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Jessie Weisstein  
Utilizing Family Therapy:  
The Perspectives of Clinicians who  
Work with Families in Which a  
Parent is Affected by Mental Illness  
A Qualitative Study

ABSTRACT

This study was conducted in order to explore the perspectives of clinicians who work with families in which a parent is affected by mental illness. The relatively small amount of research that has been conducted in this area led the researcher to choose a qualitative exploratory design. Nine clinicians who identified as practitioners of family therapy participated in this study. The clinicians were geographically located in New York City and narratives were gathered during forty-five minute in-person interviews. The questions focused on the following topics: 1.) What are the theoretical frameworks or interventions that clinicians use when working with families with parents affected by mental illness? 2.) How are clinicians affected by a client's mandated status? 3.) How do they define success or challenges with these families? Some of the key findings of this research were: 1.) Family therapy can be effectively provided by clinicians in conjunction with individual therapy; 2) Clients mandated status can have a direct effect on treatment; 3.) Children assumed identifiable roles in families with parents affected by mental illness; 4.) Clinicians do use a variety of theoretical frameworks and interventions; and, 5.) Clinicians confirmed that family therapy can lead to a significant improvement in dynamics of families with a parent affected by mental illness.

UTILIZING FAMILY THERAPY:  
THE PERSPECTIVES OF CLINICIANS WHO WORK  
WITH FAMILIES IN WHICH A PARENT IS  
AFFECTED BY MENTAL ILLNESS  
A QUALITATIVE STUDY

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2010

## ACKNOWLEDGMENTS

I would like to thank the supervisors, directors and clinicians who opened their offices to me and who have dedicated their lives to working with families. Special thanks to Shalini Schaeffer who brought me into the world of family work and has supported me with her compassion and intelligence ever since. To Adam who has moved everything we own three times, seen me through my lowest points, and who has handle it all with grace and humor. To my Smith family, thank you for your genuine reflection of what is possible and above all your laughter.

Dedicated to the memory of Dr. Michael Mendola who taught me invaluable lessons about living and dying with honesty, acceptance and love.

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## CHAPTER I

### INTRODUCTION

The researcher became interested in this topic after working in the field of family therapy and discovering that many of the parents were affected by mental illness.

Theorists in the field of family therapy have conceptualized varied ways that families become dysfunctional and how clinicians can help them become more functional. The field of family therapy itself was based on the now debunked concept that schizophrenic children were a product of overbearing, rejecting mothers. After this theory was disproven many theorist moved away from directly addressing individual mental illness within the context of family therapy. Based on the researcher's experience, clinicians who practice family therapy often find themselves treating families with parents affected by mental illness.

The purpose of this study was to explore the perspectives of clinicians who work with families with parents affected by mental illness. Much of the recent literature in this area has been focused on the outcomes of children who grow up in these families. Research has also been conducted that assesses the effectiveness of individual therapy versus family therapy. The researcher was able to find very little literature from the United States that explored the use of family therapy with parents affected by mental illness. Much of the research that is being conducted in this area of study is

geographically located in the United Kingdom and Australia. This literature offered a window into the world of these families, often through the use of narrative data.

The relatively small amount of research that has been conducted in this area led the researcher to choose a qualitative exploratory design. The researcher interviewed clinicians about their experiences of working with families with parents affected by mental illness. There are varied understandings of what defines family therapy. For the purpose of this study, participants identified themselves as clinicians practicing family therapy. The total sample size for this study was nine participants. Participants were asked a series of questions on the topic including 1.) What are the theoretical frameworks or interventions that you use when working with families with parents affected by mental illness? 2.) How are you affected by a client's mandated status? 3.) How do you define success or challenges with these families?

The findings from this study have broad implications for both social work practice and policy development. Family therapists often work with families with parents affected by mental illness and this study illustrated some of the challenges and successes they encounter. The findings illustrate the potential for family therapy to repair relationships that have been strained due to a parental mental illness. Since there is a need for more research in this area, this study could serve to both validate clinicians who do this difficult work and to allow them to reflect on their own practice. The policy-making implications show the need for both more research and for a stronger collaboration of services between individual and family therapy services.

## CHAPTER II

### LITERATURE REVIEW

The purpose of this study is to explore the perspectives of clinicians who work with families with parents who are affected by mental illness. This is an important area of research because of the high percentage of parents who are affected by mental illness in the world (Reupert & Mayberry, 2007). There has been limited research on the impact of a parental mental illness on the entire family. This literature review is divided into three sections. First the epistemology and theoretical evolution of the field of family therapy will be explored. Second, the prevalence of families in which parents are affected by mental illness as well as the risks for these families will be explored. Finally, research on the use of varied therapeutic treatment modalities and interventions as well as the overall experience of families with parents affected by mental illness will be explored.

#### The Epistemology and Theoretical Evolution of Family Therapy

In this section the epistemology and theoretical evolution of family therapy will be reviewed. The major theoretical frameworks that fall under the umbrella of family therapy will be briefly highlighted. In addition the work of specific theorists who focus on how race, gender and culture influence the relationship between families and therapists will be examined.

The origins of family therapy can be traced back to the Palo Alto Project, led by Gregory Bateson. The task of the Palo Alto project was to conduct research that would



lead to an understanding of the epistemology of schizophrenia. Nichols (2009) wrote that the group, which included theoretical innovators such as Jay Haley, John Weakland and Don Johnson, “was interested in developing a communication theory that would explain the origins of schizophrenia within a family context” (p. 14). The field of family therapy was initially conceptualized with the belief that a certain type of parent, a schizophrenogenic mother, was responsible for their child’s pathology. According to Nichols (2009) this term referred to a mother who was domineering, aggressive and rejecting of her child. The legacy of this notion of a pathological mother creating symptomatic children is one that still plagues the field of family therapy (Nichols, 2009, p. 12).

The group used the theory of cybernetics to understand how the family system influenced the patient. According to Becvar (2003), the new paradigm represented by systems theory/cybernetics was contextualized by technological advances made during World War II. The field of cybernetics focused on feedback mechanisms, information processing and patterns of communication (Becvar, 2003, p. 5). While the theoretical concepts that emerged from this group would provide the groundwork for family therapy for the next four decades, Lynn Hoffman (1985) wrote, “the articles on families and family therapy that were coming out of Palo Alto were imbued with a vocabulary based on war and adversarial games” (p 382).

The first wave of family therapies, called systems theory, was based on the cybernetics concept of homeostasis. Togliatti (2005) wrote about the significance of understanding the family unit as a closed system that is always working to maintain equilibrium. When cybernetics was applied to families, it became easier for therapists to

conceptualize why maladaptive patterns were so entrenched. The early theorists believed that a family system would unknowingly take steps to get back to homeostasis in order to maintain the status quo (p. 113).

The first wave of family therapy, held together under the modern cybernetics paradigm, gave birth to a multitude of theoretical innovations and concepts. As Miller, Anderson and Keala (2004) wrote, Murray Bowen introduced concepts like differentiation, multigenerational transmission of anxiety and triangulation that transformed the field. Bowen theory allowed clinicians to use tools like genograms to map a family's entire history and to understand how patterns of engagement could repeat over time (Miller, Anderson & Kaela, 2004, p. 454).

Salvador Minuchin had an equally profound effect on family therapy when he introduced the concepts of structural therapy in the 1970's. Nichols (2009) explained that Minuchin added recognition of the importance of the organization of the family and the boundaries and supports that help to maintain that organization. Minuchin believed in the importance of hierarchy within a family and found that porous boundaries between parents and children could lead to dysfunction (Nichols, 2009, p. 136).

Finally, the third major theory to flourish within the family systems paradigm was strategic family therapy, developed by Jay Haley. Mitrani and Perez (2003) wrote that in the strategic approach, "symptoms are viewed as having a function within the family. It is assumed that the symptom metaphorically expresses a problem" (p. 183). As Nichols (2009) explained, paradoxical questions, directive and combative interventions were typical of this approach, which was popularized in the 1970's (Nichols, 2009, p 109).

The epistemology of the second wave of family therapy is the post-modern movement. Just as systems theory came out of World War II, the second wave of family therapy is connected to the social, cultural, political and analytical evolution of the 1960's and 1970's. Besley (2002) examined the work of Michael Foucault, a post-modern theorist who was particularly interested in the inherent power of language. When analyzing the realm of therapy, Foucault was concerned with the repressive nature of power and how institutional power and knowledge undermines the patient (Besley, 2002, p.133). Walsh (2003) wrote that post-modernism had "heightened awareness that views of normality are socially constructed, influenced by cultural and professional values and biases (Walsh, 2003). If the first wave of family theorists were interested in building a scientific model to explain family functions, the second wave of family theorists were much more interested in deconstructing the model. Waldegrave (1998) wrote that it was the idea of scientific objectivity that was being challenged by the post-modernists (Waldegrave, 1998, p. 405).

Under the umbrella of post-modern family therapy, the models of feminist family therapy and narrative family therapy have been extremely influential. In addition to these two modalities, the influence of theorists like Nancy Boyd Franklin and Monica McGoldrick have brought attention to race and cultural in the realm of family therapy.

According to Nichols (2009), feminist family theory's underlying concept is to make men and women aware of the social, cultural and political realities that create gender inequality in families. It is the focus on the influence of forces outside of the family structure and the examination of power in society that provided the scaffolding for this theory (Nichols, 2009, p. 277). As Kosutic and McDowell (2008) wrote, Feminist

Family Theory allowed the clinician to examine the ways that individuals and families were constantly being shaped by shifting power relations and multiple identities of privilege and oppression within the family and society (Kosutic & McDowell, 2008, p. 144).

Perhaps the most influential theorist of the post-modern movement was an Australian clinician named Michal White, who developed narrative family therapy. Paquin (2006) wrote that narrative family therapy is a model in which problems are located in the stories of the families, not in the families themselves. The goal of the therapist is to create a space where the clients can construct a new narrative that allows the patient to envision themselves differently within the family and society (Paquin, 2006, p. 132). Nichols (2009) wrote, “narrative therapist applied Foucault’s political analysis to understand how individuals and families are dominated by oppressive narratives from which they need liberation.” (p. 288).

Anderson (2003) described the role of the narrative therapist as being transparent about their own experiences as a way of minimizing the power differential between clients and themselves (Anderson, 2003, p. 138). White (2007) wrote that the most important aspect of narrative family therapy was externalizing problem-saturated narratives from people. Problems that are internalized lead people to believe in certain truths about their nature, while ignoring the cultural and social contexts that fostered and created those beliefs (White, 2007, p. 9).

Finally, this writer will focus on the work of Nancy Boyd-Franklin and Monica McGoldrick and their work on the intersection of race and family therapy. McGoldrick (2003), a white clinician, writes extensively about her racial identity development and the

impact it has had on her practice. Specifically, McGoldrick was interested in understanding how her own racial and cultural values, assumptions and stereotypes impacted her treatment of families (McGoldrick, 2003, p. 256). In addition, McGoldrick (2003) claimed that family therapists who are part of the dominant culture must challenge the perception that their views and values are normative. This is particularly important when a white therapist seeks to cure families of color that might hold different values and traditions (McGoldrick, 2003, p. 242).

