

Parents with Psychosis

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This study examined the prevalence of parenthood in a community-based sample of first-admission patients with DSM-IV diagnoses of Schizophrenia/Schizoaffective Disorder, Bipolar Disorder with psychotic features and Major Depressive Disorder with psychosis. A total of 130 (28.7%) of 453 patients were parents at the time of first admission. Women were twice as likely as men to be parents in all diagnostic groups. Patients with mood disorder with psychosis were twice as likely to be parents as those with Schizophrenia/Schizoaffective Disorder. Substance Use Disorder was a common comorbidity among fathers and to a somewhat lesser extent among mothers as well. At the time of admission, over three-quarters of mothers were living with their children, as were half or more of the fathers with mood disorder. Most continued to live with their children after discharge. Almost 40% of mothers with mood disorders were living as single parents both before and after admission. Almost three-quarters of the children were under 16 years of age. Over 40% of mothers in all diagnostic categories had at least one child under 5 years of age. About 20% of mothers in all 3 diagnoses experienced the onset of psychosis within 6 months of childbirth. Over half of these experienced psychotic symptoms related to the child or had neglected the child prior to admission. Our findings contrast with earlier studies from more chronic patient samples in documenting that first-admission patients with psychosis are generally intimately involved in their children's lives both before and after admission. Despite the fact that over three-quarters of these parents were still in treatment at 6-month follow-up, there was virtually no evidence that any form of educational or family-oriented treatment was offered to these parents. These results, coupled with earlier reports of highly disrupted family lives and serious adverse outcomes among the children of chronically ill parents, underscore the need for early family intervention programs. In addition, there is a need for systematic research to identify effective treatment interventions for this population.

INTRODUCTION

Despite considerable evidence that parental mental illness, especially among mothers, is associated with significant levels of psychopathology in offspring (1–9), there are few reports that address the actual prevalence of parenthood among patients with psychosis. The few existing studies of patients with mood disorders (with and without psychosis) and nonaffective psychoses have reported rates ranging from

one-third to over 60% (10–13). The majority of these patients had at least one child who was not yet an adult at the onset of the disorder (10–13).

A particularly vulnerable subset of these patients is those whose illness onset occurs shortly after childbirth. Although different studies employ a range of duration definitions when examining these postpartum episodes (from 2 weeks to one year after childbirth), most suggest that mood disorder with psychosis has the highest risk of occurrence (both unipolar and bipolar psychosis) with the risk for schizophrenia being lower (14–19).

Since virtually all earlier studies have involved samples of patients who were ill for several years prior to study entry, their findings may reflect at least in part the effect of chronicity of illness on family dynamics. In addition, most reports combine findings from diagnostically heterogeneous samples of patients with both affective and nonaffective illness, thus preventing the identification of diagnostically specific conclusions. Finally, most such reports focus on

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mothers with psychosis and provide little or no information on the fathers (7,10).

Perhaps the most crucial time for active intervention to prevent adverse outcomes is at the onset of illness. The present report, part of a larger community-based study of a first-admission cohort with psychosis, allowed us to study the rates of parenthood and its concomitants in both male and female patients with schizophrenia (SZ), bipolar disorder with psychosis (BAD), and major depression with psychosis (MDD). Specifically, we address the following questions: 1) What proportion of first-admission patients with each of these psychotic disorders are parents? 2) How much contact do they have with their children before the psychotic episode? 3) What proportion of women with first-admission psychosis are in the postpartum period? 4) How much contact do these patients have with their children over the initial 6-month follow-up period?

METHODS

The data for this report come from the Suffolk County Mental Health Project, whose design is described elsewhere (20). First admissions to the 12 inpatient facilities in the county were recruited by the head nurse or social worker of the unit (or project staff at two facilities) between 1989 and 1995 if they met the following criteria: first admission or current admission within 6 months of index admission; age 15–60 years; resident of Suffolk County, New York; presenting clinical evidence of psychosis, prescription of antipsychotic medication, and/or an admission facility diagnosis indicating psychosis; absence of moderate to severe mental retardation; ability to speak English; and capacity to provide informed consent. Approval for the study was obtained from the SUNY Stony Brook Institutional Review Board on an annual basis. Written informed consent for participation was obtained after the study was fully explained, and for those aged 15–17, written informed consent was also obtained from their parents. Consents for release of medical records and interviews of significant others were obtained separately and were not requirements of participation.

A total of $N = 695$ participants were interviewed at baseline, representing 72% of patients who initially screened positive. The baseline interview included the Structured Clinical Interview for DSM-III-R (SCID) (21). An interval SCID was also administered at face-to-face follow-up interviews at 6- and 24-months after baseline. These interviews were administered by master’s level mental health clinicians. Best estimate DSM-IV research diagnoses were reached by consensus of project psychiatrists at meetings following the 6- and 24-month follow ups (22). The primary sources of information available at these meetings were the SCID, standard clinical rating scales for psychotic and mood symptoms, medical records (or discharge summaries),

interviews with relatives, other interview materials on treatment experiences, and detailed narratives based on this information written by the interviewers. The sample for this study consisted of all study participants with a 24-month research diagnosis of MDD, BAD or SZ/SA who were reported to have parented a child prior to baseline illness.

