CHILDREN OF PARENTS WITH MENTAL ILLNESSES: A SCHOOL-BASED WORKSHOP FOR HEALTHY DEVELOPMENT AND SCHOOL SUCCESS

A graduate project submitted in partial fulfillment of the requirements

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DEDICATION

This graduate project is dedicated to:

My family, friends, and cohort who have shown me unconditional love and support through the hardships of the past three years.

My father whose recent condition has inspired me to spend days upon days researching for this project.
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ABSTRACT

CHILDREN OF PARENTS WITH MENTAL ILLNESSES: A SCHOOL-BASED WORKSHOP FOR HEALTHY DEVELOPMENT AND SCHOOL SUCCESS

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This interactive school-based workshop addresses the needs of children with mentally ill parents by offering middle school students with affected parents the opportunity to come together in a safe environment to learn, support each other, and receive the support of their school counselor. The ultimate aim is to promote the healthy development of this at risk population, leading to student academic success. The first component of this 2-hour workshop is psychoeducational, intended to educate students about mental illness, healthy coping skills (i.e. discharging feelings), promoting self-care, and offering other such information that may serve as a beneficial protective factor. The second component is focused on getting students acquainted with their school counselors as a source of ongoing support, as well as discussing pertinent information about academics and means of advancement for school success. Using PowerPoint slides, handouts, and worksheets to facilitate mini-lectures, coupled with interactive activities, it is hoped that school counselors and children of mentally ill parents will work together in promoting the development of healthy and successful individuals.
CHAPTER 1: INTRODUCTION

Children of Parents with Mental Illness

According to Sherman (2007), over five million children have a parent with a serious mental Illness (SMI) in the United States. When a parent has a SMI, this affects not only the parent, but also the entire family and unfortunately, there has been little attention paid to these invisible children (2007).

Tara Elgin Halley describes her experience of living with and caring for her mentally ill mother in the following excerpt:

I wanted to love her — I did love her— but I was tired of carrying around this burden. I just wanted life to be normal ... to imagine my mother as my future was almost more than I could bear (Nathiel, 2007, p. 91).

This seemingly parent-child role reversal is common in many families dealing with a parent with a SMI. Sherman (2007) explained that the children of parents with mental illness (COPMI) would often take on parental responsibilities and commonly experience feelings of uncertainty, anger, shame, sadness, and fear.

Statement of Problem: COPMI Needs

Farahati, Marcotte, & Wilcox-Kok (2003) investigated the effect of a parents' mental illness on the ability to perform in school and found that children of these affected parents suffer greater risks of dropping out of high school. They argue that these at risk children may need special programs in place to attain school success (2003).

Unfortunately, while Sherman (2007) emphasizes the necessity of services for COPMI, resources for middle school students seem to be limited, especially on school campuses; nevertheless, these children need information, support, and hope.
Further intensifying the problem, Maybery and Reupert (2009) found that adult mental health professionals were not adequately trained nor possessing the essential skills required in assisting COPMI. These mental health caregivers also reported feeling limited on ways to help the parents handle issues that they may be confronted with in regards to their child (2009). Stallard, Norman, Huline-Dickens, Salter, and Cribb (2004) noted that in their study approximately 40% of children reported that no one talked with them about their parent’s illness. Sivec, Masterson, Katz, and Russ (2008) report that very few COPMI could name their parent’s mental illness. Furthermore, Delvin and O’Brien (1999) reported that COPMI often have misconceptions about their parent’s mental illness. The research exemplifies the neglected needs of COPMI and calls for means of supporting and educating these children, in view of the fact that their parents, family members, and mental health care professionals may feel limited on their own abilities to assist them.

**Purpose of Project: Workshop for School Success**

The purpose of this project is to develop an interactive, age-appropriate psychoeducational workshop that will ultimately meet the needs of children with mentally ill parents and promote school success. With the involvement counselors and peer COPMI, it is hoped that this workshop will educate children regarding: their parent’s illness, healthy coping skills, the essentials of self-care, and the resources available to them. By providing COPMI with ongoing support, the workshop aims to create a safe environment to process feelings, get unanswered questions answered, build student’s social support in the school community, and provide them with the resources that will in-turn lead to increased academic focus and achievement.
Terminology

1. Attachment refers to a specific feature of the relationship between the child and caregiver that entails making the child feel secure, safe, and protected (Bowlby, 1982).

2. Autonomy refers to having a sense of one's own identity and an ability to act independently and have some control over one's surroundings (Benard, 1991).

3. Bipolar Disorder refers to a mood disorder marked by periods of feeling abnormally low (depression) and abnormally high or euphoric (mania). The person’s mood may swing from high at one moment to low in the next, lasting from one week to several months (Morey & Mueser, 2007).

4. Mental Illness is a term used for a group of disorders causing severe difficulty in thinking, feeling, and relating (National Alliance on Mental Illness, n.d).

5. Major Depressive Disorder refers to a mood disorder characterized by persistent depressed mood for a two week period or longer. Symptoms include thoughts of helplessness, hopelessness, worthlessness, and suicide; and concentration problems, appetite problems (overeating or loss of appetite), sleeping problems (either too little or too much), activity problems (feeling slowed down, agitated, and apathetic); and a loss of interest in once pleasurable activities or relationship (Morey & Mueser, 2007).

6. Resilience refers to the ability to endure and bounce back from adverse circumstances (Walsh, 2002).

7. Stigma is a term used to describe a profound, shameful mark or flaw connected to the association of a group that is looked down upon in society (Hinshaw, 2007).

8. Serious Mental Illness (SMI) include conditions such as schizophrenia, bipolar mood disorder, or major depression (Sved-Williams, 2004).
9. *Schizophrenia* is a psychotic disorder characterized by drastic changes in behavior and personality. Common symptoms include *hallucinations* (i.e. hearing voices when no auditory stimuli are present), *delusions* (false beliefs that one is being, watched, persecuted, has special power, or is famous), *cognitive difficulties* (poor abilities in memory, concentration, and abstract thinking), *social perception difficulties* (recognizing facial expression, understanding others’ feelings), anhedonia (lack of pleasure from once pleasurable activities and relationships), and apathy (Morey & Mueser, 2007).

**Bridge**

Research on the family’s experience of living with and caring for a seriously mentally ill relative has revealed the difficulties these families face. Children of parents with mental illness face a unique set of negative outcomes and risks of impediment to healthy development, but previous research has provided insight about the various protective factors that can decrease these risks and promote the development of resilient children in the home and at school. Additionally, many studies and interventions incorporated factors and techniques that have been successful in assisting COPMI. The following chapter will more thoroughly review the literature in order to present the background necessary for understanding the need for implementing a successful workshop that meets these children’s needs.
CHAPTER 2: LITERATURE REVIEW

Introduction

There is a vast abundance of research on COPMI. In examining previous research, this chapter will briefly discuss the prevalence of mental illness and explore some of the possible risks these children face. This will be followed with an examination of protective factors that can decrease the various risk components. Following will be a review of previously implemented interventions, techniques and treatments that have been proven to be successful as well and unsuccessful in increasing COPMI well-being and school success. Lastly, the implications of the compilation of research and the future development of a school-based workshop aimed at addressing the specific needs of COPMI will be discussed.

