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IT HAPPENS IN REAL LIFE

The Complexities of Conflict and Mental Health Within Families

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In 2005, the city I lived in at the time was rocked to its core when a man with a mental illness lost control; lost his ability to communicate effectively with his family, with his mental health providers, and with hospital workers. Within 18 hours, six people's lives were changed forever, as were those of the family members of the six, as well as an entire community and, perhaps, a nation. It started early on a warm summer morning, when the first victim, a 54-year-old grandfather, who worked for the State Department of Transportation, arrived at work for his 6 a.m. shift. He was shot to death, in the back, at close range. After this early morning shooting, the accused killer walked in to the local hospital where he had been treated for years. He was clearly upset—asking for help, making threats to hospital workers, and demanding an appointment. When turned away, he phoned a number to a state agency that manages health care programs. He made an appointment to meet with his caseworkers later that afternoon.

Within less than an hour, the accused killer called the state agency again. He was angry, he was agitated, he wanted help. He left a threatening voice message stating that he had a list of people he wanted to kill. He never arrived for his appointment with his caseworkers. Later that day, just before 5 p.m. closing time, the same man went to a motorcycle shop and killed two more people, both employees of the motorcycle shop: a 17-year-old high school student with a bright future and a 26-year-old newlywed and father of a newborn son. The recorded 911 call from the 17-year-old is chilling. After more phone calls by the accused killer to doctors, therapists, and a local hospital, police were dispatched after 9 p.m. that evening to do a “routine” pickup of and hospital transport for a man with mental illness. The connection between the daytime murders and the standard pickup/transport had not been made at this point. A belt recording of one of the officers lasted for 23 minutes. Seven minutes later, one of

the officers made a frantic call: “Shots fired! Officer down!” Both veteran police officers, who recently rejoined the police force after retirement, were shot dead—one in the head and the other under the armpit of his bullet-proof vest, straight through to his heart. The accused was apprehended just minutes after midnight. He continues to stay incarcerated, deemed unfit to stand trial. “It was one of the worst days in the history of the city, without a doubt” (Wilham, as cited in Stafford, 2007, para. 230).

Within any 1-year period, mental health disorders directly affect about 20% to 26% of adults in the United States (Kessler, Chiu, Demler, & Walters, 2005; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). The impacts of these disorders also have far-reaching effects on family members, friends, and communities. Although the true story above has extremes, it also has events that are very typical in the lives of people who live with mental illness; family members who do not know what to do to help, individuals with mental illness who are not able to communicate the extent of their isolation, fears, and needs; and the sometimes inexplicable behavior of people who live with mental illness, which often leads to conflict within families and other interpersonal relationships. After providing some margins to this chapter, which include definitions and descriptions of mental disorders, and specific categories of mental disorders referenced within this writing, this chapter explores the role of race and ethnicity on mental health, the relationship between mental health disorders and family conflict, as well as practical suggestions for providers and families. Throughout the chapter, the opening story and another family’s story are referenced in an effort to illustrate how the research findings and definitions are manifested in specific cases.

MENTAL HEALTH DISORDERS DEFINED

Mental disorders are difficult to define largely because there is no single definition that covers all situations and because the term *mental* disorder implies a distinction between one’s mental health and one’s physical health. Mental health disorders are complex and often do not occur in isolation from physical disorders. Significant amounts of literature demonstrate that physical and mental health are interwoven (U.S. Department of Health and Human Services [U.S. DHHS], 2001). Perhaps because of these complexities, our body of literature lacks a “consistent operational definition” for mental disorder (American Psychiatric Association [APA], 2000, p. xxx). Although the worthiness/credibility of the Diagnostic and Statistical Manual (DSM) is debated, it is the guiding publication for mental health practitioners. The DSM offers a thoughtful definition of mental disorder and was first published in the DSM-III (cf. APA, 1987). Mental disorder is a

clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom), or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk for suffering death, pain, disability, or an important loss of freedom. (APA, 2000, p. xxxi)

The DSM offers an expansion of the definition by clarifying that situationally and/or culturally relevant responses must not be contributing to the disorder. “In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one” (APA, 2000, p. xxxi). It is inappropriate, therefore, to diagnose a person who is grieving the (somewhat recent) death

of a loved one with depression. Sadness and depression are natural responses to the process of grief, and according to the DSM's definition of mental disorder, a diagnosis must be made independently of an "expectable" response to a given event.

Mental disorders are broad, complex, and encompass many aspects of one's level of functioning. For the purposes of this chapter, therefore, the focus of mental disorders is limited to four areas: (1) depression, (2) anxiety, (3) substance abuse and dependence, and (4) schizophrenia.

Depression

Approximately 10% of the U.S. population suffers from a mood disorder (Kessler et al., 2005). Depression and mood disorders have extensive categories and definitions. For the purposes of this chapter, the definition of a specific type of depression—Major Depressive Disorder—is offered as a general description of what depression looks like for individuals living with this disorder. A Major Depressive Episode is when a person experiences at least 2 weeks of nearly daily feelings of "either depressed mood or the loss of interest or pleasure in nearly all activities" (APA, 2000, p. 349), and it clearly marks a difference from past functioning. In addition, at least four of the following symptoms must also be experienced: "changes in appetite or weight" (increase or decrease); changes in sleep (increase or decrease); changes in psychomotor activity; "decreased energy, feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, or plans or attempts" of suicide (APA, 2000, p. 349). Symptoms of depression often include increased levels of stress, lack of or poor social support, decreased or poor coping skills, and the burden of underprivileged socioeconomic

status (SES; J. S. Brown, Meadows, & Elder, 2007). Major depression is almost always a precursor to suicidal ideation, suicide attempts, and completed suicide.