Nancy Boyd-Franklin, an African-American clinician, has written extensively about Black families in therapy. Boyd-Franklin (2003) wrote about the intersection of class and race, specifically the treatment of poor African-American families in family therapy. Boyd-Franklin believes that all family therapists must be well versed in their own racial, cultural and class values in order to work effectively with the family system (Boyd-Franklin, 2003, p. 274). Boyd-Franklin (1998) explored the effects of implicit and explicit racism on families and ways in which oppression can lead to conflict and fracturing within communities of color (Boyd-Franklin, 1998, p. 277). The work of Boyd-Franklin and McGoldrick belong in the second wave of family therapy because of the focus on power, identity and social construction that informs their perspective

#### Families with Parents who are Affected by Mental Illness: An Overview

The prevalence of families that have a caregiver with a mental illness has been explored in many studies. In an article that provides an overview of issues facing families with mental illness, Reupert and Mayberry (2007) estimated that approximately 21% to 23% of children in the United States live in homes where at least one parent has a mental illness (Reupert & Mayberry, 2007). These statistics cover a wide range of

mental illness and are supported by other research. Using data collected from the National Co-morbidity Study, Mowbray and Mowbray (2006) found that one third of women and men in the United States have a diagnosable mental illness. Within this group of people, two thirds of the women are mothers and half of the men are fathers (Mowbray & Mowbray, 2006, p.130). These statistics show that there is a significant portion of families that have caregivers with mental illness.

There have been several studies that evaluate the risks for children living in a household with a parent affected by mental illness. In a review of literature conducted by Reupert and Mayberry (2007), several studies found that risk factors for children included higher rates of developing psychiatric disorders, more physical health problems and higher rates of insecure attachment styles. In a quantitative study of mother's admitted to a psychiatric clinic, Cunningham, Harris, Vostanis, Oyebode and Blissett (2004) used three sets of questionnaires to study the correlation between the mother's mental illness and their child's emotional and behavioral issues. This study also explored the attachment style of the mothers and children. The findings of this study confirmed previous findings that found a significant association between mother's mental illness and higher levels of insecure attachments than in the general population (Cunningham et al., 2004, p. 647).

A different perspective of potential risk factors for children was investigated by Mowbray and Mowbray (2006), looking at psychosocial outcomes of adult children of mothers affected by mental illness. The sample size of this study was 61 adult children and the racial composition of the participants mirrored the composition of the area where the study was conducted, in southeastern Michigan. The authors argued that it is

limiting to study the effects of mental illness on children, without investigating the specific type of mental illness and other contextual factors that contribute to psychological and social outcomes. While this study found that there were significant risks for children of parents with mental illness, they found that the outcomes of these children when they become adults is far from heterogeneous and can not be determined by one single factor such as mental health. This study found that one could not make generalizations about the negative outcomes for children of parents who are affected by mental illness. Factors such as class, race and cultural background were found to be extremely significant in determining the psychosocial outcomes of these children (Mowbray & Mowbray, 2006, p.131).

Now that the prevalence of mental illness in families and the potential risks to children has been described, the following section will examine how children's knowledge of their parents' mental illness and the subsequent coping skills that they develop, impact their experiences. In a study of experiences reported by stakeholders in families with mental illness, Reupert and Mayberry (2007) found that children often have many misconceptions concerning their parents' illness. In a qualitative study of twenty children of parents with mental illness, Cogan, Riddell and Mayes (2005), found that children's narratives reflected misconceptions of mental illness as well as maladaptive coping techniques. One participant spoke extensively about the feeling that his parent's mental illness was his fault. Several participants related feelings of stigma and shame to their parent's mental illness. Overall, the researchers found that children lacked information about their parent's mental illness and often developed isolating, maladaptive

coping skills due to societal stigma associated with mental illness (Cogan et al., 2005, p. 22-25).

### Therapeutic Treatment Modalities and Interventions

This section will review literature that explores the effectiveness of specific family therapy interventions with families with parents affected by mental illness. In several different data sets obtained from hundreds of mental health agencies in North America, Nicholson, Biebel, Kinden, Henry and Stier (2001) found that agencies focused services on either the parent or child, but not on the family as a whole. In addition, these services were often fragmented and uncoordinated, leading to participation of either adults or children, but rarely both (Nicholson et al., 2001). After reviewing the narratives of children with parents affected by mental illness, Cogan et al. (2005) recommended that parents and children should be engaged in therapy before children display maladaptive coping techniques or develop mental disorders (Cogan et. al., 2005, p. 25).

The research on the negative outcomes for children in these families is extensive and yet there is little research that examines the effectiveness of specific family interventions. In a recent article that explored this phenomenon Lerner (2004) wrote the following:

Family therapy is an ecological intervention in a natural environment that does not translate easily into a step-by-step procedure or intervention manual. As a collaborative and reflective form of therapy, the person's language and agency is given priority rather than a particular model or technique. Special consideration is given to issues of culture, gender, politics and spirituality. In highlighting personal and systemic narratives and solutions, family therapists may even step back from specific interventions. (p.19)



In addition, Lerner (2004) argued that evidence-based practice promotes a narrow positivism and does not validate widely accepted methodologies that are post-modern, such as qualitative research (Lerner, 2004, p. 21).

There is a study that evaluated family therapy and integrated many of the contextual factors that Lerner described above. In a meta-analysis of the effects of family therapy, Shadish, Montgomery, Wilson, Bright and Okwumanbua (1993) compared the outcomes of families using different theoretical interventions and compared the outcomes of family therapy versus individual therapy (Shadish et al., 1993, p. 993). This study was conducted in the United States and used data from 163 randomized trials. The findings from this study revealed that there was no discernable difference in outcomes between behavioral and non-behavioral family therapy and that both were more effective than no therapy at all. Shadish et al. (1993) emphasized that there is a dearth of studies comparing specific family therapy interventions that are non-behavioral. The researchers hypothesized that this is due to the eclectic use of theoretical interventions in family therapy and suggests that a new methodology is required to analyze the effectiveness of these interventions (Shadish et al., 1993, p.999). Both Lerner and Shadish came to the conclusion that a quantitative approach to measuring outcomes of family therapy is inadequate given the nuances and contextual factors that occur during treatment.

Another important factor in considering clinicians perspectives in working with families with parents affected by mental illness is the means by which they come into treatment. Often, parents are mandated to attend family therapy due to allegations of neglect and abuse. Two recent studies have explored the ways in which mandated status

affects treatment and outcomes. Jong and Berg (2001) used a case study to illustrate the ways that solution focused therapy is appropriate for mandated clients. This case study illuminated some of the basic problems inherent in working with mandated clients. Clinicians are often trained using theories that assume the voluntary participation of clients (Jong & Berg, 2001, p. 361). Jong and Berg (2001) wrote that the clinician must co-construct goals for treatment in order to ethically work with mandated clients. They wrote about the importance of creating goals for therapy that both the client and the clinician agree upon, so that the client feels empowered in the therapeutic process. (Jong & Berg, 2001, p. 372).

Snyder and Anderson (2009) investigated the impact of mandated status versus voluntary status of clients in a literature review. Building on Jong and Berg's work, this study also cited the lack of psychological theories that apply to mandated clients (Snyder & Anderson, 2009, p. 278). Snyder and Anderson (2009) found that minority groups appeared to be disproportionately represented among mandated clients. In addition to this, the literature revealed that White therapists are often not attuned to cultural attitudes about therapy and have the potential to represent a larger, oppressive, White, European system (Snyder & Anderson, 2009, p. 279). What could be viewed by a clinician as therapeutic resistance might in fact be a rejection of a cultural paradigm that differs greatly from that of the client. In the implications section of this study, Snyder and Anderson (2009) called for research that would examine factors such as mental illness in clients and cultural training of clinicians in relation to working with mandated clients (Snyder & Anderson, 2009, p. 287).

What does the literature say about the experiences of children living with parents with mental illness and their experiences in family therapy? Murdoch and Hall (2008) analyzed the narratives of twenty children living with parents affected by mental illness. For the purposes of this study, mental illness was limited to the diagnosis of schizophrenia, depression and bi-polar disorder, as defined by the DSM IV. This study was conducted in Canada and included fourteen boys and eighteen girls between the ages of six and sixteen. One of the major limitations of this study was that the race and class of the sample was not indicated (Murdoch & Hall, 2008, p. 1129).

Murdoch and Hall (2009) analyzed narratives that revealed the difficulties children had in maintaining a rhythm in their interactions with their parents. All of the children spoke of monitoring their parent's behavior and described their ability to assess moods. All of the children spoke about their desire to remain attached and connected to their parents even though it was often emotionally difficult. The researchers concluded that one of the implications of this research was that during assessments for mental illness, clinicians should present parents with the option of including their children in treatment plans (Murdoch & Hall, 2009, p. 1142).

Labatto (2002) analyzed the narratives of children involved in family therapy. This research was conducted in the United Kingdom and the sample was six children, ages eight to twelve years old. The children in this study were predominately white and lived in public housing (Labatto, 2002, p. 330). Labatto (2002) found that children were very aware of the dynamics and alliances in the room during therapy. They sighted several examples of times that they felt too much or too little focus was being placed on them by the clinician. Overall, the children in this study were unsure of the rules of

family therapy and needed more guidance from counselors about expectations and managing alliances (Labatto, 2002, p. 342).

The writer had difficulty finding studies based in the United States that explored clinician's experiences of working with families with parents affected by mental illness. Kim and Salyers (2007) conducted a statewide survey of 453 community mental health professionals in Indiana. The purpose of this research was to identify how often mental health professionals were involving families in treatment of clients with mental illness. The researchers were interested in identifying the barriers to providing services to these families. Kim and Salyers (2007) found that the majority of mental health workers that responded to this survey were white women and 28 percent had graduate level training. While this sample was not representative of all community mental health staff in the United States, the researchers found that a statistically small percentage of staff offered family therapy as part of a treatment plan. In addition, few mental health providers had been trained in effectively engaging family members and only half felt comfortable with their skill in working with families (Kim & Salyers, 2007, p. 343).

A qualitative study conducted by Nicholson, Hinden, Biebel, Henry and Katz-Leavy (2007) explored the narratives of providers who worked with parents affected by mental illness. The study involved seven different programs across the United States and the purpose was to build an evidence-based protocol for families that was derived from practice. Nicholson et al. (2007) found that the clinicians in these programs practiced from diverse or eclectic theoretical orientation and that treatment decisions evolved over time in context with the specific needs of the families. Providers felt that a rigid or narrow theoretical orientation was not realistic or effective in treating the specific,

contextual needs of these families (Nicholson et al., 2007, p. 404). Nicholson found that all of the programs in this study held a similar belief that the most effective treatment for parents affected by mental illness is a focus on the entire family

One of the key findings of the literature that has been examined is the growing awareness among researchers that families with parents affected by mental illness represent a large percentage of the population and requires further research. Conversely, one of the major limitations in the literature is the lack of research about this population group. The writer has found it difficult to find research that originated in the United States, with most family therapy research originating in the UK and Australia. While research conducted outside of the country is useful, it must be applied cautiously in different cultural context from that which it was collected. Another limitation in the literature is the relatively small number of studies that have a diverse sample, or are transparent about the racial and cultural composition of their sample.

The literature reveals that families with parents affected by mental illness are a large percentage of the population. In addition, the literature shows that these families face a unique set of risks and challenges in dealing with mental health issues. There are negative outcomes associated with children who have parents with mental illness, yet there are very few studies that explore the use of family therapy interventions with this population. The literature shows that there is a lack of research about the manner in which families begin treatment and how mandated status influences treatment. The literature shows that there are methodological and philosophical barriers to research of family therapy, specifically linked to the growing emphasis on evidence-based practice that has become the standard in most mental health agencies in the United States. Family

therapy is not easily standardized and therapists often prefer to work in an eclectic manner, drawing from diverse theoretical orientations. Finally, the literature reveals that qualitative methodology is particularly useful in exploring the treatment of families with parents affected by mental illness, given all of the contextual nuances that influence treatment decisions and outcomes.