Prevalence

One in four adults are diagnosed with a mental illness in any given year, which translates to 57.7 million people when considering the 2004 Census (Kessler, Chiu, Demler, & Walters, 2005). When examining statistics from the National Comorbidity survey, Nicholsom, Biebel, Hinden, Henry & Stier (2001) found that of these mentally ill adults, 65 percent of women and 52 percent of men are parents. Their research indicated that mentally ill adults are just as likely, if not more likely, to become parents when compared to adults without mental disorders (2001).

Family Experience of Mental Illness

Mahlbauer’s (2002) interest in the family experience of mental illness led to a qualitative research study aimed at examining the holistic process and patterns that are experienced by family members caring for a mentally ill relative. Twenty-six individuals
caring for a family member with a mental illness including the schizophrenias, major depressive disorders, bipolar disorders, disabling obsessive compulsive disorders, etc., participated in semi-structured interviewing and their responses were analyzed.

Significant issues in the family revolved around hallucinations, delusions, violent behavior, substance abuse, social/relationship problems, managing money, and coping with stress and change. When analyzing the data, spirals and cycles of events revealed the development of phases through which the majority of participants experienced: (a) development of awareness, (b) crisis, (c) cycle of instability and recurrent crisis, (d) movement towards stability, (e) continuum of stability, and (f) growth and advocacy (2002). The characteristics of the aforementioned phases will be discussed to better illustrate the holistic experience of the family members.

**Development of Awareness**

Mahlbauer (2002) characterizes this initial and daunting phase as a time in which family members report: (a) recognizing the problem, (b) the rise of concern, and (c) increasing yet ineffective attempts to seek help. Although awareness and help seeking behaviors were generally observed, Tessler, Killian, and Gubman (1987) similarly defined nine stages in family response to mental illness and followed the initial stage (1) awareness of a problem, with (2) denial of mental illness. Previous research was generally consistent concerning the experience of denial in family members after becoming aware of a relatives mental illness (Tessler et. al., 1987). In other accounts, family members report acknowledging the recognition that something is wrong but had difficulty defining it (Mahlbauer, 2002). Generally these families continued to increasingly manage their situation and seek assistance until they were in a crisis (the
following stage) and unable to continue to control the situation stemming from the emergence of the mental illness (1987).

**Crisis**

The crisis stage is defined by Mahlbauer (2002) as (a) an overwhelming increase of uncontrollable problems, (b) confrontation with mental health care system, with the possibility of diagnosis and hospital admission, (c) heightened levels of emotional distress, (d) issues getting needs met with health care providers, and (e) financial difficulties. At the crisis stage family members face psychotic and violent behavior often describes as traumatic. Karp and Tanarugsachock found families in crisis responding with relief in knowing the cause of the change, yet a concern for the future when the health care system becomes involved and a diagnosis is given (as cited in Mahlbauer, 2002). In interviews with COPMI, Fudge and Mason (2004) similarly identified communication issues with mental health care workers that do not listen to family members about their experience of the patient and they are not receiving basic information about their parent’s mental illness and the treatment. Reupert and Maybery (2007a) suggest that mental healthy agency workers do not have the proper training and knowledge to be able to work effectively with these families. Furthermore, the crisis becomes even more complex with the added stress of paying for hospital medical bills and/or dealing with insurance issues that can substantially add to financial burdens and complications for the caring family (Mahlbauer, 2002).

**Instability and Recurrent Crisis**

In the third stage, families often experience (a) instability and recurrent crisis, (b) anger, grief, and a sense of symbolic loss, (c) seek explanations, treatment, and increased
knowledge, (d) continued financial and insurance issues, (e) partial relief from new treatments, (f) frustration and disappointment in mental health care services, (g) negative feelings related to stigma (Mahlbauer, 2002). This phase involved gained awareness of the cyclical nature of the experience, where relapse became an expected norm. Many families report ill relatives being partial in compliance with treatment, visits to health care services, and taking medication (2002). Jeon and Maidar (1998) discussed the common experience of the ongoing grieving involved with the loss of the past, present, and future, and the loss of the potential life families had imagined for themselves and their mentally ill relative. The symbolic loss accounts for a past vision of the family member that cannot be regained, the present that is difficult to bear, and a future sadly envisioned with more worries than dreams (1998). In addition to the response of grief and sadness for the loss, Rose, Mallinson, and Walton-Moss (2002) provided that some hopeful families envisioned positive possibilities of improvement and recovery for the future. Yet this feeling of hope remained volatile and existed with the compromise that illness is a part of life but it is not debilitating (2002).

Throughout this phase, family members report increased efforts in looking for explanations and reasons for the development of the illness such as, family shortcomings or physiological abnormalities (Mahlbauer, 2002). In a frantic search for help and information, family members were consistently let down by mental health professionals while financial burdens continued to grow (Rose, Mallinson, & Walton-Moss, 2002; Mahlbauer, 2002). Initial concerns began to deepen and feelings of stigmatization came into play (Mahlbauer, 2002). Concerning the stigmatization of mental illness in children and parents, Hinshaw (2005) discusses it as a source of the suffering involved with caring
for mentally ill relatives. Stereotypes, prejudice, and stigma continue to surround mental illness and promote silence and shame in affected families (2005). Mahlbauer (2002) also mentions institutionalized related stigma within the government and corporate regulations that make employment and full insurance coverage increasingly difficult and problematic. The end of this phase is marked by a reported sense of control that was uneasily achieved due to internal changes made in the family members to adjust their expectations and the way they handled their interactions with their ill relative and mental health care professionals. This gained sense of adaptation, accepting, and coping moved family members from instability and crisis into stability (2002).

Movement towards Stability

Mahlbauer (2002) characterized the stability phase with the following overarching themes: (a) new discoveries of methods to get back in control, (b) coping with guilt and helplessness, (c) evolving perceptions and expectations, (d) dealing with ethical dilemmas and creating limits/boundaries, and (e) developing decent ways to manage relative’s symptoms. For the purpose of achieving normalcy, family members searched for ways to control the course of the illness (Rose, Mallinson, & Walton-Moss, 2002). Mahlbauer (2002) explained that movement into stability was evident when family members accepted their inability to fully control the lives of the mentally ill family member. The comfort is in knowing one can only control his/her own life and can choose to change the way they respond to their ill loved one as a means of regaining control within limits. At this time some find support and comfort through spiritual and religious means (2002). Mueller, Plevak, and Rummans (2001) view religious involvement as a moderating factor for the adverse effects of caring for a sick relative, as it is associated
with more rapid resolution of grief. In accordance, Foster, O'Brien, and Korhonen (2012) developed a framework for family-focused care for children and families with parents with mental illness, which incorporated religious/spiritual activities for emotional support within the community in fostering resilience.

Increased family stability was evident in family members who had a comprehensive understanding of their relative’s illness, and were able to adjust their perceptions and expectations (Mahlbauer, 2002). Similarly, Rose, Mallinson, and Walton-Moss (2002) proposed a theory of the basic social processes involved with families responding to mental illness and found that in confronting the ambiguity of the diagnosis, families were striving to achieve a sense of normalcy via crisis management. In this stage, family members tend to initially label the mentally ill individual with unfavorable qualities and characteristics (i.e. lazy, selfish, and willful), but upon understanding the manifestation of the illness, individuals began attributing these traits to symptoms of the illness (Mahlbauer, 2002; Rose, Mallinson, & Walton-Moss, 2002). A sense of relief and acceptance is achieved as this provides explanations to previous unexplainable and bizarre behavior (Mahlbauer, 2002). This led to less anxiety, tension and hostility in the home since family members were more understanding, less angry and more tolerant (2002).

