Major Mental Illness Complicating Reunification Following Maltreatment

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In the United States, termination of parental rights is an extreme legal intervention, requiring proof that the parent is "unfit;" that is, that they are not now nor in the foreseeable future able to provide safe and appropriate care for their child. The complex issue of whether it is in the best interest of the child to sever the parent-child relationship is a key issue in these cases. When a mother has major mental illness, such as schizophrenia, the issues become even more intricate.

We begin by considering pregnancy and parenting n women with schizophrenia. Then, we describe a case vignette to highlight key issues and challenges in determining the best interests of a child in foster care whose mother has schizophrenia. We also consider potential interventions for mothers with schizophrenia.

Mothers with Schizophrenia

One of the biggest fears of mothers with schizophrenia is that they are going to lose custody of their children. These fears are not unfounded since about half of mothers with schizophrenia do, at some point, lose custody of their children, usually to family members (Seeman, 2002). The number of mothers with schizophrenia who are having children is growing. In North America, about half of women with schizophrenia are mothers, and in Great Britain, about 63% of women with psychosis are parents. Losing custody of their children not only increases the stress of these mothers, but also has lasting negative impacts on the children (Seeman, 2002).

The number of women with schizophrenia who are having children seems to be increasing as services and treatments for schizophrenia evolve. Schizophrenia is being increasingly treated in the community in outpatient clinics rather than in inpatient facilities. Typical antipsychotics, which once were standard treatment, had a side effect of raising prolactin levels, making conception difficult. Some newer atypical antipsychotics have less effect on prolactin because of their transient binding to D2 receptors, which could increase the likelihood of getting pregnant (Bassett, Lampe & Lloyd, 1999).

Half of mothers with schizophrenia are raising at least one of their children. Ritsher found that 44% of these women are single and over two-thirds needed help with child care (Ritsher, Coursey & Farrell, 1997). Even though half of mothers with schizophrenia retain custody, Joseph found that only 12% were the primary caregivers of their child (Joseph, Joshi Lewin & Abrams, 1999). If a mother with schizophrenia is not single, there is a 9% chance that the significant other also had a serious mental illness (Hearle, Plant, Jenner et al., 1999). Thus, assortative mating complicates a small but meaningful number of cases.

Bassett et al. (1999) assessed mothers with schizophrenia and their infants using the Global Rating Scales of Mother-Infant Interaction and interviews. Children raised by mothers with schizophrenia showed more avoidant behaviors. Negative symptoms of schizophrenia and the medications used to treat schizophrenia can severely affect the mother-child interaction as the mothers appear more emotionally remote, insensitive, and unresponsive. Although the interaction between mothers and their children may appear compromised, mothers with schizophrenia expressed definite benefits of being a mother during interviews about parenting. They cited that they had a purpose, identity, love, and support. However, these benefits were complicated by the fears that these mothers had about losing their children or of their children also suffering from a mental illness. If they did lose custody of their children, they often suffered long lasting anger and grief.

Case Vignette

Ms. Hanson1 was court-mandated to an intervention program that serves children less than 5 years old who are placed in foster care and their caregivers. She provided information during an intake evaluation, a parent-child relationship evaluation, and a psychiatric evaluation.

1 Please note that the names used in the article are fictitious.

Ms. Hanson is a 32-year-old female from the southern United States. Ms. Hanson's parents divorced when she was very young, and she was raised by her mother and maternal aunt, along with two older sisters. She is very intelligent, and she skipped 3rd grade. She became pregnant at 18 years old and had an abortion. She disclosed this first pregnancy during evaluation of her partner violence experiences. However, she declined to discuss whether this pregnancy was the result of an abusive situation.

Ms. Hanson began college away from home, and stopped attending after one year because she struggled academically. Her maternal aunt described Ms. Hanson as unstable and very moody during this time. In fact, Ms. Hanson moved around to several family members' houses because she easily became violent, and subsequently was asked to leave. This instability occurred for several years as she struggled to maintain employment in various food service venues.

Ms. Hanson became pregnant again when she was 29 years old during a single encounter with a man whom she claimed to not know. She said that she did not know that she was pregnant until she was eight months gestation. At the time of her evaluation, Ms. Hanson was unemployed.

Ms. Hanson's family members called Child Protective Services 15 months after Ms. Hanson delivered her child, Luke. The family members stated that Ms. Hanson was locking Luke in the closet, not feeding him properly, and not getting the medical care that he needed. Child Protective Services began its investigation of this case after three calls from the family members. After investigation, Luke was placed with his maternal great aunt. Luke's mother became so upset and violent when Luke was taken away that the police took her to jail, and later to a psychiatric hospital. The Court ordered Ms. Hanson to participate in the services provided by a team of infant mental health specialists who assess the ability of parents to care for their young children, provide intervention, and make recommendations to child protection services and the Court.

