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Young Children with Mentally Ill Parents

Resilient Developmental Systems

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Mental illness is a family matter. When one member has mental illness, it affects all others in the family. In their simplest forms, the distress and functional impairment of the ill family member are felt on a daily basis by others in the household – in ways that range from empathizing with the distress, to disruption of interpersonal relationships within the family, to compromised family functioning in which tasks of daily life are not accomplished. At a more complex level, when the mentally ill family member is a parent, there are well-established risks for the children in that family. Rates of mental illness are higher throughout the children's lifespan (particularly during the typical risk periods for mental illnesses), difficulties in school are more frequent, and problems in general social adjustment (such as delinquent behavior) are manifest. Still, the mechanisms by which this risk is manifest remain obscure.

In this chapter, I describe the current state of our knowledge regarding resilience in infants and young children who have a parent with mental illness. I begin by addressing some basic issues regarding how general models of resilience may be adapted to the particular circumstances of infants and toddlers. Following this, I summarize relevant research that may be interpreted in a resilience framework. I conclude with a summary model of processes identified to date in this population, along with some commentary on how well the resilience model will ultimately serve to aid understanding in this field.

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RESILIENCE MODELS: APPLICATION TO THE FIRST YEARS OF LIFE

Differences in the lives of children whose parent has mental illness are evident from the first weeks of life (see Seifer & Dickstein, 2000, for a summary of this work). These differences are most obvious in the social-emotional domain of functioning. Relationship processes, as indexed by variables such as attachment status, reveal small but consistent trends toward insecurity and perhaps disorganization. Affective responsiveness is less well organized. This may be seen, for example, in en face interactions (close interactions in which parents and infants are facing one another) in procedures like the still face. Cognitive and motor development, in contrast, rarely is different in children of mentally ill parents (a notable exception is delay in motor accomplishments in children of schizophrenic mothers). These differences in the children are observed in the context of distinct patterns of behavior in the parents, including affective dysregulation, distorted cognitions (with particular interest in cognitions about the child), and less involved and supportive interaction patterns. Note that almost all of the studies in this field focus on mothers, as is the case in most human development research in which parental influences are a focus.

Infants and young children present some unique challenges when considering how to identify resilience processes. In the context of early childhood adaptation to parental mental illness, it is simple to identify a straightforward resilience formulation. The identified risk in such studies is the parental illness. It is also simple to identify many potential protective factors, including variables such as child temperament, parenting behavior, family functioning, marital functioning, and parental course of illness. Within this formulation, resilience would be evident by a particular type of statistical interaction (minimal differences within the non-ill group, substantial improvement within the ill group) or by multiple prediction of child outcome by risk and protective variables. Unfortunately, operationalizing such models is not straightforward.

Children in the first years of life have not yet established a developmental pathway that is substantially independent of caregivers. There is widespread appreciation that when studying behavioral processes in infants and preschool children (whether normative or deviant), it is imperative that the caregiving system be an integral part of the assessment of behavioral adjustment (Sameroff & Emde, 1989; Zero to Three, 1995). This feature places an additional burden on the already complex

research agenda of identifying resilience. What is the focus of the developmental outcome? Is it the child, the caregiver, of the child-caregiver system?

Young age brings with it another inherent complication when examining resilience. These young children have simply not had a long enough life to play out the contingent processes basic to some manifestations of resilience. Many of the processes identified in resilient youth do not appear fully formed, but take place over extended development periods. For example, establishing a relationship with a trusted adult (who may compensate for the deficiencies of an ill parent) may take years. Furthermore, the opportunities for such experiences may be linked to the developmental stage of the child. Infants and young children spend the vast majority of their time in a limited variety of social contexts, such as home, child care, or preschool. The increasingly independent access to larger and more varied social communities characteristic of older youth is not available in the first years of life.

Developmental considerations affect analysis of resilience in other ways. Young children have not yet developed many skills and functions that underlie potential resilience processes. Verbal skills are minimal; social relationships are just emerging from the caregiving context; emotion-processing abilities are limited; many cognitive developments have yet to emerge. This complex of developmental immaturity provides children with few resources to overcome adversity.

