

# THE UNFIT PARENT: SIX MYTHS CONCERNING DANGEROUSNESS AND MENTAL ILLNESS

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There is a pervasive assumption that mental illness equates to dangerousness and violence as it applies to parenting. We examine this assumption and present a comprehensive literature review of how issues of mental illness impact violence and dangerousness. A range of issues is explored, including the unpredictability of bipolar disorder and schizophrenia, stress from mental health problems inhibiting emotional stability, and past in-patient hospitalizations for suicide attempts as they impact parenting. Risk mitigation strategies are also presented.

## Practitioner's Key Points:

- While the stress and difficulties of living with a mental illness certainly present challenges for any parent to overcome, this article answers the larger question, "Does having a mental illness equate with being an unfit parent?"
- In order to explore what makes an unfit parent, it is necessary to first operationalize what skills, traits, and abilities fit parents possess. The article offers a summary of what it means to be a fit parent.
- For an individual with mental illness, there may be a risk of unfit parenting or violence. But we can only understand the actuality when we look at the severity of the mental illness, environmental stressors, and additional risk factors.
- We offer a constellation of protective approaches to better assess the risk by attending to competent risk factors, rather than making broad assumptions concerning mental illness and the ability to parent or proclivity to behave in a violent fashion.

**Keywords:** *Dangerousness; Family Violence; Mental Health; Mental Illness; Parenting; and Violence.*

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## THE NATURE OF THE PROBLEM

Media portrayals of mental illness rarely cast a positive light on those who are dealing with mental health concerns in a parenting role. Schreiber's story of *Sybil*, Stephen King's portrayal of *Carrie*, and Alfred Hitchcock's *Psycho* present a fairly negative view of mentally ill parents inflicting horror after horror on their children. In 2013, *60 Minutes* explored schizophrenia and violence, providing an example of the media's portrayal of mental illness and dangerousness. Watson (2014) describes the show as "... quite misleading and frankly stigmatizing to those who suffer with mental disorders, especially those diagnosed with schizophrenia" (p 51). Serper and Bergman (2003) support this idea, given 90% of persons with mental illness have no history of violence.

Many in the criminal justice community and mental health and law enforcement systems have had experiences with individuals where mental illness seems to play an immanent role in poor parenting or creating a greater risk for dangerousness. They share individual stories around the water cooler of cases where a parent's mental illness severely impacted the safety and development of children in the home.

The challenge before us is recognizing sensationalized media portrayals and noting that single case examples are not sufficient to accept the generalization that those with mental illness are unfit parents. While the stress and difficulties of living with a mental illness certainly present challenges for any parent to overcome, it leaves the larger question of "does having a mental illness equate with being an unfit parent?" unanswered. This question is often debated in the court system and can have devastating outcomes. In fact, "... parents with mental illness are quite vulnerable to losing custody

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of their children, with custody loss rates in some studies as high as 70% to 80%” (Aldridge, 2006, p. 10).

This article explores the issue of mental illness and unfit parenting from a variety of perspectives. First, we examine the idea that not all mental illness is the same. When attempting to answer “does mental illness lead to unfit parenting?,” we must first explore what is meant by mental illness. There are a wide variety of mental illnesses that have varying impacts on parenting fitness.

Second, we wish to clarify the detrimental effect of allowing limited case examples to drive larger correlative conclusions. Many employees in criminal justice, mental health, and law enforcement have horror stories of mental illness leading a parent to do unimaginable things to their children. However, as horrible as these single incidents are, it is important to understand a few cases do not imply a larger cause-and-effect phenomenon.

Research that examines mental illness and violence is often exacerbated because there are different methodologies to assess the rates of violence. This is a considerable limitation and does not give a standardized way of assessing what violence is when it comes to parenting (Harvard Medical School, 2011). This issue becomes further muddled given that there are a wide variety of ways to define successful parenting, harm, violence, and so on. For example, simply having a lack of physical violence within the household cannot be the only measure of successful parenting.

