

# Evaluating the Parental Fitness of Psychiatrically Diagnosed Individuals: Advocating a Functional–Contextual Analysis of Parenting

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The parental fitness of psychiatrically diagnosed individuals is often questioned in termination of parental rights cases. The goal of this article is to shift the focus from a predisposing bias of unfitness to a functional–contextual analysis of parenting behavior and competency. Three underlying biased assumptions are relevant for the courts' decision making: (a) that a diagnosis (past or present) predicts inadequate parenting and child risk, (b) that a diagnosis predicts unamenability to parenting interventions, and (c) that a diagnosis means the parent is forever unfit. Each assumption will be considered in light of empirical evidence, with major depression, schizophrenia, substance abuse, and mental retardation provided as examples of diagnostic labels often assumed to render a parent unfit. A research agenda to improve clinicians' ability to assess parental fitness and understanding of how parental mental illness, mental retardation, or substance abuse might compromise parenting capacities is discussed for forensic purposes.

Mentally ill women, like mentally well women, bear children, and usually share the same desire to raise their children. However, when women with these diagnoses are involved in the most extreme of custody proceedings, namely termination of parental rights hearings, parental unfitness may be assumed from diagnosis without close examination of how the disorder specifically impacts on their parenting. Thus a lower threshold for the termination of parental rights for these women is set. This lower threshold is reflected in some states' statutes, which permit termination of parental rights due to mental illness, mental deficiency, habitual use of alcohol or drugs, "debauchery," or "repeated lewd and lascivious behavior" (Melton, Petrila, Poythress, & Slobogin, 1997, p. 466). In this article we consider severely depressed, schizophrenic, substance abusing, and mentally retarded parents as parental groups that often come under scrutiny in order to illustrate the impact of a diagnostic label on the assessment of parental fitness. Though parental pathology does influence parenting quality

and capabilities, so does poverty, parental stress, and parental physical illness. However, we do not remove children from their parents solely because their parents are poor, stressed, or physically ill. As recently as 1980, one state's statute allowed for the termination of parental rights of mentally retarded persons without their consent or even any judicial determination that they were unfit (Field & Sanchez, 1999). More recent case law has emphasized that courts need to make custody judgments on the basis of an evaluation of parental competency and child risk, not by the mere presence of mental illness alone. Nevertheless, it has been argued that much discretion is still allowed in such cases (Grisso, 1986).

"There are few other areas of law where the courts rely as heavily on social science data as they do for decisions about children's welfare" (G. S. Goodman, Emery, & Haugaard, 1998, p. 775), and as social scientists we have the ethical responsibility to inform the courts with information that is empirically based. The purpose of this article, then, is to challenge the automatic assumption of parental unfitness of psychiatrically diagnosed parents (whatever that diagnosis might be) in order to sensitize expert witness evaluations and testimony and, ultimately, judges' decision-making. We urge consideration of factors that might determine whether and in what ways the parenting of persons with these diagnoses might be compromised, and we propose a more functional–contextual analysis of parenting capability. To do this, we consider the most extreme custody decision, termination of parental rights, and the most scrutinized parents, those with a severe affective or psychotic disorder, substance abuse disorder, or mental retardation. First, we briefly summarize the legal requirements and the human decision-making processes that are involved in the termina-

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tion of parental rights. Next, we review the research literature as it pertains to three broad assumptions regarding the psychiatrically diagnosed parent that might color the expert witness's testimony and, ultimately, the judge's decision. These assumptions are that (a) a diagnosis (past or present) predicts inadequate parenting or risk for child maltreatment, (b) a diagnosis predicts a lack of amenability to parenting interventions; and (c) a diagnosis means that the parent is forever unfit. Having reviewed the empirical evidence for these assumptions, we then outline a research agenda that might enhance mental health professionals' ability to provide balanced information to courts regarding the psychiatrically diagnosed parent and the viability of keeping the family united. Additionally, we suggest domains of the parenting context specific to evaluating psychiatrically diagnosed parents that should be examined.

## Termination of Parental Rights

### *Legal Requirements*

The process of terminating parental rights most typically begins with an initial report of abuse or neglect. (However, it should be noted that in the case of mentally ill, substance-abusing, or developmentally disabled parents, a tendency toward "predictive determinancy" has been suggested, whereby suspicions begin even before the parent has a chance to do harm, that is, during pregnancy, which may lead to removal of children at birth or undue pressure to voluntarily give up custody of the child or terminate pregnancy; Field & Sanchez, 1999). Once reported, the state investigates and takes emergency measures in the form of temporary removal of the child if deemed necessary. Depending on the conclusions of the investigation, the state attorney or social worker may then file a petition, following which disposition is determined. Ideally, custody is temporarily transferred while parents are required to meet conditions set by the court in order to improve parenting fitness and regain custody of the child. If the parent is unable to meet the conditions set forth by the court, a further hearing is likely to consider termination of parental rights (Melton et al., 1997). Whereas services are often offered by the state to help the parent meet these conditions, in the case of parents with psychiatric diagnoses, this process may be shortened or services either not offered or offered in a form that may not meet their special needs.

Mental health providers are often involved in the process as expert witnesses to inform the court either by providing a written report or directly testifying in court on the basis of evaluations of the parent and child, interviews with service providers working with the family, and reviews of child protective service records.

Before the state can sever the bond between a parent and child, the parent must demonstrate "unfitness" that is not amenable to intervention. The state must also demonstrate that it provided the services necessary to bring the parent to a level of fitness such that they can resume parenting and that these interventions were either not utilized or the parent did not show adequate progress (Melton et al., 1997).

In the past, the mere presence of certain conditions (such

as parental mental illness, mental retardation, or certain life-styles, e.g., drunkenness, immorality) was sufficient to result in termination of parental rights (Grisso, 1986). Recently, however, it has been further required that these conditions be shown to significantly affect the child's welfare and that the evidence be "clear and convincing" (Schetky & Benedek, 1992). The threshold for making such decisions, however, varies greatly depending on the jurisdiction's philosophy and is thus open to much interpretation.

The criteria for determining fitness have not been well specified in the law. Generally, there are two considerations relevant to parental fitness: imminent risk of harm to the child and minimally adequate care within community standards. Because legal definitions of parental fitness, abuse, and neglect are vague and varied, courts have turned to mental health professionals as expert witnesses to inform them on this topic with the assumption that a database and criteria for determining fitness do exist within the mental health field. This assumption may be less than sound (Azar, 1991). Universal criteria for parenting competency, let alone well-validated assessment techniques for these criteria, are not yet available.

### *Human Decision Making*

In the absence of clear statutory guidance and professionally validated and agreed upon criteria, human cognitive processes must be considered in understanding how parenting competency is determined. These processes guide decision-making and person perceptions and are heavily influenced by societally determined expectancies, and are hence, open to the biases inherent in societal views. Cognitive processes favor categorical thinking in the service of efficiency (Macrae & Bodenhausen, 2000). These general cognitive processes governing human thought have implications for both judges and evaluators. Levi (1949), in his classic discussion of legal reasoning, argued that common beliefs (i.e., the meaning ascribed to the words put forth in statutes) shape interpretation of criteria in the law. This meaning, he argues, can contradict the intent of the legislature.

Psychological testimony also may be biased by stereotypes of the mentally ill, which are founded more on societal expectancies than on empirical evidence. Complicating mental health evaluations is the fact that the legal judgments of parental fitness in termination cases are based on criteria of providing less than minimally adequate care and placing a child at imminent risk of harm. Mental health professionals, however, have a bias toward advocating *optimal* family environments for children. Consideration of minimally adequate conditions is not part of the professional schema on which theories are built and tested. Thus, there may be discordance in the information that the legal system requires to make a termination decision and the information mental health professionals can provide.

### *Societal Schema Regarding the Mentally Ill Parent*

Historically, the mentally ill have been viewed with extreme disfavor and have been treated poorly by the com-

munities in which they have lived. Even in modern times, individuals who have a diagnosis of mental disorder continue to be more likely to be viewed as incompetent. Research has documented that, presented with an equal stimulus presentation (e.g., a research confederate, written description), others will judge a person labeled as mentally ill more harshly than one without this label (Farina, 1982). The mentally ill are less likely to be seen as strong prospects for jobs or as tenants (Farina & Felner, 1973; Page, 1977), and are more likely to receive harsh treatment (e.g., longer shocks in a learning task; Farina, Holland, & Ring, 1966). Conversely, if individuals are told that the person they are about to meet believes they have a mental illness, their performance is negatively affected, even when that person has no such information (Farina, Allen, & Saul, 1968). This suggests that such individuals may behave differently in situations where their condition is "known" (e.g., in a parenting evaluation). Moreover, attitudinal research also has shown that mentally ill persons are viewed as more permanently at a disadvantage than another stigmatized group (convicts; Lamy, 1966). Even mental health professionals are biased in interpreting the behavior of diagnostically labeled individuals (Langer & Abelson, 1974; Rosenhan, 1973).