Anxiety

Approximately 18% of the U.S. population suffers from some sort of anxiety disorder (Kessler et al., 2005). Within the mental health literature, the category of Anxiety Disorders encompasses numerous conditions and includes disorders such as Panic Attacks, Agoraphobia, Obsessive-Compulsive Disorder, Post-Traumatic Stress Disorder, Acute Stress Disorder, and Generalized Anxiety Disorder (GAD), among several others. As defined by the DSM-IV-TR, GAD refers to experiencing "excessive anxiety or worry" for the majority of days over at least a 6-month period, difficulty controlling the worry, and at least three of the following symptoms must also be experienced: "restlessness, being easily fatigued, difficulty with concentrating, irritability, muscle tension, and disturbed sleep" (APA, 2000, p. 472). People with GAD also experience impairment in areas of functioning, including work, school, and social settings. A diagnosis of GAD cannot be related to other types of disorders such as panic disorders, social phobias, eating disorders, substance abuse disorders, and/or a general medical condition.

Substance Use Disorders

Approximately 4% of the U.S. population has a substance abuse disorder (Kessler et al., 2005). About 3% have a substance abuse disorder along with a mental health disorder (U.S. DHHS, 2001). Substance Use Disorders are categorized into two areas: (1) substance dependence and (2) substance abuse. Substance dependence refers to a 12-month period of time wherein a collection of "cognitive, behavioral, and physiological

symptoms indicating that the individual continues use of the substance despite significant substance-related problems” (APA, 2000, p. 192) is manifested. Due to the dependence aspect of this disorder, individuals develop a “pattern of repeated self-administration of the drug,” which leads to “tolerance, withdrawal, and compulsive drug-taking behavior” (APA, 2000, p. 192).

Substance abuse is defined as the development of a “maladaptive pattern of substance use” within a 12-month period that results in “recurrent and significant adverse consequences” related to the ongoing use (APA, 2000, p. 198). Substance abuse-related problems include using substances in situations that are dangerous and/or include adverse effects as a result of the substance abuse such as being arrested for driving under the influence, persistent relationship/familial problems, financial problems, and employment difficulties (APA, 2000). An individual can have a diagnosis of substance abuse without having a diagnosis of substance dependence. Substance abuse and substance dependence include the use of alcohol, illicit drugs, prescription medications, and self-ingested toxins.

Schizophrenia

Schizophrenia is the least prevalent mental illness addressed in this chapter. Only

about 1.3% of the U.S. population suffers from schizophrenia (U.S. DHHS, 1999). Schizophrenia is classified as a psychotic disorder and is defined as having at least two “characteristic symptoms such as delusions, hallucinations, disorganized or incoherent speech, grossly disorganized or catatonic behavior, or negative symptoms” such as inability to speak or lack of initiative or motivation (APA, 2000, p. 312). These behaviors must persist for a 6-month period and must occur over significant amount of time for a 1-month period. Social and occupational functioning, including interpersonal relationships, work, and personal hygiene are negatively affected a significant amount of time. Finally, the onset of these behaviors cannot be attributed to substance abuse, a general medical condition, and must not be in relation to pervasive developmental disorders (APA, 2000). Box 9.1 includes information about the opening case regarding the accused’s mental health status.

Overall, mental health disorders affect nearly 30% of the U.S. population in a given year. The number of people who are affected by mental health multiplies when family members, friends, colleagues, and community members are taken into account. Mental health disorders manifest differently in individual people, and there is significant evidence

Box 9.1 It Happens in Real Life: Diagnosis of Schizophrenia

The 48-year-old accused killer, deemed unfit to stand trial, has been diagnosed with paranoid schizophrenia. He was diagnosed with this disorder long before—years before—the shootings. He was a young adult when he began to struggle with illness. In the months leading up to that dreadful day in August 2005, the man’s family noticed marked changes in his behavior. His once stable employment became rocky, and eventually, he was unemployed. He stopped exercising. He began wearing all black clothing and even wore black polish on his sharpened-to-a-point fingernails. He had multiple piercings, including a recent one in his neck. He grew his hair out, long; it was never combed, and it was always dirty. It was always disheveled. His outward presentation was a mirrored reflection of the uneasy, simmering, agitated, desperate man that he was on the inside.

of how and why mental illness occurs across cultures.

THE ROLE OF RACE, ETHNICITY, AND CULTURE ON MENTAL HEALTH

Race, ethnicity, and culture are complex constructs that are used in research and practice to better understand mental health disorders. Race is a social category that distinguishes people based on physical and social characteristics that are defined as racially meaningful (U.S. DHHS, 2001), while ethnicity is centered on grouping people based on a shared history or heritage (U.S. DHHS, 2001). Culture is

a learned system of meanings that fosters a particular sense of shared identity-hood and community-hood among its group members. It is a complex frame of reference that consists of a pattern of traditions, beliefs, values, norms, symbols, and meanings that are shared to varying degrees by interacting members of an identity group. (Ting-Toomey & Takai, 2006, p. 691)

Trying to tease out these constructs is beyond the scope of this chapter. However, the federal government and the research community tend to use race and ethnicity to categorize groups within the United States, while culture is used to discuss the components of these groups. This section uses these distinctions to discuss similarities and differences in the prevalence and experience of mental health disorders.

The U.S. government identifies four ethnic minority groups: African American, Asian American/Pacific Islander, Hispanic American, and Native American/American Indian/Alaskan Native/Native Hawaiian and one ethnic majority group, non-Hispanic Whites (specifically Hispanics are described as an ethnicity, while the other groups are described as races). In addition to these overarching groups, there are many subgroups—with unique sets of cultural norms and values—that are underrepresented

in terms of mental health needs. Some of these groups include lesbian, gay, bisexual, transgendered, and queer/questioning (LGBTQ) individuals, people with physical disabilities or impairments, and veterans returning from combat. Each of these groups has rapidly changing demographics, is underrepresented in health care, and requires culturally competent services and interventions. However, these groups are beyond the scope of this chapter due to space limitations.

