

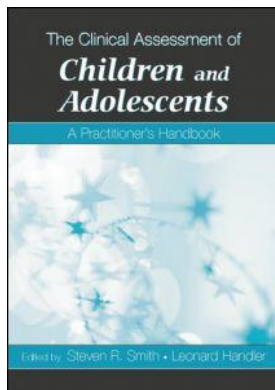
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Publisher: *Routledge*

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The Clinical Assessment of Children and Adolescents: A Practitioner's Handbook

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Hearing the Silent Need: Assessing Children Who Have a Parent With a Serious Mental Illness

Publication details

<https://www.routledgehandbooks.com/doi/10.4324/9781315827308.ch31>

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Published online on: 11 Aug 2006

How to cite :- Harry J. Sivec, Charles A. Waehler, Patricia J. Masterson, Beth L. Pearson. 11 Aug 2006, *Hearing the Silent Need: Assessing Children Who Have a Parent With a Serious Mental Illness from: The Clinical Assessment of Children and Adolescents: A Practitioner's Handbook* Routledge
Accessed on: 24 Mar 2023

<https://www.routledgehandbooks.com/doi/10.4324/9781315827308.ch31>

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HEARING THE SILENT NEED:
ASSESSING CHILDREN WHO HAVE A
PARENT WITH A SERIOUS MENTAL ILLNESS

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Some children do not invite their friends over after school because they are afraid of what their father might say or do. Others wake up during the night and find their mother crying inconsolably with her arms cut and bloody. A youngster can witness her father barricading himself in his room for hours or days while carrying on about unauthorized surveillance that he “knows” is going on. A teenage son may show up at his high school football game exhausted from having to run the four miles to school because his mother is having an “episode” or has one of her doctor’s appointments and was not able to transport him to his game.

These are some of the scenarios faced by children who have a parent¹ with a serious mental illness (SMI). These children are at risk; they are at increased genetic risk of inherit-

1. Although the authors use the term “parent” in this chapter to refer to an adult who provides a significant caregiving role with a child or adolescent, we recognize that this role is sometimes performed by a person who is not the biological parent or legal parent of a minor (e.g., step-parent, uncle, aunt, grandparent, older sibling). Similarly, many of the issues presented in this chapter relate to concerns that develop when family members other than the parent or primary caregiver (e.g., older sibling, grandparent) have a mental illness.

ing a debilitating mental illness compared with their peers, and they are also more likely than their peers to experience adjustment and relationship problems (Feldman, Stiffman, & Jung, 1987; Gotlib, & Goodman, 1999). Despite the well-known risk factors, the needs of these children often go unheard by even the best-intentioned clinicians. There is often minimal opportunity for assessment (DeChillo, Matorin, & Hallahan, 1987), let alone interventions, until these children begin to manifest their own problems.

The chronic impact of living with a parent with mental illness is well documented (cf. Johnson, 1988; Marsh, 1998). Studies involving the adult children of parents with SMI are rife with examples of the chronic difficulties associated with growing up in these families. Perhaps most common is a pervasive sense of loss and grief, accompanied by chronic sorrow (Marsh, 1998). Many adults who had a parent with a mental illness feel they missed significant parts of their childhood, that they were forced to grow up too early, and that they learned to ignore their own needs. These individuals may also be strongly motivated to "not be like my parent" to the extent that they may neglect their own emotional needs for help and support.

Anywhere between 20% and 57% of individuals with SMI have a minor child in their life (Ostman & Hansson, 2002). However, few health-care systems routinely attempt to determine whether children are present in the home of someone with SMI (DeChillo et al., 1987). Nicholson, Geller, Fisher, & Dion (1993) indicated that only 16 state mental health authorities routinely collect information pertaining to the parental status of the women in their care. In general, children of the mentally ill tend to be overlooked during the course of their parents' mental illness. These children are challenged because their struggles and needs are great but are too often unheard. When they are referred for attention it is usually because their own emotional or behavior problems have led them to be noticed. Evaluation and intervention services provided to this vulnerable population could address both prevention and intervention functions for families grappling with chronic mental illness in a family member.

Along these lines, there are two ways in which a clinician is most likely to encounter children with a mentally ill parent. One occurs when a clinician is working with a client diagnosed with serious mental illness and learns during the course of intake or treatment that the client has a child. This is probably the most common scenario in inpatient psychiatric units. For many clinicians, this information would barely scratch the surface of an assessment formulation unless evidence of abuse or neglect was suspected, and, in which case, the involvement of a Children's Service agency would be mandated.

The second way in which a clinician is most likely to encounter a child with a mentally ill parent is when the child is referred with her/his own problems being experienced at home and/or school. During an evaluation, the clinician determines that the client has a parent who is diagnosed with a serious mental illness. Although the clinical appraisal will likely include an array of assessments regarding the client and the family, unless the parent's mental illness is identified as a source of immediate concern, little else may be addressed regarding the impact of the parent's illness on the child. In general, identifying a parent or sibling with a mental illness would signal a "risk factor," and the clinician may wonder about the level of chaos or inattention at home, but it usually remains the child's responsibility to voice this concern as a major issue if it is to be addressed.