Such biases may influence judgments regarding parental fitness, amenability to intervention, and the level of risk to others. Indeed, in judging the domains most affected by a number of disabling conditions, emotional disorders were viewed as most detrimental to parenting and, in fact, parenting was seen as the domain most likely to be affected by emotional disorder (more than marital relations, vocation, etc.; MacDonald & Hall, 1969). Legal writers have cited similar biases in custody cases involving particular diagnostic groups. For example, with regard to mentally retarded parents, one legal writer stated, "From the perspective of the law, the mentally retarded parent is an oxymoron-in-waiting" (Hayman, 1990, p. 1202). It may be difficult for decision makers to transcend schematic responses to these persons.

### Three Assumptions Regarding Psychiatrically Diagnosed Parents

Three assumptions regarding psychiatric diagnosis and parenting incompetence may unduly bias the evaluation of parental fitness. It must be emphasized that our aim is not to dispute that a mental disorder may compromise or disrupt parenting behaviors but to challenge predisposing biases as to the level of disruption (e.g., unfitness) and to advocate a functional-contextual analysis of parenting competencies.

#### *Does a Diagnosis (Past or Present) Predict Inadequate Parenting or Risk for Child Maltreatment?*

The determination of parenting fitness in termination cases typically involves two judgments on the part of expert witnesses: judgments regarding risk of harm to a child if returned to the parent and judgments regarding whether caregiving falls below minimally adequate community stan-

dards. Clearly, high proportions of termination cases involve already identified child maltreaters. Although there is little national data, the information currently available suggests that the majority of these cases involve neglectful parents rather than abusive ones (Berkowitz & Sedlak, 1993; Jellinek et al., 1992). Despite this, beliefs about mentally ill individuals and their risk for violence may influence judgments regarding child risk. Mentally ill persons have been feared by society, in part because of a belief in their tendency for violence. Whether the mentally ill are more violent than others has been a subject of considerable research and debate as has been violence prediction by mental health professionals (Brody, 1990; Cocozza & Steadman, 1978; Monahan, 1981; Szmukler, 2001).

Some evidence supports increased risk of violence globally among the mentally ill. For example, in a large epidemiological study of over 7,000 community residents, the relative risk of aggression by mentally ill persons was greater than for those without psychiatric illness (two- to threefold; Swanson, 1994). However, the absolute risk was not nearly so high. Only 7% of all those with a major mental disorder (but without substance abuse) engaged in any assaultive behavior in a given year. Substance abuse was associated with a greater risk for violence than mental illness. A recent study found the prevalence of violence among mentally ill patients discharged from a hospital to be the same as the prevalence of violence among controls living in their communities when neither group had substance abuse symptoms (Steadman et al., 1998). Violence was greater among both discharged patients and community controls with substance abuse compared with those without, and the greatest violence prevalence was found in substance-abusing discharged patients.

Although still controversial, some predictive validity for violence risk has been reported in narrowly defined groups (e.g., for mental patients with specific diagnoses), under specific environmental constraints (e.g., in hospital settings), and within short time frames (e.g., immediately postdischarge; Gardner, Lidz, Mulvey, & Shaw, 1996). Under such circumstances, statements defining level of risk rather than dichotomous predictions are thought to be possible (Grisso & Appelbaum, 1992). Most recently the MacArthur Violence Risk Assessment Study (Monahan et al., 2000) has developed a tree-based method that is more accurate than other risk assessment methods and provides a multiple-risk level assessment rather than a dichotomous one. However, this is still not widely available for clinical use nor is it designed to predict child abuse risk per se.

Despite the advances in the actuarial prediction of violence, when risk prediction regarding child abuse and neglect is considered, available data fail to meet the current standards for risk prediction outlined by the field (see Grisso & Appelbaum, 1992). Moreover, it may never be possible to meet such criteria given the nature of risk involved (within a particular relationship) and the period over which prediction is required (e.g., for a 2-year-old, it is 16 years until adulthood). Only a very small literature exists regarding risk prediction in child maltreatment, and it largely addresses physical abuse but not neglect. Among already identified abusive and neglectful populations, follow-up studies with

large samples have found a number of predictors of recidivism, including perpetrator characteristics (e.g., the nature of maltreatment, level of stress, poverty, history of abuse, expectations of children, social isolation) and child factors (gender, age; Fryer & Miyoshi, 1994). Mental illness as a predictor has been found to have low specificity.

Although the question that is before expert witnesses is one of documented functional significance of the disorder for the child, strong beliefs within the field may exist that poor parenting is inherent in diagnosis. Child risk is often automatically assumed for children of parents diagnosed with substance abuse, major mental illness (affective and psychotic disorders), and mental retardation. Each of these parental conditions is briefly discussed with respect to risk of harm to the child and minimally adequate parenting.

*Substance-abusing parents.* Parental drug abuse is a major predictor of termination of parental rights (Jellinek, et al., 1992). Although there is evidence that such parents are overrepresented in child protective caseloads (Famularo, Stone, Barnum, & Wharton, 1986; Murphy et al., 1991), it is unclear whether this is due to a detection bias, in which parents are more likely to be identified and reported for maltreatment because of professionals' beliefs in greater child risk, or whether there is an actual increased risk of child maltreatment. Additionally, children exposed prenatally to substances might be more difficult to parent, increasing the likelihood of abusive parental behaviors. Wasserman and Leventhal (1993) did find more evidence of both physical abuse and neglect in medical records of children born to cocaine-dependent mothers than those born to non-cocaine-dependent controls, and there are data suggesting that assaultive behavior (in general, not specific to child maltreatment) increases in substance-abusing individuals (Steadman et al., 1998; Swanson, 1994). However, epidemiological data regarding violence toward children specifically are lacking, and research on the direct links between substance abuse and inadequate parenting is also scarce.

Maternal substance abuse might compromise the development and well-being of a child either by prenatal exposure to drugs and/or alcohol or by impairment of parenting capabilities postnatally. Evidence for the deleterious effects of prenatal drug exposure is mixed and varies depending on the type of substance exposure. For example, initial reports by the media of the dramatic impairments of cocaine babies were overemphasized and not confirmed by subsequent research (Carmichael-Olson & Burgess, 1997). The research findings on the effects of prenatal cocaine exposure have been inconsistent (Myers, 1992). In contrast, research on infants exposed to heroin and methadone more consistently points to early problems such as lower birth weights, higher levels of prematurity, and more respiratory distress (Householder, Hatcher, Burns, & Chasnoff, 1982). Mayes (1995) reviews several studies that indicate impairment in infant state regulation and responsiveness due to fetal alcohol effects and neonatal withdrawal syndrome from opiates.

How substance abuse might affect actual parenting behavior postnatally is more elusive. Substance abuse has been thought to interfere negatively with the parent-child relationship as well as negatively affect the quality of the environment provided by the substance-abusing parent.

Kaplan-Sanoff and Fitzgerald Rice (1992) observed that parents with substance addiction "have a primary relationship with their drug, not their child" (p.17). Thus, it is often assumed that substance abuse automatically leads to inadequate parenting. Data support the finding of increased behavioral difficulties, psychopathology, and substance abuse among offspring of such parents (Deren, 1986; West & Prinz, 1987). However, inadequate parenting is not the only explanation for this finding. For instance, less favorable child outcome may be due to prenatal drug exposure rather than an impaired parenting environment. Additionally, there may be a pre-existing psychiatric or neuropsychological disorder or a genetic vulnerability that predisposes these parents to substance abuse and also carries a genetic risk for their children. The minimal research available on the direct effects of substance abuse on parenting behaviors or abilities has primarily involved mothers and small samples and has yielded contradictory results. For example, although one study found opioid-dependent mothers to be less responsive and harsher than control mothers (though there was no difference in guidance and encouragement; Hans, Bernstein, & Henson, 1999), others have not found greater neglect for children of substance-abusing mothers (Harrington, Dubowitz, Black, & Binder, 1995). Heterogeneity of the substances used and severity as well as the young age of the children limit the conclusions that can be drawn from these studies.

Most studies have focused on the two dimensions of parenting that have emerged repeatedly as important to child outcome in the developmental literature: maternal control (also conceived of as restrictiveness, monitoring, or authoritarianism) and maternal responsiveness (also termed warmth or involvement; Maccoby & Martin, 1983). Extremes of control (either being overly permissive or restrictive) coupled with low responsiveness have been found to undermine children's development. One could imagine that a parent whose drug of choice is a depressant, might under-respond to and withdraw from her or his child, thus, interacting with low responsiveness and perhaps providing inadequate supervision and neglecting children's basic needs. In contrast, a mother addicted to stimulants, might have a primary mode of interaction with her child that is characterized by reacting unpredictably and impulsively, being overly responsive, or inconsistently controlling, behaviors that could possibly escalate to abuse.