Within the United States, ethnic diversity also has implications for financial diversity. Many families from ethnic minority groups have significant financial disadvantages; they are three times more likely than non-Hispanic Whites to fall below the federally recognized threshold for poverty level (U.S. DHHS, 2001). Poor SES, including lack of income, occupational status, and educational level, all have direct, and strong, linkages to poor mental health outcomes (Kessler et al., 2005; U.S. DHHS, 2001). Families in the lowest SES ranks are nearly two and a half times more likely than those in the highest SES ranks to suffer from mental health disorders (Regier et al., 1993). While there are many cultural aspects that merit discussion and examination, this chapter limits discussion to the major U.S. designated ethnic groups. Ethnic group differences are described for three of the four diagnoses described (schizophrenia is not included as there is limited evidence of ethnic difference in part because of the low prevalence of the diagnosis). Then, a summary section reinforces a key message that there is not much difference in the prevalence of mental health disorders between ethnic groups, but there are some differences in presentation of mental health and mental health services utilization.

Depression

There are inconsistencies in studies about ethnic differences and depression. Some findings indicate that African American young

adults have the highest rates of depression compared with any other group of young adults (Gore & Aseltine, 2003), while other findings conclude that, in general, Hispanics have higher rates of depression than any other ethnic minority group (Gore & Aseltine, 2003; Iwata, Turner, & Lloyd, 2002). One particular study that assessed prevalence rates within a large ($N = 5,412$), diverse sample of the population found that Chinese Americans had the lowest rates of major depression out of the entire sample population (Roberts, Roberts, & Chen, 1997). However, other studies report both Chinese and Korean Americans have the same or higher rates of depression as non-Hispanic Whites (Choi, Stafford, Meininger, Roberts, & Smith, 2002; Stewart et al., 1999). However, more recent large-scale studies (Beals et al., 2005; Harris, Edlund, & Larson, 2005; National Institute of Mental Health [NIMH], 2008b) illustrate that depression rates are lower for African Americans and Hispanics relative to Whites, while the other three ethnic groups have similar rates of depression. There is evidence that of the ethnic groups, American Indians have the highest rates of suicide (Olson & Wahab, 2006). A recent national study found that American Indians and Whites (7.7% and 7.3%, respectively) had the highest rates of past-year major depressive episode, with African Americans and Hispanics following next (5.8% and 5.6%, respectively) and Asian Americans having the lowest (3.8%) (SAMHSA, 2012).

Anxiety

A review of the literature by Paradis, Hatch, and Friedman (1994) noted that the Epidemiological Catchment Area (ECA) study—a study with more than 18,000 participants—did not find any specific differences in the overall prevalence of anxiety within different cultural groups. Both the ECA study

and another group of researchers reported a higher prevalence of specific phobias (i.e., specific categories of anxiety) among African Americans than among Whites (D. R. Brown, Eaton, & Sussman, 1990; Paradis et al., 1994). However, the more recent large-scale studies (Beals et al., 2005; Harris et al., 2005; NIMH, 2008a) illustrate that anxiety rates are lower for African Americans and Hispanics relative to Whites, while the other two ethnic groups have similar rates of anxiety relative to Whites.

Substance Abuse and Dependence

The recent large-scale National Survey of Drug Use and Health in 2010 found some differences in use and dependence/abuse of alcohol and drugs (SAMHSA, 2012). American Indians were found to have the greatest lifetime (i.e., reporting use of a particular substance at any point in one's lifetime) and past-year use of illicit drugs (58.4% and 22.6%, respectively), while Asian Americans had the lowest use (25.2% and 8.7%) (SAMHSA, 2010a). Whites had the next highest lifetime use (50.9%) followed by African Americans (45.1%) and Hispanics (37.2%) (SAMHSA, 2010a). Similarly, American Indians had the highest percentage of dependence or abuse of drugs and alcohol (6.3% and 14.0%, respectively) and Asian Americans had the lowest percentage (1.3% and 3.2%, respectively) (SAMHSA, 2010b). African Americans had the next highest percentage of drug dependence/abuse (4.0%) followed by Hispanics (3.5%) and Whites (2.5%). Hispanics had the next highest percentage of alcohol dependence/abuse (7.6%) followed by Whites (7.4%) and African Americans (5.7%). It is important to note, however, that because this sample does not provide large numbers of some population groups (e.g., American Indians and Asian Americans), the differences in percentages are not considered statistically significant.

Studies evaluating substance abuse within specific age-group populations have found some pronounced differences. For example, American Indian youth were more likely to report lifetime use of marijuana and cocaine and 30-day use of marijuana, cocaine, stimulants, alcohol, and cigarettes (Beauvais, 1992). In addition, the percentages of university students consuming alcohol in the past 30 days were as follows: Asian Americans (59.1%), African Americans (52.3%), American Indians (73.1%), Hispanics (75.3%), and Whites (75.3%; Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention, 2007). Thus, there appear to be some slight differences in the rates of substance abuse and dependence across ethnic groups.

Summary

In general, most recent researchers and mental health agencies conclude that there are only minor differences in the rates of mental health diagnoses across ethnic groups in the United States. There are slight variations for some specific disorders as noted above, but generally, these are for specific populations (e.g., youth) within ethnic groups.

That is not to say that ethnicity and culture does not matter for mental health. Two areas where culture factors in are within the presentation of symptoms and also in the seeking of services. Cultural-bound syndromes are one example of different presentation (U.S. DHHS, 2001). Cultural-bound syndromes are clusters of symptoms that appear to be more prevalent in one culture than in another. For example, some Caribbean women present with *ataque de nervios*, which includes occurrences of crying, trembling, and verbal aggression (U.S. DHHS, 2001). Such syndromes are being investigated to see if they fit within traditional *DSM* categories or whether they belong in unique categories.

Additionally, great caution must be taken by clinicians diagnosing schizophrenia in people who come from ethnic cultures different from their own. Some of the unique characteristics of this disorder (e.g., visual and auditory hallucinations and delusions) are quite common in many parts of the world in the context of traditional ceremonies, religious experiences, and spiritual rituals.