Noting that a parent has or had a serious mental illness during a child's developmental years should send out a loud call to the sensitive clinician. A conscientious assessor will appreciate that there may be both acute and chronic effects as sequelae to SMI. Three studies directly assessed the immediate impact of a psychiatric emergency/hospitalization on children. Shachnow (1987) was perhaps the first to systematically assess the short-term

impact of a parent's psychiatric hospitalization on children in the home. She interviewed patients, their children, and available spouses during the course of hospitalization. The results indicated that most of the children in this study did not have an adult to help them talk about or understand the circumstances of their parent's illness. Most of the children in this study were described as having a strong emotional response to their parent's illness. Some children were overtly symptomatic (labeled "Compromised" 22%), whereas others appeared to cope reasonably well ("Copers" 19%). Features of compromised adjustment for younger children (under 12) included sleep disturbance, diminished appetite, increased clinging behavior, crying near bedtime, and social withdrawal. Older children (12 and older) also experienced sleep disturbance, a decline in school performance, and social withdrawal. It is of note that, unless inquired into directly, these are the kinds of symptoms that can "fly under the radar" of even the most sensitive parent and astute assessor.

In a similar study, Castleberry (1988) interviewed families and their children, ages 12 and under, every 7–10 days during the parent's hospitalization. In contrast to the work by Shachnow (1987), this study did not find major problems in school performance, eating, and play activities, or in the children's relationships with other children. However, bedtime routines were altered, and children tended to ask more questions and seek reassurance at these times. Of particular note, the hospital in this study was described as offering a family-friendly milieu in which the children visited their parent almost every weekend, on the unit, and often shared meals with the parent. In addition, most children remained in their own home, under the care of a non-hospitalized family member. This study helps identify areas important to address in a thorough evaluation (e.g., How often does this child visit with her/his parent, and for how long? Are those visits child-centered or illness-focused?).

In research conducted at the Northcoast Behavioral Healthcare hospital in Cleveland, Ohio, where an intervention program focuses on education and support services for children whose parents are hospitalized in a psychiatric facility (BART's Place; see Katz, Gintoli, & Buckley, 2001), children ($N = 49$) were interviewed and administered standardized, psychological tests of anxiety (MASC: Multidimensional Anxiety Scale for Children; March, 1997) and depression (CDI: Children Depression Inventory; Kovacs, 1992). The parents in this study were hospitalized in a state psychiatric facility for an acute crisis or because they were referred for Restoration to Competency intervention by the courts. Mean composite scores for depression and anxiety fell within the normative range for the entire sample (Sivec, Masterson, Katz, & Russ, 2003). As such, most children appeared to be free of major psychological symptoms measured by the MASC and CDI at the time of hospitalization of the parent. Even so, several children (40%) in this study demonstrated significant signs of anxiety. For example, some endorsed concerns about making sure things are safe and that they have not done anything wrong (i.e., elevated Anxious Coping Scale; March, 1997). Other children in this study indicated they were frightened when alone or in unfamiliar places and that they preferred to stay close to family members (i.e., elevated Separation/Panic Scale; March, 1997). These findings are consistent with the depiction of children of mentally ill parents who are motivated to minimize the potential for harm (see Marsh, 1998). These results also argue for assessment strategies that address specific target behaviors, in addition to overall client functioning.

Other studies have also documented the broad range of social and adjustment problems that can occur when a child lives with a parent who has a mental illness. Downey and Coyne (1990) reported that school-aged children of depressed parents are more likely to show higher levels of internalizing and externalizing symptoms than children of parents without a mental illness. Feldman et al. (1987) reported that more than half of the children in their study

identified as “at risk” by virtue of having a parent with mental illness obtained scores on the Child Behavior Checklist (CBCL) suggestive of emotional and/or behavior problems. Similarly, Gotlib and Goodman (1999) reported that two-thirds of children of depressed mothers scored in the clinical range on the CBCL.

In some studies, researchers have asked patients, parents, and other caregivers about the need for services for children who have a mentally ill parent. Wang and Goldschmidt (1996) reported that 34% of the psychiatric inpatients in their study indicated that their children could benefit from additional help. In the same study, a global assessment of the child’s situation (e.g., psychiatric status of parent, home/support network of child, etc.) was determined for each child. The investigators found cause for “great child psychiatric concern” for 37% of the children. In another study (Ostman & Hansson, 2002), spouses of mentally ill patients were interviewed regarding the needs of their children. About half (55%) of spouses in this study indicated their children had further need for support. Overall, many children show significant concerns and/or symptoms when a parent is hospitalized with a SMI. Although not all children appear to be compromised by the experience, assessors need to recognize that many child concerns can manifest as subtle and indirect characteristics. The concerns appear to be mainly anxiety related (MASC scores, reports of anxiety, sleep disruption), but other problems are also often present (e.g., depression, acting out).

GENERAL ASSESSMENT FRAMEWORK

Reviewing the studies in the preceding section should help to amplify the issue of listening carefully to the whole patient system when a psychologist is assessing a child who has a parent with SMI. Importantly, given the two ways a clinician is most likely to encounter children with a mentally ill parent—indirectly by working with a client diagnosed with SMI and learning that she/he has a child, or directly when the child is referred with her/his own problems—neither the parent nor the child should be viewed in isolation. The child’s presentation must be heard and understood in the context of the parent’s illness.

Attending to the child’s developmental level and needs as these have been affected by the parent’s illness is essential. Issues of gender, cultural norms, and additional social support are individual difference factors that also need to be heeded. For instance, a mother’s two-month hospitalization for depression may have quite a different impact on her 3-year-old daughter compared with her 15-year-old son. Many assessors rely on internal norms and then draw upon additional resources (e.g., models proposed by Erickson, Freud, and Piaget) to understand age ranges associated with the development of certain skills and aptitudes. These practitioners can then better appreciate what developmental tasks may have been compromised or neglected by the presence of SMI in the family. Recognizing the challenges within this specific family system, and for this particular child, is paramount.