To that end, we will discuss what factors contribute to a parent’s general fitness. In order to explore what makes an unfit parent, it is necessary to first operationalize what skills, traits, and abilities fit parents possess. By understanding what makes a fit and successful parent, we can better explore the question of what attributes are associated with an unfit parent.

## THE DIVERSITY OF MENTAL ILLNESS

One of the challenges in trying to better understand the relationship between mental illness and parenting is first realizing that not all mental illness is the same. The American Psychiatric Association’s (2013) *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)* is the guidebook for mental health practitioners, therapists, psychologists, and doctors to reference when diagnosing and discussing mental illness. There are hundreds of mental illnesses contained within this volume and each has a different level of severity and impact on how an individual may parent.

Mental health disorders such as posttraumatic stress disorder (PTSD) or eating disorders such as bulimia and anorexia may have an effect on the environment where the child is raised. For example, a parent may limit food access for a child if they are struggling with their own eating problems. An individual with PTSD may be overly reactive to loud noises or have an exaggerated startle reflex. In more extreme cases, the parent with a serious anxiety disorder may not want to leave the house or could become incapacitated during a panic attack and not be able to care for a young child.

More serious mental illnesses include substance abuse and dependence, schizophrenia and bipolar disorder, all of which present some challenges to parenting (Rihmer, Gonda, Rihmer, & Fountoulakis, 2010). Individuals with these disorders are two to three times more likely to be assaultive (Friedman & Michels, 2013). Individuals experiencing schizophrenic symptoms or bipolar disorder may not make appropriate parenting decisions or could become consumed by the illness. Major depression has the potential to pose a risk if it leads to a lack of energy causing the parent to not keep the house clean or provide food or adequate supervision. Substance abuse and dependence, which is classified as a mental health disorder in the *DSM-V*, could lead to a parent being intoxicated or inebriated while caring for a child. Drugs or alcohol could be present in the home that could allow for easy access and danger to children. The obtainment of the drugs could also introduce unsolicited danger by introducing drug dealers and other violent individuals who may be associated with illegal substance disbursement. It is not commonly known but in reality the use of alcohol and drugs contributes more to violent behavior than mental illness. “People who abuse alcohol or drugs but have no other mental disorder are nearly seven times as likely as those without substance abuse to commit violent acts.” (Friedman & Michels, 2013, p. 455).

In addition to understanding the potential ways a mental health disorder may impact a parent's ability to function, each mental illness should be seen on a spectrum of severity. Many with cases of complex mental illness such as schizophrenia or major depression have adequate treatment and medications that help keep symptoms under control. So, in addition to understanding the type of mental illness and potential negative impact it may have on parenting, it is also essential to rate the severity of the symptoms and the treatment being used to control them.

### THE PROBLEM OF THE SINGLE CASE

The saying, "a single swallow does not a summer make" gives us insight into another important distinction. When examining mass casualty shooting events, it is common to see a single, horrific case used to make a correlation that may or may not be true.

Take the concept of postpartum depression (PPD). This common experience many women endure in the months following birth certainly has a negative impact on their energy levels, ability to complete daily tasks, and focus on the needs of a child. Wu, Chen, and Xu (2012) write, "PPD is one of the most common complications in women of childbearing age. Approximately 10–15% of new mothers experience this condition" (p. 112). The single case of Andrea Yeats comes to mind. She confessed to drowning her five children in her bathtub in 2001 and is currently serving a life sentence for these capital murders (Gesalman, 2002). While this case is particularly disturbing, it does not represent the common experience for women who endure PPD. Implying that a common outcome or worry for PPD women is the killing of their babies would be factually inaccurate.

The process we should apply, instead, involves a careful understanding of the risk factors present in a given situation and taking protective steps to ensure the fitness of the parent. Hay, Pawlby, Angold, Harold, and Sharp (2003) demonstrate that, "In contrast to their peers, children whose mothers had been depressed at 3 months postpartum showed more diverse and more severe aggressive behaviors than other children, as reflected in the weighted violence score." (p 1091). Wu et al. (2012) support this risk factor: "The meta-analysis of quite a few research studies has highlighted a positive association between violence and PPD" (p 112). The risk of PPD tends to focus more on the stress and negative developmental impact on the child rather than infanticide. In the case of Yeats, additional mental health concerns, stressors with her husband, and the pressure to continue to have children despite the negative impact on her mental health each should be understood as being more likely causal factors that led to the deaths.