The implications of this literature review in regards to this researcher's proposed study are numerous. The need for a study that examines the perspectives of clinicians who work with families affected by mental illness has been illuminated and supported by the literature. The literature shows that family therapy has been proven to be as effective as individual psychotherapy, however it has not been widely studied in respect to working with specific populations. While the literature shows that family therapists often use an eclectic approach, no studies were found that illustrates how clinicians work with families with parents affected by mental illness. Additionally, while many families enter therapy due to a court mandate, no studies were found that explores how this affects treatment with this specific population. In conclusion, the literature shows that there is a need for qualitative exploratory research that explores family therapy in regards to families with parents affected by mental illness.

## CHAPTER III

### METHODOLOGY

This study was conducted in order to explore the perspectives of clinicians who work with families with parents who are affected by mental illness. This study is an attempt to explore questions such as: What are the theoretical frameworks or interventions that clinicians use when working with families with parents affected by mental illness? How are clinicians affected by a client's mandated status, and how do they define success or challenges with these families?

There are varied understandings of what defines family therapy. For the purpose of this study, participants identified themselves as clinicians practicing family therapy. This study used an exploratory design, which was consistent with the fact that the researcher was unsuccessful in locating prior research on this topic. A qualitative design was chosen because of its ability to provide rich, narrative data. Semi-structured interviews were conducted with participants which on average lasted approximately forty-five minutes. The interviews were transcribed and the transcripts were carefully reviewed and analyzed for emerging themes.

#### Sample

Due to the restricted number of clinicians who were expected to meet the inclusion criteria, this sample was collected using non-probability techniques. A generally purposive sample allowed for the most comprehensive understanding of how clinicians work with families with parents affected by mental illness. Inclusion criteria

for participation were as follows: 1.) Participating clinicians must use family therapy with families with parents affected by mental illness; 2.) Participants must be clinicians in New York City; 3.) Participants must work in public agencies where services were provided for free or for a low-cost; 4.) Participants must be fluent in English; 5.) Participants can be trained as social workers, art therapists or psychologists, as long as they have been practicing for over one year and have some graduate level training that involves the study of family therapy; and, 6.) Participants' practices must include some number of mandated clients.

The researcher's goal was to interview twelve participants for this study. At least sixty agencies in the New York City Area were contacted in an effort to obtain this number of participants. Of the sixty agencies contacted, a total of twenty directors responded to email and phone calls from the researcher. Of these twenty agencies, ten were able to gain permission for the researcher to interview clinicians who worked there. The researcher was granted permission to speak at four agency staff meetings in order to explain her study directly to potential participants.

After speaking to each director on the phone, the writer followed up with an email that provided specific information pertaining to the study (see Appendix F). Potential participants were screened by phone to make sure that they met all of the inclusion criteria (see Appendix D). In addition to staff meetings, potential participants were recruited through email, phone calls and word-of-mouth. Potential participants were encouraged to forward the recruitment email to other clinicians who might meet the inclusion criteria.



## Participants

A total of nine clinicians were successfully recruited to participate in the study. All of the clinicians worked in family therapy agencies in the New York City area. The participants in this study came from four different agencies. All of the clinicians worked at agencies that provided free family counseling for families with children under the age of eighteen. All of the clinicians were women. Eight of the clinicians identified as white and one of the clinicians identified as identified as Latina. All of the participants had graduate level degrees and two participants had some post-graduate training. Six of the participants were social workers and three of the participants were art therapists. The participants ranged in age from 26 to 43 years old, with a median age of 33 years old. The participants had been practicing family therapy for a range of 1.5 years to 10 years, with a median amount of 2.8 years. Based on this researcher's contact with the clinicians during staff meetings at four different agencies, the study's sample appears to be broadly reflective of the potential pool of study applicants.

## Data Collection

The design for this study was approved by the Smith College School for Social Work Human Subject Review Committee (see Appendix C). Approval of the proposal provided confirmation that the study's design was consistent with the NASW Code of Ethics and the Federal regulations for the Protection of Human Research Subjects. Informed consent forms were given to the participants to review before the interviews occurred (see Appendix A). All participants were given a copy of their signed consent form. All participants were informed of the inclusion criteria for the study, given a list of

the risks and benefits of participation and given the researchers contact information in case they had questions or wanted to withdraw from the study.

The participants were given an opportunity to ask the researcher any questions they might have about the research. All potential participants were informed that if they did not wish to be part of the study, it would not affect their job in any way. If the participants choose to participate in the study and sign informed consent form, the researcher explained that it would be kept in a safe, locked place separate from other identifiable information. The researcher will keep all of the data collected from this research in a secured environment for three years, as mandated by Federal regulations.

All participants were given a brief demographic questionnaire to fill out prior to the interview (see Appendix E). All participants were asked to mask any identifying information about their clients during the interviews. The interviews were all conducted in person, following a semi-structured format and lasting forty-five minutes. A semi-structured interview format allows the research to collect rich, narrative data. The researcher followed the same script with all participants, but at times asked participants to provide further information or to clarify their responses (see Appendix B).

The following questions were posed during each of the nine interview: 1) What was your approach to working with families with parents affected by mental illness? 2) How did your client's mandated versus non-mandated status affect treatment? 3) Do you believe that family therapy is an affective treatment modality for parents affected by mental illness? 4) What were some of your successes and challenges in working with families with parents affected by mental illness? and, 5) How did your theoretical training affect your work with these families? All of the interviews were audio taped. The

researcher transcribed all of the interviews.

#### Data Analysis

Themes were developed from participants' responses to specific interview questions. After themes were developed, the researcher selected narrative passages from transcripts to illustrate the concepts being discussed. Themes were assessed for their frequency and magnitude of occurrence. The researcher presented the findings in a manner that showed the wide range of responses encompassed within the themes.

This study had several limitations. Clearly the sample size included limited gender and racial diversity. However, the information obtained from the nine respondents reflected the breadth and depth of the clinicians who have worked with families with parents affected by mental illness.

## CHAPTER IV

### FINDINGS

This study was focused on answering the following primary research question: What are the perspectives of clinicians who work with families with parents who are affected by mental illness? In this chapter, the researcher presents the findings from the interviews conducted with nine participants who in answering the questions posed by the researcher were directed to use their own definition of mental illness. The participants were asked to a total of nine questions (see Appendix A). The researcher transcribed all of the interviews. Many of the themes came directly from interview questions, while others occurred organically during the process of coding.

The findings of this study are divided into seven major sections. The finding section is organized in the following manner: 1) Demographic data; 2) Advantages of working in a family therapy modality; 3) The roles of children in families with parents affected by mental illness; 4) The impact of mandated status on the treatment of families with parents affected by mental illness; 5) Challenges in working with families with parents affected by mental illness; 6) Success in working with families with parents affected by mental illness, and 7) The theoretical frameworks and interventions that have been useful in treatment of families with parents affected by mental illness.

## Demographic Data

### *Participant Demographics*

The sample size for this study was nine. All nine of the participants identified as female. Eight of the clinicians identified as white and one of the clinicians identified as Latina. All of the participants had graduate level degrees and two participants had some post-graduate training. Six of the participants were social workers and three of the participants were art therapists. The participants ranged in age from 26 to 43 years old, with a median age of 33 years old. The participants had been practicing family therapy for a range of 1.5 years to 10 years, with a median amount of 2.8 years. All of the participants worked with mandated clients. Participants worked with a varied percentage of mandated clients. The percentage of mandated clients participants worked with ranged from 15 to 100 percent, with an average caseload consisting of 56 percent mandated clients.

### *Agency Demographics*

All of the participants in this study worked at Preventative Agencies in Brooklyn, New York. Preventative Agencies are funded through the Administration of Children Services (ACS), a city government agency tasked with protecting children in New York City. Preventative Agencies provide free family therapy for families with children under the age of eighteen years old. Preventative Agencies also offer case planning services to families.

ACS can mandate families to go to Preventative Agencies if there is an allegation of child abuse. These cases become non-mandated if the allegations of abuse are

unfounded. Courts can also mandate cases to Preventative Agencies if a child has been reunited with a parent or is in danger of being removed from a parent's care. These interviews with clinicians took place at a total of four Preventative Agencies between February 2010 and April 2010.

### The Advantages of Working in a Family Therapy Modality

Eight of the nine clinicians interviewed agreed that family therapy was helpful in the treatment of parents affected by a mental illness. Participant four had a different perspective in cases of parents with severe mental illness: "I feel like (when) a parent has been diagnosed they really need more intensive services and more in-home case management." This participant was referring to a specific program that offers case management and art therapy exclusively in the client's home. The participants identified three areas in which the use of family therapy can be particularly useful for clients. These areas were: 1) Family therapy in conjunction with individual therapy; 2) Understanding family dynamics; and, 3) Repairing relationships. Each of these areas is described in the sections which follow.

#### *Family Therapy in Conjunction with Individual Therapy*

Nine of the participants agreed that family therapy is a useful modality to work in with parents affected by mental illness, but most felt it was significantly more effective in conjunction with individual therapy. Participant six believed that some mental health issues, depending on the level of severity, could be addressed entirely in a family therapy setting. Some participants felt comfortable facilitating individual mental health service themselves, while most felt that individual services should be referred to another clinician. Participant three felt that she was unable to facilitate individual work due to

the expectations of her agency. Participant three worked in an agency that was coming under strict oversight in terms of the length of time services could occur and the type of therapeutic work that was permissible.

Participant seven spoke about the benefits of facilitating both individual and family sessions with these families:

You can see the family dynamics come out and you can see the family and you can see how the mental health plays into it and then you can use that as a platform for addressing it later. I mean you see a lot in family sessions, you can't always address them. I feel like I when start addressing mental health that (it) works much better individually.

Participants often expressed more comfort in dealing directly with mental health issues in individual sessions with parents.

Four out of nine participants spoke about using individual sessions with parents and children during the first stages of treatment. These clinicians felt that the mental health issues needed to be addressed with parents before intensive family work could begin. Several participants stated that they would work with parents and children individually and work towards family sessions. Participant one stated:

It requires a lot of individual work to move towards (family sessions). And often going back and forth from individual work with parent and the child and then doing some work together.

All of the participants believed that in cases of severe mental illness, individual therapy was necessary.

Five participants felt it was always better to have individual sessions facilitated by an outside provider. In these cases, participants spoke about the benefits to having both modalities simultaneously. Participant six said "That's where we have had the most success in our long term cases, when the parent has been connected to psychotherapy,

getting some of the individual stuff there and making a real commitment to the family work here.” Participants felt that the combination of family and individual therapy was most effective when there was coordination of services between therapists. Participant four spoke about the ways that mental illness can be addressed in different contexts using different modalities:

I think a lot of times the focus in individual therapy could be how this is affected me and also monitoring the illness and going over your thought process. I think that the good thing about family therapy when you have a parent with mental health issues is that they can really understand the impact it has on the people around them.

Family sessions can also give the participants a different perspective into the parent’s functioning. Participant one said, “Finding out what comes up for them with their kids is also another window into them.” In this sense, the participant believed that the family session could be another form of support for the parent.