In preparing to assess the needs of a child dealing with a mentally ill family member, it is helpful for clinicians to have a number of different clinical “amplifiers” to stay attuned to the particular melodies, harmonies, and discords present. We have found it helpful to frame the assessment in terms of understanding the interactions among three different cycles of development: individual (child), family, and the course of illness itself (see Rolland, 1988, 1994; and Marsh, 1998, for specific application to mental illness). Although clinicians are accustomed to hearing their clients on multiple levels (e.g., developmental, family system, and a comprehensive psychological test battery), we hope to enhance the assessment process with

the addition of two important elements: a “hearing aid” that tunes the clinician into the specific impact that a parent’s mental illness may have on children in both the short term and over time, and a “microphone” to amplify attention to assessing resilient coping processes.

FIRST-LINE AND COMPREHENSIVE ASSESSMENT APPROACHES

It is important to capture the magnitude of distress experienced by children whose parent has a mental illness and the ways in which this distress is likely to be expressed. The available research has focused on the reactions of children whose parent was hospitalized at the time of the evaluation. These research data point to signs of anxiety/distress and possible adjustment problems. Because any single approach can be flawed and incomplete, we recommend a comprehensive evaluation strategy that incorporates child self-report, observations from caregivers, and performance measures.

Of course, a good interview that develops rapport and a connection with a child is indispensable and is the cornerstone of any evaluation. Another way for children to give voice to their concerns is via standardized, self-report measures. Along these lines, brief, psychometrically sound measures of distress are appropriate. For example, the Multidimensional Anxiety Scale for Children (MASC; March, 1997) contains 39 self-report items that are separated into four major scales: Physical Symptoms, Harm Avoidance, Social Anxiety, and Separation/Panic. A Total Anxiety score may also be computed. The MASC is widely used and has demonstrated satisfactory test-retest reliability, internal consistency, and factorial and discriminant validity (ages 8–19; March, 1997).

Another commonly used measure is the 27-item Children’s Depression Inventory (CDI; Kovacs, 1992). This self-rated depression scale is suitable for young children and adolescents (ages 7–17). The test is brief, is easily scored, is frequently used by clinicians, and has demonstrated good test-retest reliability, internal consistency, and construct validity (see Kovacs, 1992; Sitarenios & Kovacs, 1999). The CDI provides a total score and five subscales reflecting various aspects of depression: Negative Mood, Interpersonal Problems, Ineffectiveness, Anhedonia, and Negative Self-esteem.

In our research work, we have found the use of the MASC to be more sensitive to reactions in children who have a parent with mental illness relative to the CDI (Sivec et al., 2003). For more in-depth, self-report evaluation with older children and adolescents, the clinician may consider the Personality Inventory for Youth (PIY; Lachar, & Gruber, 1995) or the Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A; Butcher et al., 1992). These measures are well validated but also require more time on the part of the examinee. In addition, if the initial assessment data point to a major diagnosis, the clinician may consider a structured diagnostic interview (e.g., the Schedule for Affective Disorders and Schizophrenia for School-Age Children: Present and Lifetime Version or K-SADS-PL; Kaufman et al., 1997).

Although self-report tests can be useful, low scores obtained on standardized tests may reflect a defensiveness or unwillingness to divulge symptoms (see Joiner, Schmidt, & Schmidt, 1996). Along these lines, children of mentally ill parents who were later interviewed as adults indicated that they were generally unaware of the impact of the trauma or their unmet needs until they were older (Marsh, 1998). They report that, as children, they felt they must be “good,” healthy, and strong because the family already had many problems.

To the extent that children may be generally motivated to minimize their own concerns, other assessment approaches are recommended. One approach is to obtain objective information that reflects the observations of a caregiver. In this regard, the Child Behavior

Checklist/4–18 (CBCL; Achenbach, 1991) is a widely used measure of symptoms and adjustment. Furthermore, this measure has been used specifically with children of parents with mental illness (see Downey & Coyne, 1990; Feldman et al., 1987; Gotlib & Goodman, 1999). This assessment tool can help to provide information about social competence; the seven areas rated include such things as activities and social and school competencies. Problem behaviors are measured by caregiver ratings of 118 items. These ratings are summarized by way of two broadband factors (internalizing/externalizing dimensions) and seven narrow-band syndromes (i.e., Withdrawn, Somatic, Anxious/Depressed, Social, Thought, Attention, Delinquent, and Aggressive) and an overall, total problems score (see Achenbach, 1991). It is important to identify a caregiver who knows the child sufficiently so that accurate observations can be obtained. Although no distinct pattern of impact has been identified for children of parents with SMI in the research literature, available studies consistently point to higher levels of problems, compared with children who do not have a parent with mental illness (see Downey & Coyne, 1990; Feldman et al., 1987; Gotlib & Goodman, 1999).

Adult observations are useful, but they have limitations. For instance, observations about the child in question may be distorted by an overwhelmed parent or may be based upon limited observations of an adult who steps in to care for the child. Therefore, it may be more important to undertake performance-based measures by which direct behavioral observations of the child can be made. Two relatively commonly used, quick, and adaptable assessment approaches are the Hand Test (Bricklin, Piotrowski & Wagner, 1962; see also, Sivec, Waehler, & Panek, 2004) and Graphic Techniques (e.g., Draw-A-Person [DAP], House-Tree-Person [HTP], and Kinetic Family Drawing [KFD]; Handler, Campbell, & Martin, 2004).

With its relatively unstructured, somewhat disguised, and ambiguous stimuli (10 cards with drawings of hands on them about which clients are asked, “What might this hand be doing?”), the Hand Test invites an unlimited number of free and qualitatively different responses (Sivec, Waehler, & Panek, 2004). In this way, a premium is placed on generating subjective, idiosyncratic responses, which are subjected to specific scoring criteria meant to assess prototypical attitude and action tendencies of the child. The Hand Test administration is typically brief (about 10 minutes) and is meant to supplement other clinical observations and response material in a test battery (see the chapter by Clemence in this text).