The challenge here is based on the Goldilocks principle, to find an assessment process moving forward that is neither too hot nor too cold, for example, finding a process that identifies the risk factors but does not make assumptions based on the presence of a diagnosis. We understand that an individual with a family history of heart problems is at a higher risk for a heart attack. We should not conclude from that information that the risk creates a foregone conclusion that a heart attack will occur. The addition of other risk factors such as smoking, obesity, lack of exercise, and poor diet would increase the risk profile.

As Polish American philosopher Alfred Korzybski wrote, "The map is not the territory" (Kendig, 1990, p. 299). Let us not confuse the presence of the mental illness with the idea that having a mental illness commonly leads to extreme violence and/or unfit parenting. For an individual with mental illness, there may be a risk of unfit parenting or violence. But we can only understand the actuality when we look at the severity of the mental illness, environmental stressors, and additional risk factors.

### WHAT MAKES A FIT PARENT

There are six key areas that contribute to parental fitness. These are the ability to provide safety and shelter, nurturing an educational environment, offering consistency and patience, emotional availability, compassion and affection, and empathy and understanding.

From Abraham Maslow's (1962) work in his hierarchy of needs, *safety and shelter* are the central foundation of his pyramid. Without a sense of physical safety, including a place to live, food, heat/

cooling, and places to sleep and take care of daily hygiene needs, a child will not thrive. Parents who are successful provide this kind of shelter and safety to allow for optimal development for their children.

*Nurturing an educational environment* for children is another element of parental fitness. Whether this is encouraging children to work on homework, explore extracurricular activities such as sports or music lessons, or provide homeschooling, parents offer a wide range of encouragement and support to equip their child to reach his/her personal potential. The number of opportunities for children are clearly limited by financial and environmental obstacles and it is not an intention to equate parental success to those who have access to countless resources and to denigrate parents who cannot provide that level of support. As Aldridge (2006) warns, “. . . assessing parents often relies on middle-class assumptions about ‘appropriate’ standards of domesticity and hygiene” (p. 85). Parental fitness to create and sustain a nurturing environment should be measured in terms of what is contextually sufficient, not based on external standards of wealth or opportunity.

A sense of *consistency and patience* is a hallmark of parental fitness. Teaching children the world is a predicable place where certain behaviors are consistently rewarded and other behaviors have negative consequences provides children with the needed structure to develop and grow. Inconsistent messages have a negative impact on child development. Patience is important as it relates to creating a sense of balance. Patience facilitates consistent parenting and support even when faced with the frustrations and challenges of raising children. For example, a parent who can remain patient while enforcing a consistent limit around bedtime helps ensure the child is not too tired for school the next morning. This creates a sense of balance in the child’s life. The enforcement of the limit is part of the equation. The other part is holding the child accountable with a degree of patience and grace.

As the saying goes, “the road to hell is paved with good intentions.” While a parent may have good intentions and may cognitively grasp what they need to provide for the child, there is always a limited commodity in terms of time and emotional availability that must be applied in practice. While the parent may understand what needs to be done to be a successful parent to his/her child, are they *emotionally available* to provide for the child or are they distracted by their own needs, stresses, and struggles?

As researchers, it is a challenge to identify and operationalize terms to avoid general or nonspecific constructs when describing parental fitness. Yet, there remains the challenge of writing this article without addressing the elephant in the room: love. Love for a child is the glue that holds fast the idea of a successful parent. When considering the operationalizing of love a parent has for their child, the concepts of *compassion and affection* seem to capture the larger concept well (Carroll et al., 2013). Also, of important note, love is not sufficient. A parent may love their child very deeply, but be unable to provide for him/her or achieve the other areas of fitness discussed above.

A successful parent is able not only to sympathize with a child’s worldview and experience (e.g., appreciating that a 2-year-old may not fully possess the ability to turn down that eighth cookie if left unattended), but also to have a deeper connection to why the child does not understand the rules like an adult. Corrective action, encouragement, and limit setting are better achieved when offered with *understanding and empathy*.