How do we search for resilience under these conditions? As I alluded to earlier, the classic definition of resilience may require some modification when addressing the development of infants and preschoolers. The most restrictive version of the classic model would consider the risk condition of parental psychopathology as conferring a developmental hazard on the child. When resilience processes are at work, however, the result is a positive child outcome. The restrictive aspect of this model is that an interaction effect is required. The resilience process is operative only when the risk condition is present; otherwise, it has no effect on the child's outcome (Rutter, 1987).

A variant of the classic model, which is generally well accepted, contains the same basic elements. The major difference in this less restrictive model is that there need not be an interaction effect. Instead, any characteristic demonstrated to result in a positive child outcome in the presence of risk is deemed indicative of a resilience process (Luthar, Cicchetti, & Becker, 2000). Such effects may be in the form of multiple prediction or include a mediated set of relations.

When searching for resilience in infants and young children, either variant of the classic model requires further revision to be a useful aid in understanding the core phenomena. Because of the undifferentiated nature of the caregiver–child relationship, along with the developmental immaturity and short life experience of the child, the focus of attention needs to be broadened. On the one hand, the locus of the resilience process is not simply the child, but rather the parent–child system. On the other, the positive outcome may also be viewed as inhering in the parent–child system rather than in the child alone. Elaborating on this last point, when examining risk and resilience processes in children so young, it is difficult to identify developmental outcomes that can be considered to be organized adverse responses to the risk that have functional significance for the child. What is more amenable to identification at this point in development is a set of interim outcomes that would not be considered to be fully formed adverse consequences of the risk. Instead, such interim outcomes might be viewed as perturbations to caregiving systems that if not resolved will continue to increase the risk for poor child outcomes (Sameroff & Emde, 1989). As with the resilience processes, the locus of the interim outcomes is best understood as being part of the caregiving system as opposed to the child alone.

This alternative model sets up a somewhat different agenda for describing resilience in the infants and toddlers under discussion. The interim outcomes described previously have two qualities different from those of most other analyses of resilience. First, they may not superficially appear to be the positive or negative indicators of development ordinarily discussed in the context of resilience. For example, typical outcome indicators might be academic success, occupational status, diagnosed mental illness, significant social isolation, or criminal behavior. The indicators in early childhood are more subtle – for example, the quality of relationships or the management of emotions. Second, they do not necessarily pertain to the child, but instead to the parent–child system – for example, the parent's cognitions about the child. These differences stem from a fundamental view of resilience that defines it as forces that pressure development in a positive direction.

As I will detail in the sections to follow, many of the resilience factors that can be identified from existing research on infants and toddlers are best characterized as processes affecting developments that may subsequently have long-lasting consequences for the children. For the most part, these are research findings that are tantalizing regarding whether there is a demonstration of resilience. As noted previously, in most cases

it is difficult to establish a definitive adverse outcome in children that is ameliorated by the resilience process in question.

RESEARCH FINDINGS

Few studies that examine infants and toddlers with mentally ill parents have been explicitly designed to examine resilience processes. Instead, most have been set up to elucidate how children's early development proceeds in the context of this demonstrated risk factor. This treatment of resilience will thus focus on inferences that can be made about the developmental pathways that appear to be initiated early in the lives of the children of mentally ill parents. In summarizing this research, I will categorize the findings in terms of children's emotion processing, parents' emotion processing, parents' interactive behavior, and parents' cognitions about their children. Because few of these studies have been cast as examining resilience processes, I will present the findings as the authors originally stated them (typically in terms of negative consequences of parental illness). I will add integrative material that interprets findings in terms of resilience. In almost all of the studies described, depression is the mental illness in question. There are few studies in which other mental illness have been the focus early in life, and these have tended not to be informative regarding resilience processes.

Child Emotion Processing

Attachment

Much of the research that examines children's emotion processing involves the organized behavior system reflected in attachment status. This is understandable on two counts: Attachment is one of the few developmental outcomes that is well established and measurable in the first years of life, and there is evidence that attachment has some level of enduring consequences in the years to follow. These studies have focused on both *insecure* attachment (organized strategies of children resulting in less than optimal resolution of relationship perturbation) and *disorganized* attachment (lack of an organized response to such perturbation). The latter (disorganized attachment) is viewed as indicative of more serious compromise of the caregiving relationship.

