N., & Ainsworth, F. (2003) Drug use by parents: A challenge for family reunification practice. *Children and Youth Services Review, 25*, 511-533.

(2004) note that even sub-clinical manifestations of depression in fathers were correlated with children internalising disorders. Conceivably, of course, it is possible that a causal pathway is not direct, for instance a father's sadness may lead to conflict and childhood psychopathology, or, alternatively, a father may develop sadness as a function of living with a depressed or anxious child.

Causality is also compromised by the possibility that psychopathology in a child may be a function of the genetic inheritance and not the behaviour per se of the affected parent. Whilst maternal depression may have some significance for childhood psychopathology per se, the significance may be a function of shared vulnerability associated with genetic markers for the disorder. Of course, the issue here is not whether maternal or paternal depression "causes" psychopathology, but whether parenting skills can be protective of, or facilitate the development of psychopathology.

It should also be recognised that simply having a parent who is overly anxious or depressed may not be sufficient to lead to poor outcomes for a child. It is likely that impaired parents will have more deleterious effects on children who are more sensitive to their parents' disturbance than other children. Sensitivity is not uniform in the population. About 25% of children are thought to be "high sensitives" and it is this group, in particular, for whom an impaired parent may be of greater concern (Liss et al[14]., 2004).

Kane & Garber (2004) reviewed both their own and other's work identifying incremental contribution of both maternal and paternal depression to childhood psychopathology. It seems that when both parents are depressed the effects for psychopathology in the children are greater than when only the mother or the father are depressed. In a study reported in the 1980's but conducted over three generations of families, Drake and Vaillant[15], 1988 noted that in deprived communities, the likelihood a child will reveal psychopathology or delinquent behaviour is increased if they have a parent with psychopathology or substance abuse, but a well functioning care-giver can compensate for such harm. One policy outcome of such research is the need to involve both parents in therapy even when only one parent is identified as depressed if the depression is thought to impair parenting.

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[14] Liss, M., Timmell, L., Baxley, K., & Killingworth, K. (2005) Sensory processing sensitivity and its relation to parental bonding, anxiety, and depression. *Personality and individual Differences, 39*, 1429-1439.

[15] Drake, R. E. & Vaillant, G. (1988) Predicting alcoholism and personality disorder in a 33-year longitudinal study of children of alcoholics. *British Journal of Addiction. 83*, 799-807.

Affect Regulation. A key mechanism to understand how the impact of parental depression may manifest itself on children is through the notion of affect regulation. The manner in which a person organises and responds to disappointment and success is important. Mature people are said to have good emotional regulation strategies, can inhibit emotion that might overwhelm the self, but give vent to emotion when it is appropriate. It is thought that as children mature, they develop "physiological flexibility" in the neuronal and hormonal systems that subserve emotion (Forbes et al.,[16], 2006). Experiences that inhibit such flexibility, that cause hyper arousal or catastrophic or rigid responses to emotional stimuli are injurious to appropriate development. Thus successful adaptive behaviour depends on the flexibility of the emotional sub-systems. It is possible (and indeed observed) that children who are abused lack such flexibility (Fonaghy[17], 2004).

Self-criticism. In what can be seen as a quid pro quo, research has also established the role experiences of child abuse contribute to the development of depression in adults. It is thought that one means whereby childhood abuse transmogrifies into depression is through the generation of negative or self-critical schema (Sachs-Ericsson et al., 2006) in which a person comes to blame themselves for their abuse or view themselves as worthless.

Parenting, psychopathology and substance abuse. A study by Nair[18] et al., (2003) reveals an interesting pattern of how substance abuse may mediate other risk factors. They found that substance abuse was an important predictor of abuse, but only within the framework of a cumulative risk factor model. That is, parents who substance abused were more likely to abuse their children if they had multiple other risk factors. Substance abuse with only a few other risk factors did not discriminate between mothers who abused substances and those that did not. The findings with relation to substance abuse are similar to the earlier reported findings that psychiatric impairment confers a vulnerability and it is the accretion of stressors or risk factors that need to be identified. Having said

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[16] Forbes, E. E; Shaw, D. S; Fox, N. A; Cohn, J. F; Silk, J. S; Kovacs, M. (2006) Maternal depression, child frontal asymmetry, and child affective behavior as factors in child behavior problems. *Journal of Clinical Child and Adolescent Psychology, 35*, 116-126

[17] Fonaghy, P. (2004) Early-life trauma and the psychogenesis and prevention of violence. *Annals of the New York Academy of Science, 1036*. (pp. 181-200). New York: N.Y. Academy of Science.