One final consideration that should be factored into the assessment of a parent’s fitness should be the number of children and the age and particular needs of each child. One would assume having numerous children or children with special needs would require a higher level of dedication and potentially have a higher level of stress impact on the parent. Likewise, caring for a newborn or young toddler requires more intensive support, time, and patience than caring for a teenager.

## MYTHS CONCERNING DANGEROUSNESS AND MENTAL HEALTH

### MYTH #1: MOST OF THE VIOLENCE IN OUR SOCIETY CAN BE ATTRIBUTED TO PEOPLE WHO ARE MENTALLY ILL

It is difficult to look at the television news stations or read the newspaper without seeing a story related to someone with mental illness committing violent acts. An airline pilot suffering from

depression crashes a plane carrying 150 people into the French Alps (Clark & Bilefsky, 2015). A veteran with PTSD goes on a shooting spree at a military base in Texas (Zoroya, 2014). A student with Asperger's (now defined as an autism spectrum disorder [ASD]) kills dozens of young children at an elementary school in Connecticut (Sandoval & Siemaszko, 2013).

While upsetting and often sensationalized with weeks and months of media coverage following the incident, it is reasonable for the public to assume that these kind of violent acts and planned attacks are both on the rise and often due to mental illness. In reality, there are statistically far more people with the same mental health disorders such as depression, PTSD, or ASD who never commit violent acts (Langman, 2009; 2015; Choe, Teplin, & Abram, 2008).

These black-swan events occur infrequently and bring with them an element of unpredictability and terror that leads to the lay population making assumptions about the frequency of these attacks. Black-swan events are defined as high-profile, hard-to-predict, rare events that the public attaches meaning to with the benefit of hindsight (Taleb, 2007). Peter Langman (2009, 2015) makes this point when discussing his typology of school shooters as traumatized, psychotic, and psychopathic. While these traits exist, most people who are traumatized, psychotic, and psychopathic do not commit murder.

An example to support this concept is found in the number of air disasters that occurred in 2014 and 2015. Some examples of these crashes include: the disappearance of Malaysia Airlines 370 with 239 people on board on March 8, 2014 (Macleod, Winter, & Gray, 2014), the shooting down of Malaysian Airlines flight 17 with 298 people on board on July 17, 2014 (Higgins & Clark, 2014), and the pilot who crashed Germanwings Flight 9525 into the mountainside in France killing 150 on March 24, 2015 (Clark & Bilefsky, 2015). Many people experienced a severe reaction to these news events and made assumptions about the safety of air travel.

To offer some perspective, there were 41,149 deaths by suicide in the United States in 2013 (Center for Disease Control, 2015). Out of 32,719 overall fatalities related to traffic accidents in the United States in 2013, there were 682 fatal traffic deaths in the state of Virginia alone (Insurance Institute for Highway Safety, 2015). Collectively, the air disasters mentioned took the lives of 687 people. While mental health violence is scary and brings with it an element of the unknown and increased media exposure, the likelihood of this kind of attack occurring is statically small when compared to issues of car accidents and suicide. In fact, the incidence of mental health violence is still statistically small even when compared to the highly infrequent air disasters.

While there is something certainly trivializing that occurs when, by reducing the impact of deaths to a simple body count, the concept here is that those who travel are much more likely to lose their lives on the way to the airport than they would in an airplane crash. While mental illness may be a contributing factor in some of these infrequently occurring shootings and attacks, the reality is that most people with mental illness are more likely to be the victim of a violent crime than they would be to commit such a crime (Choe et al., 2008). In some cases, people with mental illness are up to 11 times more likely to have experienced recent violence when compared to the general population (Khalifeh & Dean, 2010). Khalifeh and Dean (2010) write, "men and women with pre-existing severe mental illness are at significantly higher risk of being victims of all forms of violence than the general population" (p. 535).