Other potential effects of drug use that may bode poorly for parenting capacities are potential neurological impairments associated with long-term substance use such as memory and attention, but how or whether such impairments influence parenting has not yet been examined. Also influenced by substance abuse might be a mother's affect and impulse regulation and modulation of anxiety and frustration, both areas in which impairment might lead to increased risk for abuse. Again, well-controlled studies examining the implications of these issues for parenting are lacking. (For a thorough review of the literature on substance abuse and parenting, see Mayes, 1995.)

In addition, the context in which substance-abusing mothers live might put their children at risk (e.g., high-crime neighborhood, poverty, marital instability). For ex-

ample, abuse of illegal drugs may expose a child to increased violence or parental separations on account of incarceration. Wasserman and Leventhal (1993) found that cocaine-addicted mothers and their infants had significantly more separations in the first 2 years of life than a matched control sample.

Though parental substance abuse most probably carries risk for impaired parenting, the evidence for specific risk for any certain type of substance is quite limited, and research has yet to focus on exactly how parenting behaviors are affected and whether all parents are similarly affected. The type of substance chosen and the chronicity of usage may affect the type and level of risk. In addition, the data regarding whether parenting risk continues once substance abuse stops is very limited, but such continued risk may be of contention in court. The findings of one intervention study suggest that effects on child outcome that are not physiologically driven may be found to decrease or disappear with cessation of the substance use (Rodning, Beckwith, & Howard, 1991).

Staff members in a program offering clinical services for substance-involved families in the child welfare system noted that decisions were often based solely on current use of alcohol and drugs (such as urine screens in a treatment program; Olsen, Allen, & Azzi-Lessing, 1996). They found decision making based on such limited criteria inadequate, as many of the parents who had not made much progress in substance abuse treatment had adequate parenting skills, whereas some who appeared to make good progress in treatment had very limited parenting skills, putting their children at risk. There is a crucial need for research that identifies exactly which parenting capacities might be compromised and whether they remain compromised if substance abuse is treated successfully or spontaneous remission occurs.

*Parents with major mental illness.* Those who are suffering from major psychiatric disorders, such as schizophrenia and affective disorders, are a second diagnostic group whose parenting might come under legal scrutiny. The affective and cognitive disturbances seen in schizophrenic parents have been thought to influence parenting capacity by interfering with parent-child social interactions, whereas symptoms present in affective disorders such as withdrawal, irritability, and anhedonia have been thought to influence the parents' capacity to be warm and responsive toward their children and to control their children's behavior appropriately and consistently. Although such behaviors may influence parenting, the question remains as to whether they do in fact constitute unfitness such that parenting is below acceptable community standards.

Clearly, as with substance abuse, children of parents with major affective disorders have been shown to have an increased risk of affective disorder specifically, as well as other psychological problems more generally, including behavior problems, attention deficits, learning disabilities, cognitive and social deficits, substance abuse, anxiety, and somatic symptoms (see for example, Beardslee, Versage, & Gladstone, 1998; Weissman et al., 1987). Similarly, children of schizophrenic individuals have been shown to have an increased risk of psychiatric disorder (Watt, 1984). How-

ever, it is not clear what specifically places such children at risk.

Genetic or biological factors may play some role. For example, there is considerable evidence for the genetic transmission of depressive disorders based on twin and adoption studies. A recent review of twin studies of psychiatric illnesses documents in the literature an average heritability of liability to major depression of .33 and a range for schizophrenia from .60 to .84 (Kendler, 2001). Although the heightened problems found among offspring are partly due to genetic forces that have exerted their influence before the child was even born, we do not know how much is due to these ill parents' capacity to be a "good enough" parent and how much may be due to some third mediating variable that underlies both the parental illness and the child's difficulties. In any case, the issue of genetic risk is relevant for evaluating parents. Children with a genetic vulnerability probably require more sensitive and optimal parenting than children without genetic vulnerability and may be prone to developing problems even when parenting is adequate.

Some research has focused on the parenting capacities of mentally ill parents. It must be kept in mind that this work has been designed primarily to evaluate optimal parenting responses among such parents rather than responses indicating parenting that is below community standards, which is the threshold set in termination of parental rights cases. There is some evidence that schizophrenic and depressed individuals differ in their interactions with their children compared with nondisordered parents. (Oyserman, Mowbray, Meares, & Firminger, 2000, present a review of studies examining these parenting differences among mothers with differing diagnoses.) For example, affectively disordered mothers have been found to overreact to mild stressors they experience with their children, such as waiting in a doctor's office (Breznitz & Sherman, 1987). Other studies have found that depressed mothers are often less consistent toward their children (i.e., ranging from withdrawn to controlling or intrusive) with few mothers falling within the optimum range of involvement compared with nondepressed mothers (Hoffman & Drotar, 1991). Furthermore, depressed mothers have been found to use fewer questions and a less positive tone of voice and to use more criticism and coercion with their children (Cox, Puckering, Pound, & Mills, 1987).

It is noteworthy that there is heterogeneity in the quality of parenting styles of depressed mothers. For example, in one study, depressed mothers who enjoyed interactions with their children or received positive responses from their children were found to be more effective in sustaining positive interactions with their children (Cox et al., 1987). This study suggests that the nature of the child's behavioral style or temperament must be considered. That is, the child's special needs or strengths may exacerbate or temper the level of risk present. Severity and chronicity of parental disorder, child's age at time of onset, child behavior, parental functioning in the community, and the social support of the parent also have an impact on child outcome in families with major disorders (Oyserman, et al., 2000), although the evidence for some of these risk factors is inconclusive. Marital discord, single-parent status, social

isolation, and poverty are also common among the mentally ill and, together, may represent equal or greater risk to children than the individual risk of parental mental illness (Oyserman et al., 2000).

Differences across diagnoses have also emerged, but these have not been consistent. Compared with normal and schizophrenic mothers, parenting of depressed mothers has been found to be more variable with regard to maternal responsiveness and affective involvement (S. H. Goodman & Brumley, 1990). On the other hand, competent offspring of mentally ill mothers were more likely to have (a) an affectively disturbed parent as opposed to a schizophrenic parent, (b) a parent whose disorder was not chronic, (c) a parent whose disorder occurred later in the children's development, and (d) a mother whose lack of warmth and inactive style were compensated for by the presence of a father who was warm and active (Fisher, Kokes, Cole, Perkins, & Wynne; 1987). These data are similar to the work of others (e.g., Kauffman, Grunebaum, Cohler, & Gamer, 1979).

Whereas studies on parenting behaviors of mentally ill mothers in comparison with nondisordered mothers are accumulating, it is yet to be determined whether the levels of parenting difficulties experienced by mentally ill parents indicate the kind of below-standard parenting required to terminate rights.

*Parents with mental retardation.* Last, we describe cognitively disabled parents as a diagnostic group often seen in termination cases. Such individuals' parenting has long come into legal question, and there have even been periods in history when their forced sterilization was common. Although such practices have fallen into disfavor, the predisposing bias of incompetence may not have. Such parents appear to be at greater risk for losing custody of their children than parents of average intelligence (Seagull & Scheurer, 1986; Tymchuk, 1992). Indeed, studies have suggested that parents with mental retardation are more likely to have their children removed from them (Accardo & Whitman, 1990) and to have their parental rights terminated (i.e., an estimated 80% in the United States and Canada; Feldman, 1998).

A review of studies on the family transmission of mental retardation (Dowdney & Skuse, 1993) found mental retardation in 15% to 30% of children from parents with mental retardation. Although these findings are limited in their interpretation because the studies span 43 years during which definitions of intellectual disability varied widely, they nonetheless suggest that children of cognitively disabled individuals are not always limited themselves. The relationships between parental IQ and child IQ may be influenced by numerous other interacting variables (e.g., the presence of a normal IQ in the other parent, parental social support). Although most of the literature on mentally retarded parents has focused on the cognitive capacities of their children, less is known regarding their children's social competencies or their parenting deficits.

Factors typically seen as compromising the cognitively disabled parent's competency include direct deficiencies, such as providing less cognitive stimulation (e.g., concrete thinking), and indirect ones, such as providing a less re-

sourced environment (e.g., economic status; Schilling & Schinke, 1984). Moreover, these inadequacies are stereotypically viewed as impervious to intervention.

Although scientific data in this area are limited, that which has emerged raises questions regarding the automatic assumption of behavioral incompetence and unamenability to intervention. For example, a proportion of such parents do provide satisfactory basic care (e.g., keeping children clean, adequately fed, clothed, supervised, and in regular school attendance). Moreover, with the exception of those with very low IQ scores (30–49), the absolute level of intellectual functioning may not be systematically related to the adequacy of the care provided. Whether these parents are able to meet the more complex emotional needs of their children is more difficult to assess. Such parents also have not consistently been shown to have parenting problems in all areas (e.g., level of punitiveness toward children; Feldman et al., 1986; decision-making skills in hypothetical child-rearing situations; Tymchuk, Yokota, & Rahbar, 1990). Azar (1995) found deficits compared with average or above-average functioning parents on problem-solving capacities, attributions of negative intent to children, and unrealistic expectations of children. Yet not all parents showed such problems, and only problem-solving seemed to distinguish those involved with child protection and those who were not.