[18] Nair, P., Schuler, M. E., Black, M. M., Kettinger, L., & Harrington, D. (2003) Cumulative -environmental risk in substance abusing women, parenting stress, child abuse potential and child development. *Child Abuse & Neglect, 27*, 997-1017.

this there are numerous studies that also claim to have found direct as well as cumulative effects on parenting for both psychiatric impairment and substance abuse.

Psychiatric impairment may affect parenting and increase risk of intervention due to empathy failures bought about by the "centration" effect associated with the misery of mental illness and the reduction in attention. It may lead to inadequate food, failure to pay bills and so forth as parents struggle with the costs of economic deterioration in their circumstances as their depression erodes their working ability. It is often considered that the effect of depression or anxiety may be to cause neglect. But it is also the case the some psychiatrically impaired parents will be over-protective, rather than neglect it is the overly intrusive and controlling aspects of the illness/disorder that impact on the child. Typically, it is thought such children become themselves quite anxious and fearful.

Disabled Parents. Controversy surrounds the perception that disabled parents (psychiatric or intellectual disability), are more likely to have children removed than non disabled. A number of hypotheses for this are possible. These are:

- Disabled parents have greater problems coping with vicissitudes due to their disability, therefore when problems happen, children are more likely to be temporarily removed because the relative parenting deficits are high. (The vulnerability hypothesis).
- Disabled parents are less able to represent themselves, therefore for the same level of parenting deficit they are more likely to have children removed than more articulate parents simply as a function of parent-protection officer communication. (i.e. passive discrimination hypothesis).
- Disabled and psychiatrically impaired parents do not abuse children, but community workers hold negative stereotyped about disabled people, misrepresenting their actions and misperceiving increased rates of abuse or risk of abuse when such abuse does not exist (i.e. active discrimination hypothesis).
- Disabled and psychiatrically impaired parents are not likely to have their children removed more often than non-disabled, but merely attract more publicity when it happens (i.e. the chimera hypothesis).

Llewellyn, McConnell & Ferronato[19] (2003) investigated the representation of disabled parents with children removed in the New South Wales jurisdiction. Their research indicates that the most prevalent disability is psychiatric disability. Whilst the Llewellyn et al. group are highly critical of the notion of psychiatric disability as a general factor in parenting problems, other research has highlighted significant problems for psychiatrically impaired parents in raising children. Such problems include parenting problems based on empathy deficits, and the problems associated with personality disorganisation that sometimes accompanies psychiatric illness. To support the first contention, that high rates of removal of children exist for disabled parents, Llewellyn et al. quote a number of small sample studies that indicate high rates of removal although there is no information if these studies "matched" disabled parents against similar families where the parent was not disabled.

It is of course not surprising that psychiatric disability should be over-represented in child protection populations. There is now considerable research into child carers of parents of disabilities that illustrates the problems associated with psychiatric disability in families, despite the need to not stereotype such families. In the Llewellyn et al. study, psychiatrically disabled parents made up 21.8% of all care matters adjudicated at the Children's Court in a 9 month period. The authors contrast that to the general population estimate of between 2.6% and 5.4% of the general population of parents with a psychiatric disability. At least two issues Llewellyn et al. do not deal with are: (1) the fact that a large number of disabled parents require their children to act as de-facto carers for them - a condition not always conducive to the well-being of the child, and (2) sometimes courts do have to make hard decisions about the relative costs and benefits in retaining children in families and attempting to ensure the best outcome for them.

