Section 1 **Fundamental issues**

Chapter 1

Towards the development of a conceptual framework

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This book has been written for practitioners who work with children, parents, and families as well as for those who design and conduct applied research in the area of parental mental illness. The first and second editions chronicled the development of research, policy, and practice in this field across various countries. The third edition is completely rewritten, reflecting recent research developments as well as policy and practice changes. These reflect the greater specificity we now know in terms of what, when, and how family life is impacted by parental mental illness. Additionally, recently developed programs and interventions for children, parents, and families are showcased in this edition. These interventions provide the latest research evidence and concrete guidance to practitioners in terms of formal and informal approaches for different family members. What is especially heartening are the various workforce approaches to professional development as well as collaborative models for intervention.

Families where a parent with dependent children has a mental illness are prevalent, with one epidemiological study finding that 21–23% of children live in such families (Maybery *et al.*, 2009). Parental mental illness has the potential to negatively impact children's experiences and family dynamics; in turn, parenting and family experiences can also impact an adult's mental health. However, the presence of parental illness does not necessitate adverse outcomes in families. Specific mechanisms of risk mediate these outcomes, alongside factors that potentially buffer or minimize adverse outcomes for children as well as parents. It is the presence or absence of these factors that explains why some children and parents living in families with parental mental illness are adversely impacted while others are not.

In this chapter we critically review the available conceptual frameworks that explain how parents' well-being and functioning contribute to outcomes for children and, conversely, how family life might contribute to parents' well-being and mental health. The final chapter will then highlight possible extensions and continued gaps in our understanding of the intergenerational transmission of mental illness in families, on the basis of the various chapters. While recent research has progressed our understanding, concluding with a definitive framework is far from easy; hence, rather than a conclusive model, this edition documents the journey *towards* the development of a conceptual framework that attempts to explain the impact of parental mental illness on family life, and conversely, the impact of raising children and the experience of family life on a parent's mental health.

Several conceptual or theoretical frameworks have been developed over the last fifteen years that attempt to capture the complexities for families where a parent has a mental

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illness. These frameworks have different foci; some provide a broad ecological view of the family and the community in which they live, while other frameworks focus on a specific disorder and how that disorder might impair parenting and the parent–child relationship. These frameworks have also been developed differently, with some drawing on data collected from families, some formulated on the basis of clinical experience, and others based on prior research.

A conceptual framework for families where a parent has a mental illness will be useful to the readers of this book. Once we have an understanding of how and why a problem exists, interventions and supports can be developed that best support the needs of distressed families. Policy, resource allocation, and professional development activities for the mental health workforce can be driven by such an appropriate framework. In sum, a comprehensive and rigorous conceptual framework that helps explain the multidirectional relationships between family life and parental mental illness has the potential to guide research, program development, clinical practice, and intervention evaluation.

Conceptual frameworks can incorporate different theories as well as practitioner knowledge, depending on what is relevant to a research problem at any given point in time (Eisenhart, 1991). Such frameworks are commonly based on previous studies and existing conceptual analyses. They present a synthesis of the existing evidence base, and explicitly identify what is known, what is not known, and what could be known. In mental health research, the focus of such frameworks is a problem or mental health issue, situated within a multilayered or ecological context in which various stakeholders are represented. Interrelationships between these stakeholders are also often drawn. Eisenhart (1991) points out that a conceptual framework generally reflects the "state of the art" in research and, accordingly, might be short-lived; revisions are made when new data and ideas emerge. Frameworks are also useful in pointing out the gaps in current research and have the potential to provide a framework for clinical practice.

In this opening chapter, we review some of the most commonly cited models that attempt to explain how parental mental illness affects children and family functioning. A summary of some of the common themes and issues across existing models will be shown, as well as gaps, controversies, and unresolved methodological issues. Subsequent chapters will then present, in greater depth, different facets of these frameworks, namely assessment issues and procedures; how different types of mental illnesses might affect parenting, family dynamics, and children's well-being; various interventions for children, parents, and families; and strategies for enhancing the capacity of the workforce and community to better support families. Accordingly, these chapters extend the current evidence base by presenting relevant and timely research related to the factors that impact on family outcomes.