During Ms. Hanson's initial interview, it became clear that she did not have insight as to why Luke was removed from her custody. She said she felt that she was

protecting him from others by keeping him in the closet. She explained she would bring him out at night so that she could spend time with him. Her guess as to how she could regain custody of him was to "give him bigger toys – remote control cars."

Ms. Hanson participated in a Working Model of the Child Interview a semi-structured interview designed to assess the parent's perception of his or her child (Zeanah & Benoit, 1995). Examples of Ms. Hanson's responses are below:

> Examiner: "What is your favorite story about Luke?"
>
> Ms. Hanson: "When he was firstborn and he would sleep in his bassinet, I would tell him, 'I'm staring at you, I'm watching you.' He would look back."
>
> Examiner: "What do you like about that story?"
>
> Ms. Hanson: "I don't know, it's kind of nice, pleasant, dear to the heart."
>
> Examiner: "What are your feelings on having a boy?"
>
> Ms. Hanson: "It was a bit of a relief especially with the cleaning aspects. I couldn't imagine a girl – not to be gross – how are you going to clean that out? Thank God you're a boy!"

Ms. Hanson and Luke (then 20 months old) also participated in a parent-child interaction procedure modified from the procedure developed by Judith Crowell and colleagues' procedure (Crowell & Feldman, 1988; Crowell, Feldman & Ginsberg, 1988). Luke appeared anxious and unsettled during the evaluation. In fact, he refused to remain with his mother, and his great aunt was asked to remain silently in the room to act as a "secure base" for Luke. With his great aunt present, Luke was relatively more comfortable to explore and interact with his mother. However, he continued to maintain distance from her; resisting her efforts to hold him on her lap. The dyad exchanged limited positive affect. Ms. Hanson showed some strengths during the procedure, including maintaining interest in engaging her son and talking with him. However, she had trouble following his lead during play and reading his cues.

Ms. Hanson was referred for a psychiatric evaluation because of concern about disorganization in her thought processes. During the psychiatric evaluation, Ms. Hanson reported memory problems, and said that her heart was "differentiating." She had several neologisms, and was guarded and paranoid throughout the interview. Although she denied any psychiatric treatment, she reported she had been taken to a psychiatric hospital when Luke was brought into care. She was prescribed an antipsychotic medication at that time. Ms. Hanson reported to the evaluator that the medication was just a "suggestion" and she didn't have to take it. It was clear during the interview that she had a thought disturbance. Careful history from her and her family made clear an insidious deterioration in functioning over a several years. Ms. Hanson was diagnosed with Schizophrenia, paranoid type.

After the evaluation, the Court ordered Ms. Hanson to obtain psychiatric treatment. However, she did not follow up with these recommendations. She had been granted weekly visitation with Luke in his great aunt's home until one night she attempted to take Luke from the home. On that night, Ms. Hanson was out of control and violent as she forcibly pushed her way into her maternal aunt's house and angrily demanded her son. The maternal aunt called the police, and Ms. Hanson was transferred to an inpatient psychiatric facility against her will. She was started on an antipsychotic medication, and slowly, she began to improve. After her discharge from the hospital, Ms. Hanson began to go to psychoeducation groups, individual therapy, parenting sessions, and joint sessions with her maternal aunt. Slowly, therapeutic, supervised office visits with Luke were re-introduced. Ms. Hanson became stable and consistent with treatment, and her relationship with Luke improved gradually over several months. For example, over time, Luke chose to sit on his mother's lap and the two enjoyed playing together.

Over the course of approximately one year of intervention, the infant mental health team continued to monitor Ms. Hanson's individual progress and the progress in her relationship with her son. Although Ms. Hanson's stability improved, she continued to have poor insight into Luke's physical, developmental and emotional needs. She also failed to gain a full understanding of the circumstances under which Luke came into care. Her difficulty sustaining attention in general; and specifically to Luke's cues also put Luke at a significant risk. As Luke's ambulation increased, Ms. Hanson's anxiety increased as well. She continued to prefer confining Luke to a small area in the visit room where he had little freedom to explore. Because of Ms. Hanson's inability to discern dangerous situations and her problems with attention, the team determined that she was at very high risk for recidivism of neglecting Luke should he be returned to her care. Child protection staff and the judge agreed and care was transferred to her maternal aunt. Ms. Hanson was able to maintain a relationship with Luke through regular visitation.