### *Family Dynamics*

*“In my opinion, no one lives in a vacuum.” Participant six*

All of the participants believed that when a parent is affected by a mental illness, it impacts family dynamics. Participants were careful not to make broad generalizations about parents with mental health issues and cited specific case examples to illustrate points. Participant six spoke about a family with a mother affected by depression:

Also, just pointing out that a depression that is held inside a mother is not just held inside a mother. I think that everyone (in the family) is kind of holding it somewhere. She might be the one who is the most symptomatic, but I think that everybody is experiencing it somewhere. That’s why I think that family therapy can be the most useful.

Participant five spoke about a mother who is struggling with an undiagnosed anxiety disorder. Participant five said, “Mom’s anxiety definitely affects the whole family.”



Several of the participants noted that parenting is already a challenging role, and when a parent is affected by a mental illness, it can heighten that stress.

Participant three spoke about her work with a family with a mother diagnosed with post-traumatic stress disorder. The mother experiences panic attacks and is learning how to communicate about her mental health with her family. This parent is also learning how to cope with the challenges of raising a teenager. Participant three stated:

It's also dealing with teenage issues, which also brings up a lot of anxiety, with any parent in general. Then, with a parent who has an anxiety disorder, and has panic attacks, that just exacerbates the situation.

In this situation a normal developmental stage of adolescence is more challenging for the parent to handle due to her anxiety.

In another example provided by participant three, a mother is diagnosed with obsessive-compulsive disorder and cleans obsessively. When the teenage daughter does not maintain an adequate level of cleanliness, the mother feels that the daughter is not respectful of her diagnoses. The clinician points out that the mother feels “out of control in terms of the cleaning, but mostly other things, there are other underlying issues there.”

Participants cited many examples of parents with severe mental illness who were overwhelmed and could not provide their children with adequate attention. In these cases, parents were consumed with mental health concerns and had difficulties coping with parenting. Participant number four talks about a case with a mother who had severe mental health issues:

There was a son who was showing a lot of anger towards her (mother). I had a session just with him and her, a couple of them. I felt that it helped them bond and also helped her pay attention to his needs and also have a more thorough conversation. Then I could talk to her about bringing that into the home, having that one on one time with each of her children.

All of the participants cited examples of the impact of mental illness on family dynamics.

### *Repairing Relationships*

Many participants reported the ability to repair relationships as an advantage to working in a family therapy modality. Participants noted that in many cases relationships between parents and children or between two parents can be strained when one parent is affected by mental illness. The ability to work in the moment on relationships was cited as a unique advantage of the family therapy modality. Several participants spoke about the importance of family support for parents who are affected by mental illness.

In some cases, parents who are affected by mental illness were able to gain understanding of how their mental health impacts their children. Participant four spoke about a poignant example of repair:

This person was bi-polar, she was able through family therapy to really understand how when she went off her medication how that affected her children. She also was really able to understand that there were relationships that she needed to repair as a result. I think it gives a broader perspective.

The clinician in this example was focusing on the repair between mother and child.

Participant number nine spoke about the advantages of repairing relationships as a means of support for the parents affected by mental illness. This participant was working with a family in which the mother was diagnosed with bi-polar disorder and the father was uninformed about mental illness and unsupportive. Participant nine stated:

I tried to help the family understand more about her diagnoses, after she received one. I wanted her to feel more supported by her husband so I did some joint sessions with them. I wanted the whole family to be realistic about what was happening and to really support her and encouraged her to still go to that other agency once her case was closed here.

Many of the clinicians spoke about the impact of families spending positive time together during sessions. They cited examples of how positive experience in family therapy can impact relationships at home. Participant one spoke about the importance of “helping them talk about what the (positive) experience was like, to help them hold on to it.” In this way family therapy can help families with parents affected by mental illness repair relationships.

#### The Roles of Children in Families with Parent’s Affected by Mental Illness

This section of findings examines the roles that children often play in families affected by mental illness. Participants spoke about the different characteristics that they found when working with these children. The three major roles that seem to encompass these characteristics are divided into the following three sub-sections: 1) The parentified child; 2) The guarded child; and, 3) The flag-bearing child. Participants noted that there was overlap between these roles and that children could play different roles at various developmental stages. This findings chapter will present how these three roles manifest in families with parents affected by mental illness.

#### *The Parentified Child*

According to the participants in this study, the parentified child is the most common role of children with parents affected by mental illness. The participants in this study worked with different age children, so they conceptualize the role in varied ways. Participant two defined a parentified child this way, “children really feel like they are on the back burner, they are taking care of their parents.” Participant two notes that while

parentified children can occur in any family, they are more common in families with parents affected by mental illness.

Several participants cited examples of oldest siblings who were parentified and assuming a caregiver role for the younger children in the family. Participant one talked about an example in which a seven-year-old sibling took over many of the caregiver responsibilities for her younger brother. The mother in this example is diagnosed with bi-polar disorder and is living in a supportive home for parents affected by mental illness.

Participant number one said:

The younger brother is a year and half old and at an age where he is more vocal and of course he wanted to participate with the touching and grabbing things and the daughter, who is very parentified, was trying to control that but obviously couldn't do that well. Then that was annoying mom, so it was a great chance just to see all of this happening right there, just to say out loud to both of them, well this is what kids this age do. Also help Mom, to put it back on her, to realize that this is hard for a girl her daughters age to do, you know a daughter her age can't really do this - she is 7 years old.

Participants stated various reasons that that they believed children took over the parentified role. Participant six said, "I just think that regardless of what the presentation of the mental health issue is in the parent, it's more often times then not that the child is just worried and assumes the role of caregiver."

Participants who worked with older children noticed slightly different manifestations of the parentified child role. Participant number eight spoke about a teenager she has been working with raised by a single mother diagnosed with PTSD.

This teenager viewed her parentified role as strength. Participant eight said:

She has told me that she has more responsibility then other teens her age and she thinks that is a good thing because eventually she wants to go to live on her own and go to college. She is doing incredibly well for not having a father around and for having a mother who is not totally stable all the time and has had this

incredibly traumatic event happen. So this kid is doing really well in school, she is a poet; she performs spoken word in school.

This teenager was able to view her parentified child role as being a strength, as giving her more coping skills than her peers. Not all of the participants who work with teenagers could cite examples of the parentified child role being strength.

Participant two cites another example of a teenager playing the parentified child role in a family with a parent affected by a mental illness. In this case, it seems that the teenager's caregiver role is getting in the way of other developmental tasks. Participant two said:

What I found was, the 17 year old son, was just quiet all of the time and very sensitive and didn't really have friends. I am sure at a young age he began playing the role of really being quite the caregiver for mom, being her main support. The other day I was driving to work and I saw them on the street and mom is not a physically weak woman, but I see him holding an umbrella and having his arm on her back and walking her across the street to go home. And you know he was just so caring and so attentive.

In this case the participant felt that the teenager's caregiver role was a detriment to normal development.

### *The Guarded Child*

Another common role that participants found in children with parents affected by mental illness was that of the guarded child. Participant one said that she often worked with guarded children who think "well this wouldn't happen if I wasn't bad and it's my fault." Several participants stated that children have difficulty separating themselves from their parent's mental illness.

Participant two spoke about children who felt that their behavior was responsible for their parent's mental illness. In these cases children might feel it is not safe to express

their feelings or emotions. Participant two said “you have these kids, that are really guarded and they are not allowed in the home to say how they feel.” Several participants spoke about children who were overwhelmed with worry for their parents but felt unable to express this fear. Participant number seven spoke about a guarded child she worked with who had difficulty expressing his fears about his mother’s mental illness to his parents. Participant seven said:

The eight year old was there and the father was there and I said to the eight year old, “do you worry about your mom?” and he said “yeah” and we were able to talk about his feelings about worrying about his mom and that his mom is going to be ok and that she is taking care of herself.

In a subsequent section of findings, the impact of being mandated to services will be explored in more detail. However, in many of the examples of the guarded child role, participants reported that the involvement of outside agencies in reference to the parent’s mental health issues might exacerbate this role. Participant nine talked about one family she works with:

She has two daughters and they are 9 and 11, really close in age. I think that the kids get really anxious when they know that there is some kind of meeting going on and this was at the end of an investigation, there had been two reports. Both of the allegations were found to be unfounded, but this family has had a lot of history. So I think that the girls have learned to be really guarded and to protect their mother and not to talk about certain things. Not to be trusting of outside people.

In this case, the children felt it was necessary to guard their mother and by extension, to guard themselves. This participant said it was challenging to work with guarded children because she felt they were afraid of hurting the parent.

### *The Flag-bearing Child*

Participants also recognized the role of the flag-bearing child in families with parents affected by mental illness. Participants conceptualized this role in varied ways. Participant six said that she often finds kids who “are acting out behavior somewhere in school. Maybe it takes a couple of months of engagement and then we see that there are some mental health issues with this parent.” This participant often finds children who are acting out and unconsciously are trying to obtain help for the family. Participant number six:

The child has really decided to be the spokesperson and has alerted either the schools or gotten tripped up with some legal stuff or whatever it may be. But really it was just in an effort to get somebody in there. I see kids doing that quite a bit.

Other participants viewed this role in slightly different terms. Participant four described encountering a lot of children who exhibit anger. In these cases the participant believed that the child is often angry with the parent but acts out in different arenas. Participant four said that she worked with a family in which the mother has significant mental health issues and the son was acting out “to get his parent’s attention.”

Several participants said that they feel like the negative behavior is a cry for attention. The participants described flag-bearing children as those who act out behaviorally. For younger children this behavior might be more pronounced in school. For one clinician, who works exclusively with teens, she saw acting out behavior permeating every aspect of the teenager’s life. Participant eight said:

So they blame their parent for skipping school, the arrests, the smoking marijuana, their sexual activity and getting pregnant or an STD or whatever the case maybe. I have seen parents get upset about the child blaming them and I have seen parents not care.

In conclusion, participants said that they saw a variety of behaviors in children in families with parent affected by mental illness. They identified three roles that they find children play most often within these families. They identified many children who overlapped in different roles. They also stated that not all roles should be seen as negative and identified situations in which the child's role could be viewed as a strength or help to the entire family system.

*How mandated status effects treatment of families with parents affected by mental illness*

This section of findings explores how being mandated to family therapy services can affect treatment with parents affected by mental illness. This section is divided into three subsections: 1) Participant's perspectives about what being mandated to treatment means; 2) Positive experience of working with mandated families with parents affected by mental illness; and, 3) Negative experience of working with mandated families with parent's affected by mental illness.

As referenced in the demographic section of this findings chapter all of the clinicians in this study work at Preventative Agencies. Participants reported receiving the majority of mandated cases through the Administration of Children's Services in New York City. This is also the government agency that funds the preventative agencies in New York City. Participants also receive mandated cases through the court system and the foster care system. While not all mandated cases involve families with a parent affected by mental illness, the following section of findings specifically addresses this population.



*Participant's Perceptions of the Meaning of Mandated Family Therapy*

Some of the participants identified the safety of the child as the most important goal for treatment and felt that in mandated cases this was particularly important. In cases where a parent is affected by a mental illness the role of the participant can become one of enforcer. Participant number four identified her role with these families in the following statement:

Generally there is always a component of monitoring to make sure that the parent is getting appropriate treatment. I have had clients who are bi-polar and just making sure that they were still taking their medication and also processing with them any struggles they have.