We start with Goodman and Gotlib (1999).

Goodman and Gotlib (1999): the integrative model for the transmission of risk to children of depressed mothers

Research on children and parents, as well as on nonhuman primates and rodents, forms the backdrop for the development of Goodman and Gotlib's model (1999) (see Figure 1.1). Their aim was to develop an "integrative, developmentally sensitive model for the understanding of children's risk as a function of maternal depression" (p. 458). It is important to note that the model specifically focuses on mothers with depression. The model tries to

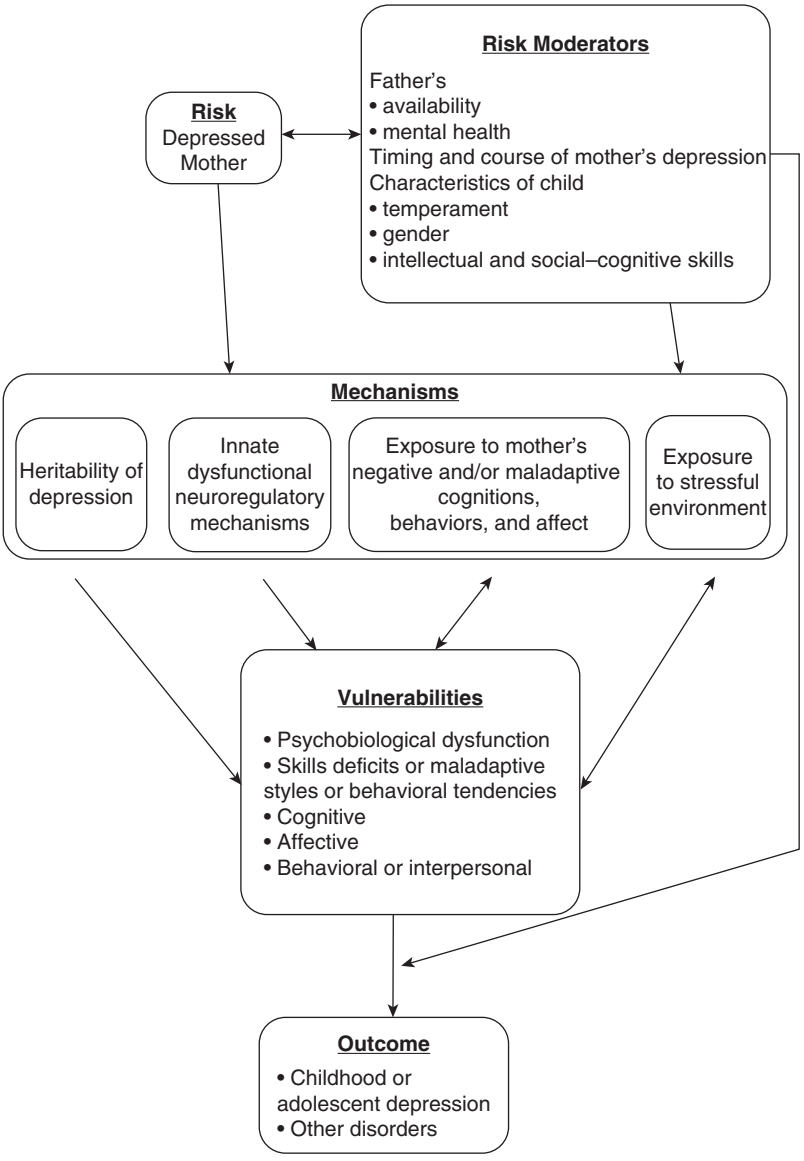

Figure 1.1 Goodman and Gotlib's integrative model for the transmission of risk to children of depressed mothers. *Source:* Goodman, S., and Gotlib, I. (1999). Risk for psychopathology in the children of depressed mothers: a developmental model for understanding mechanisms of transmission. *Psychological Review*, **106**(3), 458–90. Reprinted with permission.

identify the mechanisms underlying the elevated risk of dysfunction experienced by children whose mothers are depressed, across biological and psychological fields, within a developmental framework. Goodman provided further supportive empirical data in 2007, without changing any of the core components of the original model.