Most of the studies have focused on attachment as an important interim parent–child relationship outcome, with designs that examine how depression in combination with other factors predicts attachment

status. The normative literature on attachment emphasizes the importance of parenting sensitivity (contingent, appropriate responsiveness to the child's signals) as a mechanism for promoting secure attachment in infants. Surprisingly, this set of associations has not been a major focus in work with ill parents and their infants. One study that addressed these issues in the same sample found that maternal depression was indeed associated with lower maternal sensitivity and more insecure infant attachment (Hipwell, Goosens, Melhuish, & Kumar, 2000). Still, this report is vague as to whether maternal sensitivity mediated the association of depression and attachment (or even predicted attachment status) while emphasizing the importance of severity of maternal illness. Somewhat related to the issue of sensitivity is that children are more likely to have insecure attachment when mothers have high illusory control – the belief of control over behavior when their input had no effect during a laboratory procedure (Donovan & Leavitt, 1989). Maternal depression is only weakly associated with the insecure attachment outcomes, and thus the interpretation of illusory control as a mediator is suspect.

Maternal depression in the presence of high social-contextual risk is associated with insecure attachment in 2-year-olds (Cicchetti, Rogosch, & Toth, 1998). These children also are more likely to exhibit behavior problems – an instance in which attachment itself functions as a mediator. Chronic family adversity – the presence of multiple social-contextual risks, including maternal depression – is related to children's insecure attachment in another study of risks for early conduct problems (Shaw & Vondra, 1993). Stability of attachment patterns appears related to depression: Children are more likely to shift from secure to insecure (during adolescence) in the context of poverty, maltreatment, and maternal depression (Weinfield, Sroufe, & Egeland, 2000).

Disorganized attachment is associated with the stable presence of mothers' depressive symptoms (Teti, Gelfand, Messinger, & Isabella, 1995). Additional factors of parenting stress and parenting behavior also add to the prediction of disorganization. In a similar vein, highly stressed depressed mothers participating in a home-visiting intervention are less likely to have children with disorganized attachment or with insecure attachment (Lyons-Ruth, Connell, Grunebaum, & Botein, 1990). This intervention was designed to provide emotional and tangible support to the mothers in an effort to ameliorate the parenting stresses of the type identified in Teti et al.'s (1995) work. A counterintuitive finding in the intervention study is that mothers' parenting sensitivity is unrelated to intervention participation. This indicator of parenting

behavior is presumed by many to be the strongest predictor of attachment status.

In terms of resilience, these studies of attachment outcomes indicate that in the presence of maternal depression, the absence of other social-contextual risks will protect children from the individual risk of parental illness. Similarly, the resolution of mothers' depressive symptoms will more often result in adaptive relationship functioning of children. Depressed mothers' sensitivity to their infants' interactive behavior may serve as a mechanism that promotes more secure relationship functioning. Lyons-Ruth et al.'s (1990) intervention study provides the strongest evidence of a resilience process in which continuity of a supportive relationship reduces the risk associated with the mothers' psychopathology (akin to the effect on parenting stress in the Teti et al. 1995 study). All of these resilience processes are best viewed as processes in the caregiving system rather than as individual child processes.

It is theoretically attractive to think that the quality of attachment relationships would also serve as protection against risks conferred by parental mental illness. Surprisingly little data exist concerning this proposition. The Ciccetti et al. (1998) and Shaw and Vondra (1995) studies (the latter is described later) are notable exceptions. This state of affairs suggests the possibility that researchers have investigated this point but to date have not found evidence supportive of a resilience process involving attachment security, hence the lack of published material.

Infant Negativity

In contrast to the more organized attachment behaviors, the simple expression of negativity by infants and toddlers is also implicated in risk and resilience processes. Child negativity may be indicative of a constitutional difference in a subset of at-risk children, perhaps identifying the most vulnerable. Negativity may also be significant because of its fundamental importance in the course of everyday parent–child interactions. Interacting with a difficult relationship partner may be the most challenging situation for a young parent. Furthermore, this challenge may be heightened for a parent working with the more limited resources associated with mental illness.

Examination of en-face interactions has been widely used to study interactive processes in the first year of life. This method provides the opportunity to examine the social behavior of infants when the social demands are well identified, as when the procedure includes a period when mothers are instructed to maintain a still face. Furthermore, the

procedure lends itself to microanalytic processing, facilitating identification of infants' behavioral and emotional signals to their social partners. The expression of emotion by infants during the still-face procedure is viewed as indicative of adaptive social signaling to an (inappropriately) unresponsive caregiver.