## **MYTH #2: MENTAL ILLNESS DRIVES INDIVIDUALS TO COMMIT MASS SHOOTINGS**

Mass shootings are a specific form of black-swan event that have recently been attributed to the influence of mental illness or those on medication (Ross, 2013). While it does appear many of those involved in mass shootings have been on psychiatric medications (Roberts, 2013), the idea that the mental illness or medication directly contributed to the shooting does not necessarily follow. There are hundreds of thousands of other people on these medications who never carry out such attacks.

In 2012, James Holmes killed 12 and injured dozens of others in a movie theater in Aurora, Colorado (Elliot, 2013). Prior to his attack, he mailed a notebook to his psychiatrist that offered a

foreshadowing of the attack (La Ganga, 2015). The desire to be known, to communicate their motives, and to influence the media message is often strong for those who commit mass violence. Holmes was diagnosed with schizotypal personality disorder during the course of the investigation and trial (McKinley, 2015).

Adam Lanza, who shot 20 children and 6 adults at Sandy Hook Elementary School in December 2012 (Sandoval & Siemaszko, 2013), was said to suffer from Asperger's Syndrome. In the aftermath of the shooting, the question was asked if the Asperger's was the primary contributor to the shooting. Perhaps elements of the disorder contributed to Lanza's development of the plan and contributed to the stress he was under prior to the attack. Lanza's social isolation by secluding himself in his house and severely limiting his communication to only his mother prevented the detection of any leakage about the pending attack. Yet to make the jump that all individuals on the spectrum of autism have a higher potential for violence is not supported by the literature (Søndenaa et al., 2014).

In both of these cases, mental illness was one of a multitude of risk factors that likely set the stage for the attack. More often, the risk factors such as hopelessness, social isolation, injustice collecting, and a hardened point of view often overlap with mental health diagnoses, giving the impression that mental illness itself is the cause of these attacks. When we carefully examine the component risk factors for mass shooting, we find many more risk factors beyond mental health concerns that are much more accurate to explore in prevention of violence (Van Brunt, 2015).

### **MYTH #3: THOSE WITH SCHIZOPHRENIA OR BIPOLAR DISORDER MAKE FOR DANGEROUS PARENTS**

Those experiencing active symptoms of schizophrenia or bipolar mania may, in fact, present a higher risk of committing violence (Friedman & Michels, 2013; Harvard Medical School, 2011; Rihmer et al., 2010; Choe et al., 2008). Untreated schizophrenia may include powerful hallucinations and delusions that could cause the individual to lose touch with reality and make questionable, impulsive decisions regarding parenting or caring for those around them. Likewise, some experience an intense manic phase of their bipolar disorder with racing thoughts and impulsive actions that could put their children, or those around them, at risk.

With proper symptom management, however, the hallucinations, delusions, impulsive actions, or racing thoughts are reduced and allow the individual to function much like those without the disorder. The caution here is to avoid a myopic focus on the presence of the diagnosis and instead assess how the individual and his/her treatment providers and support system ensure medication and treatment compliance. Much in the same way untreated diabetes or a parent in severe pain from a broken leg would impact his/her ability to attend to daily life requirements, once the underlying issues are treated, the individual is once again able to continue performing parenting, work, and life skills in a normal and appropriate manner.

In the end, the issue of whether or not an individual with schizophrenia or bipolar disorder is a fit parent necessitates further exploration of their compliance with therapy, medications, social supports, and history of remaining consistent and in communication with treating professionals about their symptoms. These secondary questions are much more likely to yield accurate information about the fitness of a parent.

### **MYTH #4: THE STRESS OF PARENTING AND CHILD CARE INCREASES THE RISK OF VIOLENCE FOR THOSE WITH MENTAL ILLNESS**

Parenting is stressful for almost all who choose to raise children. Different people experience stress differently. Some might find a cross-country flight or speaking in front of a large audience to be stressful situations. Others may do these activities as part of their daily work. Issues of providing education, financial support, and a safe environment that nurtures exploration are all part of daily stressors a majority of parents have to face. Growth takes time, patience, and an emotional toll on

parents. However, stress is subjective and individualized, the extent of it must be examined on a case-by-case basis.