The analysis utilized descriptive information, including gender (M/F); age (15–29, 30+); race (white/other); marital status (married/other) and living status (with child/not) at baseline; ages of children; degree of contact with the children at baseline and at the 6-month follow-up; and treatment status at 6-month follow up.

RESULTS

The proportion of the sample who were parents varied by gender and diagnosis (Table 1). Among the mood disorder groups, about half of the BAD and MDD women were parents. Fewer of the men had children at the time of their admission. In the SZ/SA group, 29.1% women had children while only 14.2% of the men were parents.

As shown in Table 2, at baseline, two-thirds or more of all gender/diagnosis parent groups were age 30+ and white. With respect to marital status, about half of each of the gender/diagnosis groups was currently married at baseline, with the exception of the SA/SA fathers, among whom only 19.1% were married.

More than two-thirds of the fathers in all three diagnostic groups met lifetime criteria for substance use disorder (SUD). The rates were somewhat higher in fact than the lifetime rates for men who were not fathers. The lifetime SUD rates for mothers ranged from 17.3% among SZ/SA patients to 41.9% among BAD patients. Overall these rates were similar to those for the women without children. Most importantly, in all gender/diagnostic groups, about half those meeting lifetime SUD criteria were actively using one or more substance at the time of baseline admission.

The vast majority of mothers in all three groups were living with one or more children at baseline. In contrast, while

Table I Percent of Sample Who Were Parents at Baseline, by Diagnosis and Gender

	All Patients <i>N</i>	Parents at Baseline	
		<i>N</i>	%
BAD			
Males	70	16	22.9
Females	69	31	44.9
MDD			
Males	36	12	33.3
Females	51	27	52.9
SZ/SA			
Males	148	21	14.2
Females	79	23	29.1

Table II Background Characteristics and Child Contact, by Diagnosis and Gender

	BAD		MDD		SZ/SA	
	Fathers N = 16 %	Mothers N = 31 %	Fathers N = 12 %	Mothers N = 27 %	Fathers N = 2 %	Mothers N = 23 %
Baseline						
Age 30+	84.2	64.5	75.0	77.8	66.7	78.3
White	81.3	87.1	66.7	74.1	76.2	65.2
Married	62.5	48.4	58.3	48.2	19.1	52.2
Lives w/child	75.0	90.3	50.0	81.5	28.6	78.3
Age of youngest child						
0–5	56.3	54.8	25.0	40.7	28.6	47.8
6–15	31.3	32.3	58.3	40.7	47.6	30.4
16+	12.5	12.9	16.7	18.5	23.8	21.7
Lifetime SUD dx	75.0	41.9	66.7	37.0	66.7	17.3
Six-Month Follow-up	N = 13 %	N = 28 %	N = 11 %	N = 27 %	N = 20 %	N = 21 %
Lives w/child	69.2	75.0	45.5	66.7	20.0	66.7
In treatment	84.6	74.1	72.7	70.4	70.0	81.0

75% of BAD fathers lived with children, this was true for only 50.0% of MDD fathers and 28.6% of SZ/SA fathers. For all but two of the fathers living with children, a spouse or partner was also living in the home. In contrast, over one-third of the mothers with mood disorders with psychosis were living alone with their children as were 14.2% of mothers with SZ/SA.

The total parent sample of 130 patients had 265 children at baseline, of whom 69 (26.0%) were ages 0–5 years, 117 (48.0%) were 5–16 years and 69 (26.0%) were 16+ years. BAD parents had more children on average (2.43 for fathers and 2.22 for mothers) than those with MDD (1.66 for fathers and 1.86 for mothers) or SZ/SA (1.38 for fathers and 2.08 for mothers). Over half the BAD parents had children under 5 years of age, as did over 40% of mothers with MDD and SZ/SA. Fewer fathers with MDD or SZ/SA had children that young.

Seven (22.5%) BAD mothers, 6 (22.2%) MDD mothers, and 4 (17.3%) SZ/SA mothers had onset of psychotic symptoms within 6 months after childbirth. For seven of these mothers, the presenting symptoms related to the child, including: command hallucinations to kill the child (one mother with MDD); fear of harming the child (one MDD, one BAD); fear that harm would come to the child (one MDD, one BAD); belief that the devil was in the baby (one BAD); and fear that her husband wanted to kill her and the child (one SZ/SA). In addition, one BAD mother tried to beat her infant in the hospital, and two SZ/SA mothers had severely neglected their infants resulting in the children being placed in foster care.