The Llewellyn et al. (2003) study can be compared to the study of Dong[20] et al., 2003. This study also reports that in their sample of abused children approximately 23.3% had a household in which one family member had a mental illness. Thus, the prevalence rate in the New South Wales does appear

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[19] Llewellyn, G., McConnell, D., & Ferronato, L. (2003) Prevalence and outcomes for parents with disabilities and heir children in an Australian court sample. *Child Abuse & Neglect, 27*, 235-251.
[20] Dong, M., Anda, R. F., Dube, S. R., Giles, W. H., & Felitti, V. J. (2003) The relationship of exposure to childhood sexual abuse to other forms of abuse, neglect, and household dysfunction during childhood. *Child abuse & Neglect, 27*, 625-639.

similar to prevalence rates for psychiatric disability in other studies. The Dong et al. study also shows that substance abuse has a higher prevalence (29.5%). However, research in the field of violence has shown that the impact of mental illness on violence is often mediated through substance abuse and similarly substance abuse magnifies the effects of mental illness. The Llewellyn study provides some information on psychiatric impairment separate to, and in association with substance abuse. When the psychiatric impairment groups are looked at in terms of with or without substance abuse, it becomes clear that over-representation is most concentrated in those groups with comorbid substance abuse, a finding common in other literature. Thus, the assessment of psychiatric disability has to consider the mediating impacts of substance abuse.

The Llewellyn et al (2003) study did find that approximately half of those parents classed as disabled had children removed. Whilst this may be because the additional weight of a disability made compliance with support programs difficult, it does appear to support both the vulnerability and the passive discrimination hypothesis. That is, when abuse is identified, it is dealt with in a much more intrusive manner than might otherwise have occurred.

Towards effective parenting assessments. DePanfilis & Zuravin (1999) investigated the recurrence of child abuse in families (n=1,181) referred for child abuse or neglect followed up over a 5 year period. This study coded a number of potential variables that might predict recurrence of abuse. DePanfilis and Zuravin make the point that their analysis suggests that it may be conditions that affect future adjustment (such as domestic violence and social support) rather than past events (such as prior mistreatment, prior substance abuse histories, or past diagnosis) that are the more important. A conclusion derived from their work is that need assessments have to complement assessment concentrating on static risk factors in child abuse assessments[21]. In practical terms the onus on the clinician is not to emphasise the assessment of the historical mental health history but rather to emphasise the current and likely future psychological functioning.

It seems that if we can predict that psychologically disabled parents are 1. More likely to be self-critical and also be child-critical, 2. Model ineffective emotional regulation, 3. Increase conflict, 4.

[21] Lennings, C. (2005) Risk Assessment in Care & Protection: The case for actuarial approaches. *Australian e-Journal of Adolescent Mental Health. 4.* (1) http://www.auseinet.com/journal/vol4iss1/index.php

Reduce self-esteem in their children, and 5. Reveal restricted or volatile emotional responses. The question remains what may we identify in parenting assessments that reveals good coping as opposed to risk of developing psychopathology?

Heide[22] lists 7 characteristics which she believes typifies healthy families. These are, in short: safety, open communication, self-care, individualised roles, continuity, respect for privacy, and focussed attention. The key issue appears to be that the possession of at least some of these attributes appears to help inoculate or create resilience in the family in response to stress. By extension we can argue that their absence provides risk factors for delinquent behaviour. Such behaviours become targets in the assessment to identify, as strengths to be set against risk factors.

It is an observation that not all families in which the parents have symptomatology, or high levels of conflict produce damaged children. Studies suggest that as many as 50% of children in such homes reveal good levels of psychological functioning (see Bosco et al., 2003 for a review). The research on resiliency defines resiliency as factors that may be inherent in the individual such as an easy temperament at birth, or high intelligence, familial, such as emotional availability of a parents, and at the community/social level such as social support. Table 1 provides a brief review of factors thought to be associated with resiliency or coping in children exposed to noxious family environments.

Table 1. Resiliency Factors in Childhood and Adolescence.

Individual/ Psychological	Parental/Family System	Social/Community
High(er) levels of autonomy	Positive relationship with at least one parent	Positive relationship with at least one adult
Competence in normative roles	Parent who is emotionally available/responsive (despite being depressed)	Strong connection with school or other social institution (e.g. church)
High levels of verbal competence	Parent who is affectionate (despite being depressed)	Presence of social support
High self esteem	Encouraging parenting style	Opportunities for achievement
High IQ		
Positive peer relationships		

[22] (From Cermak, 1988 cited in Heide, K. M. (1995) *Why kids kill parents. Child abuse and adolescent homicide*. Sage: Thousand Oaks, California. p. 45).