Another major theme was the tendency to try to manage the negative behavior of their ill relative while attempting to handle the ethical concern it created (Mahlbauer, 2002). Similarly, Rose, Mallinson, and Walton-Moss (2002) found that questioning responsibility for symptom management was a common theme observed in individuals seeking a sense of control. Limits had to be set between controlling the individual and
respecting the patient’s right to independence, free will, and privacy (Mahlbauer, 2002). Family members often report facing internal battles between what they believe to be ethically moral treatment of the individual, yet managing to successfully control the patient’s potentially problematic or dangerous behaviors. At this stage, it is recognized that clear boundaries and limits need to be set regarding problem behavior. Once feelings of guilt had decreased, and perspectives changed, family members were better able to make decisions. With a realization that family members themselves have needs that must be attended to, they learned to act rather than react to the ill member when also attending to their needs and attempting to managing symptoms. The more skilled families became in solving problems, making decisions, and following a system to best manage their relative, the development of healthy care patterns emerged (2002).

Continuum of Stability

Family members are able to maintain stability in this phase while (a) continuing to produce successful ways to cope with the relative and negative symptoms through the use of practical care patterns, and (b) utilizing their available support network (Mahlbauer, 2002). As individuals caring for a mentally ill family member developed realistic ways to attend to their relatives needs, many noted the assistance and needed support from others in similar situations in community organizations and psychoeducational groups (2002). Correspondingly, Baucom, Shoham, Mueser, Daiuto, and Stickle (1998) mention the focus of family programs to foster the development of all family members to integrate a support system larger than just within the family. It was also suggested that families with mental illness, specifically schizophrenia, could benefit when they incorporate family-assisted interventions, disorder-specific interventions, and regular couple or
family therapy. These successful family interventions focus on three main aims including: (1) education on the ill members disorder, (2) understanding and changing the methods by which family members can create an environment in which their ill relative can manage and improve problematic symptoms, and (3) developing relational patterns that help the entire family to cope effectively (1998). As the family’s become more knowledgeable and better able to cope, longer periods of relief kept them hopeful and optimistic about managing the future (Mahlbauer, 2002). Well-developed approaches were in play to help their relative with a mental illness handle symptoms, manage money, decrease anxiety, and acclimate to change. This led to the final phase in which family members developed a sense of empowerment and personal change that came about from managing to navigate through the storm of previous phases (2002).

**Growth and Advocacy**

Although many family members continually worried about relapse and wondered what the future held for their ill relative, some individuals experienced a final stage in which awareness of their personal growth and an increase in advocacy activities (Mahlbauer, 2002). Participants report the experience as promoting self-evaluation and reflection that helped create meaning and value clarification. Others advocated for the needs of ill individuals with the increased sense of knowledge and gained ability to create change. However, this did not remedy the ongoing fears family members have about the future of their mentally ill relative when they are not able to assist or attend to their needs. The unpredictable nature of the course of mental illness sustains some level of helplessness for caretakers. Although empowerment and personal growth resulted as part of the experience, their relative’s future posed as one of the greatest worries for family
members. Furthermore, it is interesting to note that not all participants of the study reported a sense of personal growth (2002). The human capacity to thrive after extremely aversive events was discussed by Bonanno, (2004) who proposed hardiness as a personal quality that may enhance an individual’s ability to manage stressful situations. Hardy individuals were described as yearning to finding meaning and purpose, they were confident in their ability to control their environment and outcome of events, and they had an optimistic outlook based on the belief that they can learn and grow from all types of life experiences. Consequently, they are more likely to experience lower levels of stress from potentially negative life experiences as hardy persons view these situations as minor threats. Moreover, the body of research links the individual’s trait of resiliency, which has often been ignored and underestimated, with better outcomes for individuals faced with aversive situations (2004).

Resilience

Resilience in Children

Goodman and Gotlib suggest that mental illness, alone, does not ensure negative outcomes for children with mentally ill parents, yet outcomes are affected rather through the combination of components such as the child’s capacity for resiliency and the degree of exposure to various risks (as cited in Nicholson, Biebel, Hinden, Henry, & Stier, 2001). While many family experiences with mental illness differ substantially, it is advantageous to examine the qualities of individuals who successfully bounce back from adversity. Bernard (1991) provides a profile of the resilient child possessing specific characteristics that aid the child’s ability to manage in times of severe stress. These include (a) social competence, (b) problem-solving skills, (c) autonomy, and (d) sense of
purpose and future. The attributes of social skill identified as most essential were responsiveness, flexibility, empathy, effective communication, and a sense of humor. Children with these qualities are more likely to establish positive relations with others, create positive perspectives, elicit more positive responses from others and adapt better (1991). Additionally, Bonanno (2004) shares that positive emotion and laughter foster resiliency after stressful events by decreasing negative emotion. The second ability, problem solving, involves the capacity to think abstractly, reflectively, and flexibly, and to be able to come up with varying solutions for cognitive and social issues (Benard, 1991). The third factor, autonomy, refers to the sense of independence and control one has over his/her environment. Chess made mention of the protective factor of distancing oneself from the family focus of the dysfunctional behavior to preserve healthy development and the ability to attain productive goals (as cited in Benard, 1991). The last quality, having a sense of future and purpose, has been linked with resiliency as it is related to the following protective factors: having positive expectancies, goal setting behavior, being motivated to achieve, perseverance, hardiness, and anticipation of a hopeful future (1991).

**Resilience in Families**

Positive and negative risk factors can also be identified within the child’s family environment (Benard, 1991). Family functioning affects recovery and resilience factors since crisis and challenges concern the family unit and the at risk members within it (Walsh, 2002). But unfortunately this had led many recovery efforts to involve resources from outside the dysfunction of the family rather than building hardy family systems equipped for the adversities they face. The benefit of a family systems approach for
resilience is that the attention shifts from dysfunction and psychopathology to familial strengths (2002). Walsh (1996) developed a framework incorporating the key processes necessary for family resilience. It identified essential protective factors embedded in the family’s belief systems, organizational patterns, and communication processes of families. Belief systems that involved: making meaning of the crisis, optimism, confidence in overcoming obstacles, learning, growth, and spirituality promoted resilience. Familial organizational patterns incorporating flexibility, connectedness, and social and economic support resources were necessary for families managing crisis. Effective communication consists of clear and consistent clarification; empathic and open emotional sharing; and collaborative problem solving focuses on goal setting and shared decision-making for conflict resolution (1996). Efforts put toward enhancing family resilience empowers and gives hope, while building the family resources to meet challenges effectively (Walsh, 2002).

Benard (1991) offers specific protective factors in families that optimize the outcomes for children and youth. Troubled families that still manage to have ongoing care, support, and affection for their children promote resiliency. In addition, families that have high expectations for their children raise more resilient children. The author lastly suggests encouraging children to participate in family activities/ duties by assigning responsibilities so that they feel like valuable and capable participants of the family. With a supportive family environment that incorporates the factors stated above, children develop the traits of resiliency. These kids are more likely to be socially competent, possess problem-solving skills, achieve autonomy, and have a sense of purpose. To
further foster resiliency in our youth, systems in the environment can also positively influence outcomes for children (1991).