The level of specificity in this model demonstrates that the impact of maternal depression on children is complex. Starting with the depressed mother, the subsequent impact on children is mediated and moderated by several variables. Living with a depressed mother means not only inheriting risk but also increasing the likelihood of exposure to environmental stressors (e.g., family dysfunction, a parent's negative cognitions, behaviors, and affect), which leads to the dysfunction of neuroregulatory mechanisms. In this model, the term "mechanism" is synonymous with the statistical concept of mediation. In turn, the presence of one or more of these risk mechanisms is associated with various adverse outcomes in children, including, for example, cognitive dysfunction, problems with affect (e.g., difficulties with emotional regulation), and behavioral and interpersonal difficulties, as well as specific psychopathology not limited to depression.

Goodman and Gotlib (1999) argue that these pathways are not straightforward and involve a number of interrelated components and mechanisms. For instance, they review evidence to demonstrate each of the following steps: (1) depressed mothers exhibit negative cognitions, overt behavior, and affect; (2) because of these depressive symptoms, mothers are unable to attend to their child's social and emotional needs; (3) this inadequate parenting has adverse impacts on children's psychosocial development; (4) through modeling, children acquire depressive symptoms that (5) place them at risk of developing depression themselves. The age of the child when exposed to maternal depression is highlighted as an important factor in appreciating the risks for children, alongside the acknowledgement that children are often exposed to several episodes of maternal depression throughout their childhood. Moreover, the bidirectional nature of family relationships is incorporated whereby children's behaviors are seen to affect their mothers' depression, mother–child interactions, and parenting behaviors. Finally, the model incorporates several moderating variables that indicate when or under what conditions children's outcomes might vary, and includes factors such as the availability of fathers and their mental health; the child's age, temperament, and intelligence; and the timing and course of the mother's depression. The model is able to explain, at least partially, why it is that not all children whose mothers suffer from depression will become depressed, and, conversely, why not all children who become depressed have a mother with depression.

Goodman and Gotlib provide a critique of the available evidence, including methodological weaknesses and gaps, and, by doing so, critique their own model. They concede that "although none of the mechanisms or moderators proposed in the model can be considered to have been supported conclusively, support for some components of the model is more robust than for others" (p. 475). They raise other questions arising from research gaps such as the *extent* to which the various highlighted mechanisms are associated with adverse outcomes on children.

The Goodman and Gotlib model is extensive and is based on a comprehensive overview of a wide range of empirical data. The updated Goodman (2007) paper includes practice, prevention, and treatment implications largely missing from the original model. As Hammen (2003) points out, maternal depression is not just about depressed *women* but is also about *families*, given that children often contribute to negative interactions between parent and child, mothers were often raised in dysfunctional families themselves, and the environment in which they live can be stressful. Goodman (2007) is aligned with this view when she describes her practice implications as "transactional," and advocates the involvement of fathers, the reduction of stressors in families (such as marital conflict), the screening of children, and the delivery of age-appropriate child interventions that enhance children's

coping skills and their understanding of parental depression. She concludes with an acknowledgement that not all children will develop psychopathology; hence, prevention and treatment initiatives need to target those most at risk, based on better understanding of the factors that moderate risk (Goodman, 2007).

Nicholson and Henry (2003): the family recovery model

The ecological model of family recovery was originally proposed to provide a broad-brush-stroke structure for developing the evidence base on interventions for parents with mental illness and their families – to serve as a "translational bridge" (Nicholson and Henry, 2003). The family recovery model concerns intervention targets for service provision rather than mediators and moderators of the impact of parental mental illness on children's outcomes over time. The model was originally grounded in the literature on child developmental psychopathology and parents with mental illness, and research on parent training interventions (National Research Council and Institute of Medicine, 2009; Nicholson *et al.*, 2008; Taylor and Biglan, 1998).

Following an in-depth provider survey and systematic site visits of programs across the USA, key intervention approaches, theories, and assumptions were identified (Hinden *et al.*, 2005, 2006; Nicholson *et al.*, 2007). Rigid adherence to a single theory or practice was often felt to be inappropriate by program staff members, who largely defined themselves as eclectic in theoretical orientation and pragmatic in addressing day-to-day problems. Providers shared a common commitment to family-centered, strengths-based approaches as key to success in working with families living with parental mental illnesses. The essential service components provided by the majority of programs included (1) some form of case management (emotional support and problem solving, coordination of multiple services, and crisis management) and (2) parent support, education, and skills training.