During one of Ms. Hanson's last interviews, she discussed her feelings about schizophrenia. She stated, "It's held me back a lot. Just from the stigma feeling to not show my feelings. I feel trapped inside…. My family – I think, 'Do you just see me as this crazy person sometimes?' I feel they'll blame it on the schizophrenia if I do something. I want to express my emotions but I feel a little held back."

Recommendations

To conclude, we present recommendations to assist mothers with schizophrenia and their young children.

System collaboration. Unfortunately, women with schizophrenia often have a mistrust of legal and mental health services, and consequently, many times care for these mothers and their children is not initiated until after the child comes into custody of the State. The reasons for this are complicated. The mistrust these women have of the systems available to assist them due to factors associated with psychosis (e.g., distorted thought process, paranoia) and the reluctance to accept diagnosis or treatment, coupled with the inconsistency in availability, quality, and access to services offered by the systems seem to be some of the deterrents to helping mothers with schizophrenia (Bassett et al.,1999; Seeman, 2002. Collaboration between legal, mental health, and child protection systems is important to ensure that the needs of the child and mother are being met. This sentiment is echoed by the women with schizophrenia in Bassett's focus groups, who stated that they wanted support, information, better access to community services, and therapeutic programs and family planning.

Family planning and prenatal and postnatal care. Although it would be preferable to begin family planning education before pregnancy, many mothers with schizophrenia do not obtain prenatal care. Many times these mothers are single and are at low socioeconomic levels, which may make access to medical

care difficult. The risk of premature delivery and low birth weight for mothers with schizophrenia is 50% greater than for mothers without the illness (Nilsson, Hultman, Cnattingius, Olausson & Lichtenstein, 2008). Proper prenatal care can reduce risk for problems in the infants and mothers. after the child is born, continued postnatal care is necessary to provide the child with proper medical management. Nilsson et al. showed that children with mothers and fathers who have schizophrenia are at an increased risk of medical problems (Nilsson, et al.,2008). They hypothesized that smoking by mothers with schizophrenia increased the risk of medical problems. Further, infant mortality has been shown to be increased in children whose fathers have schizophrenia, and more studies are needed to determine why this increase exists (Crowell & Feldman, 1988). These children require early interventions such as early developmental screening. Mothers can benefit from in home parenting instructions on caring for an infant. Therapeutic child care can aid the child and provide needed social supports and peer interaction (Seeman, 2002).

Child protection assessments. When a mother and her young child come to the attention of child protection services, a parenting assessment is needed. It is important to conduct parenting assessments with mothers with schizophrenia and their young children at different intervals to ensure accuracy. These assessments should include evaluations of safety and risk factors for abuse and neglect, quality of the relationship and attachment, and parenting capacities. Early parenting assessments can identify any immediate dangerous situations which need to be addressed, and they can guide the examiner in determining what supports are needed. When conducting evaluations, it is essential to consider that the postpartum period is a sensitive time because psychiatric symptoms can increase. During this time, the mother's functioning should be carefully assessed and interventions should be implemented when necessary. Mother-infant interaction may look very different a few weeks after birth. Later parenting assessments usually involve evaluating the developmental functioning of the child. It is sometimes difficult to ascertain if developmental delays are due to parenting deficits or to genetics or to other factors. It is known, however, that regardless of the etiology of the delays, these children will benefit from extra stimulation and an enriched environment, and these can be provided through child care centers. The need for extra stimulation alone does not justify taking the child's custody away from a mother with schizophrenia.

Following assessment, a comprehensive plan should be put into place with the goal of keeping the mother and child together. Mental health providers can play a key role not only in assessing and treating the mental health of mother and child, but they can aid in bringing together the different services to create a cohesive team. This team should include the mental health care workers, family workers, legal services, child protective services, case workers, obstetricians, and pediatricians. Ideally, services should be in place prior to the birth of the baby. This team can provide appropriate medical and psychosocial interventions (Seeman, 2002). As the team collaborates and communicates, the best interests of the child can be adequately determined by considering strengths and concerns of the parent's ability to care for her child safely and effectively. Many mothers with schizophrenia may find that with the support from her team, she is able to care for her child. After a complete assessment, it might become clear that the mother with schizophrenia is not able to adequately meet her child's needs, as in the case described above. With a comprehensive plan in place, however, mothers with schizophrenia may still be able to remain meaningfully involved in their children's lives when this involvement is in their interest.

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