Infants of depressed and well mothers who show little smiling during the still-face procedure have higher rates of externalizing problem behaviors at 18 months of age. Less crying during this procedure is also associated with lower rates of internalizing problem behavior at 18 months. This may indicate that children who continue to signal mothers to engage in normative social discourse, rather than becoming affectively dysregulated, ultimately develop fewer symptoms. These findings were only loosely related to whether or not mothers were depressed, calling into question a strong mediation or multiple predictor interpretation (Moore, Cohn, & Campbell, 2001).

Infant negativity expressed more generally, indexed by measures of temperament, interacts with maternal depression to predict sensitive parenting (Pauli-Pott, Mertesacker, Bade, Bauer, & Beckmann, 2000). Unlike most studies of infant temperament, both mothers and observers provided information about the children, eliminating an important method confound; both measures revealed the same interaction effect. Work in my own laboratory reveals a similar finding in preliminary analyses (unpublished). Associations between maternal depression and parenting sensitivity are moderated by infant negativity; the association is stronger when infants express higher negativity.

In the study by Shaw and Vondra (described previously), girls have more behavior problems at 3 years of age when mothers are depressed and the child had a difficult temperament in infancy. For boys, more behavior problems are associated with the combination of maternal depression and low maternal involvement. Furthermore, insecure attachment is in general associated with later behavior problems (Shaw & Vondra, 1995). Thus, negative emotionality and attachment insecurity both appear to behave as predictors of behavior problems in the context of risk due to maternal depression.

A different approach to negative affect is to examine physiologic correlates in the infants. A pattern of asymmetrical electroencephalographic (EEG) activation has been well established to be related to negative affectivity (Davidson, Schaffer, & Sron, 1985; Fox & Davidson, 1988). Dawson and colleagues found that children of nondepressed mothers show the typical pattern of EEG asymmetry during play, whereas children

of depressed mothers do not. During separations from their mother, children of depressed mothers show heightened asymmetric activation. Their behavioral responses are also different: The children of depressed mothers show lower peak distress and longer latency to distress (Dawson, Klinger, Panagiotides, Hill, & Spieker, 1992; see also Dawson, Hessl, & Frey, 1994).

The evidence for resilience in these studies of emotion expression implies that children of depressed mothers who maintain positive emotional states will be more likely to have more positive social and behavioral adjustment. Also, those infants who respond more normatively to the day-to-day perturbations in the flow of parent–child interactions may be less liable to develop behavior problems (although the link to the risk of parental illness is tenuous). Finally, those infants whose EEG activation is consistent with normative patterns may be more likely to exhibit typical behavioral expression of emotion, perhaps reflecting a constitutional bias toward adaptive functioning.

Parenting Behavior

Parenting Sensitivity

Several studies have examined parenting behaviors as predicted by parental mental illness and other factors. When viewed from the perspective of resilience, these studies reflect the type of extension of the classic resilience model I discussed earlier – viewing the outcome as a property of the caregiving system rather than of the child at risk. Many of the studies that lend themselves to a resilience interpretation focus on the construct of parenting sensitivity, which I noted earlier has been viewed as an important predictor of child attachment security.

Findings from the National Institute of Child Health and Human Development (NICHD) study of child care provide evidence regarding maternal depression and parenting sensitivity. Multiple prediction of sensitivity by depression, demographic factors, and infant negativity was identified. Still, there remained independent prediction of sensitivity by depression (NICHD, 1999a). These differences in maternal sensitivity are, in turn, associated with several child outcomes in the preschool period. These outcomes include school readiness, expressive language, verbal comprehension, competent social behavior, and behavior problems. Parenting sensitivity mediates the association between depression and these outcomes; some interactions of small magnitude are found as well (NICHD, 1999b).

Fathers who are alcoholic and depressed are likely to engage in insensitive parenting (Das Eiden, Cavez, & Leonard, 1999). Similar effects have been found for mothers, but there was a smaller number of alcoholic mothers in the study. Taking a slightly different tack, Donovan, Leavitt, & Walsh, (1998) find that sensitivity – defined as the ability to detect infant crying in a signal detection paradigm – is associated with maternal depression, conflict over work and parenting roles, and marital happiness.