Both the quality of these parents' social support and their income level relate to being seen as satisfactory parents (Mickelson, 1947; Seagull & Scheurer, 1986). There is also some evidence that specific skill deficits (e.g., problem solving) coupled with contextual stress may differentiate those who show parenting problems from those who do not (Azar, 1995). Heterogeneity of outcomes has been demonstrated in the offspring of such parents during some periods of development (Martin, Ramey, & Ramey, 1990), further suggesting individual differences in the parenting environment provided. Again, more research is needed before definitive statements can be made regarding this group's ability to parent and the risk mental retardation poses to their children.

*Conclusions.* The database for making predictions of parenting risk on the basis of a diagnosis of affective or psychotic mental illness, mental retardation, or substance abuse is still quite limited for forensic purposes. The link between mental disorder and violent behavior is tenuous, and even more so for violent or negligent behavior toward one's child. Further, the link between mental disorder and compromises in basic parenting competency may be more complex than originally thought. Because diagnosis alone is not sufficient to determine risk, we must consider the child's age at the time of parental expression of illness, the intensity and duration of that illness, the protective factors that might have existed and continue to exist in the child's environment (e.g., parental supports, a well other parent) and the child's behavioral style, temperament, and current competencies (Silverman, 1989).

The "at-risk" paradigm of research may not be the most useful for forensic purposes. Musick, Stott, Spencer, Goldman, and Cohler (1987) have argued that this paradigm may be flawed in that it assumes a continuity between infancy,

early childhood, and later adjustment that is not justified on the basis of the literature on children's social and emotional development. This literature has also focused almost exclusively on factors that have been related to optimal child outcomes (e.g., parental warmth, responsiveness) and not on the kinds of neglectful or abusive behaviors that often lead a parent to be considered for termination of parental rights. Finally, it has been argued that such work has not attended to the self-righting tendencies of young children (Sameroff & Chandler, 1975) and has not fully considered the range of other family factors (e.g., context, marital support, extended family involvement) that may preserve or undermine such self-righting tendencies.

Musick et al. (1987) also emphasized that risk is a statistical concept, not a psychological one. Although such an actuarial perspective does have utility within the legal system, expert witnesses must interpret the more fine-grained meaning of risk (e.g., interactive effects, effects over time) and the multitude of other variables that may exacerbate or temper the risk of parental diagnosis. The issue of vulnerability (Garmezy, 1974) may be more useful to consider. The child of a mentally ill (or mentally retarded or substance-abusing) parent is one who may be impaired in his or her ability to cope because of genetic predispositions, prenatal and perinatal complications, or ongoing interactions with an impaired parent (Musick et al., 1987). In considering parental fitness, each of these factors needs to be highlighted for the court along with its importance in understanding children's current functioning and future potential.

### *Does Diagnosis Predict Amenability to Parenting Interventions?*

The belief that diagnosed parents are not amenable to parenting intervention is also open to question. Studies with mentally retarded parents, for example, have shown the effectiveness of behavioral strategies for improving parenting (e.g., Fantuzzo, Wray, Hall, Goins, & Azar, 1986; Wolfe et al., 1982), meal planning and budgeting (Sarber, Halasz, Messmer, Bickett, & Lutzker, 1983), and a myriad of other skills (e.g., identification and response skills to emergency situations; Tymchuk, 1992). Retention of skills has also been shown over short follow-up periods. Unfortunately, such specialized training is not available in most communities. A national survey in the early 1990s reported that only three states had special efforts aimed at this group (Berkowitz & Sedlak, 1993). We have no reason to believe that this situation has changed much since then. The impact of intervention to ameliorate more fine-tuned emotional recognition and response skills has not been examined as yet.

Although treatment amenability data are more limited with drug-abusing parents, at least one study found that when mothers have abstained from drugs, less child disturbance is found (Rodning, Beckwith, & Howard, 1991). This suggests that successful treatment may reduce child risk. As with mentally retarded parents, however, services directed toward the parenting needs of drug-abusing parents are lacking in most localities (Berkowitz & Sedlak, 1993). A

few studies that investigated programs aimed at drug-abusing mothers have found that program changes to address women's needs and provision of child care actually lead to better program retention (Metsch et al., 2001). In fact, treatment programs that include children and address parenting issues may be much more effective for substance-abusing mothers. One study found that only 18% of women who entered a substance abuse program with their children reported drug use 6 months post-discharge compared with 79% of women whose children never entered the program (Metsch et al., 2001). Although treatment of substance-abusing mothers alone might reduce child risk, inclusion of the child in the treatment program may increase the effectiveness of treatment.

Some limited attempts have been made to intervene with mothers who have major psychiatric disorders. For example, Waldo, Roath, Levine, and Freedman (1987) described a model program, the Denver Mothers' and Children's Project, to teach parenting skills to schizophrenic mothers. The program includes a home assessment; small group meetings for mothers and children together, focusing on developmental education, directed play, and role modeling; and a therapeutic nursery for the children to attend while the mothers meet as a group to discuss how their illness complicates parenting and to receive didactic parent training. The program reportedly has decreased the number of children in temporary foster care and improved interactions between mothers and their children as judged by social workers and therapists. In addition, 83% of the mothers had improved treatment compliance as indicated by fewer re-hospitalizations. These efforts, although showing some good outcomes, are not widespread.

Globally, the needs of these mothers do not seem to be addressed. Nicholson, Geller, Fisher, and Dion (1993), having reviewed state policies and programs that address the needs of mentally ill mothers in the public sector, concluded that such needs are not being met and that the mother-child relationship is not considered an essential focus of public sector psychiatric care. They found that fewer than one third of the states in the United States even identify the parenting status of women in their public sector patient populations. None of the states have policies providing for contact between hospitalized mothers and their children, and though 19 states and the District of Columbia reported having programs to assess and improve parenting skills, only 8 of the 69 programs reported by these states specifically focus on the needs of mentally ill parents and their children.

Along with a dearth of programs, cross-trained intervention agents (i.e., ones who have expertise in treating these disorders as well as parenting interventions) may be scarce, and those currently providing services may not be aware of the parent's inadequacies. In a custody case seen by one of the authors (Sandra T. Azar), the parent aide program to which a mentally retarded mother was referred was unaware of her intellectual limitations, as the mother had mastered many social skills to cover her limitations. The parent aide, therefore, interpreted her difficulties mastering new skills as resistance rather than lack of understanding. This failure was at the center of her report to the court. Although federal agencies have sought to improve the availability of pro-

grams directed toward both substance abuse and parenting, these are new and little data are available regarding their effectiveness.

Psychiatrically diagnosed parents' amenability to treatment directed toward improving parenting has received little research attention. Thus, assumptions that their parenting difficulties cannot be ameliorated may not necessarily be valid. Few interventions specifically designed to address their dual needs (mental disorder and parenting problems) have been developed. Evaluators must therefore be cautious in deciding whether such parents have received suitable intervention and whether that intervention was successful or not. Although such conclusions are always reached within the constraints of a given community's resources, evaluators should not be restrained from citing potential interventions that have been empirically examined and that might have been used if available in the community.

### *Does Diagnosis Mean Forever Unfit?*

The data on the parenting risk of mentally disordered parents suggest chronicity of disorder may be an important predictor of child outcome (Fisher et al., 1987). This makes sense on the basis of the transactional views of child development, which argue that child outcome evolves out of the multiple transactions that occur between environmental forces, caregiver characteristics, and child attributes, rather than from single parental acts (Sameroff & Chandler, 1975). Having a mental disorder or substance abuse problem may have many implications for the individual and the marital dyad as well as for the family system as it operates within the larger community and society. This might mean multiple separations (i.e., hospitalizations), marital disruption, more general social-relational and economic distress, and negative transactions with the larger society. It is these reverberations that may impact the adequacy of the parenting environment.

The natural course of disorders has been documented more for some disorders than for others. In the case of alcohol abuse, 65% of higher functioning individuals with an alcohol use disorder have a 1-year abstinence rate following treatment and potentially 20% or more with alcohol dependence maintain long-term sobriety even without active treatment (American Psychiatric Association, 1994). Among men with narcotics addiction, during a 10-year interval, one study found a .29 probability of relapse among those who had stopped and a .25 probability of cessation among those who were using (Hser, Anglin, & Powers, 1993). Unfortunately, not enough long-term follow-up studies with women have been conducted to allow us to make predictions regarding remissions, nor do we know whether cessation of substance use necessarily "fixes" potential parenting impairments in previously addicted individuals.