Several other participants spoke about their role as making sure that parents are complying with mental health treatment. Participant number five cited this as an impediment to effective treatment with these families:

You know, I just had a case conference for this woman who is not taking her medication yesterday. I had to make a report because they weren't being compliant with services. She felt mental health was something she could heal or cure on her own and I was trying to really educate her but she became very defensive. So it really can ruin the therapeutic role when you're trying to maintain that case planner role.

In mandated cases it seems that many of the participants felt pressured to make sure that parents were pursuing individual mental health services, possibly in conjunction with psychopharmacology. Most participants felt that this had a negative affect on their relationship with the parents.

Several participants said that they viewed mandated status in another way. These participants believed that when a case was mandated to services it meant that family therapy was being recommended by ACS. In cases where families were not directly ordered into services by the court system, participants viewed mandated status in a different way. Participant six said:

Our line with mandated clients is that ACS is recommending this, but that we are not mandating them to services. We use that line quite often, that we can't pressure them to do anything, if they make the choice to come here then all we can do is inform ACS if they choose to come here. But it comes down to their choice. Even though we have these mandated cases, I never really think of them as mandated to services, I just don't see it exactly that way.

Participants who shared this viewpoint did not talk about making sure that families were compliant with individual mental health treatment. These participants stated that it was important for families to feel that they were making a choice to be in treatment.

Participant number six qualified this remark by saying, " We have had situations when we have had such serious untreated mental health issues we have had to re-involve ACS in the middle of a crisis."

Participant five said that the ambiguity over what being mandated to services means often complicates her relationships with families with parents affected by mental illness. Participant five said:

Since the beginning the families feel pressure from ACS to sign up for the services and actually our services are voluntary, they can terminate the case at any time if they feel that the services are not benefitting them. However, the fact they were pressured at the beginning means that they sign up for the services and then don't want to continue.

Overall, it seems that that the participants' understanding of what it means to be mandated to services had a great effect on the treatment of families with parents affected by mental illness. Participants who felt that they had to enforce compliance with individual mental health services and medication cited more difficulties in treatment.

#### *Positive Experience of Working with Mandated Families*

Several participants could cite positive experiences working with mandated families with parents affected by mental illness. Participants six and seven reported that

the engagement process was incredibly important in these cases. Participant six spoke about her philosophy of engagement when working with these families:

When we have a parent who is resistant and may also have a very severe untreated mental health issue, we work to build a relationship for a long time, we have the patience to see if we can make head way. I don't care what you have read about or heard about engagement might take 10 months.

Participant seven believes that when the initial engagement process goes well then it can affect a client's feelings about being mandated. Talking about one of her long-term cases involving a mother with severe mental health issues, she said: "In that case it doesn't matter that it's mandated, we forgot about that a long time ago." In both of these participants' experiences the initial engagement period was key to working with mandated families with parents affected by mental illness.

Participant seven reports that in cases when a parent might be reluctant or scared to ask for help mandated status could lead a clinician to work harder in the engagement period. She spoke about a client with a dual diagnosis of drug abuse and PTSD who was mandated to services through ACS. Participant seven tried to engage the family in services for several months without much success. She noted that even though the family never actually obtained family therapy from her directly, her constant attempts to engage had some affect. Participant seven said, "and then at one point [the mother] called me and said to me, 'I have to go to a drug place' which she somehow felt that I was safe and that she could tell this to me." In this situation, the participant believed that her consistent attempts to engage the client were directly related to her mandated status.

Two participants cited examples of cases that were referred to the agency through ACS as mandated, but eventually the mandate was lifted for various reasons. In these particular cases the families decided to remain in family therapy.

A couple of participants said that there could be advantages to mandated status when a parent affected by a mental illness is having difficulties parenting. Participant number one said that in a difficult case that she worked on, in which there was some concern about the parent's treatment of her children, the family's mandated status was actually helpful. She said:

[We were able to request] some more mandates within the already mandated service of coming here. And for this particular parent, as much as she was very upset about that initially, it has really helped her because she really needed the structure and support. And over time, at least some of the time, she was able to view them as a support.

In this case the client's mandated status allowed for access to more resources and supports within the ACS.

#### *Negative Experiences of Working with Mandated Families*

*"A lot of what I do is damage control." Participant four*

Participants cited more negative than positive experience working with mandated families with parents affected by mental illness. Participants two, four, eight and nine spoke about working with increased resistance due to the mandated status in conjunction with the mental health status. Participant number eight said, "It is more difficult working with that resistance as opposed to regular resistances that you always come across." These participants said that the level of resistance often present in these cases makes treatment difficult. Participant number eight said:

Because a lot of people with mental illness have been labeled and they have been taken advantage of in the past. When they are aware of their impairments, I think that sometimes it makes them very skeptical and not want to trust anybody.

In addition to the stigma sometimes associated with mental illness, participants also spoke about the stigma associated with being mandated to services. Participant number four said, “mandated families, they come here and they are just so defensive, which I don't blame them. They feel they have been violated, someone has come into their home, someone is claiming that they are not parenting they right way.” Participant two spoke about the difficulty of creating a “strong working alliance” with clients who feel stigmatized.

Participant nine spoke about a case in which a family was court ordered to family therapy. In this case the participant felt that the family’s mandated status could have been used to persuade the parents to obtain more support. This participant felt that the mandated status had no affect what so ever on the parents in the family. Participant nine said:

There were all these issues; the teenage daughter had been hospitalized. She had been in the ICU for untreated diabetes as an eighth grader. She was truant and her older sister was truant and nothing changed because the girls would sometimes come here for counseling, but then they would go back into the home where the dad was at work and the mom had mental health issues and I think was depressed and was really verbally abusive. The dad really though, he was definitely the more capable parent, but he definitely had this position like I am providing food and shelter and I can’t provide one more thing. So he wasn’t invested in therapy,

In this case, the participant was not able to engage the parents and being mandated did not persuade them to enroll in treatment.

In conclusion, participants seem to have had varied experiences working with mandated clients when a parent is affected by a mental illness. Participants cite more

negative than positive experiences. The positive experiences seemed to be linked with a longer engagement process. The negative experiences seemed to be linked to the double stigma associated with being mandated and having mental health issues.

#### Success in Working With Families with Parents Affected by Mental illness

This section of findings explores the successful experiences of participants treating families with parents affected by mental illness. The participants were asked to define success subjectively in the context of both their clients and their own experiences. All participants except one could recall positive treatment experiences working with families with parents affected by mental illness. This section of findings will be divided into the following subsections: 1) Family therapy as a first step; 2) Improving family dynamics; and, 3) Recognizing triggers.

##### *Family Therapy as a First Step*

Several participants spoke about family therapy as a first step in the process of the parent addressing mental health concerns. Many participants stated that they felt treatment had been successful if the parent eventually felt comfortable obtaining individual mental health treatment. Participant six said “families feel safer coming to family therapy because they don’t associate it with mental health.” Several participants said that they believed their clients were more comfortable seeking family rather than individual therapy.

Participant number nine spoke about a case in which a mother had shown up in tears at her agency after her husband told to “go to the psych ER, or don’t come home.” In this case the mother had a relationship with the family agency from a treatment years ago and felt comfortable reaching out for support. The mother, who was eventually

diagnosed with bi-polar disorder, was reluctant to have any mental health treatment.

Participant number nine said:

I worked with them for a year and a half, but it took me months to get her to eventually seek her own individual therapy. So success in that case would be that the mother found an individual mental health provider that she really connected with and then also met this other group of women and starting going to this parenting support group for clients at the same agency, she was so excited about joining. So she would go twice a week, once for her individual session and once to this support group, so I felt really good about her being really connected to that agency and I don't think she will stop going there.

Several other clinicians cited experiences like this one, in which a parent was able to obtain individual therapy after going through a family therapy treatment.

Two participants spoke about their ability to work with a family for an extended period of time until the parent was ready to engage in individual mental health services.

Participant number six said:

That case that I had for two years and then some one else had for a year and then she finally left preventative services because you really can't be here your whole life and then she did go to mental health services, I think that was a huge success. It took a very long time and there were things going on with the kids so it made sense in some ways, but I think that the success was that we stuck it out until she was really ready. I cannot tell you how many appointments I went to, the other worker went to, of going with her to intake appointments that she just never ended up following up on. We were never going to close her case until we knew she was connected to a mental health place, we really felt like she we need some ongoing support to address her depression issues.

The combination of family therapy and case planning in this example helped the parent to obtain individual mental health services.

### *Improving Family Dynamics*

Many participants identified the goal of family treatment as an improvement in family dynamics. This goal was consistent in treatment of families with parents affected by mental illness. Several participants cited examples of improvement in family

dynamics in the context of family therapy. In the following three case examples, participants talk about cases in which family dynamics were improved due to family therapy. Participant three said:

Mom has a chronic illness that in turn makes her depressed, chronically depressed. It's something that she has to deal with for the rest of her life, it's something that she has known about for a while but it's something that has been very difficult for her to live with as well. Her children know what she has but it was a challenge for her to tell her children. Just giving you a brief history of this case, she felt a lot of it was her fault that she contracted it, this virus, and this was something that she has been dealing with on her own in individual therapy, as well as the depression. Because of that, she didn't develop a real relationship with her kids when they were younger and that in turn is why they came here. Mom wanted to come and wanted to work on her family issues because she felt like she was losing her children. I was working with her daughter and she had two older children who were over the age of 18. She just felt like she didn't want to drop the ball with her youngest so that's why she felt that they needed a lot of family counseling... I worked on the relationship between the mother and daughter and what was so successful about that was that they developed such a friendship, as well as a mother and daughter relationship. The key was the communication between them and for the daughter to understand why the mother does some of things that she does. (And for the mother to understand) why her daughter does some of the things that she does, because she was truant and she ran away. Since coming here she stopped running away and she graduated. What was successful was working on the communication, what was successful was that the family was very devoted in coming and working.

Participant six said:

A mom with three children and undiagnosed depression and she would never go to mental health services ever. It was so clear that she kept her children home [from school] because, I think that she felt unsafe if they weren't going to be home with her. So there was work that was done with her individually as well as with the kids to get her to a place where she could feel safe enough. I mean she was directly impacting their individual needs in order to get her own needs met because she couldn't feel safe at home. And the family work that was done was the kids telling her how worried they were about her and her hearing that. Then it was us doing some individual work and she didn't want her kids to feel like that. This was a long process for her to get to a place where the kids went to school consistently.



Participant one spoke about a case example in which she played a board game with a mother diagnosed with bi-polar disorder and her seven year old daughter.

Participant number one said:

It was the first time that there was some kind of positive connection between them, not the first time, but in a while, that it's been more positive. Initially, most of mom's focus was on how much she liked the game herself, how much the questions felt self-referential, how much she couldn't believe it, like oh my god they are asking me about my life, this is exactly my issue. So while she wasn't able to really listen to her daughter more actively it was a start. It felt positive that mom didn't get upset with her daughter to the point that she often does. This is a family that has a very hard time being together. It was also an opportunity just to say some positive things out loud for both mom and the daughter to hear.

In all three of the case examples the participants illustrate how the parent's mental illness impacted family dynamics. All three participants felt that some level of improvement of family dynamics had occurred during family therapy treatment.

### *Recognizing Triggers*

Several participants spoke about the importance of parents recognizing their triggers in relation to their mental health issues. Participants spoke about clients that were particularly triggered in the context of family situations. In these cases, most of which involved parents affected by PTSD or depression, participants believed that improvement came when the families were able to recognize triggers. Participant six spoke about a mother with depression who was able to "learn what her triggers were and how she could have some coping skills."