The task in refining further iterations of the family recovery model was to integrate the literature and research findings into a working model of intervention targets, and translate this model into treatment or rehabilitation approaches drawing from research on "what works" for parents in general and for parents living with disabilities conveyed by mental illnesses specifically. The psychiatric disability and rehabilitation perspective was chosen for several reasons:

(1) The acknowledgement that mental illness may convey disability in particular role domains (e.g., parenting, employment) places it as a condition on the list along with intellectual, developmental, sensory, and physical disabilities (National Council on Disability, 2012). This suggests that parents with psychiatric disabilities fall under the purview of US federal and state legislated policies and programs for parents with disabilities and their families, with protections and accommodations theoretically protected by law.
(2) The notion of disability is role or context dependent. That is, a person may be disabled in one role or setting, but not in another. A parent with mental illness may be able to function well as a parent, but not be able to sustain employment, for example. Therefore, from the disability perspective, a parent living with mental illness is not automatically assumed to be a "bad" parent, allowing for the identification of individual strengths and recognition of differences.
(3) Because disability is context dependent, rehabilitation interventions may be targeted to the context (e.g., accommodations in role expectations, or the physical or service environment) as well as to the individual (e.g., target training to learn or relearn skills). Parents may function as well as possible with adequate accommodations and tailored supports.

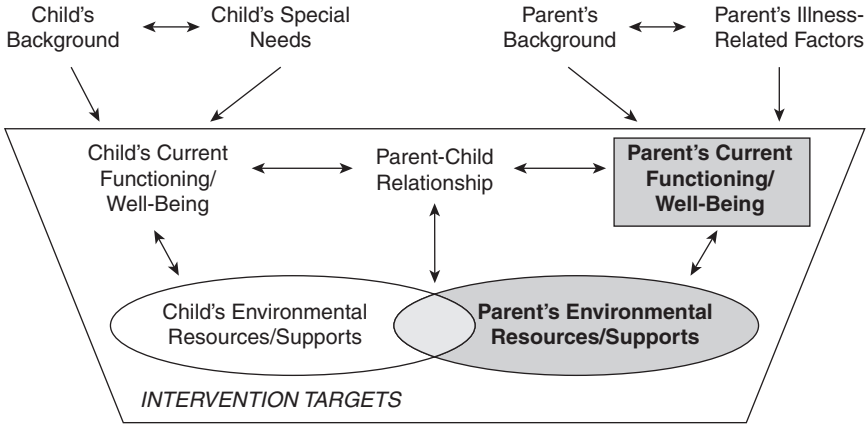

Figure 1.2 Nicholson and Henry's family recovery model. *Source*: Nicholson, J., and Henry, A. D. (2003). Achieving the goal of evidence-based psychiatric rehabilitation practices for mothers with mental illness. *Psychiatric Rehabilitation Journal*, **27**, 122–30. Reprinted with permission.

A contextual model of disability demands that attention be paid to person–environment interactions and underscores the relevance of an ecological perspective on parenting, rehabilitation, and recovery (US Department of Education, 2007). The family recovery model lays out the relationships between parent and child characteristics, the family, and the environment, and the interactions and transactions among them to suggest targets for intervention and pathways for recovery (Nicholson and Henry, 2003). Outcomes are optimized when parents and children are functioning as well as possible, their interactions are as positive as possible, and they have access to and benefit from the appropriate environmental resources and supports (i.e., formal treatment and rehabilitation, relevant benefits and entitlements, and informal resources like friends and family). Specific intervention targets suggested in the model include the parent's current functioning, the child's current functioning, their interactions, and their environmental resources and supports (see Figure 1.2).