Recovery and relapse rates for other severe psychopathology have also been documented. Episodes of major depression last an average of 20 weeks (Solomon et al., 1997). Although more than 50% recover from a major depressive episode by 6 months, the rate of recovery drops dramatically thereafter. After 5 years, 11.5% remained ill (Keller et al., 1992); that percentage had dropped to 8%

after 10 years (Solomon et al., 1997). The rate of relapse for depression is 20% during the initial 2 months, 30% by 6 months, 40% by 1 year, and 50% by the end of 2 years (Lavori, Keller, & Klerman, 1984). Although 50%–60% of those who have suffered a major depressive episode will have another sometime in their life, the risk of future episodes increases with each subsequent episode (American Psychiatric Association, 1994).

A review of relapse rates for schizophrenia in several studies (Ayuso-Gutierrez & Del Rio, 1997) concludes that there is a mean 1-year natural relapse rate of 69% for placebo groups (not receiving pharmacological intervention) and a 26% relapse rate for those given neuroleptics. Higher doses of neuroleptics can reduce 1-year relapse rates to around 7%–10% (Johnson, Ludlow, Street, & Taylor, 1987; Kane et al., 1983). Among those schizophrenics who discontinue medication, there is a very high relapse rate, ranging from 64% at 1 year to 94% after 2 years of having discontinued medication. This suggests the importance of evaluating compliance to pharmacological treatment for these parents. It was found that the majority of those with schizophrenia who were rehospitalized (73%) did not comply with pharmacological treatment (Ayuso-Gutierrez & Del Rio, 1997). Although long-term relapse rates are not favorable, these generally only assess positive symptoms and do not address the negative symptoms of schizophrenia, which often remain present even in the interim. These parents, even if currently competent and currently adhering to pharmacological treatment, may not be competent throughout the 18 years of caring for their children and may require periodic monitoring.

Factors influencing remission in both affective disorder and schizophrenia have received some study (e.g., psychosocial factors such as the emotional context of the family setting to which the ill individual returns; Moline, Singh, Morris, & Meltzer, 1985). There is little information regarding improvements in parenting behavior if remission occurs. However, some evidence suggests that children's maladjustment may continue after the remission of their parents' depression (Billings & Moos, 1983). For example, even when mothers' postpartum depression had subsided 19 months after childbirth, their interactions with their children differed from those of mothers who had not experienced depression earlier (Stein et al., 1991). Although currently depressed mothers had less desirable interactions with their children than mothers with remitted depression, the latter group still showed less facilitation and rapport with their children, less affection, and increased levels of withdrawal and hostility toward their children compared with mothers who had never been depressed. Other studies involving older children have not consistently found such effects for all children (Silverman, 1989). The timing of the episodes may impact this outcome for children. Furthermore, although differences in interaction may continue to exist, whether these constitute parenting that is below community standards is not discussed and whether such differences are linked to child harm is not clear.

No definitive conclusions can be reached regarding the continuity of parental maladaptive behavior. Some portion of parents with a major mental illness or substance abuse



recover. We know less about whether such recoveries signal an end to impairments that influence parenting. Moreover, even if some impairment remains, it is not clear whether this impairment continues at a level of disruption that places the child at significant risk or is below minimally adequate community standards.

#### Future Directions: **Toward a Functional–Contextual Analysis of Parenting Capabilities**

As noted earlier, our goal in this article is not to dispute that mental illness, substance abuse, or mental retardation influences parenting, as it most certainly does, but to caution forensic evaluators against the predisposing bias that individuals with such diagnoses are incapable of adequate parenting, are not amenable to parenting interventions, and will remain “unfit” even if their diagnostic status changes. Diagnostic labels may define areas of concern to be explored by the evaluator, but because of the current state of the research, cannot be considered conclusive evidence of parental incompetence for forensic purposes. For the field to progress and to be able to make more valid and reliable assessments of psychiatrically diagnosed individuals’ capacity to parent, the following research agenda is suggested.

#### *Model Development*

As a starting point, greater attention to the development of larger, more general models of parenting is needed. We are unable to know how well we are evaluating parenting capacities if we have not adequately defined them. Models most useful for the courts would take a continuum view of parenting (i.e., ones that consider the range of parenting from optimal to minimally adequate).

First, these models need to define parenting competencies and skill areas and the thresholds that define minimally adequate parenting responses. Clear and specific operational definitions of competencies and skills are necessary in order to ensure that common terms have standard meanings. For example, we do not have commonly accepted standards as to what constitutes appropriate parental supervision for children at different developmental levels or under specific environmental contexts (e.g., rural vs. urban living situations). Furthermore, we do not know whether community standards are consistent with empirical evidence regarding children’s developmental needs.

Cognitive and behavioral models, as well as systems and ecological models, are presently available that might provide starting points for theory development (Azar & Twentyman, 1986; Belsky & Vondra, 1989; Epstein, Bishop, & Baldwin, 1982; Wolfe, 1987). For example, skill areas required to parent might include problem-solving abilities, a repertoire of child management skills, medical care and physical care skills, safety and emergency response skills, capacities for warmth and nurturance, sensitive and discriminant interactional response capacities, social–cognitive skills, self-control skills, stress management skills, and social skills. These areas have been discussed in greater depth elsewhere (Azar, Lauretti, & Loding, 1998).

Second, the models must also allow for cultural diversity.

That is, in defining these skills and competencies, their universality must be documented or the cultural groups for which they hold must be noted (Azar & Benjet, 1994). There must be sufficient flexibility built into the model that allows for culturally diverse parenting practices within universally minimum standards of parenting adequacy.

A third aspect of such models would be the consideration of ecological factors. That is, the context in which these parents’ skills and competencies are manifest may determine their adaptiveness. For example, parents who have a strong social support network may allow for compensatory factors to enhance areas of weakness within the parent’s own repertoire (Belsky & Vondra, 1989). Conversely, the model must take into consideration the child’s special needs and developmental level. A child with a disability may be at greater risk with a nonresponsive parent than a child who is constitutionally competent. This aspect may be especially relevant for families in which the parent is impaired with a psychiatric illness. Similarly, some parenting skills are needed in every developmental era of childhood and adolescence, whereas others are needed only during certain periods. Stress coping skills are required during all developmental stages, whether it involves the stress of an infant crying or a teenager’s moving toward autonomy. Child management skills vary with developmental era (e.g., management of a toddler might involve use of distraction and manipulating the environment as in moving objects out of reach, whereas dealing with an older child might include explanation, use of rewards, and time out). With such a model, a developmentally relevant and competency based approach to assessing parenting could occur.

Finally, the list of skill areas outlined needs to be broadened beyond those involving psychological factors (e.g., maternal warmth, responsiveness) to include aspects of basic care, such as hygiene knowledge, home safety, and so forth. The work of Sarber and colleagues and Tymcuk and colleagues is exemplary in this respect (Sarber, et al., 1983; Tymchuk et al., 1990).

With these constructs clearly defined, models could be validated and measures developed and also validated. Large and diverse samples would need to be included in such validation studies in order to provide representative samples of parents and ample diversity of appropriate reference groups (e.g., the full range of disordered parents). The degree of impairment for different diagnostic groups could then be assessed against the norms as well as the impact of that impairment on child outcome.

#### *Assessment Issues*

To ensure the utility of forensic parenting assessments, as in all assessments, the issues involved in construct, criterion, and content validity must be addressed. Most important is the development of assessment methods specific to the evaluation of functional parenting competency. Many evaluators and expert witnesses rely on traditional psychological instruments (e.g., Rorschach Inkblot Test, Thematic Apperception Test, Wechsler Adult Intelligence Scale, Incomplete Sentences Test), the popularity of which may be due in part to the perception that they reveal hidden aspects

of personality or simply because most mental health professionals are trained to use them (Jacobsen & Miller, 1997). However, what is measured with these instruments is only indirectly or tenuously related to parenting, and hence the usefulness of these measures for the purpose of forensic evaluation of parental fitness is quite limited.

Jacobsen and Miller (1997) provided two dramatic examples of how evaluation results differ with the use of traditional psychological tests in comparison to the use of a comprehensive parenting assessment program. A traditional assessment of a 21-year-old woman, previously hospitalized on two occasions, concluded on the basis of projective and intelligence measures that, among other things, she had poor reasoning (according to her performance on the WAIS), irrational thinking (as based on her Rorschach results), and lacked connection to her children and was suicidal (also based on the Rorschach). The determination in this assessment was that she was not competent to parent. A comprehensive parenting assessment, including a psychiatric interview, interviews with collateral historians, a review of medical and psychiatric records, videotaped observation of her in interaction with her children, and results from the Parent Opinion Questionnaire, the Parental Stress Index, the Social Support Inventory, the Home Inventory, and a developmental assessment of her children determined that her two episodes of psychotic depression were due to hypothyroidism, which, when properly treated and after leaving an abusive boyfriend, had fully remitted for 3 years. This assessment revealed that she had a good relationship with her children who were developing normally and that there was no evidence of child maltreatment risk, thus leading to the opposite recommendation. Jacobsen and Miller also provide the opposite example of a case in which conclusions drawn from traditional assessment methods recommended parental reunification, whereas the competency-based assessment suggested and confirmed maltreatment.