**Resilience in Schools**

The literature has identified factors that are in place in school settings that have supported children’s development of resiliency. Benard (1991) identified that the protective factors observed in family environments also served as effective and supportive factors necessary in schools. Schools that supported the development of resilient youth were generally composed of caring and supportive communities, had a school culture of positive and high expectations for each student, and provided ample opportunities for contribution and involvement in meaningful roles of responsibility within the school system (1991). Through the collection of personal reflections of principals and teachers at schools, Johnson (1997) identified various compensatory factors for children in disadvantaged situations. Those relevant to school relationships included having a positive role model, receiving encouragement and the concern of an adult, and having supportive relationship with school personnel. Positive and supportive human interaction was identified as the most critical compensatory factor for at-risk students. Additionally, programs for substance abuse, anger management, and social skills training were rated as beneficial protective factors. While academic achievement was noted as a protective factor, it has been more commonly been described as an expression of resiliency in children (1997). Rak and Patterson (1996) suggest that school counselors can play a positive role in promoting resiliency of at risk children by focusing on their strengths rather than weaknesses, be understanding, implementing age appropriate guidance groups, and developing realistic methods to improve self-concept.
Risk Factors for COPMI

In addition to the possible negative outcomes previously mentioned, COPMI are susceptible to a variety of risk factors. Maybery, Ling, Szakacs, and Reupert (2005) report that these children were found to be at a significantly higher risk of experiencing lower social, emotional, psychological and physical health than children in families not affected by mental illness. Data gathered from participating COPMI and their parents in focus groups revealed common issues with coping (Maybery et al., 2005; Twibell, 1998). Twibell (1998) found that immediate family members (spouse and children in comparison to siblings, grandchildren and grandparents) are more likely to engage in ineffective coping styles due to the increased sense of loss experienced by close relatives whose daily lives involve interaction with the affected individual.

Corrigan (2004) finds that stigmatization of mental illness creates additional barriers since stereotyping, prejudice, and discrimination lead to a decline in seeking mental health services. According to Hinshaw (2005), those whom are dependant on their family members are least likely to engage in help seeking behaviors and may be at risk of the negative effects of stigma. COPMI often experience feelings of shame, guilt, confusion, and embarrassment due to societal stigmatization of mental illness. This leads to secrecy, isolation, and a tendency for children to blame themselves when they don’t have knowledge about the mental illness (2005). When stigma causes family members to engage in acts of rejection and distancing toward their mentally ill relative, fear and ignorance about the illness increase, creating a vicious stigma-sustaining cycle (Hinshaw, 2007).
Pretis and Dimova (2008) identified additional risks including: reduced self-esteem and social competence, as well as less optimism and healthy family relationships due to feelings of guilt. Additionally, being a child of a mentally ill parent can increase the likelihood of disrupting a child’s secure attachment in relationships (Maybery et al., 2005). These children often become young caretakers, affecting their participation in school and in their social lives (2005). A more thorough examination of the effects of parental mental illness on attachment will be discussed in the sections to follow.

In examining the effects of parental mental illness on children’s rate of secondary school completion, Farahati, Marcotte, & Wilcox-Gok (2003) analyzed data gathered by the National Comorbidity Survey (NCS) and discovered an increased likelihood of dropping out of high school for COPMI when compared to families without mental illness. According to Barton (2006), the difficult living environments that result in academic failure can create lifelong economic and social disadvantages for young students. Farahati et al. (2003) established that there are more negative effects relating to child schooling if the ill parent was the mother, suggesting that mothers may be more influential than fathers in children’s school attainment. These researchers also reasoned that a mentally ill mother might cause more burdens and added responsibilities for children that may lead to school withdrawal. The researchers concluded that programs aimed at supporting COPMI might indirectly endorse higher levels of educational and socioeconomic success (2003).

Nicholsom, Biebel, Hinden, Henry and Stier, (2001) reveal that thirty to fifty percent of offspring of mentally ill parents are diagnosed with mental disorders, whereas the general population has a twenty percent diagnosis rate. Furthermore, Clarke,
Hornbrook, Lynch, Polen, Gale, Beardslee, O’Connor, & Seeley (2001) state that many COPMI who develop recurrent depression in adulthood experience their first depressive episodes in adolescence. The data puts COPMI in a high-risk category and suggests a need for early intervention and preventative measures.

**Protective Factors for COPMI**

With all the known risk factors that COPMI are predisposed to, the research on protective factors has been growing. For children, learning that their parent has a SMI may be a frightening concept, especially when they do not understand much about the illness. Sherman (2007) argued that it is essential that they be provided with educational resources, are able to get their questions answered, and know that they are not to blame for their parent’s illness. Nicholsom, Biebel, Hinden, Henry & Stier (2001) recommended educating families about mental illness to overcome stigma and developing peer supports to promote well being and healthy functioning for affected family members. They additionally recommend advocating efforts to all systems and domains that the affected members may be involved, including the family members, school counselors, etc. (2001).

Morey and Mueser (2007) bring awareness to the importance of open and effective communication between family members in promoting a low-stress, supportive environment for the family. Although families generally spend much emotional energy attending to the mentally ill parent, the researchers argue it is important that family members be able to appropriately cope in order to minimize negative effects. Moreover, they urged care taking of the self by allotting time and energy for the needs, goals, and well being of the often invisible and forgotten family members (2007). In a compilation
of previous research, Pretis & Dimova (2008) identified several evidence-based resilience factors in COPMI’s personality and environment including: easy temperament, self-efficacy, high self-esteem, optimism, hardiness, social competence, involvement in community or school activities, being informed and knowledgeable about their parent’s mental illness, having an attachment to a healthy adult professional, and separation from unhealthy backgrounds.

Sherman (2007) stated that children living in difficult familial circumstances have better outcomes when they have at least one healthy, trusting adult in whom they can confide and receive support. The researcher also indicated that additional support from and open communication with others facing similar issues results in universality and is found to be a therapeutic (2007). Furthermore, Harrison (2003) mentioned that in the case where an attachment figure such as a parent is unavailable for appropriate attachment and support, meaningful emotional ties could be effectively established with others. Teachers and school counselors are often the first professionals to be in contact with these children and are in an ideal position to offer them the support they need (Pretis & Dimova, 2008). This is especially crucial as it had previously been mentioned that COPMI faced higher risks of disruptions in attachment (Maybery et al., 2005). It can be argued that the opportunity for COPMI to develop a positive adult attachment with school professionals essentially creates a “safe haven” that the child can return to at times of distress (Bowlby, 1988).

**COPMI and Attachment**

Ainsworth and Bowlby’s (1991) combined efforts led to the development of Attachment theory. In a search for understanding personality development, Bowlby
formulated the theory’s points, while Ainsworth was able to empirically test and expand on the theory (Bretherton, 1992). Ainsworth introduced the notion of the “secure base” that the attachment figure serves and the importance of maternal sensitivity and its effects on the development of healthy attachments (1992). Waters and Cummings (2000) describe attachment as the secure base from which one can explore and return to as a haven of safety in times of need for comfort from distress. Infants begin predicting and expecting specific responses from caregivers when they are distressed at as early as 6 months of age; the development of their corresponding attachment styles are categorized as either secure, avoidant, resistant, or disorganized (Ainsworth, Blehar, Waters, & Wall, 1978; Van Ijzendoorn, Schuengel, & Bakermans-Kranenburg, 1999).