There are many studies in which parenting sensitivity functions more as the protective process than as the indicator of developmental outcome. Many of these were reviewed earlier in the discussion of child emotion processing, in which the combination of parental illness and insensitive parenting is associated with poorer child functioning (Hipwell et al., 2000; Pauli-Pott et al., 2000; Teti et al., 1995). With respect to a different child outcome, the combination of maternal depression and insensitive parenting is associated with poorer child cognitive functioning at 18 months and 5 years of age (Murray, Fioru-Cowley, Hooper, & Cooper, 1996a; Murray, Hipwell, Hooper, & Stein, 1996b).

Resilience may be discerned in these studies in that sensitive parenting is less likely to be manifest when depression occurs in isolation. When depression co-occurs with other factors, such as alcoholism, infant negativity, marital distress, or internal conflicts, insensitive parenting is more likely to occur. Parenting sensitivity, in turn, may be viewed as integral to resilience processes when other outcomes are considered (see the preceding discussion regarding the child's emotion processing). Taken together, research on parenting sensitivity points to complex developmental pathways from parental mental illness to positive or negative child outcomes.

Other Parenting Behavior

The language environment parents provide for children affects their cognitive and emotional growth. Although this has not been a major focus in studies of parental illness, two studies are relevant for the present agenda. The content of mothers' speech relevant to their infants in combination with mothers' depression predicts cognitive development in the second year of life (Murray, Kempton, Woolgar, & Hooper, 1993). There is also evidence that depressed mothers do not adjust their speech to their infants, as is typical of most adults, that is, the use of "motherese" or characteristic pacing and intonation of speech (Bettes, 1988). Still another aspect of parent–child interaction is the presence of overt conflict during social discourse. When such conflict occurs in the context of mothers' depression, there is a higher incidence of behavior problems (Leadbeater, Bishop, & Raver, 1996). The conclusion regarding resilience processes that can be inferred from this work is that parental adjustment to the language contexts of infants and the absence of overt conflict may contribute to positive adjustment in children of ill parents.

Parent Emotion Processing

The vast majority of studies relevant to resilience in young children born to mentally ill parents involve depression. Surprisingly, most of these studies do not address emotion processing in these parents with affective disorders. Still, a few studies do speak to this issue by addressing affective symptoms and family conflict.

One component of emotion processing is the maintenance of affective symptoms associated with the disorder itself. Hostile behavior in school and at home is more frequent in children whose mothers have consistent depression in the first years versus those whose symptoms resolved (Alpern & Lyons-Ruth, 1993). Campbell, Cohn, & Myers (1995) find depression chronicity in the first year of life to be associated with poorer-quality mother–infant interaction. In our own research, we have found that nonspecific aspects of mental illness are associated with child social-emotional and cognitive outcomes (Sameroff, Seifer, & Zax, 1982), with chronicity of illness the most relevant characteristic for the present discussion. In a different study where we examine the issue of symptom maintenance more precisely, mothers' depressive symptoms in the second and third years of life are associated with family functioning as well as child behavior problems (Seifer, Dickstein, Sameroff, Magee, & Hayden, 2001). In both of these studies we find that the nondiagnostic illness parameters predict child behavior after controlling for the presence of a lifetime diagnosis of depression.

When overt conflict in families is examined, the association of depression and intrusive parenting is mediated by this conflict (McElwain & Volling, 1999). This is similar to the finding discussed earlier regarding overt parent–child conflict (Leadbeater et al., 1996). Other studies have examined emotion not in the behavior of ill parents, but in their verbalizations. Expressed emotion (which in prior work has been associated with relapse in ill adults) in combination with maternal depression is associated with intrusive, hostile parenting (Jacobsen, Hibbs, & Ziegenhain, 2000).

Resilience in these studies may again be interpreted as the absence of additional negative features beyond the risk of parental illness. Absence of continuing symptoms, overtly hostile behavior, or verbally expressed hostility may portend more positive development in the children and in the caregiving system.

Parent Cognitions about the Self and the Child

When considering parents' contributions to resilience processes, the focus so far has been on behavior. Another set of findings concerns cognitions that parents have about their child. These cognitions take many forms, ranging from positive or negative feelings about the child, attributions about the child's abilities, and attributions about the parents themselves.