In the case of substance-abusing parents, child welfare decisions are often based on assessments of current substance use such as urine screens (Olsen, Allen, & Azzi-Lessing, 1996). Because of the concern that indicators of substance use are not directly related to parenting fitness, Olsen et al. developed an instrument to assess parenting risk specific to substance abuse. This inventory contains eight scales measuring the parent's commitment to the recovery process, the parent's patterns of substance use, the effect of the parent's substance use on their ability to care for their children, the effect of the parent's substance use on their ability to carry out everyday responsibilities, the social supports of the parent ranging from the presence of persons who undermine recovery and contribute to child risk to those who provide consistent reinforcement for the parent's recovery, self-efficacy, and ability to care for oneself, and neighborhood safety.

The development of comprehensive and competency-based approaches to parental fitness evaluations, such as these, is exemplary, and will be greatly enhanced in the future by model development and validation. Continued research is needed to develop and test assessment instruments for parenting competency in general and, more spe-

cifically, for parents with particular limitations such as a psychiatric disorder.

### *Issues Specific to Psychiatrically Diagnosed Parents*

Whereas a functional-contextual analysis of parenting competencies is advocated for the assessment of all parents, certain issues need to be addressed in competency evaluations that are specific to psychiatrically diagnosed parents. These issues include insight into one's illness, pharmacological or treatment adherence, and social support of others who are well.

A parent's insight or understanding of their illness and treatment needs should be considered. One study found that for mothers with a major psychiatric illness, better insight into their illness (which was not related to past psychotic symptoms, type of diagnosis or level of education) was associated with more sensitive parenting behavior and lower clinician-assessed risk for child maltreatment (Mullick, Miller, & Jacobsen, 2001). Additionally, parents' ability to recognize symptoms so that they can receive adequate treatment at the onset of decompensation might affect their ability to continue parenting their child (Nicholson & Blanch, 1994).

We previously discussed the importance of pharmacological adherence for schizophrenic parents. Treatment adherence of mentally ill parents is an area that should be addressed by evaluators, as it may demonstrate a parent's ability to manage his or her disorder.

Whereas social support is an area of importance for all parents, it may be particularly important for these impaired parents. The presence of a well other may provide a control mechanism for maintaining parenting behavior within an acceptable range and provide children with added stability. Although courts cannot allow parental custody on the basis of the presence of some other well person, the ability of a parent to form social support networks and to adequately plan for child-care arrangements, for example, when hospitalization is necessary, can and should be included in assessments of these parents.

Finally, the law requires that "reasonable efforts" be made to assist parents so as to reunify families. Yet, *reasonable* has typically been defined as the services available in the community in question. As noted earlier, specialized services are quite limited. The Americans with Disabilities Act (1990) requires reasonable accommodations for parents with disabilities, which has led to some innovative efforts for cognitively impaired parents (e.g., dual foster care programs in which parent and child are placed in foster care). It has been further argued that cognitively impaired parents are a separate "cultural" group where dependency relationships with others is the rule and thus judgments regarding their competency need to be made within the context of their support network.

### *Implications for Application and Public Policy*

In our society, we value diversity in family matters and resist governmental efforts to impose orthodoxy (Field & Sanchez, 1999). We have legislation (such as the Americans

with Disabilities Act) intended to protect and support disabled individuals. However, society, and in turn, social welfare agencies may not be particularly tolerant or supportive of psychiatrically diagnosed parents. A greater understanding of these parents' needs and capabilities is required to reshape social policy. Practicing professionals need improved training resources for working with the dual needs of disordered individuals who are also parents. This also calls for social policy changes that involve the development of intervention programs specifically directed toward the parenting needs of psychiatrically diagnosed parents with different disorders as well as studies to evaluate their effectiveness. With well-trained intervention agents and programs that address the special needs of disordered parents, a more accurate assessment could be made of the state's efforts to bring parents back to a level of fitness required to meet their children's needs. This may ultimately increase family reunification, on the one hand, while allowing us to more quickly and accurately identify those parents who are not capable of adequate parenting, on the other hand, thus serving children's needs better.

Many of the studies that we and others in this area base conclusions on are borrowed from other research areas. More research is needed specifically with this population of parents whose parenting is under scrutiny, designed specifically to address questions relevant for custody and termination decisions. Until the field has empirically based answers to the relevant questions, expert witnesses need to guard against predisposing biases in their testimony and take extra care to provide a balanced and cautious assessment to courts regarding the link between a psychiatric diagnosis and parenting capacities. Whereas many of these parents are impaired, some unknown proportion are likely functioning adequately as parents. Factors to consider that might allow such parents to function adequately include less chronic and severe parental disorder, older age of child at onset of parental disorder, a constitutionally well child, parental insight into his or her disorder, treatment adherence (especially adherence to pharmacological treatment for severely mentally ill parents), ability to form social supports, the presence of well others, and living in a safe environment.

Despite our limited database and potential for bias, mental health professionals have much to offer in such cases, for example, knowledge regarding the global functioning of persons with different disorders, the developmental processes of children, family functioning processes, and special observational skills that are invaluable to the courts. Progress has been made on the development of measures directed toward specific aspects of parenting (e.g., parental stress, social support, parenting attitudes, parenting knowledge). We are further able to inform the court on the processes that influence all human decision-making and the impact these processes may have on legal judgments regarding the mentally disordered individual. Family-based research, in particular, is in a unique position to contribute to model development, assessment, and intervention in this area. Whereas family research has made strong contributions in other legal areas such as divorce outcomes and custody arrangements (Azar, 2002; Melton et al., 1997),

there has been less focus on the children and families most in need, that is, those involved in termination decisions.

With the passage of the Adoption and Safe Families Act (1997), which calls for quicker decision-making for permanency planning in child protection cases, it can be anticipated that more children in the Child Protective Services (CPS) system will be considered for adoptive placements and the rights of their biological parents considered for termination. Thus, greater numbers of psychiatrically diagnosed parents will require parenting evaluations. Because of the issues raised in this article as to the dearth of information regarding the level of parenting risk posed by these parents and the potential predisposing biases resulting from assumptions made about them as a group, such parents present unique challenges to forensic fitness evaluations. Many mentally ill, mentally retarded, and substance-abusing parents who end up in the Child Protective Services system may in fact be unable to fulfill the parental role because of the risk of harm to their children, and society will have to protect such children by permanently removing them from their parents. However, we share Field and Sanchez's (1999) call to suspend predictive determinations of unfitness unless there are data to support it. The balancing of parents', children's, and states' interests and rights, and the decision or recommendation to terminate a parent's right to custody of his or her child, is never easy. However, further empirical inquiry can only facilitate these endeavors and ensure a more accurate evaluation of the parental fitness of psychiatrically diagnosed parents.

## References

- Accardo, P. J., & Whitman, B. Y. (1990). Children of mentally retarded parents. *American Journal of Diseases of Children, 144*, 69-70.
- Adoption and Safe Families Act. (1997). U.S. Public Law 105-189.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.
- Americans With Disabilities Act, 42 U.S.C. §§12101-12213 (1990).
- Ayuso-Gutierrez, J. L., & Del Rio, J. M. (1997). Factors influencing relapse in the long-term course of schizophrenia. *Schizophrenia Research, 28*, 199-206.
- Azar, S. T. (1991). Models of child abuse: A metatheoretical analysis. *Criminal Justice and Behavior, 18*, 30-46.
- Azar, S. T. (1995, April). *Is the intellectually low functioning parent at risk for child maltreatment?* Symposium presented at the biennial meeting of the Society for Research in Child Development, Indianapolis, Indiana.
- Azar, S. T. (2002). Family research and the law: Can family research help Solomon? Contributions and challenges. In J. McHale & W. Grolnick (Eds.), *Retrospect and prospect in the psychological study of families* (pp. 283-320). Mahwah, NJ: Erlbaum.
- Azar, S. T., & Benjet, C. L. (1994). A cognitive perspective on ethnicity, race, and termination of parental rights. *Law & Human Behavior, 18*, 249-268.
- Azar, S. T., Lauretti, A. E., & Loding, B. V. (1998). The evaluation of parental fitness in termination of parental rights cases: A functional-contextual perspective. *Clinical Child and Family Psychology Review, 1*, 77-100.