Two Hand Test variables are particularly relevant for this group. The Hand Test Acting-Out Score has consistently identified acting-out potential in children across a number of studies (e.g., Clemence, Hilsenroth, Sivec, Rasch, & Waehler 1998; Clemence, Hilsenroth, Sivec, & Rasch, 1999; see Sivec & Hilsenroth, 1994, for a review). Likewise, the Hand Test Pathology score has been linked to social/emotional maladjustment and acting-out behavior and used as a marker of psychopathology in a number of studies with children (Sivec et al., 2004). A third variable, FEAR, has been found in samples of individuals exposed to abuse and threats (Rasch & Wagner, 1989) and may also provide useful clinical information for this population. In these ways, the Hand Test may help a child express through indirect responses useful information regarding the degree of distress and maladjustment she or he is experiencing.

Graphic techniques also invite the child to engage in a specific behavioral activity that can provide insight into her or his personal functioning. Graphic techniques have their critics (cf. Joiner, Schmidt, & Barnett, 1996), but these performance-based measures can supplement other assessment methods in a test battery (Handler, Campbell, & Martin, 2004). Graphic techniques have the advantage of limiting cultural bias, while also being simple and quick to administer, easy for most children to produce, and useful with clients who are evasive or guarded (Waehler, 1997). They can also offer a natural bridge for discussing specific con-

flict areas, because, as Reithmiller and Handler (1997) suggest, drawings allow clients to express themselves in intensely personal ways. The content of drawings can also provide a medium for discussing difficult topics in a way that also affords some safe emotional distance. Drawings such as the Kinetic Family Drawing (K-F-D) have also been linked with attachment issues (Pianta, Longmaid, & Ferguson, 1999), which may be relevant for this population.

Rorschach and TAT

For a more in-depth evaluation using performance-based measures, clinicians may also use the Rorschach Inkblot Test and/or the Thematic Apperception Test (TAT; Murray, 1943). As with other measures, the Rorschach Inkblot Test can be used to identify personality strengths and signs of psychopathology (Exner & Weiner, 1995). Both the Rorschach and TAT also offer methods for exploring interpersonal themes and dynamics. For example, Urist's (1977) Mutuality of Autonomy Scale (MOAS) measures a range of adaptive to more pathological object representations (Tuber, 1992). In research with children/adolescents, the MOAS has been shown to be sensitive to changes associated with an acute crisis (Tuber, Frank, & Santostefano, 1989) and to distinguish between clinical and control groups (see Kelly, 2004, for a review). Also relevant for the children described in this section, Tuber (1992) reported that the MOAS appears to have specific relevance for difficulties with separation (see also Goddard & Tuber, 1989). Regarding the TAT, Westen (1995) has developed a method (SCORS) for assessing social-cognitive and affective processes that are considered theoretically important to understanding a person's capacity for relatedness to others. The SCORS has also been used with children/adolescents in clinical situations (see Kelly, 2004, for a review) and shown to be sensitive to developmental changes (Westen et al., 1991). Children whose parents have a mental illness may be particularly vulnerable to disruptions in the ways that they view and experience relationships. In this regard, both the Rorschach and TAT offer theory-based and empirically tested methods for assessing these issues.

Assessing Resilient Processes/Coping

As we have reviewed, having a parent or family member with mental illness can lead to a plethora of negative outcomes for children. Despite this, some children are able to survive and thrive, despite their parent's mental illness (Anthony & Cohler, 1987). These children can be characterized as resilient, because resiliency refers to a positive outcome, despite adverse circumstances (Masten & Coatsworth, 1998). Understanding what processes lead to resiliency in children of mentally ill parents can inform interventions designed to help this special population. Furthermore, it is important to look for resilient coping processes in children with an SMI parent in order to counterbalance the all too common tendency to look for deficits (i.e., confirmation bias) in cases that involve high-risk background variables.

Seifer (2003) proposes a model of resilience processes in young children that includes child characteristics (e.g., positive emotions, physiology, secure attachment), as well as the contextual variables of the family (e.g., economic resources, social supports, few risks) and parent characteristics (e.g., positive thoughts, positive feelings, and self-efficacy). Following along with this model, practitioners' assessment efforts with children of the mentally ill must "hear" the child within his or her developmental context. Recognizing how developmental needs have been interrupted, delayed, neglected, changed, or ignored because of the presence of mental illness in the family is critical to understanding how all family members (and their relations with one another) are being affected.

Take, for example, the situation of a 14-year-old girl whose father is hospitalized at mid-life for a major depressive disorder with psychotic features. She had seen some of the symptoms developing as her father became more and more withdrawn, depressed, and angry. She is too young to visit her father in the hospital, and no one discusses the reality of mental illness with her. She does not need to be told verbally to “Keep this to yourself because we don’t want other people to know.” She does this automatically by having this behavior modeled for her. The girl is confused and afraid of what might happen to her family. She doesn’t want to add more stress to her mother’s life by asking questions, so she learns to deny her feelings and channels all of her energy into schoolwork. She becomes the proverbial “good girl” who is afraid to further burden her family with her worries. She is resilient and may not manifest overt symptoms immediately, but her normal developmental tasks of socialization and dating are disrupted, and her family role mutates into being mother’s personal helper and confidant in her father’s absence. This pattern reflects a common coping strategy for children with mentally ill parents. That is, the child ignores/avoids the issues and/or attempts to reduce stress in the family by taking on more caregiving behaviors (Riebschleger, 2004).