The family recovery model suggests intervention targets and provides a foundation for translating domains and relationships into theoretically sound intervention approaches and outcomes through the psychiatric rehabilitation and recovery lens. Interventions must be linked to evidence-informed theory, with conceptually consistent outcomes relevant to parents and families. Essential service components, such as (1) case management and (2) parent support, education, and skills training documented in previous research on parents with mental illness; and a shared provider commitment to family-centered, strengths-based service delivery suggest relevant change strategies for intervention development and testing (Hinden *et al.*, 2006).

The family recovery model aims to promote exploration and evaluation, rather than explanation, to facilitate contributions to the evidence base of interventions for parents living with mental illness and their families.

Hosman, van Doesum, and van Santvoort (2009): a developmental model of transgenerational transmission of psychopathology

Hosman and colleagues (2009) present a developmental theoretical model for families where parents have a mental illness, based on what they call "practice-based and theory-based knowledge and related evidence," the sum of which includes epidemiological and clinical studies, clinical and preventive practices, and their own extensive contacts with children and families. They also cite the Goodman and Gotlieb (1999) model in their work. The resulting framework has been used to shape prevention policy, family interventions, and the research agenda in the Netherlands. The model acknowledges both mothers or fathers with a mental illness and cites research across a range of diagnostic disorders. It highlights multiple, interacting domains including parents, children, family, social network, professionals, and the wider community. Within each of these domains, specific risk factors and protective factors are identified including genetics, prenatal influences, parent–child interactions, the family environment, and the broader context in which the family lives (see Figure 1.3). A developmental perspective underlies the model, in which a child's specific developmental tasks, starting with pregnancy, and other age-related risk factors are indicated.

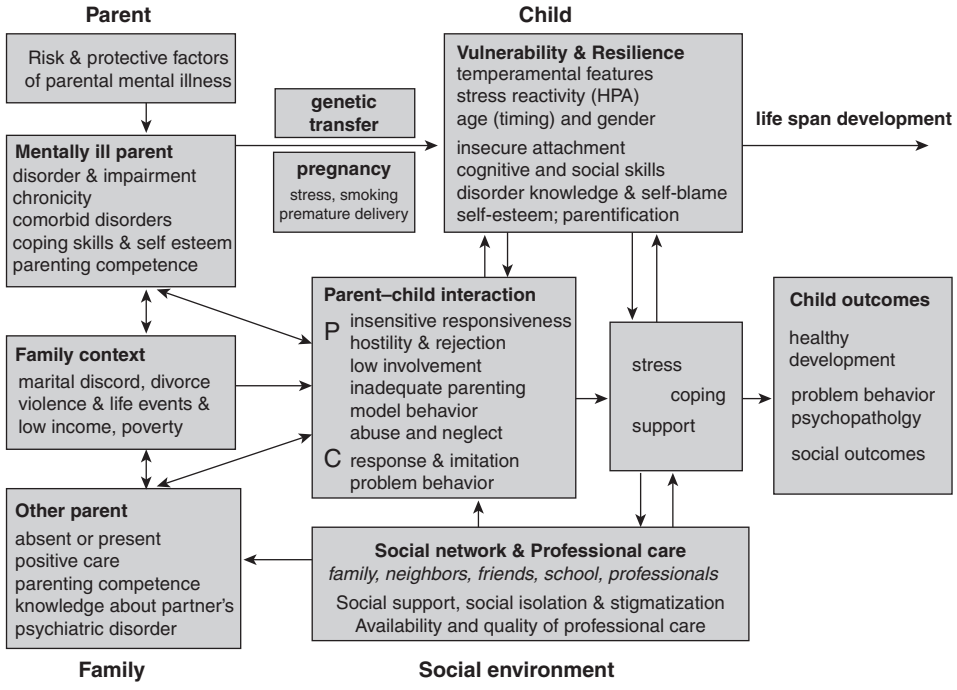

Figure 1.3 Hosman, van Doesum, and van Santvoort's (2009) developmental model of transgenerational transmission of psychopathology. *Source:* Hosman, C. M. H., van Doesum, K. T. M., and van Santvoort, F. (2009). Prevention of emotional problems and psychiatric risks in children of parents with a mental illness in the Netherlands. I. The scientific basis to a comprehensive approach. *Australian e-Journal for the Advancement of Mental Health*, **8**, 250–63. Reprinted with permission.