Although there are limited differences in the prevalence of mental health disorders, the majority of published studies have demonstrated that people from underrepresented minority groups utilize mental health services less than Whites and are less satisfied with those services (Harris et al., 2005; Novins, Harman, Mitchell, & Manson, 1996). For example, Harris et al. (2005) examined a large database (more than 200,000 people) and found that American Indians had greater unmet need than Whites, while African Americans, Asian Americans, Mexican Americans, and Central Americans used mental health services less than Whites.

Despite some clear cultural differences in aspects of mental health, research is lacking in terms of identifying cultural differences in family conflict and communication. While there are clear differences in family conflict patterns across cultures (e.g., Oetzel et al., 2003), these differences have not been tied to issues of mental health very well in the literature. This is a clear limitation of the literature and a need for future research. For this reason, the remainder of this review will not make large distinctions about ethnicity and culture in family conflict and communication.

THE RELATIONSHIP BETWEEN FAMILY CONFLICT AND MENTAL HEALTH

Regardless of culture, numerous people suffer from depression, anxiety, substance abuse, and schizophrenia. While we do not know

the exact causes for many mental disorders, we do know that certain factors play a role in all health—both mental and physical. These factors typically do not operate in isolation. Rather, causes of disorders usually result from an interaction between one’s biological, psychological, and social/cultural functioning (U.S. DHHS, 2001).

Family is of fundamental importance to the social development and future adjustment of children (Schrodt & Ledbetter, 2007). Family influences are greatest on individual behaviors when it comes to communication behaviors (Koerner, this volume; Koerner & Fitzpatrick, 2002b). Seminal work from the late 1970s put forth the notion that mental health and illness comes from a Biopsychosocial Model of Disease (BMD; Engel, 1977), which posits that mental illness is the result of contributing factors such as genes, parenting, culture, and stressful events as opposed to any one individual factor (i.e., biological factor). Familial communication patterns, level of conflict, stressful events such as marital discord,

familial violence, and antagonistic divorce are well established environmental factors in the development of mental health issues in youth and teenagers (Gavazzi, 2006; Kazdin, 1995). Importantly, Kendler, Aggen, Prescott, Jacobsen, and Neale (2004) reported on additional studies that, in fact, have observed numerous aspects of the family environment that actually modify the effects of genetics in many mental health outcomes, including alcoholism, schizophrenia, conduct disorder, and antisocial personality disorder. At the same time, when family members have mental health issues, these issues often create conflicts about the illness, how to treat it, the effects on the family, and other related topics.

The BMD is a well-founded and recognized framework used to understand and conceptualize the complexities of mental health. Because there is no one reason or explanation for the onset of mental illness, I use the BMD to illustrate the connections of substance abuse, depression, and family communication patterns that contribute to poor mental health outcomes. Figure 9.1

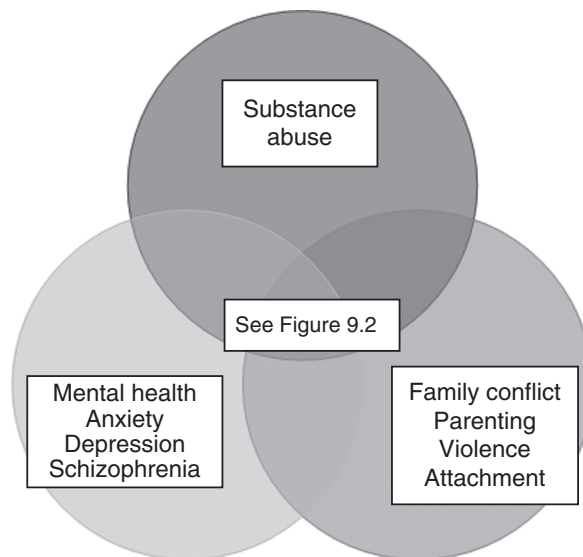


Figure 9.1 Intersection of Mental Health, Substance Abuse, and Family Conflict

illustrates the (noncausal) relationship among family conflict, mental health, and substance abuse as consistent with the BMD. The figure demonstrates an overlap among all of these constructs in that the presence of serious family conflict co-occurs with depression and substance abuse in a number of individuals. However, the model also illustrates that there are unique experiences to each construct. For example, presence of serious family conflict does not always co-occur with depression or substance abuse even though it can be a contributing factor for some individuals. This literature review explores the research that explains the connections among the constructs. The next section discusses the alarming evidence of how family conflict, parenting, violence, and poor patterns of attachment lead to poor mental health and substance abuse and dependence outcomes. It begins with a discussion of family conflict and communication.

Family Conflict and Communication

Family conflict is consistently reported as a top stressor and contributor to children's mental health, particularly suicide (Prinstein, Boergers, Spirito, Little, & Grapentine, 2000). "The more family members dispute with one another, the higher the stress and the lower the level of home satisfaction, a key factor that relates to suicides among young and older adults across nations" (Chen, Wu, & Bond, 2009, p. 134).

Family conflict is described in many ways. Some studies (e.g., Cecil & Matson, 2006) report family conflict as measured by the Conflict and Cohesion subscale of the Family Environment Scale Real Form (FES-R; Moos & Moos, 1993). On this scale, conflict is measured by levels of conflict (disagreement with issues important to the family) among family members, levels of openly expressed anger, and levels of aggression. Other studies

(e.g., Fainsilber Katz & Gottman, 1993) evaluate the patterns of marital conflict and how they relate to childhood development. Marital conflict, in part, is described as how partners engage in conflict, how they show agreement and disagreement, the amount of negative affect displayed during a conflict, and how they discuss/resolve conflict (Fainsilber Katz & Gottman, 1993). In sum, family conflict in this context involves various issues including disagreements, discord, aggression, violence, and affect. This section addresses how family conflict via marital discord, parenting, violence, and attachment impact the psychological development of children exposed to this conflict.