There are many personality characteristics that make resiliency more likely in children. These include intelligence, social skills, problem-solving ability, self-esteem, and self-efficacy (Garmezy, 1981; Rutter, 1987). Assessing these positive characteristics, which might normally go unheard because of the “noise” made by dramatic presenting of clinical concerns, becomes important to making realistic case determinations and recommending interventions.

One area that can be assessed somewhat easily is intelligence. This variable is associated with adjustment and is likely to be related to coping skill development. Although a comprehensive evaluation of intellectual abilities is likely to be too cumbersome, there are brief measures of intelligence available. For example, both the Wechsler Abbreviated Scale of Intelligence (WASI, Psychological Corporation, 1999) and the Kaufman Brief Intelligence Test (K-BIT, Kaufman & Kaufman, 1990) have solid standardization samples/norms and many studies documenting acceptable psychometric properties.

Although some characteristics associated with resilience (e.g. physiology, intelligence) are not easily changed, a child’s repertoire of coping strategies is one area that is modifiable. Existing coping strategies can be assessed to reinforce current strategies and to identify other skills to be learned.

Assessing Coping Skills

When we refer to coping we are drawing on Lazarus and Folkman’s (1984) definition of “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (p. 141). This definition indicates that stress is a subjective experience (e.g., the individual *appraises* the situation as exceeding her resources; the situation is not inherently, objectively stressful). Lazarus and Folkman also make it clear that coping efforts “constantly change.” Therefore, when a child’s coping strategies are being assessed, it is important to look at many aspects of the situation in order to determine the child’s full range of coping abilities and areas needing improvement.

Considering that a situation is stressful based on how it is appraised necessitates determining which aspects of the mental illness a child finds stressful. For example, if you ask, “How did you deal (cope) with things when your mother was taken to the hospital?” children may answer in a variety of surprising ways. A 7-year-old boy may respond by telling what he did to manage his emotions when he was first told his mother was leaving (went and played

with toys), or he might say that he was happy to be able to watch all the television he wanted. A 13-year-old girl may remark that a few days after her mother left, she got help from her cousin with her homework because her mother wasn't available to help as usual, or that she was glad that no one was bugging her about her homework being done. When a clinician begins to speak with children about a stressful situation, asking specific, targeted questions about what aspects they, personally, find stressful is important. Abstract questions may lead to children leaving out key coping strategies that they used to manage secondary stressors (Coyne & Racioppo, 2000). Subsequently, asking questions about what they have done to cope with the situation so far becomes more effective. In addition to informal, subjective interviews with a child, standardized assessment methods are also available to assess coping.

Measures Used to Assess Coping

There are several measures that are used to evaluate coping skills in children. We have selected three groups of measures we believe are relevant to working with children who have parents with SMI. The first group includes two measures: the Children's Coping Strategies Checklist (CCSC) and the How I Coped Under Pressure Scale (HICUPS; Ayers, Sandler, West, & Roosa, 1996) ask children ages 9–13 to rate how often they use a given coping strategy when faced with a problem. The CCSC asks children how they cope with stressors in general, whereas the HICUPS asks children how they responded to a specific stressor. The measures are composed of 45 items that form 10 subscales and 4 factors (Active Coping Strategies, Distraction Strategies, Avoidance Strategies, and Support-Seeking Strategies). Items are rated on a 4-point, Likert-type scale. The 10 subscales include Cognitive Decision Making, Direct Problem Solving, Seeking Understanding, Positive Cognitive Restructuring, Physical Release of Emotions, Distracting Actions, Avoidant Actions, Cognitive Avoidance, Problem-Focused Support, and Emotion-Focused Support. These scales have demonstrated good reliability and validity and have been used in studies of children coping with parental divorce and bereavement (Ayers et al., 1996; Sandler, Kim-Bae, MacKinnon, 2000).

In the next group, the Kidcope (Spirito, Stark, & Williams, 1988) is a brief screening measure that consists of 10 items for adolescents aged 13 to 18 and 15 items for children aged 7 to 12. The Kidcope is like the HICUPS in that it asks children to report on how they coped with a specific stressor in the past month. Then children rate the frequency and efficacy of each item. Older children and adolescents use a 4-point Likert-type scale for frequency and a 5-point Likert-type scale for efficacy. Younger children respond yes/no to frequency and use a 3-point Likert-type scale for efficacy. This measure has frequently been used in pediatric populations (e.g., Spirito et al., 1988) and suicide attempters (Spirito, Francis, Overholser, & Frank, 1996).

Finally, the Responses to Stress Questionnaire (Connor-Smith, Compas, Wadsworth, Harding Thomsen, & Salzman, 2000) is a coping measure that is designed to assess both voluntary coping responses and involuntary, automatic reactions. Voluntary coping responses include *primary control engagement coping* (which refers to problem solving, emotional regulation and expression), *secondary control coping* (which refers to positive thinking, cognitive restructuring, acceptance, and distraction), and *disengagement coping* (which refers to avoidance, denial, and wishful thinking). Involuntary responses to stress include *involuntary engagement* (such as rumination, intrusive thoughts, and emotional and physical arousal) as well as *involuntary disengagement* (such as emotional numbing, cognitive interference, inaction, and escape).

The Responses to Stress Questionnaire has been validated on three samples of adolescents (ranging from 11 to 19 years of age) and two samples of parents. There are two ver-

sions of the Responses to Stress Questionnaire: an adolescent self-report form and parents' report of their adolescents' responses. Two main sections comprise the questionnaire. The first section assesses how frequently in the past six months the adolescent experienced a given stressor. This first section can be tailored to a specific domain of interest. For example, Jaser et al. (2005) asked adolescents questions specifically pertaining to coping with parental depression. In the second section, adolescents use a 4-point Likert-type scale to indicate the frequency with which the coping strategy or response occurred. This section contains 57 items. It is worth noting that a study by Jaser et al. (2005) found that adolescents' use of strategies such as distraction, cognitive restructuring, positive thinking (i.e., secondary control coping) to cope with family stress was related to lower levels of depression, anxiety, and aggression. Conversely, evidence of involuntary engagement stress responses (i.e., increased arousal, rumination) was associated with higher levels of depression, anxiety, and aggression.