- Azar, S. T., & Twentyman, C. T. (1986). Cognitive behavioral perspectives on the assessment and treatment of child abuse. In P. C. Kendall (Ed.), *Advances in cognitive behavioral research and therapy* (Vol. 5, pp. 237–267). New York: Academic Press.
- Beardslee, W. R., Versage, E. M., & Gladstone, T. R. G. (1998). Children of affectively ill parents: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, *37*, 1134–1141.
- Belsky, J., & Vondra, J. (1989). Lessons from child abuse: The determinants of parenting. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment* (pp. 153–202). New York: Cambridge University Press.
- Berkowitz, S., & Sedlak, A. J. (1993). *Study of high risk: Child abuse and neglect groups. State survey report*. Washington, DC: National Center on Child Abuse and Neglect.
- Billings, A. G., & Moos, R. H. (1983). Comparisons of children of depressed and nondepressed parents: A social–environmental perspective. *Journal of Abnormal Child Psychology*, *11*, 463–486.
- Breznitz, Z., & Sherman, T. (1987). Speech patterns of natural discourse of well and depressed mothers and their young children. *Child Development*, *58*, 395–400.
- Brody, B. (1990). Prediction of dangerousness in different contexts. In R. Rosner & R. Weinstock (Eds.), *Ethical practice in psychiatry and the law* (pp. 185–196). New York: Plenum.
- Carmichael-Olson, H., & Burgess, D. M. (1997). Early intervention for children prenatally exposed to alcohol and other drugs. In M. J. Guralnick, (Ed.), *The Effectiveness of Early Intervention* (pp. 109–145). Baltimore, MD: Brookes.
- Cocozza, J., & Steadman, H. (1978). Prediction in psychiatry: An example of misplaced confidence in experts. *Social Problems*, *25*, 265–276.
- Cox, A. D., Puckering, C., Pound, A., & Mills, M. (1987). The impact of maternal depression on young children. *Journal of Child Psychology and Psychiatry*, *28*, 917–928.
- Deren, S. (1986). Children of substance abusers: A review of the literature. *Journal of Substance Abuse Treatment*, *3*, 77–94.
- Dowdney, L., & Skuse, D. (1993). Parenting provided by adults with mental retardation. *Journal of Child Psychology & Psychiatry*, *34*, 25–47.
- Epstein, N. B., Bishop, D. S., & Baldwin, L. M. (1982). McMaster model of family functioning: A view of the normal family. In F. Walsh (Ed.), *Normal family processes* (pp. 115–141). New York: Guilford Press.
- Famularo, R., Stone, K., Barnum, R., & Wharton, R. (1986). Alcoholism and severe child maltreatment. *American Journal of Orthopsychiatry*, *56*, 481–485.
- Fantuzzo, J. W., Wray, L., Hall, R., Goins, C., & Azar, S. T. (1986). Parent and social skills training for mentally retarded mothers identified as child maltreaters. *American Journal of Mental Deficiency*, *91*, 135–140.
- Farina, A. (1982). The stigma of mental disorders. In A. G. Miller (Ed.), *In the eye of the beholder* (pp. 305–363). New York: Praeger.
- Farina, A., Allen, J., & Saul, B. B. (1968). The role of the stigmatized in affecting social relationships. *Journal of Personality*, *36*, 169–182.
- Farina, A., & Felner, R. D. (1973). Employment interviewer reactions to former mental patients. *Journal of Abnormal Psychology*, *82*, 268–272.
- Farina, A., Holland, C. H., & Ring, K. (1966). The role of stigma and set in interpersonal interaction. *Journal of Abnormal Psychology*, *71*, 421–428.
- Feldman, M. A. (1998). Parents with intellectual disabilities. In J. R. Jutzker (Ed.), *Handbook of child abuse research and treatment* (pp. 401–420). New York: Plenum Press.
- Feldman, M. A., Towns, F., Betel, J., Case, L., Rincover, A., & Rubino, C. (1986). Parent education project II: Increasing stimulating interactions of developmentally handicapped mothers. *Journal of Applied Behavior Analysis*, *19*, 23–37.
- Field, M. A., & Sanchez, V. A. (1999). *Equal treatment for people with mental retardation*. Cambridge, MA: Harvard University Press.
- Fisher, L., Kokes, R. F., Cole, R. E., Perkins, K., & Wynne, L. C. (1987). Competent children at risk: A study of well-functioning offspring of disturbed parents. In E. J. Anthony & B. J. Cohler, *The invulnerable child* (pp. 211–228). New York: Guilford Press.
- Fryer, G. E., & Miyoshi, T. J. (1994). A survival analysis of the revictimization of children: The case of Colorado. *Child Abuse and Neglect*, *18*, 1063–1071.
- Gardner, W., Lidz, C. W., Mulvey, E. P., & Shaw, E. C. (1996). Clinical versus actuarial predictions of violence in patients with mental illnesses. *Journal of Consulting and Clinical Psychology*, *64*, 602–609.
- Garnezy, N. (1974). The role of competence in the study of children and adolescents under stress. In B. H. Schneider & A. Grazia, (Eds.), *Social competence in developmental perspective* (Vol. 51, pp. 25–39). Norwell, MA: Kluwer Academic.
- Goodman, G. S., Emery, R. E., & Haugeard, J. J. (1998). Developmental psychology and law: Divorce, child maltreatment, foster care, and adoption. In W. Damon (Ed.) *Handbook of child psychology* (Vol. 4, pp. 775–873). New York: Wiley.
- Goodman, S. H., & Brumley, H. E. (1990). Schizophrenic and depressed mothers: Relational deficits in parenting. *Developmental Psychology*, *26*, 31–39.
- Grisso, T. (1986). *Evaluating competencies: Forensic assessments and instruments*. New York: Plenum.
- Grisso, T., & Appelbaum, P. S. (1992). Is it unethical to offer predictions of future violence? *Law and Human Behavior*, *16*, 621–633.
- Hans, S. L., Bernstein, J., & Henson, L. G. (1999). The role of psychopathology in the parenting of drug-dependent women. *Development and Psychopathology*, *11*, 957–977.
- Harrington, D., Dubowitz, H., Black, M. M., & Binder, A. (1995). Maternal substance use and neglectful parenting: Relations with children's development. *Journal of Clinical Child Psychology*, *24*, 258–263.
- Hayman, R. L. (1990). Presumptions of justice: Law, politics, and the mentally retarded parent. *Harvard Law Review*, *103*, 1201–1271.
- Hoffman, Y., & Drotar, D. (1991). The impact of postpartum depressed mood on mother–infant interaction: Like mother like baby? *Infant Mental Health Journal*, *12*, 65–80.
- Householder, J., Hatcher, R., Burns, W., & Chasnoff, I. (1982). Infants born to narcotic addicted mothers. *Psychological Bulletin*, *92*, 453–468.
- Hser, Y., Anglin, M. D., & Powers, K. (1993). A 24-year follow-up of California narcotics addicts. *Archives of General Psychiatry*, *50*, 577–584.
- Jacobsen, T., & Miller, L. J. (1997). Assessing parenting competency in individuals with severe mental illness: A comprehensive service. *Journal of Mental Health Administration*, *24*, 189–199.
- Jellinek, M. S., Murphy, J. M., Poitras, F., Quinn, D., Bishop, S. J., & Goshko, M. (1992). Serious child mistreatment in Massachusetts: The course of 206 children through the courts. *Child Abuse and Neglect*, *16*, 179–185.
- Johnson, D. A. W., Ludlow, J. M., Street, K., & Taylor, R. D. W. (1987). Double blind comparison of half-dose and standard dose flupenthixol decanoate in the maintenance treatment of stabilised out-patients with schizophrenia. *British Journal of Psychiatry*, *151*, 634–638.
- Kane, J. M., Rifkin, A., Quitkin, F., Woerner, M., Reardon, G.,