Based on the research cited above the following has been developed in my parenting assessments to assess risk of harm to a child as a function of a parent with some form of psychological disability. (In order to facilitate the assessment, it is also important to be able to identify the temporal pattern of behaviour. Short-term gains following a long-term pattern of dysfunction are not as convincing as long-term gains. Short term, in this context refers to behaviours less than 6 months in duration, with median terms being times frames of 18 months and long term gains from 2 to 5 years. Realistically it is improbable to ask for time frames or predictions beyond 5 years. Consistently research in decision making and time perspective have found that even the most sophisticated decision makers cannot effectively estimate outcomes and contingencies beyond a 5 year time span and typically much less.)

- Evidence of parents psychosocial stability[23]
- Meeting supervision/parenting program goals
- Meeting treatment goals/adhering to treatment
- Long term absence of violence, drug and alcohol abuse:
- Long term, sustained reduction in or control of symptoms
- Evidence of bonding between parent and child, and identification
- Good response of child to placement whilst preserving contact with parent
- Insight achieved

Case Studies. To illustrate the issues raised on the forwarding discussion two case studies are presented. Both refer to mothers with diagnoses of serious mental illnesses - Bipolar disorder and Paranoid Psychosis. All names and some other minor details have been changed to protect the anonymity of the family involved.

Case 1: In this case I was asked to undertake an assessment following an acrimonious dispute between the father and mother over custody and access of the 13 year-old male child. There was also an adult daughter living independently of the family but closely aligned with the father. The mother had a prior diagnosis of Bipolar Disorder and was alleged to have current residual (at least) symptoms

[23] Psychosocial stability consists of demonstrated stability and effective living in the following domains education/ employment, housing, peer group relations (size of network and pro-social nature of the network), financial responsibility.

of this and a comorbid prescription medicine (painkillers) abuse problem. The father was much older than the mother, and allegedly had engaged in considerable controlling and alienating behaviours against the mother. Although the mother had a court order awarding custody to her with frequent access by the father, the reality was the child was with the father and only saw the mother intermittently. In fact, the child made it clear he preferred the de-facto arrangement and did not want to return to the mother's full time care. My assessment of the child's maturity revealed adequate or better maturity based on school performance, leadership qualities within his sporting involvements, presentation on interview and good emotional regulation strategies: that is, his wishes appeared credible and something that some weight should be given to.

Considerable documentation was reviewed but of specific interest in this analysis were psychiatric reports from the last 4 years. Essentially these reports revealed that four years ago the mother had suffered from a severe Bipolar disorder but with good levels of compliance with medication (both mood stabilisers and anti--psychotics) she had recovered. For the last three years the psychiatrist (and other medical experts) had rated the mothers mental health as stable and good (euthymic). On interview her mood was good, there was no evidence of even residual symptoms of depression and she presented as having reasonable insight into her situation, empathy for her son's position, and a frank willingness to accept some aspects of her history and disabled parenting when she had been ill. As might be expected, she continued to assert her version of events as far less disabled than that given by the father. During this three-year period of apparent remission the father continued to make complaints of the mother demonstrating at least residual symptoms of depression and psychosis – symptoms not evident when assessed independently nor were they present on my interview with her. No evidence of medication abuse was noted in any files, and denied by the mother, but supported by comments from both the father and the daughter whom I interviewed separately. Throughout the period of apparent remission her son's behaviour was regarded as good at school and on assessment he revealed no psychopathology. Nonetheless he was quite hostile and unforgiving towards his mother. Despite being a mature lad, his presentation in my interviewed revealed elements of coaching and "agreed upon language" by all family members (father, subject child and daughter) in describing the mother.

The issues for the assessment included consideration of the risk of abuse or problematic development to the child if returned to his mother, the mental health of the mother, the support the family could give the mother, and the impact on the child if the status quo was maintained and the orders changed to allow for custody to revert to the father. Over and above the "usual" assessment the issue of the contribution mental illness might make to the mother's stability, as well as to risks of parenting had to be considered.