Van Ijzendoorn, Schuengel, and Bakermans-Kranenburg (1999) describe the caregivers’ patterns of response to infant distress leading to the different attachment styles: Secure infants’ caregivers are sensitive and loving to the infant’s display of distress; Avoidant attachments arise from caregivers that ignore, are impatient and ridicule an infant in times of need; resistant infants’ caregiver’s respond in inconsistent and unexpected ways. Main and Solomon (1986) introduced the disorganized attachment style, in which display unusual, contradicting disorganized behavior in response to caregivers’ atypical responses to their infant’s negative emotions. The latter three attachment styles are labeled insecure, and are linked to higher risks of issues with social and emotional regulation later on in life (Van Ijzendoorn et al., 1999). These high risks are especially seen in disorganized individuals who are unable to solve the dilemma of having a “safe haven” that is also a source of pain, confusion, and distress (1999).
The relationship between parental mental illness and the attachment style of their offspring became of particular interest. Van IJzendoorn, Goldberg, Kroonenberg, and Frenkel (1992) in a meta-analysis of 34 clinical studies to test the degrees at which maternal issues, such as mental illness, and infant issues, such as autism, are likely to contribute to the development of insecure attachments. As measured through the Strange Situation procedure, the researchers found maternal mental illness to be a larger factor in disorganized and deviated attachment styles than impairments in the child. The data suggests mothers are better able to compensate for infant issues, whereas infants will have a difficult time compensating for the lack of love and responsiveness from the disturbed behavior of a seriously mentally ill caregiver (1992).

Nonetheless, Hipwell, Goossens, Melhuish, and Kumar (2000) revealed that other factors, such as maternal diagnosis, play an important role in infant-mother attachment styles. Although COPMI are at risk for insecure attachment styles, it is important to take the mediating factors into consideration. A compilation of the research conducted by Cummings and Cicchetti; Field, Healy, Goldstein, and Guthertz; Goodman and Brumley; Lyons–Ruth, Zoll, Connell, and Grunbaum; Pound, Cox, Puckering, and Mills; Teti and Nakaon-gawa make note of relevant factor such as: The length and course of the disorder, treatments in place, the child’s age at the onset of exposure to the parental illness, the intensity of family discord, whether the parent with the illness is the primary caretaker of the child, etc., (as cited in Hipwell, Goossens, Melhuish, & Kumar, 2000).

**School Supports**

When the chaos and distress stems from the home environment, children can be best supported where they spend a great deal of their time – school. Fudge and Mason
(2004) set out to recognize ways in which children can be supported so that they can better cope with having a parent who is ill at times. One major area of focus was within the school system and they found that children do distinguish school as a safe and temporary getaway from family distress. In their study, twenty-five young individuals between the ages of 13 and 20 participated in focus groups and peer interviews and collectively identified counselors, good friends, and teachers as individuals at school that it would be helpful to talk to, especially at times of crisis. Participants also valued the support of an adult to speak to and a safe place that was available for that purpose before and after school. Some also commented on the need for school personnel to show they care and for teachers to be more flexible if they know a child’s parent is ill. As for the role of the school counselor, there were varied responses but some valued the support and information attained from their competent counselors. Younger children between the ages of 7 and 12 stated that schools could provide general information about mental illness and help educate children on positive coping skills (2004). The findings provide implications for services at school settings and the possible benefits of the involvement of competent and caring school counselors.

Similarly, Reupert and Maybery (2007b) conducted an investigation of strategies used in the school system to support COPMI. In the study, 6 teachers, 2 school counselors, and a principal were interviewed after being nominated by COPMI and their families as supportive school personnel. For many participants, the school counselor served as a helpful source of advice for ways in which they could help COPMI on campus. Participants often reported a lack in academic achievement motivation with students dealing with difficulties at home. As a result, several teachers reported paying
extra attention to COPMI students by praising their work, departmentalizing lengthy projects, leading class discussion on general coping skills, and encouraging them to take part in school activities. They also reported taking special interest in COPMI well being by simply asking how they were doing. While many children were referred to counselors, these counselors felt limited on time and often helped to support the teachers to better assist COPMI. As problems at home may be overwhelming, participants generally found it more helpful to put the focus on the child in school rather than with parents and families. Although each individual had their own particular approach to support and find ways of meeting the psychosocial needs of the vulnerable COPMI, this study exemplified the value of creative individual strategies that families themselves identified as best practice for their children (2007b).

**Relevant Outcomes of Program Evaluations**

In an effort to assist the COPMI needs and promote protective factors, several interventions have been implemented and evaluated for efficacy. Maybery, Reupert, & Goodyear (2006) evaluated the Vic Champs intervention that ran 37 programs (on school holidays and/or after school) in Victoria, British Columbia, aimed at promoting resiliency, emotional well-being, social connectedness and by providing support and age appropriate information. As measured by the Strengths and Difficulties Questionnaire (SDQ), the major key findings regarding the efficacy of this program were an overall increase in children’s well being, characterized by less emotional problems, higher self-esteem, a growth of connections, and generally less total difficulties. The majority of children felt more comfortable in asking questions and gained a sense of universality. Interviews and focus groups revealed successes for children in normalizing mental
illness, decreasing isolation, validating their experience, creating their own identities, and providing education and disproving myths.

Alternatively, the researchers found a significant decrease in the children’s prosocial behavior. They reasoned that the degree of well being at entry of the program can affect program efficacy and recommended future programs to have defined referral and selection criteria. Other insightful recommendations for facilitators included following clear guidelines, being responsive and flexible to children’s needs, and informing and including parents in the process of the program (2006).

Hargreaves, O’Brien, Bond, Forer, Basile, Davies, and Patton (2005) evaluated an 8-week peer support program known as Paying Attention to Self (PATS) that was also aimed at alleviating the risk factors for COPMI. Facilitated by a health professional and a peer leader, 12 to 18 year old COPMI participated in this program to improve their coping skills and to decrease chance of future mental health problems. In their evaluation, the researchers found significantly lower levels of depressive symptoms, risk of homelessness and stigma associated with having a parent with a mental illness. The participants reported feeling that the program facilitated them in increasing their confidence in asking for help, helping them realize they were not alone nor to blame, becoming more self-accepting, learning and understanding their parents’ illness and helped them enhance their coping skills. In implementing the program they established that family involvement was the most effective way to keep members engaged. It was additionally recommended that future programs include alternative ways to reach out to COPMI who do not wish to attend a group setting (2005).
In a broader program evaluation project, Hinden, Biebel, Nicholson, Henry, & Stier (2002) identified and systematically described previously interventions and were able to recognize the programs essential and key components, as well as other relevant outcomes. When examining the data, they found it essential that programs incorporate comprehensive case management, an array of services, crisis intervention, parenting training, and education aimed at fostering the parent-child connection. The elements associated with program success featured family-centered and strengths focused practices that were provided by trusting, supportive and unconditionally loving leaders. When evaluating programs for positive outcomes, they discovered that optimal functioning of family members, enhanced parent-child relationships, attainment of basic needs, broadened social networks, and improvements in children’s school readiness and school attendance (2002).