Each of these four measures has strengths and weaknesses. All of them can be adapted to assess specific stressors. All of them assess problem solving, distraction, social support, cognitive restructuring, and wishful thinking. The Kidcope additionally assesses coping strategies that are likely to be maladaptive, such as social withdrawal, self-criticism, and blaming others, whereas the Responses to Stress Questionnaire additionally assesses involuntary stress responses. The HICUPS and the CCSC can be obtained for free on-line through Arizona State University's Prevention Research Center. The HICUPS/CCSC and Responses to Stress Questionnaire are both much longer than the Kidcope, which may be better in terms of the reliability of the measures, but has the cost of being more time-consuming. Each measure has varying degrees of empirical support as a research instrument: More studies that examine the measures as clinical assessment instruments are needed.

Assessing Family Life Cycle and Functioning of the Family Unit

While establishing some sense of developmental achievement, deficits, and coping styles for the child with a parent with SMI, it is also important to examine the functioning of the family unit. Carter and McGoldrick's (1988) model of family development identifies six phases experienced by families:

- Launching of the single person from the family of origin
- Joining of families through marriage
- Becoming parents and adjusting to young children
- Transformation of the family system in adolescence
- Launching children and moving on
- Changes in later life

Imagine the situation of a couple in the throes of early parenthood and all of the adjustments that entails. They married young and are both in their early twenties. They have a three-year-old son and a six-month-old daughter. The father experiences his first episode of mania in what is later diagnosed as a chronic bipolar disorder. The family, located at the stage of "becoming parents and adjusting to children," is thrown into a chaotic state in which the normal task of the family (adjusting to life as parents with children) is significantly complicated by the erratic behavior of one parent. Uncertainties arise about how the family life will be affected and changed and how much energy, time, and money will be available for the

normal tasks and activities they had expected. It is important to inquire about the goals and plans the family had hoped to accomplish, in order to understand their grief and loss.

In addition to assessing the impact of SMI on the family's functioning, it is also important to identify the family's positive coping processes. For example, one factor consistently revealed in the literature and in clinical practice regarding the health of the children is the availability of a functional caregiving system in the absence of the SMI parent. Figley (1989) also describes 11 characteristics that tend to differentiate families that cope well with stress from families that struggle when stressors emerge. These might serve as a checklist for the assessor to consider when consulting with the family: (1) clear acceptance of the stressor, (2) family-centered locus of problem, (3) solution-oriented problem solving, (4) high tolerance, (5) clear and direction expressions of commitment and affections, (6) open and effective communication utilization, (7) high family cohesion, (8) flexible family roles, (9) efficient resource utilization, (10) absence of violence, and (11) infrequency of substance use.

Understanding the family unit also requires that the assessor become attuned to which person (or persons) within the system provides care to the particular child in question. This may require setting aside traditional Eurocentric assumptions that the biological mother and/or father is in the best position to provide constructive care. At times having other relatives, "kin," or guardians serving in primary or secondary parental roles can afford optimal development for children. Availability and consistency of the caregiver are two characteristics to assess, in addition to basic relationship, caring, and communication skills, regarding whether productive care can be provided for a child or adolescent (Reid & Morrison, 1983; Schachnow, 1987).

Assessing the Life Cycle of the Illness

In considering the life cycle of the illness itself, Rolland (1988, 1994) developed a model to look at the dimensions of a chronic physical illness. This model has been adapted to mental illness (see Marsh, 1998) and includes four critical dimensions:

- I. Onset—acute or chronic;
- II. Course of the illness—progressive, constant, or relapsing/episodic;
- III. Outcome/recovery—full, partial, none;
- IV. Incapacitation—level of actual impairment and social stigma.

Determining these illness dimensions and the family's understanding of these dimensions (and integrating them with family life cycle and individual coping strategies) can be essential to the comprehensive appreciation of the situation.

The onset (Dimension I) of mental illness varies, depending on the individual: coming on suddenly with little warning for some; developing gradually over time for others. A sudden onset can send a family into shock, denial, anger, paralysis, or other incapacitating emotions. The family can spend a lot of time resisting what they are actually dealing with despite the fact that their loved one is hospitalized in a psychiatric facility. The family's normal life and ways of coping are often shattered by this new kind of crisis. Often, because of the shock and resistance to the idea that they are actually dealing with the stigmatizing reality of a mental illness, their ability to regroup and organize their resources may be delayed or never happen. This pattern may be expected to contribute to anxiety and distress seen in some children. Gradual onset, on the other hand, may lead the family to look away from the grow-

ing gravity of the symptoms. They may excuse, rationalize, minimize, or avoid asking dreaded questions. If the illness is masked by the use of substances (legal or illegal), the family may think they are dealing only with a drug problem. Alternatively, sudden angry outbursts, mood swings, insomnia, or isolation may be attributed to various stressors in daily life. With this onset pattern, assessors need to identify the use of avoidance strategies in family members adjusting to a relative's mental illness.

The course of illness (Dimension II) can be described as "progressive, constant, or relapsing/episodic." As in the case of differing onset patterns, each course of illness is laden with its own set of challenges. A "progressive" course, for example, entails persistent symptoms that become more severe and disabling over time. With many serious mental illnesses, the parent's treatment avoidance or noncompliance often leads to a progressive worsening of symptoms. This course can be associated with other complications (e.g., loss of job, relationship disturbance, homelessness), so that assessing this information can lend further understanding to the situation.