Attributions about the Child

Parents hold strong opinions about the characteristics of their children, and these opinions likely affect the caregiving environment provided for these children. Furthermore, cognitive distortions are often a component of psychopathology. Depressed mothers who perceive their children to be vulnerable have children who are less exploratory and perform worse on standardized developmental tests at 1 year of age (Field et al., 1996). Anxious and depressed mothers perceive their infants to be fussy, hungry, and demanding. These mothers, in turn, have more feeding difficulties and stop breast-feeding earlier than those without negative perceptions (Hellin & Waller, 1992). In a slightly different vein, anxious mothers who perceive their infants as having low intentionality in their behavior themselves evidence less sensitive parenting behavior (Feldman & Reznick, 1996).

Feelings about the Child

The studies described previously focus on parents' understanding of their children's developmental competence. A few studies focus on parents' more immediate emotional responses to their children, perhaps indexing more strongly arousing (and less socially desirable) thoughts and feelings about their children. Unfortunately, the studies only reveal tantalizing clues about whether these are important processes to consider. Parents who are alcoholic and have psychopathology are more often aggravated with their children (Das Eiden & Leonard, 2000). Depressed parents with low social support and poor marital quality may be more susceptible

to having less investment in their children (Bradley, Whiteside-Mansell, Brisby, & Caldwell, 1997). Still, these studies reveal little about the consequences of these attributions for child or caregiving system adaptation.

Attributions about the Self

Parents not only have thoughts and feeling about their children, but also a parallel set of cognitions about themselves. Depressed mothers have lower perceived self-efficacy, which in turn is associated with lower behavioral competence with their children (Teti & Gelfand, 1991). Depressed mothers with a low internal locus of control (a component of dysfunctional attributional styles associated with depression) behave in a more controlling style when interacting with their children (Houck, Booth, & Barnard, 1991). A slightly different approach examined mothers who stayed at home with their children but who had a stated preference for being in the work force. Mothers with this attribution about their own roles have higher levels of depression (Hock & DeMeis, 1990). Still another way of viewing parents' attributions is by using the illusory control paradigm described earlier. Depressed parents with higher illusory control have more insecurely attached infants (Donovan & Leavitt, 1989).

In our own work, we have examined an aspect of parents' attributions about the caregiving system based on the construct of goodness of fit. In essence, this attribution concerns the degree to which parents perceive the characteristics of their child (e.g., negative mood, activity level, sleep habits) as being a good or poor fit with their own or their family's expectations for the child. This approach also includes parents' emotional response to these perceived mismatches and the adequacy of their coping strategies. Preliminary analyses of these unpublished data indicate that goodness of fit mediates associations between depression and parenting sensitivity and between depression and child social-emotional competence.

Resilience processes may be inferred from these findings in many ways. In the context of depression, the presence of positive parental cognitions about children portends well for more positive parenting behaviors in the caregiving system, with some evidence of more positive developments in children's social and cognitive development.

SUMMARY AND INTEGRATION

The intergenerational transmission of psychopathology has been a focus of research for over a century. The risk to children when parents

have mental illness has been well established. Beyond this simple risk, the degree of consensus in the field begins to decline. Some assert strong specificity in transmission, whereby children are at risk for the specific condition of their parents, often attributed to genetic factors. Others view the evidence as supporting a more varied picture, in which the risks conferred on children are far less specific and not restricted to the realm of mental illness. Instead, a more diverse set of developmental pathways is required to appreciate the manner in which children adapt to their circumstance of having a mentally ill parent (Seifer, 1995).

Developmental Models

When examining familial patterns of mental illness, an increase in the children's incidence of the specific disorder is typically identified in the parent. Still, the children are at risk for many things aside from attaining the same diagnosis as their parent – other mental health problems, school failure, low occupational status, substance abuse, health risk behavior, antisocial behavior, and poor social relationships. Conversely, diverse risks in the parental generation may converge on the same developmental outcome (such as a specific psychopathology diagnosis). From a more quantitative perspective, the findings from many studies of multiple risk factors point to the conclusion that a greater number of risks, regardless of what those risks may be, predicts a wide variety of adverse child outcomes (Burchinal, Roberts, Hooper, & Zeisel, 2000; Sameroff, Seifer, Baldwin, & Baldwin, 1993).