In considering the assessment it seems clear that despite a prior history of severe mental illness there are no real fears for relapse at the moment, and her health has been good for more than the last two years. There are complaints of residual symptoms, but no independent evidence of these other than some financial stress. In terms of the issues raised by my review to consider risk of abuse the following seems apparent.

- *Evidence of parents psychosocial stability.* There is good psychosocial stability (reasonably stable accommodation, reasonable peer group relations (in that she has friends and some external family support), and has some leisure and educational goals. Although financial stress is occurring, it is the lack of multiple stressors that is important.
- *Meeting supervision/parenting program goals.* No such goals have been set because to date no requirements has been made. Although complaints had been made regarding parenting deficits, prior Court hearings had not been convinced of those complaints and not required any program supports.
- *Meeting treatment goals/adhering to treatment.* Good adherence to medication, and contact with medical staff is reported and her progress attests to her treatment management.
- *Long term absence of violence, drug and alcohol abuse*: Although allegations of prescription painkiller abuse is made, the mother is on Epilim and requires occasional blood tests. No concerns have been raised about the presence of drugs of abuse in such screens and there is no independent evidence of any drug abuse.
- *Long term, sustained reduction in or control of symptoms.* Long terms and sustained reduction in symptomatology is observed. The possibility that residual symptoms remain has to be considered,

but equally, the report of such symptoms in the absence of any independent evaluations confirming these may be self-serving by the father.

- *Evidence of bonding between parent and child, and identification.* There is poor bonding between mother and chid. It seems inescapable that the genesis of this bonding lies in the mother's earlier illness compounded by the father's ability to control the situation. Although the undoubted parenting deficits have since passed, the father's presence in the child's life has been to continue to inflame the situation. The child has become somewhat alienated from the mother, and she lacks the ability both financially and emotionally to reverse this alienation. Although the history of the illness contributed to the genesis of such poor binding, the current situation is maintained by factors external to the mental illness.
- *Good response of child to placement whilst preserving contact with parent.* The mother has remained trying to involve herself as best she can in her child's life despite considerable opposition to this and has sought to develop her own relationship without denigrating the father.
- *Insight achieved.* The mother appeared quite open about and resigned to the lesser role she was likely to have to play in her son's life. Her continuation of the litigation was to avoid a situation developing in which a voluntary agreement with the father would be made as she (quite reasonably I thought) did not believe the father would honour any agreement without some degree of compulsion to do so.

In conclusion, despite a strong argument being made about the issues associated with mental illness in this case, such concerns are essentially irrelevant. Considerations of the impact mental illness might play in the adjustment of the child are secondary to the specific issues of the tug of war between the parents, the strength of the attachment of the child to his father, and the need to place weight upon the wishes of the child, given his age.

Case 2. The second case is somewhat more complex and complicated by involvement of the Department of Community Services. In this case the mother fell pregnant with her first child at age 13 (the child is now 8 years old) and has a younger child as well, currently two years of age at time of investigation. The mother reports a history of abandonment and family breakdown, although interviews with the grandparents reveal a more benign history although the family of origin did have its

problems and the mother and father separated when the mother was 11 years old. At age 13 the mother went to live with her biological father (to keep her in the same school zone as the grandmother had moved away) but this did not work out. The mother then ran away, got pregnant and went to live with her boyfriend. The history since then appears to have been a most dysfunctional one, the relationship characterised by mutual drug abuse and domestic violence and frequent moving. Although DoCS did not get involved until 12 months ago (when the mother abandoned her two children at a medical centre and then attempted to kill herself) at one point the maternal grandmother had removed the oldest child (then only child) and kept her for a year.