**Summary: Future Implications**

Due to the significant number of COPMI who are struggling to cope and are being exposed to the various risks discussed above, the purpose of this project is to develop a workshop aimed at improving the well-being of COPMI and promoting school success during such a developmentally crucial period in their lives. In designing this project, the researcher will be utilizing various discussed protective factors and other previously implemented key components that were proven to be beneficial and successful in helping COPMI attain their needs.
CHAPTER III: METHODOLOGY

Introduction

Families consisting of a parent with a serious mental illness commonly face recurrent stressors and are in need for crisis intervention. Often times, the children of mentally ill persons are the last ones to get their needs met, although they are prone to a variety of negative outcomes. The body of research indicates that these at-risk children can strive to grow and work towards positive outcomes as resilient individuals when given the proper support and education. The proposed school-based workshop for children of parents with mental illness intends to incorporate various protective factors to promote the healthy development of COPMI, resulting in academic achievement for future success. The specific factors and details involved with the implementation of the workshop are to proceed. Namely, the process involved in the development of this project, the intended target population, the necessary qualifications of professionals administering the workshop, and the proper environment and equipment utilized for the effective management of the project workshop. Additionally, an outline of the content and activities presented in the workshop will be provided.

Development of Project

The inspiration behind this project stemmed from personally being the adult child of a parent with a mental illness. Experiencing the unfamiliarity’s of mental illness and the daunting reality of role reversal between a father and a daughter, it became a mission to identify the factors that promoted my resiliency and the factors that could have provided relief to the distressing experience. Needing human support and answers to various questions, a counselor-conducted psychoeducational workshop on mental illness
seemed appropriate. As outside research supported the data collection of risk factors and the concerning protective factors associated with being a COPMI, a workshop with content and activities aimed at addressing COPMI needs was developed. Furthermore, evaluations conducted on previously implemented programs, such as Vics Champs and PATS, served as guidelines by which procedures comprised the proposed project. See Appendix A for a copy of the workshop presentation slides.

**Intended Audience**

The target population for the workshop consists of children who have parents with a serious mental illness, specifically mood disorders (Depression and Bipolar Disorders) and schizophrenia-spectrum disorders. Based on the premises that early intervention is a necessary for preventative measures, the workshop is geared toward children in middle school (ranging from approximately 10 to 14 years of age) as it is designed with age-appropriate material. To support the limited attention span of the population, the workshop was designed to last no longer than 2 hours in length. Participants are required to turn in an informed consent form signed by a parent or legal guardian prior to attending the workshop. See Appendix B for a copy of the informed consent form.

**Personal Qualifications**

Ideally, this workshop is best facilitated by the school counselor(s) of the middle school where the workshop has been approved as an intervention for COPMI. A suitable counselor should possess a variety of qualities that help foster a therapeutic relationship. This is because the counselor serves as a “healthy adult” that COPMI can form a positive ongoing attachment with throughout the duration of their stay at the school. Hence, personality traits such as being empathetic, caring, and sensitive to others needs, will
assist the therapeutic process. Credentialed school counselors also licensed as marriage and family therapist (MFT) may be more qualified as their training may require more experiences with families dealing with mental illness. Licensed therapist may also be better versed in providing personal therapy, and in teaching coping skills and emotional awareness.

**Environment and Equipment**

All students attending the workshop must return a signed informed consent form found in Appendix B. An intimate setting on the school campus such as a classroom, library, or small auditorium would be ideal for this workshop presentation. The room should be large enough to seat 20 to 30 participants, preferably in a semi-circular formation facing the speaker on the other side of the room. This arrangement promotes equality while creating an intimate and open environment for children to participate in activities and stay engaged in the learning process.

The workshop is presented through the use of PowerPoint, thus access to a system compatible with PowerPoint software, a projector to display the slides, and a screen or flat surface on which the PowerPoint slides may be viewed are required. Handouts of the PowerPoint slides may be printed and provided for attending COPMI as a visual support for focusing on the various topics and as a resource for open discussion with family members after the conclusion of the workshop. All attendees will also receive a three-page handout on the various types of serious mental illnesses as well as a “Care Plan” worksheet that will require a pen or pencil and a desk to write on as each student will be filling out their own unique care plans on their worksheet. See Appendix C and D for a copy of the “Types of Serious Mental Illness” handout and “Care Plan” worksheet.
CHAPTER IV: CONCLUSION

Summary

This interactive school-based workshop addresses the needs of children with mentally ill parents by offering middle school students with affected parents the opportunity to come together to in a safe environment to learn, support each other, and receive the support of their school counselor. As the child goes through the various phases of the family experience of caring for a mentally ill relative, they are exposed to various risks factors. Nevertheless, childhood resiliency has been noted in children who have family and school environments that implement protective factors. The majority of these protective factors have been put to practice in a variety of programs for COPMI, which have been found to improve the likelihood of positive outcomes for such children. By implementing a school based resiliency program for COPMI, the ultimate aim of this workshop is to promote the healthy development of this at risk population, which will result in higher student academic achievement.

The first component of this 2-hour workshop is psychoeducational, intended to educate students about mental illness, healthy coping skills (i.e. discharging feelings), promoting self-care, and offering any other information that may serve as a beneficial protective factor. The second component is focused on getting students acquainted with their school counselors as a source of ongoing support, and discussing pertinent information about academics and means of advancement for school success. Using PowerPoint slides to facilitate mini-lectures, combined with interactive activities, the school counselors and children of mentally ill parents can work together in promoting the students development as healthy and successful individuals.
Future Research

There is a growing body of research concerning future outcomes of children who have parents with mental illness. Although the risk factors they face are well understood, new and enhanced strategies to counter the negative effects are continually being implemented in hopes of better results for COPMI. Children can greatly benefit from age appropriate resources incorporating findings of best practice for families who have a parent with mental illness.

Due to the complex nature of project development, this workshop did not fully incorporate the body of research supporting parental and community involvement as contributors in the promotion of healthy child development. If implemented efficiently, a more integrative model involving more supports other than peers and school counselors, may have resulted in better outcomes. The workshop was geared toward children of parents with a serious mental illness (schizophrenia-spectrum disorders and mood disorders) and can be expanded to include other mental disorders, but further analysis and research on effectiveness and proper execution of programs that overlap yet acknowledge the uniqueness of differing experience must be conducted. Additionally, the project did not take into account cultural factors. Currently, the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev. DSM-IV-TR; American Psychiatric Association, 2000) provides ethnic and cultural considerations aimed at increasing cultural sensitivity and decreasing unintended biases. Analysis and consideration of cultural backgrounds that affect the display of symptoms and the family’s experience of mental illness would enhance cultural sensitivity and increase cross-cultural applicability of this workshop.

Furthermore, this workshop addresses the needs of COPMI from a general standpoint and
does not assess children’s level of competence on mental illness, academic progress, or ability to cope and engage in self-care. Screening interviews and evaluations on potential participants conducted prior to the launching of the workshop may be useful in guiding the school counseling facilitators on addressing each student’s individual needs.