Marital Discord and Family Conflict. Marital and family conflict and dysfunction have long been implicated in poor psychological development in children (Kazdin, 1995). Similar to the parenting literature, family communication literature describes parent-child communication patterns in the context of parents having discussions with their children about expectations (conversation orientation) and children conforming to parent's demands (conformity orientation). These communication patterns are reported by Schrodt and Ledbetter (2007) to be connected to numerous mental health implications, including depression, levels of perceived stress, self-esteem, overall well-being, and risk-taking behaviors. These two communication orientations are gauged on continuous scales (i.e., high/low levels of conversation and conformity). Families who rate high on the conversation orientation tend to have open dialogue, limitless topic boundaries, and share thoughts in a safe environment. They participate in shared decision-making discussions and are invited to express concerns (Koerner & Fitzpatrick, 2002a). Families who rate low on this same scale do not invite open dialogue, have fewer interpersonal interactions, and do not readily share private thoughts and intimate

feelings (Schrodt & Ledbetter, 2007). Families who rate high on the conformity orientation dimension seem to possess a collectivistic approach: They value the family and core beliefs within, they follow a hierarchical set of rules and norms, and the interest of the family comes before any given individual (Koerner & Fitzpatrick, 2002a). Families who are low on the conformity orientation dimension seem to possess an individualistic approach: They value each individual's contributions, beliefs, and opinions; they value—equally—each member of the family, as well as the growth and development of each individual (Koerner & Fitzpatrick, 2002a). Myriad researchers have concluded that conversation-orientated families have healthier conflict management skills and more effective communication patterns than do conformity-orientated families (Schrodt & Ledbetter, 2007). It is important to note, however, that this research reflects values of individualistic societies and, thus, may suggest some cultural bias. Marital conflict and discord are often linked to poor communication patterns and the development of childhood aggression (Connor, 2002). Positive and negative communication patterns affect both the marital relationship and the parent-child relationship.

Given that conversation-oriented families have more effective communication patterns, marriages within these families also tend to have more effective communication patterns. Contrary to some beliefs that divorce alone has negative impacts on children and parent-child relationships, recent studies have focused on comparing mental health outcomes in children from divorced and nondivorced families as well as evaluating mental health outcomes in children from “intact,” nondivorced families who have different levels and types of marital discord (Schrodt & Ledbetter, 2007). A major consensus in these studies is that children from “intact,” nondivorced families with continuous high conflict and contention have

poorer parent-child relationships and poorer overall well-being than do children who come from highly conflicted families who divorce (Schrodt & Ledbetter, 2007). Marital conflict and discord, and specifically, how much the adults enmesh with the children during this process, seem to have a greater impact on the adjustment and well-being of children than divorce by itself.

Parenting. Like many mental health disorders, family history plays a role in contributing to mental health outcomes for future generations. Likewise, parenting styles tend to repeat themselves throughout generations and have also been identified as major contributors to psychological adjustment in children. Although there are numerous theories on parenting and psychological adjustment, many scholars view parenting in terms of levels of control and rejection, and acceptance and warmth (Baumrind, 2005). Three common ways to categorize parenting are authoritarian, permissive, and authoritative.

Authoritarian parents demand a high level of obedience and enforce a high level of control over their children (Baumrind, 2005). These parents tend to have low warmth and nurturing skills. Permissive parents are on the other end of the spectrum and allow children to operate with few rules and boundaries; children are given power to make their own decisions. These parents typically display high levels of nurturing and are supportive of their children; they have high levels of warmth and low levels of control (Baumrind, 2005). Authoritative parents fall somewhere in the middle of authoritarian and permissive parents. This parenting style allows for boundaries within the context of expectations, while also providing experiences for children to learn and grow within those boundaries. They set clear limits, enforce guidelines, and offer support and encouragement. Authoritative parents have appropriate levels of warmth and

find a healthy balance with levels of control (Baumrind, 2005).

Children whose parents display an authoritative style of parenting tend to have better psychological adjustment than children with either authoritarian or permissive parents (Baumrind, 2005; Rothrauff, Cooney, & An, 2009). Parents who display high levels of rejection tend to have children who suffer from depression (McLeod, Weisz, & Wood, 2007), while parents who display high levels of control have children who have high levels of anxiety (McLeod, Wood, & Weisz, 2007). Furthermore, poor effective communication as demonstrated by children's perceptions of their parents as hostile and controlling are more likely to experience higher levels of stress, lower levels of self-esteem, and more depression than their peers without the same perceptions (de Man, Lebreche, & Leduc, 1993).

Family Violence. An extreme area of marital conflict with more acuity, perhaps, is family violence and aggression. Children's future levels of depression, anxiety, maladjustment, and poor behavioral outcomes are also affected by family violence. Family aggression, violence, and related dysfunction have been implicated in poor behavioral problems in children. Specifically, domestic violence (DV) between parents negatively affects not only future behavioral problems but also interpersonal relationships and psychological functioning (Edleson, 1999). Findings from one large study illustrate that adults who witnessed DV as teenagers had higher levels of depression, anxiety, and aggression than did adults who did not witness DV as adolescents (Straus, 1992).

Several reasons for this relationship exist. The first reason is modeling (Diamond & Muller, 2004). Social learning theory suggests that children learn behaviors through observation of and modeling from people within their environment (Bandura, 1973). Children who

witness violence learn maladaptive ways of functioning in future interpersonal relationships (Zimet & Jacob, 2001). Parents who model violence for their children teach them how to behave in other contexts of their lives—whether it is being violent, or being the victim of violence, in future interpersonal relationships. Likewise, a study on suicidal ideation in youth found that parents who have ineffective communication and poor problem-solving skills are less likely to model adaptive reactions to stressful situations and, thus, model maladaptive coping strategies (Chen et al., 2009).

The second reason for the relationship between DV and poor future psychological outcomes is enduring feelings of insecurity within the family unit (Diamond & Muller, 2004). Children who are exposed to chronic feelings of insecurity in terms of the stability of the family are likely to develop insecure levels of attachment and, thus, develop maladaptive psychological patterns as adults (Diamond & Muller, 2004; Zimet & Jacob, 2001).