- Sarantakos, S., Schiebel, D., & Ramos-Lorenzi, J. (1983). Low-dose neuroleptic treatment of outpatient schizophrenics. *Archives of General Psychiatry*, *40*, 893–896.
- Kaplan-Sanoff, M., & Fitzgerald Rice, K. (1992). Working with addicted women in recovery and their children: Lessons learned in Boston City Hospital's Women and Infants Clinic. *Zero to Three*, *13*, 17–22.
- Kauffman, C., Grunebaum, H., Cohler, B., & Gamer, E. (1979). Superkids: Competent children of psychotic mothers. *American Journal of Psychiatry*, *136*, 1398–1402.
- Keller, M. B., Lavori, P. W., Mueller, T. I., Endicott, J., Coryell, W., Hirschfeld, R. M., & Shea, T. (1992). Time to recovery, chronicity, and levels of psychopathology in major depression. A 5-year prospective follow-up of 431 subjects. *Archives of General Psychiatry*, *49*, 809–816.
- Kendler, K. S. (2001). Twin studies of psychiatric illness: An update. *Archives of General Psychiatry*, *58*, 1005–1014.
- Lamy, R. E. (1966). Social consequences of mental illness. *Journal of Consulting and Clinical Psychology*, *30*, 450–454.
- Langer, E. J., & Abelson, R. P. (1974). A patient by any other name . . . Clinician group difference in labeling bias. *Journal of Consulting and Clinical Psychology*, *42*, 4–9.
- Lavori, P. W., Keller, M. B., & Klerman, G. L. (1984). Relapse in affective disorders: A reanalysis of the literature using life table methods. *Journal of Psychiatric Research*, *18*, 13–25.
- Levi, E. H. (1949). *An introduction to legal reasoning*. Chicago: University of Chicago Press.
- Maccoby, E. E., & Martin, J. A. (1983). Socialization in the context of family: Parent-child interaction. In E. M. Hetherington (Ed.), *Handbook of child psychology. Socialization, personality, and social development* (Vol. 4, pp. 1–102). New York: Wiley.
- MacDonald, A. P., & Hall, J. (1969). Perception of disability by the nondisabled. *Journal of Consulting and Clinical Psychology*, *33*, 654–660.
- Macrae, C. N., & Bodenhausen, G. V. (2000). Social cognition: Thinking categorically about others. *Annual Review of Psychology*, *51*, 93–120.
- Martin, S. L., Ramey, C. T., & Ramey, S. (1990). The prevention of intellectual impairment in children of impoverished families: Findings of a randomized trial of educational day care. *American Journal of Public Health*, *80*, 844–847.
- Mayes, L. (1995). Substance abuse and parenting. In M. H. Bornstein (Ed.), *The handbook of parenting* (Vol. 4, pp. 101–125). Hillsdale, NJ: Erlbaum.
- Melton, G. B., Petrila, J., Poythress, N. G., & Slobogin, C. (1997). *Psychological evaluations for the courts: A handbook for mental health professionals*. New York: Guilford Press.
- Metsch, L. R., Wolfe, H. P., Fewell, R., McCoy, C. B., Elwood, W. N., Wohler-Torres, B., Petersen-Baston, P., & Haskins, H. V. (2001). Treating substance-abusing women and their children in public housing: Preliminary evaluation findings. *Child Welfare*, *80*, 199–220.
- Mickelson, P. (1947). The feebleminded parent: A study of 90 family cases. *American Journal of Mental Deficiency*, *51*, 644–653.
- Moline, R. A., Singh, S., Morris, A., & Meltzer, H. Y. (1985). Family expressed emotion and relapse in schizophrenia in 24 urban American patients. *American Journal of Psychiatry*, *151*, 314–320.
- Monahan, J. (1981). *The clinical prediction of violence*. Rockville, MD: National Institute of Mental Health.
- Monahan, J., Steadman, H. J., Appelbaum, P. S., Robbins, P. C., Mulvey, E. P., Silver, E., Roth, L. H., & Grisso, T. (2000). Developing a clinically useful actuarial tool for assessing violence risk. *British Journal of Psychiatry*, *176*, 307–311.
- Mullick, M., Miller, L. J., & Jacobsen, T. (2001). Insight into mental illness and child maltreatment risk among mothers with major psychiatric disorders. *Psychiatric Services*, *52*, 488–492.
- Murphy, M., Jellinek, M., Quinn, D., Smith, G., Poitras, F. G., & Goshko, M. (1991). Substance abuse and serious child mistreatment: Prevalence, risk, and outcome in a court sample. *Child Abuse & Neglect*, *15*, 197–211.
- Musick, J., Stott, F. M., Spencer, K. K., Goldman, J., & Cohler, B. J. (1987). Maternal factors related to vulnerability and resiliency in young children at risk. In E. J. Anthony & B. J. Cohler (Eds.), *The invulnerable child* (pp. 229–252). New York: Guilford Press.
- Myers, B. (1992). Cocaine-exposed infants: Myths and misunderstandings. *Zero to Three*, *13*, 1–5.
- Nicholson, J., & Blanch, A. (1994). Rehabilitation for parenting roles for people with serious mental illness. *Psychosocial Rehabilitation Journal*, *18*, 109–199.
- Nicholson, J., Geller, J. L., Fisher, W. H., & Dion, G. L. (1993). State policies and programs that address the needs of mentally ill mothers in the public sector. *Hospital and Community Psychiatry*, *44*, 484–489.
- Olsen, L. J., Allen, D., & Azzi-Lessing, L. (1996). Assessing risk in families affected by substance abuse. *Child Abuse & Neglect*, *20*, 833–842.
- Oyserman, D., Mowbray, C. T., Meares, P. A., & Firminger, K. B. (2000). Parenting among mothers with a serious mental illness. *American Journal of Orthopsychiatry*, *70*, 296–315.
- Page, S. (1977). Effects of mental illness label in attempts to obtain accommodation. *Canadian Journal of Behavioral Science*, *9*, 84–90.
- Rodning, C., Beckwith, L., & Howard, J. (1991). Quality of attachment and home environments in children prenatally exposed to PCP and cocaine. *Development and Psychopathology*, *3*, 351–366.
- Rosenhan, D. L. (1973). On being sane in insane places. *Science*, *179*, 250–258.
- Sameroff, A. J., & Chandler, J. J. (1975). Reproductive risk and the continuum of caretaking causality. In D. Horowitz, M. Hetherington, S. Scarr, S. Salapatek, & G. Siegel (Eds.), *Review of child development research* (Vol. 4, pp. 187–243). Chicago: University of Chicago Press.
- Sarber, R. E., Halasz, M. M., Messmer, M. C., Bickett, A. D., & Lutzker, J. R. (1983). Teaching menu planning and grocery shopping skills to a mentally retarded mother. *Mental Retardation*, *21*, 101–106.
- Schetky, D. H., & Benedek, E. P. (1992). *Clinical handbook of child psychiatry and the law*. Baltimore: Williams & Wilkins.
- Schilling, R. F., & Schinke, S. P. (1984). Maltreatment and mental retardation. *Perspectives and Progress in Mental Retardation*, *1*, 11–22.
- Seagull, E. A., & Scheurer, M. D. (1986). Neglected and abused children of mentally retarded parents. *Child Abuse & Neglect*, *10*, 493–500.
- Silverman, M. M. (1989). Children of psychiatrically ill parents: A prevention perspective. *Hospital and Community Psychiatry*, *40*, 1257–1265.
- Solomon, D. A., Keller, M. B., Leon, A. C., Mueller, T. I., Shea, M. T., Warshaw, M., Maser, J. D., Coryell, W., & Endicott, J. (1997). Recovery from major depression. A 10-year prospective follow-up across multiple episodes. *Archives of General Psychiatry*, *54*, 1001–1006.
- Steadman, H., Mulvey, E., Monahan, J., Robbins, P., Appelbaum, P., Grisso, T., Roth, L., & Silver, E. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry*, *55*, 393–401.

- Stein, A. Gath, D. H., Bucher, J., Bond, A., Day, A., & Cooper, P. J. (1991). The relationship between post-natal depression and mother-child interaction. *British Journal of Psychiatry*, *158*, 46–52.
- Swanson, J. W. (1994). Mental disorder, substance abuse, and community violence. In J. Monahan & H. J. Steadman (Eds.), *Violence and mental disorder: Developments in risk assessment* (pp. 101–136). Chicago: University of Chicago Press.
- Szmukler, G. (2001). Violence risk prediction in practice. *The British Journal of Psychiatry*, *178*, 84–85.
- Tymchuk, A. J. (1992). Predicting adequacy of parenting by people with mental retardation. *Child Abuse & Neglect*, *16*, 165–178.
- Tymchuk, A. J., Yokota, A., & Rahbar, B. (1990). Decision-making abilities of mothers with mental retardation. *Research in Developmental Disabilities*, *11*, 97–109.
- Waldo, M. C., Roath, M., Levine, W., & Freedman, R. (1987). A model program to teach parenting skills to schizophrenic mothers. *Hospital and Community Psychiatry*, *38*, 1110–1112.
- Wasserman, D. R., & Leventhal, J. M. (1993). Maltreatment of children born to cocaine-dependent women. *American Journal of Diseases of Children*, *147*, 1324–1328.
- Watt, N. F. (1984). In a nutshell: The first two decades of high-risk research in schizophrenia. In D. Ricks, A. Thomas, & J. E. Roff (Eds.), *Children at risk for schizophrenia: A longitudinal perspective*. New York: Cambridge University Press.
- Weissman, M. M., Gammon, G. D., John, K., Merikangas, K. R., Warner, V., Prusoff, B. A., & Sholomskas, D. (1987). Children of depressed parents. *Archives of General Psychiatry*, *44*, 847–853.
- West, M. O., & Prinz, R. J. (1987). Parental alcoholism and childhood psychopathology. *Psychological Bulletin*, *102*, 204–218.
- Wolfe, D. A. (1987). *Child abuse: Implications for child development and psychopathology*. Newbury Park, CA: Sage.
- Wolfe, D. A., St. Lawrence, J., Graves, K., Behony, K., Bradlyn, D., & Kelly, J. (1982). Intensive behavioral parent training for a child abusive mother. *Behavior Therapy*, *13*, 438–451.

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