Participant one spoke about a situation in which a mother had been raped and was diagnosed with PTSD. In this case it was useful for both mother and teenage daughter to be aware of triggers. Participant one said that the mother was:

Getting triggered when her daughter became an adolescent both by her daughters risk taking behavior, you know her budding sexuality, and just a lot of the back talk and stuff. Mom would quickly become frightened and go from one to ten in rage. So preparing her to understand, to educate the daughter a little bit too, but in session really slowing things down.

Participant number one felt that this case was successful because both mother and daughter were able to understand what was triggering certain reactions in the family.

Participants conceptualize success in a multitude of ways. In addition to the three subsections of findings presented above, participants also cited examples in which enhancing parenting skills, strengthening coping skills and reframing using a strength-based approach led to success in the treatment of families with parents affected by mental illness.

#### Challenges in Working with Families with Parents Affected by Mental Illness

This section of findings explores the challenges specific to treating families with parents affected by mental illness. The participants were asked to define challenges subjectively in the context of both their clients and their own experiences. All of the participants were able to identify challenges in working with these families. Four themes emerged in these findings and are organized in the following subsections: 1) Lack of coordination of services; 2) Symptoms interfering with treatment; 3) Lack of compliance with treatment; and, 4) Lack of support systems.

#### *Lack of Coordination of Services*

*“I can’t lie; I think it’s a real struggle.” Participant two*

Several participants identified the lack of coordination of services as a major challenge in treating families with parents affect by mental illness. Three participants identified the lack of coordination of individual and family services as negatively

impacting family treatment. Participant number two identified the lack of an inter-disciplinary team treatment as a detriment to her work with these families. She said:

We are trying to handle both the mental health issue that's occurring with the parent and also multi-task and look at the impact of the mental health issue on the rest of the family and the children and combine it all. So actually I think its much more challenging to work with anyone, whether it's a caregiver or a child, with a mental illness in this type of setting. Just based on the fact that we don't have those really critical supports that can kind of take the treatment to a whole new level.

Only one of the family therapy agencies had a staff psychiatrist and psychologist on site to perform mental health evaluations. Participant number six said that these clinicians did not work inter-disciplinarily and had limited training and regard for the family therapy modality.

Other participants spoke about the difficulty in coordinating services with the ACS. Three participants spoke about the difficulties they had in obtaining additional resources for families through this city agency. Participant number nine spoke about an incident when a family had been mandated to services through ACS. In this case the participant identified severe mental health concerns related to trauma in the mother upon meeting her. Participant nine explained, "I said [to the ACS worker] I hope that you can refer her for an evaluation and she still didn't really see the need. So now I have this case that ACS doesn't want because the allegations are not true. This participant was frustrated that once a case is not mandated anymore, ACS will not assist in obtaining individual mental health services for families.

Even in cases where families have been able to obtain individual mental health services for a parent, it is not always easy to coordinate. Participant number two states that she often is not informed of mental health issues: "you're working for six months or

so and then all of a sudden the client will say oh and when I spent this time at Bellevue.”

Participant eight spoke about a situation in which a parent had an individual mental health provider but would not give consent for the providers to coordinate services.

Participants who identified lack of coordination as a theme spoke about the frustration of not being able to provide clients with better treatment.

### *Symptoms Interfere with Family Treatment*

Participants reported that symptoms related to the parent’s mental health issues could be a challenge to family therapy. Participants one and eight spoke about the difficulty developing trust with some families with parents affect by mental illness. Participant one spoke about a mother she worked with who is diagnosed with bi-polar disorder and suffered from paranoid ideations: “there are periods of time when she has paranoid thoughts and of course mistrusts almost everybody and has a pretty thin connection to me at those times.” Participant eight recalled a mother who she works with who had cognitive delays and was distrustful of her presence. Participant eight said, “I have been working with them for about 2 months and she’s like who are you, what are you doing here, what’s your job?” In both of these cases the parents had difficulty trusting their clinicians due to symptoms related to their mental illness.

Participants eight spoke about the difficulty of working with families when a parent has a drug or alcohol use disorder and is actively using. Participant one said that she has two clients who have PTSD and are often triggered during sessions. She says this is particularly difficult when the parent is not aware of what is triggering them:

I mean something that is very unconscious, a color in a room, a smell, something that happened on the way here, sets them off. I have found that is often true in

family sessions, where they can be quickly frightened and triggered and then just start raging at the child, but sometimes at me. So that can be a challenge.

In cases where a parent has PTSD and has an explosive episode, or is actively using drugs or alcohol, participants found it more challenging to provide family therapy.

#### *Lack of Compliance with Treatment*

Participants cited lack of compliance with treatment as the most frequent challenge to working with families with parents affected by mental illness. Participants one, two and seven found that parents would indicate that they were interested in family therapy and then were reluctant to have family sessions. Participant two spoke about working with a mother affected by mental illness who only wanted individual sessions: “I really felt like she isolated her children. It was a constant struggle to get to the children.” Participant seven had similar experiences trying to schedule family sessions: “I found that I had certain clients who would come to individual sessions consistently and then when you try to schedule a family session they cancel them.” In these cases the participants found the lack of contact with the entire family to be detrimental to treatment.

Participants spoke about cases in which parents rejected their diagnoses or refused recommended psycho-pharmacological treatment as challenging. Participant four, five and eight have all encountered parents who fit into this category. Participant four works with a mother who is diagnosed the Major Depressive Disorder with psychotic features and has been hospitalized for suicidal ideation. In this case the mother “took herself off of medications and there is a concern because we want her to be monitored.” Participant four believes that the mother is in denial and finds it difficult to work with her.

Participant five spoke about cases in which she believed that parents have an undiagnosed mental illness. She said, "I would say that the cases in which parents are not aware of their diagnoses or don't see it as a problem are the most difficult." This participant found that when she would recommend that parents seek individual mental health treatment they would often terminate family therapy. In some cases, parents are aware of their diagnoses but prefer not to enter individual mental health treatment.

Participant number eight spoke about a case like this:

The case of the borderline mother with the two girls, we are really encouraging her to get into mental health treatment herself. She had been in the past, but then her therapist left and she didn't like the new person. She claims that she doesn't need to go and she is not feeling depressed or suicidal or any of these things and she does not see the need to be in therapy and she feels worse when she is in therapy.

Many participants encountered the challenge of parents rejecting individual mental health treatment. Participants had varied experiences of success in encouraging parents to comply with individual mental health treatment.

#### *Lack of Support Systems*

Participants identified the lack of support systems as another challenge to working with families with parents affected by mental illness. Participants four and nine specifically cited the lack of family support for the parent affected by mental illness as a barrier to treatment. Participant four said:

I find that a lot of parents, or at least the parents that I have worked with who have mental health issues, they don't have support from their own family members. There is a lot of denial that surrounds mental health issues. I guess that's where the stigma comes in. So I think that the lack of education and then the denial and lack of support from other family members makes it really hard for a parent who had mental health issue to get the support and treatment that they need.

Similarly, participant number nine found that family members would “make jokes or align with each other if [the mother] is getting upset about something.” In both of these examples the stigma of mental illness and lack of psycho-education interfered with the parent’s support system.

### Theoretical Frameworks and Interventions

This section of findings explores the theoretical frameworks and interventions that participants use when working with families with parents affected by mental illness.

These findings are divided into the following subsections: 1) Family systems theory; 2) Structural theory; 3) Psychodynamic concepts; and, 4) Art therapy and play therapy.

Some participants referenced specific cases in this section, while others spoke about the general application of theory with families with parents affected by mental illness. All of the participants reported using concepts from more than one theoretical framework.

#### *Family Systems Theory*

Four participants said that family systems theory is useful in working with families with parents affected by mental illness. Participants identified many concepts that fall under the umbrella of family systems theory. Participant number three spoke about the significance of the family understanding how everyone in the system has an impact on each other. For instance, “if mom is dealing with anxiety, that’s not going to affect mom but also the child.” Participant number one also felt that an emphasis on family interactions was useful:

To see mental illness in a larger context, its not just this thing that this person has, its really impacting the whole family. One thing I really got from that training was to learn to ask really specific questions about interactions, ok, what exactly happens, people’s schedules – what’s happening after school, or when is this happening and really kind of flesh that out to get a realistic picture. Also to have

a chance to see some things enacted, to really work on them in the moment. I am talking about the family systems training.

In addition to being aware of interactions and working in the moment, improving communication was also raised as being important. Participant number three encourages her families “To be able to say ‘I don’t like what you did.’ Actually to talk about feelings, to talk about stuff they have never talked about before and normalize those thoughts and feelings.”

Participant five talks about the concept of attachment from one generation to the next. She believes that by understanding family history and processing inter-generational relationships, families with parents affected by mental illness can better recognize patterns.

And how they try to carry over, or they carry over without thinking about it, to the new generation. The case that I told you about, with the anxious mom, I am at the beginning, so I am gathering the family history and I see a lot of similarities between the way that she was raised and the way that she is trying to raise her children. There were definitely problems with the attachment between mom and the grandmother and the grandfather as well. I’m trying to point this out, but at this point mom doesn’t seem to see it or doesn’t seem to understand, so I am just going to keep trying.

In this scenario the participant reference concepts from attachment theory and Bowen family systems theory. Gaining an understanding of family patterns, improving communication and understanding how every member of the family affects the other are all concepts from family systems theory.



*Structural Theory*

*“The parent needs to be the parent and the kid needs to be the kid” Participant six.*

Four participants identified using concepts from structural theory in their work with families with parents affected by mental illness. Specifically, participants spoke about the importance of rebuilding the family hierarchy and creating strong boundaries.

Participant nine illustrated these concepts in the following case example:

Working with boundaries is very important. Always in family therapy, but particularly with mental illness. I think when they hit teenager stage they are at a point when they are testing their boundaries and their limits anyway... For example the client that I told you about, the mother who let her child convince her that she was too sick to go to school. But really she is just tired because she stayed up late the night before, our goal was, unless she has above a 100-degree fever or is vomiting you need to send her to school. If she is sick the nurse will send her home. It needs to be very concrete with them and that is a very clear boundary... Also creating structure, the parent needs to be the parent and the kid needs to be the kid.

In this case, the teenager had assumed a more powerful role in the family than the mother.

Participant number four, six and nine spoke about the importance of the parents assuming hierarchical power within the family. Participant number six reported that this can often be a difficult adjustment for children who have been playing the parentified role in the family. Participant number six stated, “We have seen that where there is the backlash of empowering the mother and now this parentified child, who now doesn’t have this worry and doesn’t have to be responsible for everything and is now like, well what am I suppose to be doing ‘Who am I now.’”

Participant number four spoke about using art directives to reinforce the hierarchal power of the parents, “I will make mom the boss, so mom is the boss and she

is making the rules so she is going to come up with idea that you are going to draw.”

Participant nine spoke about facilitating couple’s session with a father that was undermining his wife in front of their kids due to her mental illness. In this case the participant felt that the father was colluding with his children and upsetting the hierarchal balance of power in the family. The participant used the couple’s therapy to get the parents “on the same page with parenting.”

### *Psychodynamic Concepts*

Five participants identified using concepts that fall under the umbrella of psychodynamic theory with families with parents affected by mental illness. Participant one and seven said that ego-supportive therapy was useful in working with these families.