Stress is also cumulative. Excess stress for anyone can impact their ability to function (Hart, 1995; Howard, 1999). Stress can impact the ability of a person to care for him/herself in terms of washing, eating, maintaining social friendships, attending work or school, being available to support a significant other, and parenting children.

The question is better asked as “At what point are the individual’s coping skills stretched to the point of being ineffective in parenting his/her children?” And this question could be asked in relation to mental illness, but also for individuals working several jobs or to those trying to balance a college education with work and parenting.

An individual’s mental illness could certainly increase the chance of becoming overwhelmed by stress and therefore not being available for their children. The challenge here for those understanding the fitness of parents must be to focus less on the presence of a particular diagnosis, and instead assess how the individual is managing the stress in his/her life.

#### **MYTH #5: ONCE A PERSON IS HOSPITALIZED FOR MENTAL ILLNESS, THE RISK FOR VIOLENCE SKYROCKETS**

Hospitalization for an individual with a mental illness can occur in a variety of contexts. A hospital stay may be set up to adjust medications or provide a brief respite and reduce his/her overall stress level. Other times, an inpatient hospitalization may be in reaction to a crisis event such as a suicide attempt, severe anxiety attack, or losing touch with reality.

When attempting to draw an inference between a hospitalization and an increase in violence or inability to parent, the context of the hospitalization must be fully explored. If the stay was voluntary and the individual receives help during his/her time in the inpatient unit, the hospitalization may very well improve his/her ability to manage stress and parent more effectively upon discharge. In fact, one would hope that the intervention of most hospitalizations would leave the individual in question better than s/he was prior to being hospitalized. Watson’s (2014) research supports this: “Individuals who are diagnosed with ‘mental illness,’ even when being recently discharged, are ‘not statistically more dangerous than people in the communities they were discharged to, and those same patients were no more dangerous even if they had threat/control delusions’” (p. 55).

Understanding the situational factors surrounding the hospitalization becomes essential in understanding the potential risk for future violence or impact on the individual’s availability to parent his/her children. Simply drawing a thick line of connection between being hospitalized and an increase in the person’s violence risk oversimplifies the complexities at hand. Instead of focusing on hospitalization, other more accurate factors should also be considered. For example, violence is more common in young people, particularly males, who also experience social or personal stress and have early exposure to violence (Harvard Medical School, 2011).

#### **MYTH #6: IF A PARENT HAS BEEN SUICIDAL, THERE IS NO WAY TO PREVENT THEM FROM ATTEMPTING TO KILL THEMSELVES IN THE FUTURE AND PUTTING THE CHILDREN AT RISK**

This may or may not be the case given the particular individual in question. Suicide attempts may offer an individual with a mental illness a sense of hitting bottom and, following the attempt, s/he may be more aware of his/her mental health needs. Individuals may be more open to seeking services, treatment, and support for their mental illness to get the help they need. The suicide attempt itself may be the wake-up call that leads to positive, lasting change.

On a less positive note, it may also be the case that the suicide attempt is one of many and this chronic behavior has a devastating effect on the children in the home. The potential death of a parent presents children with threats to the stability, consistency, and safety of the home. Though Aldridge (2006) limits the risk of even this severe repeated behavior to the children to psychological rather

than physical harm: “from the interviews with the children, parents and key workers in this study, no evidence was found of physical harm or neglect of children by parents, even when these parents were self-harming or regularly attempted suicide” (p. 82).

With such a wide range of potential impacts following a suicide attempt, looking at the situation from a subjective perspective allows a better understanding of how the incident impacts the ability of the individual to parent.

## **HOW TO MITIGATE THE RISK**

There are a number of ways to mitigate the risk of overattributing mental illness to potential violence or misrepresenting the impact on an individual’s fitness to parent. The following constellation of protective approaches allows those in law enforcement, criminal justice, and psychological services to better assess the risk by attending to competent risk factors, rather than making broad assumptions concerning mental illness and the ability to parent or proclivity to behave in a violent fashion.