A third compelling notion for the interaction between DV and poor psychological outcomes is the child's attribution of the violence. How a child attributes the violence affects the coping strategies she or he employs throughout life and, thus, leads to poor psychological adjustment such as depression and anxiety (Snyder, 1998). Specifically, if children in violent homes attribute the violence to their own actions (e.g., the child overhears arguments that involve or regard him or her), they often feel an overwhelming sense of responsibility and guilt for the violent behavior. Internalizing the family violence (i.e., carrying the burden of feeling responsible for family violence) can lead to poor coping strategies, such as the initiation of substance use, feelings of depression, and/or increased levels of worry and anxiety.

The final postulation that DV between parents has a lasting, negative impact on psychological functioning is the impact that the violence, aftermath, communication, and

high levels of stress have on the parent–child relationship. Parents in violent relationships may be communicating (nonverbally or otherwise) that they are emotionally unavailable to the child and may be displaying a lack of attention and responsiveness to the child (Diamond & Muller, 2004). This physical and emotional unavailability contributes to a deterioration in the parent–child relationship and invites children to develop their own coping strategies, which often includes coping by using substances to mask the anxiety and depression.

Attachment. Parent–child attachment has implications for many mental health outcomes, and poor parent–child attachment has also been named as a cause for the development of anxiety in children. Attachment is defined as a long-lasting emotional bond between a child and an attachment figure (Ainsworth, 1989). A child develops a secure sense of attachment when he or she perceives that the attachment

figure responds in an emotionally and physically available and consistent way. It is from this secure place that children launch to explore the world and have confidence that the secure “base” will be there when needed (Ainsworth, 1989). Children develop insecure patterns of attachment—either ambivalent or avoidant—when the attachment figure responds in an inconsistent, unavailable, and insensitive manner (Ainsworth, Blehar, Waters, & Wall, 1978). Children are less likely to seek respite and comfort from this insecure “base” in times of need. The quality of early-life parent–child attachment is said to influence development of personality later in life (Bowlby, 1969). Bowlby (1969) suggested that children develop anxiety when they have concerns about the inability to rely on the unavailable and inconsistent attachment figure. Anxiety typically arises for these children when they are unable to predict when the inconsistent attachment figure will respond. If the prediction is incorrect, the child

Box 9.2 It Happens in Real Life: What About His Family?

The accused killer is one of two children. His younger brother, Robert, remembers typical sibling rivalry stuff and also, as a child and young adult, how smart and well rounded his brother was. Robert looked up to his brother. Neighbors remember him as friendly; helping out whenever he could. Robert recalls that his big brother was better (than he) at everything, was a National Merit Scholarship finalist, and could have attended any college of his choice on scholarship. He came from a family of privilege—he went to a private high school; he is remembered as being a charming and handsome young adult. His family was baffled when he decided not to attend college at all. Instead, he took time off from school and went to live on the family ranch in a neighboring state.

In his early 30s, the accused had minor cosmetic surgery on his face—he had a mole removed. After the mole was removed, the accused became certain that doctors changed his face in a substantial way—that his face was no longer his. He told his brother, Robert, that people were following him. Robert knew something was amiss. This behavior was not at all typical. “I remember calling my mom and saying ‘This is not about alcohol and drugs, this is a mental illness.’ And she was just floored. We had no experience. We didn’t know what to expect. What do you do?” (Hyde, as cited in Stafford, 2007, para. 183).

Although his mental illness was successfully controlled for much of his life, as the days, months, and years went on, the accused’s mental health became less stable. Doctors changed. Medications changed. The accused changed. Tragedy unfolded in 2005. Robert says about breaking the news of the shooting spree to his mother: “And you just never think that that would ever happen in your life that you’d have to say something like that to your mother” (Hyde, as cited in Stafford, 2007, para. 227).

responds with fear and anxiety (Brumariu & Kerns, 2010).

In summary, this section examined four types of communication and conflict issues in families: (1) family communication and marital conflict, (2) parenting, (3) family violence, and (4) attachment. They represent general patterns of communication and conflict with conflict embedded in each. The effects on mental health for each of the four types of communication and conflict issues were also identified. In the next section, the effects of mental health disorders—both for family conflict and for other aspects of mental health—are discussed.

Mental Health

Depression. Depression and anxiety are the two most common psychological disorders in youth (Costello et al., 1996). Depression is a costly illness and worldwide is one of the leading causes of morbidity and mortality (Gladstone & Beardslee, 2009). Far more than monetary costs, it is the precursor to suicidality. “Youth depression is quite common and is associated with negative long-term psychiatric and functional outcomes, including impairment in school, work, and interpersonal relationships, substance abuse and suicide attempts” (Gladstone & Beardslee, 2009, p. 213).

Parental depression has extensive and serious implications on family members. Depression affects childhood mental health well-being as well as mental health outcomes later on in life (Solantaus, Paavonen, Toikka, & Punamaki, 2010). Depression in parents often translates to parents who are emotionally distant or unavailable toward their children, and depression in children often stems from depression in parents. Specifically, depression in children whose mothers suffer from depression is significantly greater than rates of depression in children whose mothers do not have depression (Goodman, 2007). Rates of depression in young children and teenagers

whose mothers are depressed range between 20% and 41%, with several factors accounting for the variability. Some of these factors include the level of severity of the mother’s depression, depression levels in fathers, as well as other social and demographic factors (Goodman, 2007).