Participant number one reports:

But the strength building piece is really even more necessary with parents affected by mental illness because they are lacking in so many things that other people take for granted, ego strengths, they need a lot of building up and modeling and support and really reflecting what they are capable of, even if it is something that on the whole isn’t positive but can be used to move towards something positive.

Participant seven used similar techniques with a mother who felt that her parenting was affected by her trauma history. In this case participant seven also used ego supportive techniques by focusing on the mother’s strengths.

Participants two and eight talk about the importance of object relations in working with families with parents affected by mental illness. Participant two references Winnicott in her work, “providing that safe and non-judgmental space.” Participant number eight believed that her relationship with teenagers in families with parents affected by mental illness benefits their development. She believed that her consistent presence in the teenager’s life, even if the child “gets arrested... builds the constant

object.” In both of these examples, the focus is on the participant’s relationship with the family.

### *Art and Play Therapy*

Five participants reported using art and play therapy in their work with families affected by mental illness. Participant three said using art and play, “lightens the fact that they are in therapy in general.” Participant four reported a similar experience working with these families, “I do feel that the art modality is a really great way to build a relationship with a client, especially when they might be defensive.”

Several participants spoke about the benefits of art therapy when a family has difficulty spending time together. Participant one said:

And then I think in the family sessions using play therapy or games or art therapy can be a way to non-verbally help the family to connect in a more playful way. This again is true for all families, but when there is mental illness I think that the discussion piece can be kind of heavy or it’s hard to even talk about some of that between parent and child and some of the related issues. So I think that just having the experience together, that is maybe more positive than they have on their own, is actually really big.

Participant three also felt that families benefit from having recreational time together.

Participants four and eight reported using art therapy to better understand family dynamics and roles. Participant eight reported using masks to better understand how members of a family affected by mental illness felt others perceived them. Several of the participants felt that the non-verbal aspect of creating art was particularly therapeutic for families with parents affected by mental illness.

In addition to the four theoretical subsections reviewed above, participants also spoke about the importance of psycho-education and case planning. Participant number eight felt that her work as a case planner helped her to build solid relationships with

families and teach them how to advocate for themselves. Participants one and five felt that psycho-education about mental health issues and normal childhood development was an essential piece of their work with parents affected by mental illness.

The findings in this chapter have shown that clinicians have had varied experiences working with families with parents affected by mental illness. The majority of participants believed that family therapy is a useful modality to address the impact of a parent's mental illness on the family as a whole. Many felt that treatment was more effective in conjunction with individual mental health services for the parent. Several participants cited the lack of coordination of services as a major challenge when working with these families. Participants had extremely varied perspectives on how being mandated to services affects treatment of families with parents affected by mental illness. Some felt that being mandated to services further stigmatized clients and added to resistance. Others felt that being mandated to services caused clinicians to facilitate more outreach, prolonged the engagement period and ultimately helped to build strong therapeutic relationships with parents who had mental health issues. All of the participants felt that children were greatly impacted by having a parent affected by mental illness. They found that children usually fell into three roles: the parentified child, the guarded child and the flag-bearing child. The participants used an eclectic mix of family systems theory, structural theory, psychodynamic theory and art/play therapy to work with families with parents affected by mental illness.

## CHAPTER V

### DISCUSSION

The purpose of this study was to answer the question, What are the perspectives of clinicians who work with families with parents who are affected by mental illness? The study's findings included 1) Family therapy can be effectively provided by clinicians in conjunction with individual therapy; 2) Clients mandated status can have a direct effect on treatment; 3) Children assumed identifiable roles in families with parents affected by mental illness; 4) Clinicians do use a variety of theoretical frameworks and interventions; and, 5) Clinicians confirmed that family therapy can lead to a significant improvement in dynamics of families with a parent affected by mental illness.

In this section the key findings of this study are compared to the studies and theoretical frameworks explored in the literature review. The relationship between key findings and social work practice are examined, and the areas for further research are discussed.

#### Effective Family Therapy in Conjunction with Individual Therapy

Nicholson (2001) conducted a study reviewing data sets from hundreds of mental health agencies in North America. He found that when agencies treat parents with mental health issues they focused services on the parent or child, but not on the family as a whole. The findings from this study show that when services are focused on the family in conjunction with individual therapy, the results are often advantageous. A majority of

participants said that family therapy is most effective in conjunction with individual therapy in working with families with parents affected by mental illness.

Another key finding from the Nicholson study was that services were often fragmented and uncoordinated. The findings from this study strongly support this finding from Nicholson. Several participants in this study identified the lack of coordination of services as a major challenge in treating families with parents affected by mental illness. Three participants identified the lack of coordination of individual and family services as negatively impacting family treatment. Participant number two identified the lack of an inter-disciplinary team treatment as a detriment to her work with these families. She said:

We are trying to handle both the mental health issue that's occurring with the parent and also multi-task and look at the impact of the mental health issue on the rest of the family and the children and combine it all. So actually I think it's much more challenging to work with anyone, whether it's a caregiver or a child, with a mental illness in this type of setting. Just based on the fact that we don't have those really critical supports that can kind of take the treatment to a whole new level.

This study confirmed that family services are available in New York City, but that there is a lack of coordination with individual mental health agencies. A majority of participants in this study agreed that while family therapy is an effective modality of treatment with these families, it is more effective in conjunction with individual therapy. Community mental health agencies and community family therapy agencies require more coordination in order to better serve families with parents affected by mental illness. Another key finding was that participants felt that a multi-disciplinary approach at family therapy agencies could help provide more individual mental health support for parents while providing services to the entire family.

### The Effect of Clients' Mandated Status on Treatment

Jong and Berg (2001) used a case study to illustrate some of the key issues involved with working with clients who are mandated to therapy. The focus of this article was that clinicians must co-construct goals for treatment in order to ethically work with these clients. The findings of this study showed that participants who believed that they were responsible for enforcing compliance with individual mental health services had difficulty working with mandated families. Participants who believed that being mandated to family services meant the families were encouraged to enroll in services, but emphasized the families choice in the matter, reported more success with these families. The findings from this study do support Jong and Berg's concept that it is important to empower mandated clients, without specifically referring to co-construction of goals. This finding also implies that making family clinicians responsible for monitoring the compliance of parents with individual mental health services is detrimental to working with mandated clients.

One of the key findings of this study that did not appear to be addressed in the literature is how a client's mandated status impacts the length of the engagement process. Several participants referenced the fact that they worked harder to engage clients who were mandated to services. Participants six and seven reported that the engagement process is incredibly important in the case of mandated clients. Participant six spoke about her philosophy of engagement when working with parents who were mandated to receive treatment:

When we have a parent who is resistant and may also have a very severe untreated mental health issue, we work to build a relationship for a long time, we

have the patience to see if we can make head way. I don't care what you have read about or heard about engagement might take 10 months.

Participant seven believed that when the initial engagement process went well it could positively affect a client's feelings about being mandated. The implication of this finding is that being mandated to services could provide families with a longer period of engagement, which might be particularly beneficial to parents affected by mental illness, who have been historically resistant to treatment.

#### Children's Assumed Roles in Families With Parents Affected by Mental Illness

The qualitative studies done by Cogan, Riddell and Mayes (2005) and Murdoch and Hall (2009) analyzed the narratives of children with parents who were affected by mental illness. These narratives showed that children had a variety of feelings about their parents' mental illness. One participant felt that his parent's mental illness was his fault. Several participants related feelings of stigma and shame about their parents' mental illness. Other participants felt that they had to constantly monitor their parents' mood in order to cope. The Murdoch and Hall study cited the children's desire to remain connected to their parents, even though it can be emotionally difficult.

The findings from this study confirm that children are greatly impacted by their parents' mental health issues. The perspectives that clinicians reported in this study were that children often played specific roles within the family system: 1) The parentified child; 2) The guarded child; and, 3) The flag-bearing child. Participants noted that there was overlap between these roles and that children could play different roles at various developmental stages. While the previous studies did not organize children into different roles, several of the behaviors and feelings described in the narratives fall under the



umbrella of these three identified roles and thus serve to strengthen this particular finding.

One of the key findings of the Cogan, Riddell and Mayes study (2005) was that children often felt responsible for their parent's mental health. Participants in this study noted that children who fell into the roles of the "parentified" and "guarded child" also felt a great sense of responsibility and worried about their parent's mood and mental health issues. The Ruepert and Mayberry (2007) study and the Cunningham, Harris, Vostanis, Oyeebode and Blisset (2004) study found that children who grew up in households with a parent affected by mental illness have higher rates of psychiatric disorders and high rates of insecure attachments styles. The short-term and long-term effects for children who have a parent affected by mental illness have already been described in the literature review section of this study. The implication of this finding is that the needs and well being of children in the family need to be taken into account by clinicians when they are conceptualizing cases. Also, it would be important to provide parents with the opportunity to receive family therapy sessions, even when they may be seeking only individual mental health therapy.

#### Clinicians Varied Use of Theoretical Frameworks and Interventions

A surprising finding of this study was the absence of second wave family therapy frameworks being used by the participants. None of the study's participants reported using techniques associated with narrative family therapy or feminist family therapy. Participants identified using techniques and interventions associated with first wave family therapy such as structural therapy and family systems therapy.

Nicholson et al. (2007) found that the clinicians in family therapy agencies practiced from diverse or eclectic theoretical orientations and that treatment decisions evolved over time in context with the specific needs of the families. Providers felt that a rigid or narrow theoretical orientation was not realistic or effective in treating the specific, contextual needs of these families (Nicholson et al., 2007, p. 404).

The findings of this study supported Nicholson's work. Participants identified using a variety of different theoretical frameworks and interventions with families with parents affected by mental illness. Four participants identified using concepts from structural theory in their work with families with parents affected by mental illness. Specifically, participants spoke about the importance of rebuilding the family hierarchy and creating strong boundaries. Four participants said that family systems therapy was useful in working with families with parents affected by mental illness. Participant number one said this about family systems theory, "To see mental illness in a larger context, its not just this thing that this person has, its really impacting the whole family." Participants also identified using theories from psychodynamic theories such as ego supportive techniques and object relations in their work with these families.

The participants in this study were trained as social workers or art therapist and both groups identified using art/play therapy interventions with families with parents affected by mental illness. Several participants spoke about the benefits of art therapy when a family had difficulty spending time together. Participant three felt that families benefit from having recreational time together. Participants four and eight reported using art therapy to better understand family dynamics and roles. Participant eight reported using masks to better understand how members of a family affected by mental illness felt

others perceived them. Several of the participants felt that the non-verbal aspect of creating art was particularly therapeutic for families with parents affected by mental illness.

Shadish (1999) found that there was a dearth of studies comparing different family therapy interventions. He suggested that this was due to the eclectic use of theoretical interventions used by clinicians. The findings of this study support this concept, as all of the participants used varied theoretical approaches in their work with families affected by mental illness. Several participants identified working with overlapping theoretical concepts.

#### Improvements Associated with Family Therapy Conducted in Families Where a Parent is Affected by Mental Illness

Shadish et. al (1993) compared the outcomes of families using different theoretical interventions and also compared the outcomes of family therapy versus individual therapy. The findings from this study did not point to there being a discernable difference in outcomes between behavioral and non-behavioral family therapy and both were more effective than no therapy at all. Shadish also went on to lament the dearth of studies on specific non-behavioral family therapy techniques.