At 6-month follow up, for all gender/diagnostic categories, the proportion of parents living with children was 5–15% lower than the rates at baseline. In 5 cases, the mothers lost custody of their children to foster care (4) or to a relative. However, only 2 mothers with MDD and one with BAD

reported having no contact at all with their children during the 6-month follow-up, whereas among fathers, 8 (of 20) with SZ/SA, 3 (of 11) with MDD and 1 (of 13) with BAD reported no contact.

More than 70% of all gender/diagnosis groups were receiving treatment at 6-month follow up. Of those not in treatment, 21 were living with one or more children (4 with SZ/SA, 8 with MDD and 9 with BAD).

DISCUSSION

This report is the first to examine parenthood in a community sample of first-admission patients by specific diagnosis. It is also one of the few to include fathers in the sampling frame and to follow up these patients over time to examine their relationships with their children after discharge from the hospital. Since studies of more chronic, mixed samples of patients with psychosis have found that up to 35% of such patients with children had their first episode of psychosis before their first child was born, the rates of parenthood we found in our total population must be considered lower estimates of the potential impact of psychosis on offspring (10,11,13).

In answer to our first study question, up to half the female patients were mothers at first admission. Our finding that 52.9% of the female patients with MDD were mothers is similar to the finding from a more chronic sample of MDD patients (48.1%) (23). In contrast, the rates for SZ/SA patients are lower than the rates (combined for the genders) of 36.4%–39.5% found in more chronic samples, perhaps related to the generally earlier age of onset of psychosis in these patients (10,11).

In response to our second study question, almost all the mothers, regardless of diagnosis, were living with at least

one of their children but only half to three-quarters of the fathers were living with their children at first admission. These findings contrast with those from studies of more chronically ill patients where 50% or fewer mothers were even in contact with their children (10,12) several years after illness onset. It must also be noted that almost 40% of mothers with mood disorders were the sole caretakers of their children, suggesting in these cases the need for more direct support and training in coping with both a psychotic illness and the rigors of single parenthood.

A striking exception to these findings is the social isolation of the fathers with SZ/SA, less than 20% of whom were married and less than 30% of whom lived with their children at baseline. These findings suggest that their role in their children's lives was more circumscribed even before admission to the hospital, perhaps as a consequence of the prodromal symptoms of schizophrenia and the relatively long duration of psychosis preceding the hospitalization (24).

A compounding factor for these parents is the presence of SUD, especially among the fathers. However, the rates of SUD even among the mothers is generally higher than that reported for more chronic populations, suggesting another specific area for early intervention to prevent an adverse impact on both the parents and offspring (2,23).

An important difference between our findings and those of earlier studies of more chronic populations is the fact that about three-quarters of the children of these parents were less than 16 years old at first admission (e.g., compared to 23% in the Hearle *et al.* sample [10]). This finding underscores the need to initiate interventions, such as parent training classes, at the first onset of illness to prevent the negative outcomes reported for more chronic patient samples in which children are exposed to the psychotic illness for longer periods of time (1–2,5–8).

In relation to study question 3, our findings regarding psychosis during the postpartum period are unique in examining the rate of these disorders across diagnostic groups. Contrary to earlier reports which suggested that postpartum psychoses were primarily related to BAD or mood disorders in general (14–17,19), our findings suggest almost equal rates across all three diagnostic groups of mothers. In addition, when postpartum psychosis as defined as onset within the first 6 months after delivery, it is far from rare, comprising about 20% of all first-admission psychoses among mothers. Our data further confirm that this condition is frequently associated with thoughts of harm to the child or even actual child neglect. Our findings support the need for close observation of such patients during the psychotic phase, given the high rate of potentially harmful thoughts/events associated with this condition, regardless of underlying diagnosis.

In addressing our fourth question, at 6 month follow-up, the majority of parents were still living with their children, with the exception of fathers with SZ/SA. The fact that

virtually all mothers had some contact with their children contrasts with findings of studies of more chronic patients where as few as 25% of chronically mentally ill mothers are living with at least one child (25) and up to 38% had not had contact with their children in over 2 years (12). Likewise, a relatively small number of mothers in our study had lost custody of their children, compared to several studies cited by Joseph *et al.* (12) where up to half of the mothers with severe mental illness had had children in foster care.

Our finding that parents were still receiving treatment at follow-up is reassuring in the short-run although this treatment was largely pharmacologic. Only a handful of patients received any form of family intervention or psychoeducation that might have been helpful in preventing adverse effects on the children. More disquieting was the number of parents living with their children who were no longer in treatment at 6 months. These findings suggest the need for more intensive follow-up by the treating providers to ensure adherence to treatment in this high risk population.

In summary, our findings suggest the need for implementing an aggressive rehabilitation initiative at first onset of illness to prevent potential adverse effects seen in more chronic patient samples. In our sample, while treatment of the psychotic illness was generally provided and adhered to over the 6-month follow-up, there was little evidence that this treatment addressed needs such as those described by Beardslee *et al.* (26). A 10-year follow-up of this sample is currently underway which should shed light on the longer term course of these patients as regards their familial relationships over time.

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