The second possible illness course, a constant presence of noticeable symptoms, is commonly seen with individuals who have treatment-resistant illnesses. Families run the risk of giving up hope or distancing themselves from the ill family member. The central issue to assess in this illness course is treatment adherence by the parent-patient.

The Relapsing/Episodic pattern, a third possible illness course, can be the most vexing and frustrating. The fluctuating course of the illness may render families helpless in their efforts to attain stability. They can "put everything on hold" as they wait for the next crisis. The exhaustion, frustration, and disruption to normal functioning can be markers seen in families that are constantly living on the edge of an impending crisis. This pattern may predispose some children to anxiety issues or concerns.

Once the onset and course of illness are identified, it is important to ascertain the family's response. In particular, do the adult caregivers experience significant levels of burden in dealing with the illness (Solomon & Draine, 1995), which leaves them with diminished resources available for the children (Marsh, 2001)? These factors will directly affect the child being assessed. Although they do not always identify this need, children benefit from having concrete information as to what is going to happen to them based on the illness course.

Assessing the type of recovery outcome expected (Dimension III) for the parent—full, partial, or none—makes up the third illness dimension. Once the topic of mental illness is broached in the evaluation, family members will want to know about possible outcomes. Often the reality is that no one can predict outcome at the outset of an illness. Although there may be identified signs indicating a positive prognosis, it is important for families to seek a balanced perspective offering both hope and a reasonable range of expectations. Listening for the family's method for dealing with uncertainty can be essential to understanding how the child is attempting to cope with the problem.

Incapacitation (Dimension IV; Rolland, 1988, 1994) includes both actual impairment from the illness and social stigma. The greater the degree of incapacitation, the more important it becomes to identify the person who has assumed the primary caregiving role for the child. If the assessor observes a lack of clarity as to who is responsible for the children and how their basic needs are going to be met, he or she can understand the child's lack of safety and trust in the world. It is also important to assess the number and degree of changes the child faces (e.g., changing caregivers, homes, school districts, or friends). These changes can contribute to feelings of distress (e.g., feeling overwhelmed) or maladaptive coping (e.g., emotional numbing; silent, resentful compliance; or acting out). Finally, it is important to gauge the degree to which family members face social stigma associated with mental ill-

ness. For example, the family's report of isolation and withdrawal from other people in their lives may reflect the impact of stigma.

Assessing Grief Issues

An assessment of children and family members of the mentally ill would not be complete without a discussion of the issue of grief. Grief is perhaps the most common and poignant issue faced by patients and family members at some stage in their illness and recovery (see Marsh, 1998; Miller, Dworkin, Ward, & Barone, 1990; Solomon & Draine, 1996). As the poet John Greenleaf Whittier declares, "For all sad words of tongue and pen, the saddest are these, 'it might have been.'" Mental illness can mean that the life one thought one was going to have is altered, sometimes drastically, sometimes forever. Assessing how children and families address the reality of the losses that mental illness brings can be essential. Although SMI can be a line of demarcation in a family's life, there is life before and after the illness. One six-year-old child, with wisdom and perceptiveness beyond his years, puts it this way, "Before mommy got sick she was like Christmas. Now she's like Halloween."

Kubler-Ross's (1969) well-known stages of death and dying can be applied to a family struck by mental illness: Denial, Anger, Bargaining, Depression, and Acceptance. The level of grief among family members in relation to a family member with SMI may be comparable to grief felt by families who experience a death in the family (Miller et al., 1990). Acknowledging the family's struggle with grief can do much to understand the situation. Discussion of this area, and any associated guilt, may help to unleash the energy needed to proceed with additional assessment and possible treatment. Not acknowledging the presence of grief and/or not addressing it can lead to distance in the relationship between assessor and family.

Practical Considerations

Another group of factors to take into consideration is the concrete and practical strengths and liabilities of families. When assessing the family system, it is important to assess the following qualities of family members: physical health, financial stability, educational levels, prior or current legal problems, communication skills, level of community involvement and support, availability of extended family, and the safety of their neighborhood. The old adage "Don't assume anything" is important in being sensitive to these families, helping them to maximize their internal and external resources, and not alienating them from the mental health system. Do they have a phone, a car, money for gas, stable housing? Inner-city families may be struggling with some of these issues under the best of circumstances. Mental illness can deplete any family's resources, no matter how wealthy. Especially when the major breadwinners have been struck by an illness, or when divorce has occurred and finances are in disarray, the family may not have ready access to the most basic of resources. Referring to Maslow's (1968) hierarchy of needs may be a useful guide to assessing what level of intervention is required in meeting the most pressing client needs.

CASE EXAMPLE

Ms. X. is a 31-year-old, married Amish woman who was admitted to the hospital with a Major Depressive Disorder, Recurrent with Psychotic Features. She had stopped taking med-

ications six weeks prior to this admission. She became irritable; was sexually preoccupied; reported what seemed to be auditory hallucinations with instructions to scratch her neck and hands; and was reported to have made suicidal threats, the fact that was most prominent in her being brought to the hospital. Ms. X. has a history of Major Depression, Post-partum type, first diagnosed four years ago following the birth of her third child. She was hospitalized at that time and treated with medications and counseling. Her biological mother had been diagnosed with Schizophrenia. Ms. X.'s two children—Susan, age 9, and Joshua, age 7—were referred to assess the impact of the current hospitalization on them. They were seen during a visit with their mother, which she requested after being in the hospital for one week and feeling stabilized on her medication.