Suicide is a tragic aspect of depression that people often avoid talking about. Suicide is a complex issue, and risk factors vary by age, race/ethnicity, and family history of mental disorders. Although preventable, in 2007 in the United States, suicide was the 10th leading cause of death among all people (NIMH, 2010). The national average of death by suicide is 11.3 deaths per 100,000 people (NIMH, 2010). Some risk factors for suicide include depression and other mental health disorders, family history of substance abuse, substance abuse, family history of suicide, prior suicide attempts, and family violence (NIMH, 2010). Interestingly (because of the rates of depression reported above), non-Hispanic Blacks (5.1 per 100,000), Hispanics (6.0 per 100,000), and Asian Americans and Pacific Islanders (6.2 per 100,000) have the lowest rates of death by suicide, while Native Americans/American Indians (14.3 per 100,000) and non-Hispanic Whites (13.5 per 100,000) have the highest rates of death by suicide. People above the age of 65 (14.3 per 100,000) have the highest rates of suicide, while non-Hispanic White males above the age of 85 have the highest rates of suicide among all ethnicities and age-groups (47 per 100,000; NIMH, 2010). Box 9.3 recounts a true and recent event and illustrates the tragic ending of life by suicide. This person was a 40-year-old Hispanic male.

Anxiety. Like depression, family history plays a large part in the development of anxiety and anxiety-related disorders. Anxiety is one of the most common psychological disorders found in youth (Hudson, Dodd, & Bovopoulos, 2011). Because it has become such a common theme among children and

Box 9.3 Another Case of It Happens in Real Life: Death by Suicide

While preparing this book chapter for publication, we got word that our former neighbor in a city in which we used to live, Martin, died by suicide. As an electrician by trade, Martin spent several hours at our home over the years helping with repairs. He was a funny man; he made lots of self-deprecating jokes, had everyone around him laughing. He was jovial; he whistled and sang songs while he worked, and talked out loud to himself—and to whatever it was he was trying to fix (something I always found particularly charming). And, most important, he was a partner and a dad. He left his wife and his darling three children. He mustn't have known that in that instant, when he took his life, that he permanently, forever after, increased the risk of his young children's risk for death by suicide. His son, only 2 years old, will likely never remember his dad. He will not remember his love, his humor, his wit. He will not remember that his dad didn't work on Mondays because that was Martin's day to have special father-and-son time. He will only know his legacy. He will know the stories that people tell him. His two girls are school aged. His girls used to chase our sons around the front lawns of our homes . . . something Martin joked about (saying he will keep an eye out on our sons as they all get older). His girls will remember their dad. They will remember his love, his smile, his humor, and they will remember his death. Like the rest of us, they will always wonder why. They are old enough to witness their mother's grief, anger, and confusion. They are old enough to experience their own grief, anger, and confusion. They are old enough to ask questions. Observing death by suicide from the angle of three small children and a partner, we must recognize that, to Martin, the demons felt insurmountable. Martin made a phone call just hours before his death. He called the person who taught him how to be an electrician. He called his father. Sadly, his dad didn't realize that Martin was calling because he didn't know where to turn or what to do. His dad was busy and asked to call him back later. He will live with the guilt forever; he had no way of knowing that this call was "the call." I knew Martin well enough to know that he would not have wanted to leave his wife and children grieving. He smiled brightly when he talked of his three children and his wife. He would not have wanted to increase their risk of depression or death by suicide because of his own actions. The pain was too great; he couldn't imagine a tomorrow, and in that moment, he didn't know how to ask for help.

adolescents, the study of anxiety, its causes, and treatment modalities has increased over the past few years. Although there are still many unanswered questions, the literature points to several issues that have been concluded from the research, namely, parental anxiety, parenting styles, and attachment.

Children whose parents have anxiety are seven times more likely to develop an anxiety disorder than are children whose parents do not have anxiety (Turner, Beidel, & Costello, 1987). Similarly, anxious children are more likely to have a parent with anxiety than are nonanxious children (Cooper, Fearn, Willetts,

Seabrook, & Parkinson, 2006). Although the diffusion of anxiety from a parent to child is often thought of as a genetic influence, anxiety in children is also attributed to parental modeling of anxiety and also parental communication about anxiety (Hudson et al., 2011).

Parents who have anxiety demonstrate high control and low warmth to their children (Hudson et al., 2011; Laraia, Stuart, Frye, Lydiard, & Ballenger, 1994), and these types of behaviors (high control, low warmth) have the potential to lead to broader negative outcomes for children and also influence mental health outcomes when these children become

adults. Children whose parents demonstrate high control, or over involvement, typically do so in perceived high anxiety-producing situations. These children, therefore, do not develop strategies for dealing with anxiety, have a fear of anxiety-producing (threatening) situations, and have an increased perception of, and desire to avoid, threatening situations (Hudson et al., 2011). Perhaps along the lines of family environment, and levels of warmth and control, high levels of family conflict have also been linked to childhood anxiety (Barnow, Lucht, & Freyberger, 2001).

Schizophrenia. Just as noted with each of the disorders above, schizophrenia is something that has higher rates of prevalence within families. “First degree, biological relatives” of people with “schizophrenia are 10-times” more likely to develop the disorder than the “general population” (APA, 2000, p. 309). Interestingly, identical twin studies show that environment plays a large role in the onset of schizophrenia. Studies have demonstrated that identical twins raised in the same and different environments have different outcomes, illustrating that genetics is not the only factor that leads to schizophrenia. The level of stability within one’s environment can either protect against, or facilitate, the onset of schizophrenia (APA, 2000; U.S. DHHS, 1999).

The context of family makes up a large part of the environment for an individual living with schizophrenia. Although, for many years, the study of schizophrenia focused on the strong biological foundation, more recent efforts have turned attention to the importance of family and social support. Family behaviors relate to the course and treatment of schizophrenia (Lopez et al., 2004). Families’ reactions to an individual with schizophrenia posthospitalization have implications for recovery and relapse (Butzlaff & Hooley, 1998). Specifically, patients who enter an environment with families who demonstrate high levels

of hostility, emotional overinvolvement, and criticism on discharge are more likely to relapse than patients who enter an environment with families who demonstrate low levels of hostility, emotional overinvolvement, and criticism (Butzlaff & Hooley, 1998). Additional research found that the level of warmth displayed within an environment is directly related to relapse as well. Patients, posthospitalization, who return to an environment that displays high levels of warmth are less likely to relapse than patients who return to an environment that displays low levels of warmth (Ivanovic, Vuletic, & Bebbington, 1994).