With this backdrop, the examination of infants and preschool children has proceeded within the more inclusive examination of multiple outcomes and processes, if only for the simple reason that diagnosing the syndromes of adult psychopathology makes little sense in children this young. What is also apparent is that many young children with mentally ill parents show no indication of an adverse outcome. As in other areas of research, this has spurred a search for resilience processes to aid understanding of why some children succumb to the risk, whereas others do not (Garmezy, 1985).

In this chapter I have reviewed many studies that may shed light on these issues. How can this set of research findings best be summarized? Several general points can be made. First, few existing studies have been explicitly designed to identify protective processes. Thus, as I have emphasized throughout, there is some degree of inference (beyond that

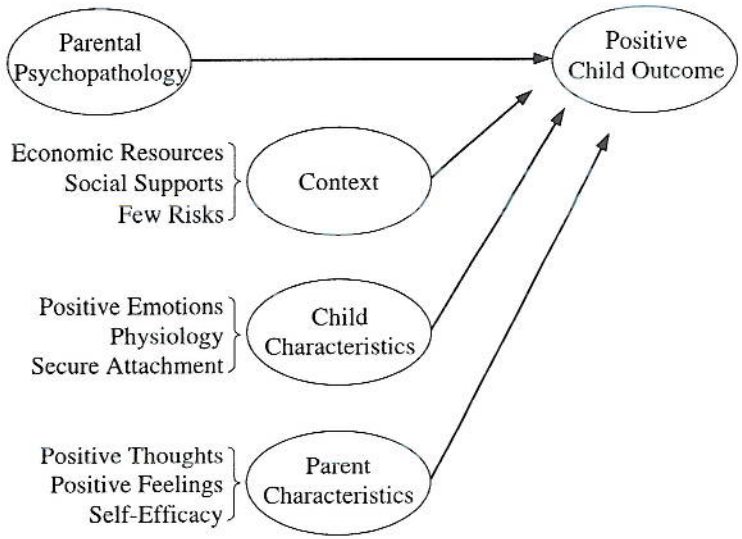

FIGURE 2.1 Resilience processes in young children of mentally ill parents.

normally found in resilience research) when interpreting the studies. Second, the research methods are very diverse. Although not enumerated in the discussion of specific findings, the definition of the initial risk was quite varied, ranging from psychopathology diagnosed by clinicians to self-reported subclinical symptom expression. This may result in some interpretation errors because the different studies reference different populations. Third, many components of the caregiving system may reveal evidence of resilience processes. These range from child attachment, to parenting sensitivity, to attributions parents hold about their children.

From the perspective of identifying specific developmental processes, the pathways to child competence are typically viewed as having many predictors, mediators, and moderators. This is in contrast to the relatively streamlined resilience models, where single protective processes buffer the effects of single risks. Given the multiplicity of research findings I have described in this chapter, it is likely that single-factor models will prove to be insufficient for elucidating resilience in this population of children; this array of forces is depicted in Figure 2.1. The arguments supportive of examining many factors simultaneously in multiple risk models – lack of specificity, accumulation of adversity, and increased predictive power – will likely apply to resilience models as well (Sameroff et al., 1993; Seifer, 1995).

Inferences Regarding Prevention

The relatively abstract presentation of research findings begs the question of what can and should be done to aid the young children known to be at risk because of their parents' psychopathology. Obviously, the best way to answer this question would be in the context of evaluating clinical trials of different prevention approaches designed to reduce the morbidity in this group of children. Unfortunately, little such evidence exists (e.g., Cicchetti, Toth, & Rogosch, 1999). We are thus left with making reasonable inferences from existing research to guide such prevention efforts. Several tentative conclusions can be drawn.