**Conclusion**

My experience as an adult child of a parent with mental illness mirrored that of the children mentioned in the research. Immediately faced with daunting novel situations, overwhelming responsibilities, and recurrent crisis, I knew I had to master coping skills and self-care if I wanted to continue on my path of healthy development. Most gratefully, I have been given opportunities that foster my resiliency and I credit my successes to my strong, empathetic, and empowering support network, as well as my desire to seek assistance and information. As a result of my experience, I created this project to provide and foster what I was blessed to have to those who are at high risk for negative outcomes.

In essence, this project was developed as a means of further enlightening myself, as well as others coping with similar circumstances. The process of developing a project on a subject that I hold close to my heart has been comforting. It has additionally provided me with the opportunity to grow personally, professionally, and academically. It is my hope that this will be a tool used in the future to support and guide children with mentally ill parents in schools.
References


National Alliance on Mental Illness (n.d.). Mental illness affects the whole family: We have answers [Brochure]. Los Angeles, CA: NAMI Westside LA.


Appendix A: Workshop Presentation

CHILDREN OF PARENTS WITH MENTAL ILLNESSES: A SCHOOL-BASED WORKSHOP FOR HEALTHY DEVELOPMENT AND SCHOOL SUCCESS

By

Monica Zaghi

CALIFORNIA STATE UNIVERSITY, NORTHRIDGE
Children of Parents with Mental Illness

A school-based workshop for healthy development and school success

By Monica Zaghi

Workshop Goals

The purpose of this presentation is to...

1. Give you information about mental illness
2. Teach Coping Skills and Self-Care
3. Connect with School Counselors as Support
4. Provide Information for School Success
Definition of Mental Illness

What is mental illness?

Mental illness (also known as brain disorder) is a term used for a group of disorders causing severe difficulty in thinking, feeling, and relating.

(National Alliance on Mental Illness, n.d.)

Types of Serious Mental Illness

Let’s review the “Types of Serious Mental Illness” handout that’s being passed around

Can we get a volunteer to read aloud?

Does anyone have any questions about any of the material on the handout?
Mental Illness is Common

If someone in your family has a mental illness, you are NOT alone.

• About 1 in 4 families in the U.S. will have a loved one with a mental illness.

• Mental illnesses are more common than cancer, diabetes, or heart disease.

(National Alliance on Mental Illness, n.d.)

Mental Illness is No Ones Fault

• People of all ages can have brain disorders.

• They can occur in any family in any culture.

• Mental illnesses are not the result of weak character, they are diseases, biologically based, and NOT anyone’s fault.

(National Alliance on Mental Illness, n.d.)
Stigma of Mental Illness continued

Stigma prevents people from seeking information and help, causing more fear and misconceptions about mental illness.

Let’s start by talking about mental illness openly...

You would be surprised how many people know someone with a mental illness but have been afraid to speak about it.

Remember, you are not alone!

(Corrigan, 2004; Hinshaw, 2007)

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Stigma of Mental Illness

*Stigma* is a term used to describe the shame attached to being a part of group that is looked down upon in society.

Mental illness is often misunderstood, leading to stigma.

Stigma causes feelings of shame, guilt, confusion, and embarrassment.

(Hinshaw, 2005; Hinshaw, 2007)
Stages of the Family’s Experience

(a) **Awareness:** Recognize there’s a problem and trying to find help

(b) **Crisis:** More problems and high stress

(c) **Cycle of instability & repeated crisis:** Experience anger, grief, & stigma

(d) **Moving to stability:** Working towards better coping

(e) **Continued stability:** Successful use of support & coping

(f) **Growth & advocacy:** Feeling knowledgeable, stronger, & in control

(Mahlbauer, 2002)

*Would anyone like to share their family's experience and the stage they think they're in?*

---

Resiliency

*Resilience refers to a person's ability to bounce back from tough situations*

(Walsh, 2002)

Factors for resiliency:

- Making meaning of the crisis
- Optimism
- Confident of conquering obstacles
- Having a desire to learn & grow
- Spirituality (ex. religion)

(Walsh, 1996)

*You all have the ability to be resilient!*
Coping Skills

Stress is inevitable but you can overcome it!

Turn to “Care Plan” worksheet and fill out:

1. Healthy ways I cope (manage/deal) with my stress

Let’s share answers and get ideas from each other

Add new healthy ways to cope with stress to your Care Plan worksheet as you hear them!

Sample Coping Skills

Exercise: Run, dance, hike, bike, swim, play sports, join a gym

Expressing feelings on paper: Write in a journal, draw a picture, write a letter, or create a collage to express how you’re feeling

Express feelings verbally: talk to someone, cry, laugh out loud

Do something you like: Read a book, volunteer, find a hobby, plan an outing (ex. picnic or beach day) with people you enjoy

Try to relax: meditate, yoga, muscle relaxation, mindfulness, get a massage, guided imagery, listen to soothing music

Humor: Laugh off stress, read jokes, watch a funny clip, smile

Expressing feelings and relaxation techniques can be practiced with your counselor & continued on your own
Just ask your counselor!

(Healthwise, 2010)
Self-care

*Your needs are most important, make sure to engage in self-care!*

Turn to “Care Plan” worksheet and fill out:

2. Things I do for myself and to take care of myself

Let’s share answers and get ideas from each other

Add new healthy ways to take care of yourself to your *Care Plan* worksheet as you hear them!

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Examples of Self-Care

*Take time off for yourself:* Relax, take a long bath, enjoy the things around you, have an outing, take quiet time, take it slow

*Nourish your body:* Eat healthy, drink enough liquids every day, do physical activity, get enough sleep, avoid alcohol and drugs

*Stand up for yourself:* Say “No,” set limits, and boundaries

*Get organized:* Make plans, have a schedule, use your time and energy wisely

*Treat yourself to something good:* Get your nails done, buy yourself something

*Be social:* Talk to friends and those you trust to express feelings

*Practice acceptance:* Accept things you cannot change

(Virginia Polytechnic Institute and State University, n.d.)
Support Network

Don’t forget you have support, you are not alone!

Turn to “Care Plan” worksheet and fill out:

3. My list of supports, including names and phone numbers

Let’s share answers and get ideas from each other

Add new supports to your Care Plan worksheet as you hear them!

Resource List

- National Alliance on Mental Illness (NAMI)
  NAMI is the nation’s largest mental health organization aimed at improving lives of children and adults living with mental illness and their families. www.nami.org

  Mindzone is a mental health website for teens that includes information on mental illnesses and how to cope with stress. www.copecared.deal.org

- Information Helpline
  Trained volunteers provide information, referrals, and support to all who have questions about or are affected by serious mental illness. Dial 1-800-950-NAMI

- National Suicide Prevention Hotline
  Are you in crisis? Dial 1-800-273-TALK

- L.A. County Department of Mental Health
  The Psychiatric Mobile Response Team (PMRT) provides 24-hour service for evaluating patients on site and determining if they require hospitalization. Dial 1-800-854-7771

- In the case of an EMERGENCY, Dial 911
School Counselor Support

Counselors give your introductions...

Students, get to know your counselors

They WANT to support YOU...