In the assessment session, both children completed a K-F-D, the MASC, the Kidcope, and the CDI in addition to an interview. For the K-F-D, they were instructed to draw a picture of their family doing something three months ago “before mommy started acting sick” and then to draw a picture of their family doing something “right before mommy came into the hospital.”

The “Before” K-F-D pictures of both children reflected a busy, smiling, and connected family, going about various household tasks. Mom was in the kitchen baking or outside, hanging up the laundry. The children were pictured close to her and involved with her. Dad was also in the pictures, either eating or working in the yard. The “After” pictures provided a striking contrast. Susan’s “After” picture did not include her mother: Susan was in the kitchen doing dishes, and her brother was throwing a ball against a wall. Joshua’s picture portrayed the family in the kitchen at the table. Mom and Joshua were crying, and he stated that no one was eating.

Drawing Commentary. These pictures portray some of the common themes experienced by families in this type of situation: the oldest daughter taking on more caretaking responsibilities. Joshua is overidentified with his mother’s emotional life and conveys his concern about some needs not being met (no one is eating).

On the MASC, although Susan’s total scores were not elevated, she showed a slight elevation in the Perfectionism scale. Otherwise, there were few indices of acute distress identified on MASC or CDI. On the other hand, Joshua produced moderately high elevations on the Negative Mood subscale of the CDI. He also obtained a significantly elevated score on the Anxious Coping subscale and moderate elevations on the Separation/Panic subscale of the MASC. His drawings and self-report indicate issues related to anxiety, distress, and concerns about separation and meeting needs.

Ms. X.’s husband, Susan and Joshua’s father, was asked to complete CBCLs for both children. In spite of being involved in interviews with his wife and children, Mr. X. did not complete these instruments for his children—offering no explanation for not doing so. Also, both children appeared to be somewhat insulated from the family distress at this time by the active involvement of grandparents and others in the community.

Coping and resiliency were assessed with both children through interviews and by use of the Kidcope. Susan, who achieved high grades at school, focused more on ways to fix problems. She clearly understood that she did not cause the problem and recognized that the most recent episode could have been prevented had her mother adhered to her medication regime. On the Kidcope she endorsed “I tried to fix the problem by . . . thinking of answers . . . (or) talking to someone.” Joshua, on the other hand, was concerned about causing his mother’s illness, and on the Kidcope also endorsed “I wished the problem never happened.” He appeared

to be narrowly focused on causing the problem and hoping that his mother's return home would "make everything go away."

Case Assessment Summary. Joshua appeared to be more vulnerable than his older sister, showing the most distress across measures. He was concerned about safety and not doing anything wrong. His mood was mildly dysphoric. His method of coping involved self-blame and avoidant behaviors. He presented with internalizing problems and separation concerns. Susan was better adjusted. She has developed outlets at school for success, and she recognized that her mother's symptoms were not her fault. She focused on activities that will help the situation. Her primary risk involved a more insidious process of deferring her own needs at critical points and later experiencing the impact of missed opportunities for age-appropriate challenges and growth.

Contextual variables and frameworks considered in this chapter that applied to this case included *Child Developmental stages*. Susan was age 5 (nearly 6) at the time of illness onset, and she had already begun a successful adaptation to school (beginning the industry/inferiority stage). At the time of her mother's current hospitalization, she was 9 and continued to do well in school (experiencing both academic and social success). Joshua was age 3 at the time of illness onset, and he was at home with his mother during the onset of the illness and her first recovery. He was at the stage of initiative/guilt and dealing with sibling rivalry issues during his mother's first episode. During his mother's most recent hospitalization, he had begun school (age 7) and was facing the developmental challenges of industry/inferiority and socialization tasks.

Family Stage of Development. The X family would be classified in the "New Family, Raising children" phase at the time of onset and were at the "Raising kids, school-age years" during the relapse. As such, they experienced an ongoing set of changes associated with the school-age years (socialization, intellectual development, increased self-directed behavior, etc.). It is also of note that living in the Amish community meant that they strictly adhered to a family-centered philosophy. Amish culture also tends to be very conservative, and specific roles are clearly defined for men, women, and children. In addition, there is a strong mandate to support family members during any type of illness or hardship.

Illness Life Cycle. The onset of illness was sudden (past and current episodes). Ms. S's course was relapsing. The outcome was full recovery (in past), and the degree of incapacitation was considered high when Ms. X was off medication. As such, the children are faced with uncertainty about the duration of their mother's "well" or "sick" periods. At the same time, living in a supportive community, with minimal social stigma, helped to buffer the children from some of the effects of a sudden-onset, relapsing illness (e.g., readily available caregivers, few changes in jobs or roles). Also, they may have greater hope in the benefits of interventions because of the positive treatment response achieved by their mother in the past.

CONCLUSION

In summary, there are many issues involved in a thorough assessment of the children and family members of a person experiencing mental illness. Assessors in these situations need to attend to many different client messages: The developmental stages of individual family members that get interrupted, neglected, or denied; the tasks and stages of family life that become

even more overwhelming; the dimensions of the illness that need to be addressed and that have ramifications for everyone; the sociological and practical strengths and limitations of individuals and the family as a whole; and the acknowledgment of grief reactions to the presence of mental illness. Unfortunately, very few studies have examined assessment strategies with this particular population. A variety of specific assessment tools may be used to identify common reactions (i.e., anxiety, distress, etc.). In addition, we emphasize the importance of evaluating resilience and coping in children and their families. Along these lines, measures of coping strategies have recently been applied with children in situations involving stress associated with a parent's mental illness (e.g., Jaser et al., 2005). Overall, it is perhaps most important to remember that the assessor is providing a valuable service to the child and family by recognizing that mental illness in a family member affects the child as much, if not more, than anyone else. In this way, the child's silent need is heard.

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