First, it is unlikely that a narrowly focused approach will be successful. Most of the effects noted early in life are small in magnitude and cover a diverse range of functions. Second, short-term approaches will also likely be ineffective. The little available work with mentally ill mothers, as well as other work with high-risk families early in life, suggests that intensive approaches over months or years are required to produce meaningful effects (Cicchetti et al., 1999; Olds et al., 1997). Third, intervention will need to focus on parent–child and family systems. At young ages, children's outcomes are intimately tied to the functioning of their caregivers. As I noted in the review of existing literature, differentiating purely child-focused outcomes does not tell the whole story; focusing on the caregiving system provides more insight into resilience processes. Finally, processes that are promising targets of preventive efforts include affective symptoms of the parent's illness, comorbid problems such as substance abuse, parenting behavior, parents' appraisals of their children, parent and family emotion management, family responses to difficult child behavior, and relationship formation. Also, even though it is not a major focus of many studies, poverty most likely exacerbates all of the difficulties families face in this realm, ranging from increased rates of psychopathology, to more coexisting risk factors, to fewer resources to counteract these multiple risks.

Developing effective preventions is not an easy task, and features peculiar to mentally ill mothers of young children present some unique difficulties. Psychopathology in young mothers is widely recognized as a problem, but important barriers to identifying families in need of assistance remain. Social stigma regarding mental illness continues to exist and may be particularly strong in new mothers, who are generally perceived to have entered a uniquely rewarding phase of their lives. The natural course of affective symptoms in the first year of the child's life

also presents barriers. Many (perhaps most) new mothers have an increase in depressive symptoms that typically pass with time. Still, many of these women do in fact experience significant psychopathology, and our current health care system is not designed to have regular contact with new mothers provided by individuals who are well trained to distinguish mental illness from the normative dysphoria associated with childbirth. A related issue is that our health care and social service systems tend to be fragmented, with different components addressing a narrow range of focused problems. An important consequence is that the presence of multiple risk conditions often goes undetected, leaving the most vulnerable families without much-needed assistance. Thus, in addition to developing approaches that are effective in preventing developmental problems in children, we need to become much more sophisticated at identifying mothers who might benefit from such prevention efforts before their children become too old to reap those benefits.

Early Development and Resilience Models

In the end, it is important to consider the question of how well resilience models fit the phenomena under study, ultimately providing guidance about how to assist children at risk. One answer to this question is that the models clearly reveal an important fact – that some children do well despite the adversities that accompany their early development. Another answer is that the models are probably interim aids to our understanding that will eventually need significant updating. The two areas where this is most apparent are (1) the simultaneous handling of multiple influences and (2) the variable-centeredness of the models. Both of these points emphasize the individual pathways that children take through their development. Adequately describing such pathways will ultimately require models more complex than those containing a few variables having more or less the same influences across diverse populations of children.

In summarizing the empirical work, I drew mainly from studies designed from a risk perspective, resulting in findings about negative child/caregiving system outcomes and processes. When making interpretations about resilience, I simply inferred that absence of the negative influences (or presence of the same influences in a positive direction) would result in positive child outcomes. Two potential problems are that this inference might simply be incorrect (since full evidence was not contained in these studies) and that an interpretation of resilience may be suspect if it is based simply on the absence of multiple risks. This issue

of multiple factors highlights the point that individual development is a product of the interplay of individual and contextual factors. In fact, one of the difficulties in organizing the research on these young children was differentiating the outcome factors from the protective factors; they were often interchangeable across studies.

A final point to consider is that resilience models are often portrayed as depictions of individuals overcoming externally imposed adversities. The danger in using such an emphasis is to make overly negative attributions about those individuals who do not evidence such success. They may not be the victims of their own weaknesses as much as they are the victims of their multiply risky contexts. Particularly with young children, in whom the distinction between individual characteristics and caregiving-system influences is blurred, inferring internal versus external sources of developmental outcomes can be fraught with error.

Despite some potential shortcomings of the general approach, resilience models continue to provide an important reminder to emphasize positive aspects of individual development that are often neglected in a discipline driven by understanding negative life outcomes (Masten, 2001; Seligman & Czikszentmihalyi, 2000). This positive focus may be particularly important when examining the development of infants and young children, who may be the best candidates for interventions that result from increased understanding of the processes that yield positive outcomes under conditions of risk. The existing data suggest there are many processes amenable to such interventions. But the small effect sizes typical in these studies also suggest that addressing any single process will likely have only a small impact on children's developmental outcomes. Instead, improving the course of children's lives when faced with familial mental illness will likely require multifaceted approaches that address the range of functions examined earlier – relationship quality, emotion regulation (of parents and children), parenting behavior, and parents' attributions about themselves and their children.

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