Employing the concepts of equifinity and multifinality, the authors consider the question of disorder specificity as well as the broad spectrum of risk across diagnostic groups. They conclude that specific to the disorder are genetic and biochemical factors and role modeling of parental behavior where children copy their parent's dysfunctional coping behavior. Common risk factors include poverty and isolation. This model also highlights various protective factors that tend not to be disorder specific such as the quality of social support accessible to the child and family. The translational implications for these arguments are important, with the conclusion that "children have much in common across different parental diagnoses. On the other hand, children and their parents might have specific questions and needs relating to the parental disorder (e.g., knowledge about the disorder, how to cope with symptom behavior). These disorder-specific issues should also be addressed as part of a comprehensive approach" (p. 253).

Adrian Falkov: the family model (2012)

The family model has been developed over the last fifteen years by Adrian Falkov, on the basis of his experience as a psychiatrist treating mentally ill parents and their children in England and Australia. The model extends his original work, *Crossing Bridges*, which was developed as a training and organizational development package for mental health services. The family model provides a framework for mental health service responses that might be provided for families though it is acknowledged that "No single service can meet the needs of all family members" (Falkov, 2012, p. 8).

While family or systems theory is not cited, the model primarily focuses on interactional relationships between parents and their children, and other interrelationships between multiple individuals and factors proposed to influence parent and child mental health (see Figure 1.4). For example, Falkov (2012, p. 80) notes that "the various experiences of different individuals in a family are influenced by, and influence, each other – a system of interconnected relationships between family members, and between the family and their neighbourhood, community and service networks." Accordingly, the six links or influences among the following domains frame the family model:

(1) "an adult/parent-to-child influence" – where the parental illness affects the child
(2) "a child-to-parent influence" – where the child's behavior and emotional state affect the mental health of the parent
(3) "a childhood-to-adulthood family life-span influence" – where parental mental health influences children over time
(4) "a closer-environment-to-family influence" – where environmental factors, such as low socioeconomic status affect the family
(5) "a service-to-family influence" – which includes the quality of the services available to the family and their level of engagement with such services
(6) "a broader-environment-to-family influence" – involving the broad cultural and community influences on the family.

The aim of the model is to facilitate an appreciation of the processes that underlie and influence how:

- parental mental illness affects children
- mental illness can affect parents, parenting, and the parent/child relationship
- parenthood can precipitate, exacerbate, or otherwise influence mental illness

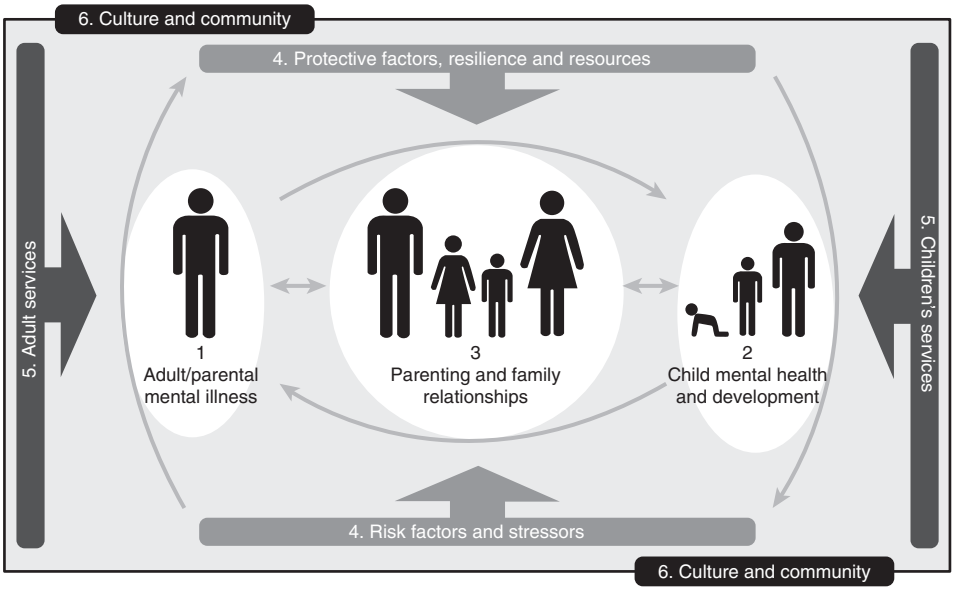

Figure 1.4 The Falkov family model, reproduced from *The Family Model Handbook* © Dr. Adrian Falkov (2012) with permission of Pavilion Publishing and Media Ltd.