### **LOOK AT THE BEHAVIOR, NOT THE DIAGNOSIS**

A theme of this article has been examining the fundamental areas of mental illness that may stand in the way of effective parenting. Instead of assuming individuals with a certain diagnosis to be necessarily at a higher risk for poor parenting or violence, symptoms and behaviors that directly impact the ability of a parent to provide a safe, nurturing, and supportive environment for the child should be explored. While single case studies may give the impression that certain disorders such as schizophrenia or bipolar disorder lead to unfit parents, there are many parents with such disorders who receive proper treatment and care that allows them to be exceptional parents. This is also true for parents with depression; the assumption that they will not have the energy to be consistent or emotionally available for their child is highly dependent on external factors. Instead of focusing on the diagnostic label, it is vital to assess the severity of the symptoms, past experiences with treatment, and how the individual is managing the stress in his/her life related to the mental illness.

Having a mental health diagnosis does not necessarily make someone an unfit parent or prone to violence. Similarly, just being prescribed and taking medication does not equal a higher risk for dangerousness or unfit parenting. Research shows that “the more psychiatric medications someone is given, the more someone becomes vulnerable to relapse, disability, psychosis, and violence” (Watson, 2014, p. 56). This may be a partial explanation of why uncharacteristic acts of violence are seen in patients who experience the sudden termination of psychiatric medication (Watson, 2014).

### **UNDERSTAND AN INDIVIDUAL’S STRESS TOLERANCE AND MANAGEMENT**

We all experience stress differently. For some of us, losing our car keys or iPhone may be enough to spin an otherwise peaceful week into disarray. For others, balancing two jobs, attending school, and raising four children while managing the mental health symptoms of an anxiety or eating disorder may simply be par for the course. To assess fitness for parenting or potential for an impulsive or violent reaction, it is vital to first gain an understanding of how affected individuals manage stress in their lives.

Mental illness can certainly have an exacerbating effect on the overall stress a person experiences and thus have a negative impact on a parent’s emotional availability, willingness to empathize, and expression of compassion. With accumulation of such stressors, parents may not provide a child with basic needs for shelter, food, and safety. However, it is just as likely that an individual with a mental illness may have quality 24/7 access for support to keep their stress better managed, allowing them to be more available for family commitments. In the end, this must be assessed subjectively and contextually given the environment, supports, and stressors. One should not assume an increase in stress

necessarily leads to a failure to cope for someone with mental illness. Many with mental illness are very familiar with stress and have extensive resources and supports they may access during times of heightened stress.

### **RISK ASSESSMENT IS ABOUT IDENTIFYING TRIGGERS AND ASSESSING SUPPORT**

When assessing risk in a system, it is not sufficient to identify the factors that may make a situation worse (Hart & Logan, 2011; Hart, Logan, & McMuran, 2011). While an understanding of potential hotspots or triggers such as losing a job, an increase in symptoms of depression, or hearing voices should be identified as events that increase risk, a more accurate risk assessment also evaluates supports and the level of resiliency an individual has in his/her life that may help the situation improve. While rain may be a negative stressor, it is less so for the individual who has an umbrella. While an increase in manic or impulsive decision-making behavior should be an area of potential risk, it is less so for an individual who can lean on his/her therapist and has a social support group and experience managing these symptoms. Assessing risk should involve both identifying how to reduce the negative or trigger events in a person's life and looking at the presence of mitigating factors such as peers, family, treatment access, social supports, and past success managing his/her illness.

### **CONCLUSION**

Despite what media news, popular movies, and TV shows depict, mental illness is rarely associated with increased dangerousness and never assumed as a cause of violence by those who study this field. Having a mental illness does not equate to being an unfit parent. Instead, further assessment is required to gain a better understanding of the parent's behavior, treatment compliance, social and peer support, resiliency to stress, and access to crisis services. While those with substance use/abuse, schizophrenia, or bipolar disorder may be at a slightly higher risk for violence, the risk still remains much lower than the general population. Many parents who live with mental illnesses actively seek therapy or medication for their illness and lean on an impressive structure of social, family, and peer supports. Those in law enforcement, criminal justice, and mental health community are trained, taught, and encouraged to focus on a wide variety of contributing factors that may indicate violence as opposed to narrowing the focus on a mental health diagnosis.

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