They are the link between you and the rest of the school & community

School Success

Counselors want you to be healthy, successful, & supported

You can ask them questions about:

• Academics: classes, grades, graduating, & college
• Programs & resources at school & in the community (ex. tutoring or therapy)
• Extracurricular sports, activities, and clubs at school
• How they can help you during a crisis
Counselor Appointments

Don’t forget to make an appointment with your school counselor to discuss any further questions about available support and ways to succeed academically in your middle school experience.

We also urge setting up a parent/guardian meeting.

References


National Alliance on Mental Illness (n.d.). Mental illness affects the whole family: We have answers [Brochure]. Los Angeles, CA: NAMI Westside LA.


Appendix B: Informed Consent Form

This consent form is intended for review by the student and a parent/legal guardian. The school counselors at ______________________ (school’s name) are inviting ______________________ (student’s name) to participate in a 2-hour school-based workshop on the date of ______________. The workshop will be facilitated/co-facilitated by ____________________________________________.

Goals
This interactive workshop offers students who have a parent with a mental illness the opportunity to come together in a safe environment to learn about mental illness, support each other, and receive the support of their school counselor. The ultimate aim is to promote the healthy development and academic success of our students.

Content
The first component of this workshop is psychoeducational, intended to educate students about mental illness, healthy coping skills, and promoting self-care. The second component is focused on getting students acquainted with their school counselors as a source of ongoing support, and discussing pertinent information about academics and means of advancement for school success.

Confidentiality
During the workshop, we may discuss personal and private matters. Participation is important as it helps provide feedback for other members but we must remember to keep confidentiality. This means we do not discuss what another member said during the workshop, although talking about the workshop with a parent or guardian is permitted. Confidentiality may be broken by facilitators if they believe someone is being harmed, a danger to themselves, or a danger to anyone else.

Participation
You have the right to refuse participation. The assent and consent of the student and Parent/legal guardian is needed in order to participate in the workshop. If interested in participation, please sign and complete the consent form below after reviewing and agreeing with the terms stated above. If you have any questions or concerns, please do not hesitate to contact us at: ________________________.

Sincerely,

(Cut and turn into the Counseling Office)

Please Print Student’s Name: _____________________________________________

☐ I want to participate in this workshop ☐ I want my child to participate in this workshop

__________________________________________  ____________________________________________
Student Signature             Date            Parent/Guardian Signature             Date
Appendix C: Serious Mental Illness Handout

Types of Serious Mental Illnesses

MOOD DISORDERS

The word mood is used to describe a person's emotional feeling at the time (example: very sad or very happy). When there is a problem with a person's mood for long periods of time and it is affecting them in a bad way, they may have a mood disorder. Mood disorders are the most common mental illness.

Two main mood disorders are:

1) Depression: deep sadness
2) Bipolar disorder: Both times of deep sadness (depression) and extreme excitement (mania)

Signs of depression include:

- Continual sad mood
- Less interest in usual activities, less energy, and being very tired
- Less hungry & losing weight; or more hungry & gaining weight
- Sleeping too little or too much and at unusual times
- Feeling guilty, that there is no hope, and that you aren't good enough
- Difficulty concentrating
- Thinking about or wishing to be dead; hurting or trying to kill yourself

Signs of mania include:

- Overjoyed/excited, uncontrolled mood; or short-tempered mood
- Endless energy, enthusiasm, and being very active
- Less need for sleep
- Fast, loud, speech that may not make sense
- Short temper, easily get in arguments
- Delusional thinking
- Activities with big consequences (spending lots of money or driving dangerously)

General Facts & Statistics

Depression will affect between 10% and 20% of people at some time during their lives. Extreme depression will affect between 3% and 5%, some as often as once or twice a year, with periods that may last longer than 6 months each. Depression is a very treatable illness most of the time. About 70% to 75% of people correctly diagnosed react well to treatment. There are many types of depression, and each responds differently to depression medications and therapy. People with depression are blamed for their problems and told to "snap out of it" but it is important to know that depression is a serious illness.

About 0.8% to 1.5% of people have bipolar disorder. Luckily, it can be one of the most treatable mental illnesses. Lithium medication works for 70% of people with bipolar disorder. In addition to medicine, many people with bipolar disorder do therapy and/or peer support groups.
SCHIZOPHRENIA-SPECTRUM DISORDERS

Schizophrenia is one of the most serious mental illnesses. About 1% of people will have it at some time during their life and it is usually first noticed between the ages of 17 and 25.

At first, the person may feel anxious and have a hard time concentrating, begin to pull away, work less, general appearance may decline, and friends may drift away. The person may seem like a completely different person, and doesn't usually understand that they have the illness.

Signs of schizophrenia include:

• Changes in senses: Their ability to see, taste, smell, touch, & hear may be stronger or unclear.

• Hallucinations: Hallucinations happen when someone senses something that isn't there. The most common hallucinations are imaginary sounds (example: hearing “voices” real people that are not really there).

• Delusions: Are false ideas that the person believes to be true even against logical arguments.

  Two main types of delusions are:
  1) Paranoid delusions: The belief that you're being watched, controlled, or singled out
  2) Grandiose delusions: The belief that one has special power, or is a famous person

• Difficulty understanding and reacting in proper ways: Since it’s difficult to understand what they see and hear, and because they experience delusions and hallucinations that others are not aware of, their responses usually do not make sense to others.

• Changes in emotions: The person may have quickly changing, random strong feelings. Many times emotions are not appropriate (example: laughing at something very sad). Later there may be apathy, lack of drive, loss of interest and inability to enjoy activities.

• Changes in behavior: Slowness of movement, inactivity, and withdrawing are common. Ritualistic behaviors in movement are sometimes present.

As of now, there is no cure for schizophrenia, but medications can help make symptoms better.

Schizophreniform Disorder: Occurs if schizophrenia symptoms last for less than 6 months.

Schizoaffective Disorder: An illness with a combination of psychotic symptoms such as hallucinations or delusions, and major mood symptoms, either depression, mania, or both (bipolar). The psychotic symptoms are there even when the mood symptoms are gone.
SUICIDE

Suicide may be a sign of mental illness, but not all people who commit suicide are mentally ill.

Warning signs of depression and suicide include:

- Sad, short-tempered, anxious, tired, unable to make up mind, uninterested, or moody
- Difficulty concentrating on tasks; loss of appetite; crying
- Oversleeping or little sleeping, sometimes with waking early
- Loss of interest in friends, hobbies, or other activities previously enjoyed
- Fear of losing control, "going crazy," or hurting oneself or others
- Worries about money or illness, either real or imagined
- Feeling of helpless and worthless
- Feeling that there's no hope for the future
- Abusing drug or alcohol
- Recent loss through death, divorce, separation or a broken relationship
- Loss of a job, money, status, confidence or self-esteem
- Loss of religious faith
- Talking about committing suicide and trying to end your life the past
- Having plans for "leaving," by giving away belongings or admitting a desire to die
- Being overly active or tense

Threats of suicide or actual attempts should always be taken seriously. If you believe the situation may be dangerous, do not hesitate to call 911 for emergency help.

References


Appendix D: Care Plan Worksheet

Name: _____________________

My Care Plan

1. Healthy ways I cope (manage/deal) with my stress:

*Stress is inevitable but you can overcome it!*

2. Things I do for myself and to take care of myself:

*Your needs are most important, make sure to engage in self-care!*

3. My list of supports, including names and phone numbers:

*Don’t forget you have support, you are not alone!*