- children's mental health and developmental needs can have an impact on parental mental health (Falkov, 2012, p. 12).

The model is developmentally framed, with a focus on children's ages and stages as well as a longitudinal approach that incorporates "the background events and circumstances leading to the current presentation (e.g. the childhood experiences of mentally ill adults) as well as future circumstances (e.g. the mentally ill parent's prognosis or a child's well-being or progress)" (Falkov, 2012, p. 81). This broad life-span approach is important in the model given that the context of the book is on service/workforce change, and the particular need to refocus health services away from individuals and towards families in children and adult services.

Given that the aim of the model is to highlight workforce responses, the need for prevention and early intervention services is emphasized as, too, is the development of family-centered policies, staff training, and local implementation groups. Probably because the emphasis of the model is on workforce change and treatment of the family, the targeting of risk factors dominates the model, as opposed to the promotion of protective factors.

Sociological frameworks for children living in families where a parent has a mental illness

While many of the preceding frameworks acknowledge the contextual living environment for the family, other authors conceptualise the family through a predominantly sociological lens. In this framework, mental illness is seen as a response to overwhelming environmental stressors, and family problems are the result not so much of the parent's mental illness *per*

se, as of societal constructions of mental illness and the problems associated with mental illness, such as stigma, isolation, and poverty. In this view, the "problem" is not located "in" the person or the family, but is instead sourced from the environment or the family's social situation. For example, Tanner (2000), an academic social worker and herself the child of a parent with a mental illness, argues that the inequalities of women, unrealistic expectations of motherhood, stigma and shame, and the fear of the involvement of statutory bodies constitute the main problems of such families, rather than the parent's mental illness. On this basis, she argues that social structures, rather than individuals and families, need to change. Accordingly, she cautions against the creation of a new and stigmatizing social identity, namely "the child of an adult with mental illness" (p. 293).

Similarly, Gladstone *et al.* (2006, p. 2542) stress the potential of stigma for children: "Being identified as 'at risk' is a powerful label, which children of parents with mental illnesses cannot evade. When screening reveals no diagnosis or only vague problems, many children are described as 'distressed,' 'having problems,' or 'being in trouble.'" The authors urge the need for a "recasting" of such children as competent though potentially at risk, and rather than being seen as passive victims, they should be regarded as active contributors to family life. For example, the authors draw on caring research to demonstrate that while caring for siblings and an ill parent might be a risk factor, the opportunity to care might also (or instead) provide children with a constructive family role, during times of stress (Gladstone *et al.*, 2006).

Stigmatization and labeling can be as distressing as the symptoms of illness, and they are significant risk factors for families where a parent has a mental illness. Research in this area, however, is relatively recent, and it is still unclear how stigma is experienced and what public interventions might be developed to best address public perceptions of parents and children in families where a parent has a mental illness. Gladstone and colleagues (2006) as well as others (Steer *et al.*, 2011) make it clear that these families are not homogeneous, and that it is critical to elicit information directly from children and parents about their respective roles, needs, and required supports. Indeed, children sometimes have very different perceptions of "what works" from their parents or practitioners (Maybery *et al.*, 2005), further emphasizing the need to seek input from all family members, including children, when developing family interventions.

Towards a common conceptual framework

The models presented in this opening chapter attempt to identify the components and mechanisms by which risk is transmitted and mitigated in families where a parent has a mental illness. Common themes or issues include the interrelationship between the parent and child, as well as the within-person characteristics (of the parent and the child), that defines this central relationship. Other themes involve appreciating the developmental tasks of children and parents, the environmental or contextual factors that affect family life, and the translational links between research and practice.

The interrelationship between the parent and child in families where a parent has a mental illness

Across models, there is some acknowledgement (with varying levels of importance) regarding the interrelationship between the parent and child. This interrelationship recognizes