Family Recovery

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Two excellent recent articles on individualism and collectivism in this journal [1, 2] have prompted me to think about the psychiatric needs of families in which one or both parents suffers from mental illness. Since one in four adults in the general population report either occasional or continuous psychiatric symptoms, families with a mentally ill parent are not rare. Many individuals in psychiatric care are parents, but their parental needs are often ignored. This is true in individualistic cultures that may be so client-focused that mental health workers don't even know, or care, about how many children the person has. It may be true in collectivist cultures where the needs of adults often take precedence over the needs of children. As a profession, we need to pay attention to the development of healthy children and to the specific rehabilitation needs of parents.

One way in which psychiatry has treated ill parents in the past is to place its focus on illness, ignoring all else. Another way has been to enlist the aid of family members in the ill person's recovery—teaching spouses, parents, siblings, and children effective coping and communication skills and encouraging emotional and instrumental support. Psychoeducation for family members of psychiatrically ill individuals has become an important intervention, and is welcome because knowledge translates into confidence and power. But family members knowing and coping and communicating is not enough when there are young and vulnerable children in the family.

Children and adolescents need direction and nurturance from their parents. Parents with mental illness have much to teach their children, but they need help, guidance,

support, and respite. When extended family is available, and grandparents or uncles or aunts are able and willing to step into the breach, children prosper. This is perhaps easier in collectivist cultures where generations of the family live close by. It is more difficult in the West where a family usually consists of a small, two-generation nuclear unit, separated geographically from kin and from intimate friends. When a parent suffers from mental illness, the other parent is busy providing spousal care and attempting to keep up with financial obligations. The 'well' parent is a heavily stressed parent and child needs are often neglected at home.

School teachers may notice when a child suffers and school guidance officers may intervene. Churches, mosques, and temples can be turned to. Social services and housing agencies can be called on for assistance, and children's mental health agencies can step in and find new homes for children whose situation at home is untenable. Well-resourced communities offer many possible avenues of help in family mental health crises, but such well-intentioned services are, by their nature, fragmented and transient. What is needed is a wrap-around-the-family approach [3] that promotes family growth and healing and that pays equal attention to all family members, with a focus on the urgent and on the most vulnerable.

Mental illness does not disqualify parents from parenting nor does it absolve them of that responsibility. Children need safe and effective parenting. This means that mental health workers need to make certain that this is adequately provided. It requires assiduous monitoring, constant encouragement, appropriate teaching, modeling and explaining, and it requires 24-h accessibility to a helping hand. It means therapy in the home rather than office or agency visits.

Family rehabilitation cannot wait upon requests. Parents living with mental illness may be afraid to ask for help for

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fear of losing their child if they appear to be needy. Like any other parents, they have many concerns about their child's health, schooling, and friendships. In addition, they may worry about passing on their mental illness to their child, or about neighbours undermining their attempts at parenting, or about the effect of their medications on their ability to serve their children's needs. They may be battling addiction or experiencing violence. Besides the multiple stressors of their illness and its management, they may be additionally burdened by victimization and by mental illness stigma. Even when they do not ask, they need psychosocial support.

What can mental health workers do? There are many targets for intervention besides directly addressing the parent's mental health—the parent–child relationship, the spousal relationship, the child's academic and social health, the social support system of the family, financial and housing and dietary adequacy, the family's place and role in neighborhood and community. If the work is new, schooling and practice are, of course, necessary.

Much of psychiatric work addresses defects. For family recovery work, a strengths-based approach is best. It's best to focus on what the family already does well, and help make it even better. It's best not to start by seeking out weaknesses that need correction, but, rather, to marvel at jobs well done. And it's never good to blame. If intervention doesn't work, the fault is not with the family. Personal engagement and gaining the family's trust will go a long way to ensure a family's recovery.

Some families, despite mental illness, are very resourceful and need short-term input only. But some are not. These families will need intensive help and advocacy, and they may need a mental health wrap around team for a long time. No one worker can solve all the family's problems, nor meet all their needs. A team is always needed. Part of that team are the family members themselves. Peer support may also be useful, and liaison with medical, legal, spiritual, financial consultants will be necessary from time to time. A constant, experienced, compassionate team cheerleader to steer the way forward for the family is much to be desired. A short bibliography follows [4–14].

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