The mother has a previous history of psychiatric treatment – the mother says for depression, but file review reveals it was for a mixed depression and psychotic disorder. The mother's presentation continued to reveal intense paranoid delusions (believing that people were putting ideas in her head and were following her) and her manner indicated significant drug abuse although she denied this. Cognitive assessment did not reveal any substantial cognitive deficits but her memory remained unaccountably poor, for instance the mother was unable to remember how many siblings she had. The mother reported a history of non-compliance with medication and was not currently complying with medication (anti-psychotics). The mother reported a superficial parenting history but interviews with the oldest child revealed substantial contradictions to this. The mother appears to have been either asleep or manic for much of the time and the oldest child was required to parent the younger child. The children had no established routines, the oldest often missed school, and it was only the frequent moves made by the mother that seemed to have avoided the family coming to the notice of DoCS previously. Although the children now both lived with the maternal grandmother, access was only for one hour per week. The mother was not always consistent in her attending, claiming she was avoiding being followed to her mother's home.

In considering the assessment it seems clear that a long term and pernicious complex psychopathological condition, characterised by substance abuse, depression and paranoia had impacted on the mother's general level of functioning as well as parenting for many years. The early onset of the condition, her non-compliance with treatment and her lack of insight into her condition

indicated a poor prognosis. In terms of the parenting issues raised earlier the following analysis took place.

- *Evidence of parents psychosocial stability.* The mother reports poor psychosocial stability. She has unstable accommodation (had been in her current Housing Commission place for only 2 months) and reports frequent moving due to being "scared". She reports no friends and has a poor quality relationship with her family of origin. She supports herself on benefits but cannot budget and presumably spends her money on drugs. In addition she has a minor criminal history for theft. Mood regulation skills are basically absent.
- *Meeting supervision/parenting program goals.* The mother has not complied with any suggestions for parenting supports. She has not evidenced any insight into her parenting deficits, and seems unaware of the distress of her children.
- *Meeting treatment goals/adhering to treatment.* The mother shows no capacity to adhere to treatment goals, and has not been complaint either previously or currently with medication.
- *Long term absence of violence, drug and alcohol abuse*: The mother reports a history of mutual domestic violence and relationship drug abuse. Although the relationship is no longer one of co-habitation, the couple continue to meet from time to time and argue. The mother's substance abuse appears ongoing and related to her mood disturbance. She reveals no insight into her ongoing abuse, and denies it. She refuses to engage in urine screens and reveals ongoing deficits such as memory attributable to substance use.
- *Long term, sustained reduction in or control of symptoms.* There is no evidence of a reduction in symptoms. Whilst she has better coping at times, her behaviour remains dominated by her various complex psychopathological problems.
- *Evidence of bonding between parent and child, and identification.* Some bonding and attachment is obvious but on the whole the mother presents as self-absorbed and her children remain peripheral to her behaviours.
- *Good response of child to placement whilst preserving contact with parent.* The children seem able to tolerate care from the maternal grandmother without obvious distress, and the older child seems in fact to have improved her behaviour and in-school performance since placement with her. The children do not show distress when the mother leaves and do not appear to fret for her in

her absence. The reality seems to be the 2 year old has been so used to the major parenting tasks being conducted by the 8 year old, that the mother is quite peripheral to her focus.

- *Insight achieved.* The mother opposes the placement and yet has been somewhat unreliable in her access. She seems oblivious to the concerns raised by DoCS and the Court and continues to assert the return of the children without making any changes in her own behaviour.

In summary, the assessment reveals the strong dominance over the mother of her lack of insight and ongoing psychosocial dysfunction associated with her untreated substance abuse and mental illness. It is the large aggregation of problems that give the mental illness particular force in this assessment, and complicates any attempt to ameliorate the situation by designing care plans or restoration plans. Until some insight is achieved and compliance with treatment affected it is unlikely that the mother will be able to safely parent her children.

General Conclusion. Overall, the case studies reveal the conditions under which a mental illness, be that depression, serious mental illness or substance abuse may complicate care assessments. It is not always the case that even relatively recent claims of mental illness need obviate the capacity of a parent to care for her children, and in such cases other features of the assessment may be the key issues to assess. In case 1 the mother revealed a number of strengths including a willingness for open communication, respect for her child's point of view and respond appropriately to do this, and a capacity to adequately care for her self (e.g. treatment compliance). On the other hand, where psychopathology is clearly present, without insight or treatment compliance, parenting skills are almost always negatively affected. The combination of psychopathology with poor psychosocial stability remains a major issue in the capacity of a parent to care for their children, especially where there is no compensation for that lack by an effective alternate caregiver.