This study provided an overview of how therapists using non-behavioral family therapy techniques can be successful in working with families with parents affected by mental illness. The emphasis on improving family dynamics seemed to be a particularly important aspect of this work. Several participants provided case examples in which a family that had been struggling due to the parent's mental illness learned how to improve communication and resolve conflict. Participant number six provided this example:

A mom with three children and undiagnosed depression and she would never go to mental health services ever. It was so clear that she kept her children home [from school] because, I think that she felt unsafe if they weren't going to be home with her. So there was work that was done with her individually as well as with the kids to get her to a place where she could feel safe enough. I mean she was directly impacting their individual needs in order to get her own needs met because she couldn't feel safe at home. And the family work that was done was the kids telling her how worried they were about her and her hearing that... This was a long process for her to get to a place where the kids went to school consistently.

While every family is different and every family intervention is contextual, the narratives provided by participants in this study confirmed that family therapy could be crucial in improving family dynamics and creating successful outcomes.

The purpose of this study was to explore the perspectives of clinicians who work with families with parents who are affected by mental illness. This study was successful in collecting rich, narrative data that illuminated the perspectives of these clinicians. The qualitative exploratory design was well suited for collecting data about a subject matter in which it is difficult to find previous studies. Past studies have cited the lack of research in this area to stem from the preference of researchers to use quantitative designs in their studies. The use of a qualitative exploratory design allowed for a more flexible, contextualized analysis of this complex subject matter.

#### Limitations

While the sample size of this study was only nine participants, it nonetheless provided rich data on this subject matter. The researcher made every effort to obtain a desired sample of at least twelve respondents. The researcher launched an intense recruitment effort by contacting at least sixty family therapy agencies in New York City and attempted to obtain permission from directors to conduct interviews with their staff

clinicians. The researcher also went to several staff meetings in an effort to recruit participants directly.

Judging from the staff meetings that the researcher attended, this sample does seem to be representative of the gender and racial distribution in family therapy agencies in New York City. A limitation of this study was that mental illness was defined by the participants and covered a range of diagnoses with varying severity. More specific research on the severity of mental illness and examining interventions based on specific diagnosis could be an area of research in the future.

Issues of reliability and validity were considered by audio taping all of the interviews. Audiotapes of all nine interviews were transcribed in full. The researcher analyzed the participants' narratives to code the data. The bias of the researcher, due to knowledge of prior studies, might have influenced how the data was ultimately interpreted. In addition, the researcher's own experiences as a family clinician could have biased her interpretation of the data.

#### Implications for Social Work Practice and Policy

The findings of this study have broad implications for social work practice. Social workers often work as family therapy clinicians. It is clear from this study that family therapy clinicians often work with families with parents who are affected by mental illness. This study reflects the many challenges that these clinicians face, as well as the ways in which they have been successful. Since this subject matter is not widely researched, this study might help to validate the work that clinicians engage in and help them to reflect on how to better work with these families. Family clinicians might use

this study to gain insight on theoretical interventions to use in order to work more effectively with clients with mandated status.

Another finding from this study was that a client's mandated status can have a significant impact on the process. Clinicians who work with mandated clients with parents affected by mental illness might benefit from emphasizing the engagement period over monitoring the client's compliance of individual mental health treatment. Clinicians might strengthen treatment by empowering their patients and allowing them to choose to engage in services.

Another significant implication for social work practice is the potential for family therapy to repair relationships that have been strained due to a parental mental illness. Several participants spoke about situations in which relationships between parents and their children were significantly improved due to specific family therapy interventions. In addition, clinicians might place more emphasis on parents having both individual and family therapy sessions, since these seemed to produce the best outcomes.

The findings of this study have broad implications for social work policy. Several participants identified family therapy as a first step for parents who also need individual mental health therapy. This indicates that family therapy treatment programs should be aware of this population and develop stronger ties with individual mental health providers. In addition, individual mental health agencies and providers should be encouraged to screen individuals and find out if they are parents and whether they would be willing to engage in family therapy services. Overall, a stronger coordinating relationship should be encouraged between mental health agencies that offer different treatment modalities directed to meeting the needs of the same individual/families.

Another policy implication of this study is that the process of mandating families with parents affected by mental illness to family therapy should be thoroughly reviewed and possibly revised. Making family therapists responsible for enforcing individual mental health treatment and engaging families in family therapy seems to create profound difficulties in treatment. Clinicians who were not responsible for individual mental health treatment compliance reported better relationships with families. In these cases it seems that most of the parents did eventually seek individual mental health services upon the recommendation of their family clinician.

More broadly, the impact on society of families with parents affected by mental illness is profound. This study has shown that family therapy in conjunction with individual therapy can assist these families and perhaps lead to better outcomes for both the parents and the children. Social workers should advocate for more research and funds for programs that support family therapy. Before this research was completed one of the agencies in which participants worked was closed due to state and city budget cuts. Since the field of family therapy research has been limited, there was little data that could have been provided that justified retaining the programs facing budget cuts or creating new programs.

The perspectives of clinicians who work with families with parents who are affected by mental illness have been illustrated by this study. While some of the findings support the literature on this subject, many new areas of study have also been identified.

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## Appendix A

### Informed Consent

Dear Participant,

My name is Jessie Weisstein and I am a graduate student at Smith College School for Social Work. I am currently conducting a study that involves research. I am conducting research on the perspectives of clinicians who work with families with parents who are affected by mental illness. The purpose of this study will be to explore the narratives of clinicians in order to analyze how they provide treatment to this specific population. This research will be used for my MSW thesis, presentation and publication.

If you choose to participate in this study, you will be asked to fill out a brief demographic questionnaire. In addition, you will be asked to participate in an interview for a period no longer than 50-minutes. Inclusion criteria are that you be a clinician who uses family therapy with families with parents affected by mental illness. In order to participate in this study, you must be a clinician in New York City. In addition, you must work in a public agency, where services are provided for free or for a low-cost fee. Your training can be in social work, art therapy or psychology, as long as you have been practicing for over one year and have some graduate level training that involves the study of family therapy. You must be fluent in English to participate in this study. All of the interview will be audiotape and transcribed. If I hire someone to transcribe any of the audiotapes, then that person will sign a confidentiality form.

A possible risk to participating in this study is that you might reflect on your work and become uncomfortable with a decision you have made while treating clients.

The possible benefits for participating in this study are that you will have an opportunity to reflect on your own therapeutic process with family therapy clients. You will also have an opportunity to share your experiences and possibly benefit clients by providing information that will bring awareness to an underserved population. You will also be able to read a summary of the research when it is complete and explore how your work benefits the clients you work with. This study will benefit professionals who work with this population. This study will benefit the field of social work by laying the groundwork for further research of a population to whom social workers often provide services.

All of this information will be kept in a locked, safe place that only the researcher has access to. In addition to this, the informed consent form will be kept in a separate location that is also locked and safe. If anyone other than the researcher has access to the tapes in order to transcribe them they will sign a confidentiality agreement.

Due to the face-to-face contact required for the interview process and because interviews will be conducted at the workplace, your participation in this study will not be anonymous. However, what is discussed during the interview will be kept confidential.

The research advisor for this study will have access to the data after the identifying information has been removed. In order to protect your confidentiality any illustrative narratives you provide will be disguised. I will not use any quotes that will be easily identifiable to anyone reading the study. All data will be stored in a locked safe for a period of three years as required by federal law. This will include any electronic data, such as audiotapes and computer files that are created during this study. All data and tapes will be kept secure for three years as required by Federal regulations. If the writer continues to need that data after three years they will be kept secure until no longer needed, at which point they will be destroyed.

Your participation in this study is completely voluntary. If you wish to withdraw from the study please contact me at the email address or phone number provided below. You can request to withdraw by email or phone and your data will immediately be destroyed. You have the right to refuse to answer any questions that are asked. You have the right to withdraw from the study until April 30<sup>th</sup> 2010. Participants who withdraw from the study will not risk any penalties. Should you have any concerns about the research you can call the chair of the Human Subjects Review Committee at Smith School for Social Work at 413 – 585-7947. If you wish to contact me with any further questions or to withdraw from the study, you can do so by using the contact information below.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

(Participant Print Name)	(Participant Signature)	(Date)
(Researcher Print Name)	(Researcher Signature)	(Date)

Thank you for participating in this study. Please feel free to contact me at the following email address: [jweisste@smith.edu](mailto:jweisste@smith.edu). Please keep a copy of this informed consent for your personal records.

## Appendix B

### Interview Guide

1. Please talk a little about the structure of your agency and your role within it.
2. How long have you been practicing family therapy at this agency?
3. How does a client's mandated or non-mandated status affect your work with these families?
4. Please describe your approach to working with families with parents affected by mental illness.
5. Is there something specific to family therapy that you feel is particularly useful in working with parents affected by mental illness?
6. In your experience working with families with parents affected by mental illness, please describe the ways in which you have felt treatment has been successful.
7. In your experience working with families with parents affected by mental illness, please describe some of the challenges that you have encountered?
8. Are there particular interventions or techniques that you find to be well suited to this specific population?
9. How has your training influenced your work with families with parents affected by mental illness?

## Appendix C

## Human Subject Review Committee Approval Letter



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Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950  
F (413) 585-7994

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February 11, 2010

Jessie Weisstein

Dear Jessie,

Your revisions have been reviewed and you have made all of the changes requested. We are happy to give final approval to your interesting study.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script that reads "Ann Hartman".

Ann Hartman, D.S.W.  
Chair, Human Subjects Review Committee

CC: Victoria Winbush, Research Advisor

## Appendix D

### Screening Questions

- 1.) What is the highest level of education that you have completed?
- 2.) How long have you been working as a clinician?
- 3.) Do you currently provide family therapy to families through an agency?
- 4.) Does this agency provide free or lost-cost family therapy to clients?
- 5.) Have you ever worked with families who have a parent that is affected by mental illness?
- 6.) Have you ever worked with families with parents affected by mental illness who were mandated to treatment?
- 7.) Are you fluent in English?

Appendix E

Demographic Questions

**Please Circle the most appropriate answer(s)**

**Gender:** Male    Female    Transgender

**Racial Identity:** African-American    Black    Hispanic    Latino    Pacific Islander    Other  
Asian    Biracial    Multiracial    White

**My highest level of education is:**

Some graduate training    Master's degree    Some Doctoral training    Doctoral Degree

**My training is in:**

Social Work    Art Therapy    Psychology

**The theoretical approaches that influence my work are:**

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**Fill in the appropriate answer**

Age: \_\_\_\_\_

I have been working in a family therapy modality for \_\_\_\_\_ years.

The percentage of my caseload with families who have been mandated to services is approximately \_\_\_\_\_ percent.



## Appendix F

## Recruitment Letter

Hello,

My name is Jessie Weisstein. I am a second-year Master's student at Smith College School for Social Work collecting data for my thesis, which explores the question: What are the perspectives of clinicians who work with families with parents who are affected by mental illness?

I am currently looking for participants for my study. I am seeking clinicians who work in a family therapy modality at agencies that provide free or low-cost services. I am asking clinicians to take part in a 50-minute interview that can be conducted at their work place. All data collected for this thesis will be kept confidential. If you are interested in participating in this research please contact me via email [jweisste@smith.edu](mailto:jweisste@smith.edu) or phone 347-XXX-XXXX.

If you have any concerns about this study, please contact me via email [jweisste@smith.edu](mailto:jweisste@smith.edu) or the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974. To refer personal or professional contacts that are family therapists please forward this email directly to them. Referring other family therapist will help with the study, by providing more participants. Your decision to refer others to the study is independent of your own study participation. Thank you for your assistance in this process.

Sincerely,  
Jessie Weisstein