Substance Abuse and Dependence. Family environment and familial relationships each have a robust connection to the onset and continuation of substance abuse among adolescents. “Specific aspects of family life and family relationships have strong and consistent connections to the initiation, exacerbation, and relapse of drug problems” (Rowe & Liddle, 2003, p. 97). Regardless of culture, numerous familial factors consistently predict adolescent substance abuse over time (Rowe & Liddle, 2003). Familial relationship factors such as poor parent-child relationships predict adolescent substance abuse (Brook, Brook, Arcinibia-Mireles, Richter, & Whiteman, 2001), while parenting styles that encompass low levels of monitoring and poor parent-child communication are predictive of substance abuse initiation and continuation by adolescents (Liddle, Rowe, Dakof, & Lyke, 1998).

Existing mental health disorders also play a role in adolescent substance abuse. People who have two mental health diagnoses are considered to have “dual diagnosis,” and people with three or more diagnoses are considered to have “multiple diagnosis disorder.” Mood disorders (depression) and anxiety disorders are commonly diagnosed as a dual diagnosis, with the other diagnosis being substance abuse (Greydanus & Patel, 2005).

Not surprisingly, a review of the literature by Hawkins, Catalano, and Miller (1992) demonstrated that many of the same environmental and familial characteristics that lead to depression, anxiety, and even the relapse of schizophrenia are also linked to the onset and continued use of substances. Some of these factors include parenting styles that are too permissive, overly critical, inconsistent with expectations, fail to monitor behavior, and lack of maternal warmth; high levels of family conflict; and low parent involvement in child engagements and low parental warmth.

In summary, there is a great deal of overlap among the mental health disorders addressed in this chapter. One commonality is that each of these disorders can be viewed from the BMD meaning that biology, parenting, communication, marital discord, culture, and levels of stress, and environment each play a role in the process of these disorders. No one area can be labeled as the cause of a given mental health disorder, and we have seen how culture plays a role in the way people experience, communicate, and even define mental illness. A second commonality is that substance abuse and dependence is often a co-occurring disorder in people struggling with mood disorders (e.g., depression), anxiety-related disorders, and schizophrenia. A third commonality among these disorders is that family members often do not know how to support an individual with mental illness. They do not know how to effectively communicate with the individual who is ill; they do not know how to communicate with providers about their observations and fears; and they are often at a loss for ways to demonstrate support. A fourth commonality among these disorders is that family matters. In some cases, we have seen that parenting styles and family violence lead to maladaptive behaviors for children as they enter adulthood (high levels of depression and anxiety). We have also seen that high levels of hostility, emotional overinvolvement,

and criticism by family members have a direct impact on the recovery process for someone with schizophrenia. Additionally, evidence suggests that higher levels of warmth displayed by family members also have a positive impact by reducing the chances of relapse for someone with schizophrenia. It seems, then, that sometimes family environment can shape the outcome of the onset of some types of mental illness, as well as be a critical part of the recovery process. The next section will address another way that families can affect the role of mental illness: prevention and treatment.

PREVENTION AND TREATMENT FOR FAMILY CONFLICT AND MENTAL HEALTH

Without placing blame on family members for mental illness, it is important to recognize that families do play a large role in the environment in which we live. It is necessary to recognize the influential relationship that family members hold. As illustrated in the sections above, regardless of genetics, families can support and also hinder mental well-being. The beauty of the role of the family is that they can contribute in a major way to prevention and treatment of mental health. However, family members are often at a loss for how to help their loved ones when dealing with mental illness. Resources are scarce, they do not know who to ask for help, and they fear creating more distance between themselves and the individual who needs support. Furthermore, because of evidence that demonstrates the importance of family environment, and in an effort to address the critical and harmful responses from family members, treatment programs for families include psycho-educational training in effective communication and problem-solving skills (McFarlane et al., 1995). This section discusses numerous studies that identify ways

Box 9.4 It Happens in Real Life: Families Dealing With Mental Health Disorders

The accused killer's family knew that things were wrong—very wrong, in fact. Up until this August day, the accused killer never had a violent episode in his life. He was a standout high school student—earning scholarships that would allow him to attend any college in the country. He was a very high-functioning member of society—caring for his frail mother, attending his medical appointments, and volunteering at the hospital to support other people with the same diagnosis. His younger brother said that things began to unravel 10 months prior to the killing spree. His psychiatrist changed, his diagnosis changed, his medications changed. One morning, his brother and his brother's girlfriend woke to each of their cars having a slashed tire—from a knife. On another occasion, the accused cut the brakes in his brother's car. And, on yet another occasion, the accused locked his severely arthritic mother in her house. The police were called, and they responded to each of these situations. At the time, to those who didn't know him best, he seemed stable and didn't sound any alarms. The accused killer wrote an open letter to the hospital pleading for a new psychiatrist and new medications (it is unknown if he ever sent the letter). His family wrote letters to the psychiatrist treating him, they made numerous phone calls. The accused was becoming more agitated, more bizarre as the days and months went on. He began asking for guns and weapons. Finally, in April, the hospital agreed to an evaluation. He was held for 4 hours at the hospital and then released. The hospital staff told the family that there was nothing to be done: "We are going to have to wait until he escalates." "We did not know what to do," his younger brother said during an interview.

in which families can be involved in prevention as well as the process of treatment of mental health illnesses organized around the four diagnoses.

Figure 9.2 illustrates the essential aspect of families in the prevention of and treatment for mental health disorders. It also illustrates the complex—and unanswered—dynamics between family conflict, mental health disorders, and substance abuse. Specifically, the treatment and prevention of poor mental health outcomes should happen within the family context. Given the overlap of family conflict, mental health outcomes, and substance abuse, the family dynamic must be integrated within treatment and prevention methods. Individually focused prevention and treatment models (e.g., individual therapy) do not effectively address the problems in a holistic, comprehensive manner, as demonstrated in the BMD. Thus, the center of the figure represents the important roles of family in

the prevention and treatment of poor mental health outcomes. While there is substantial

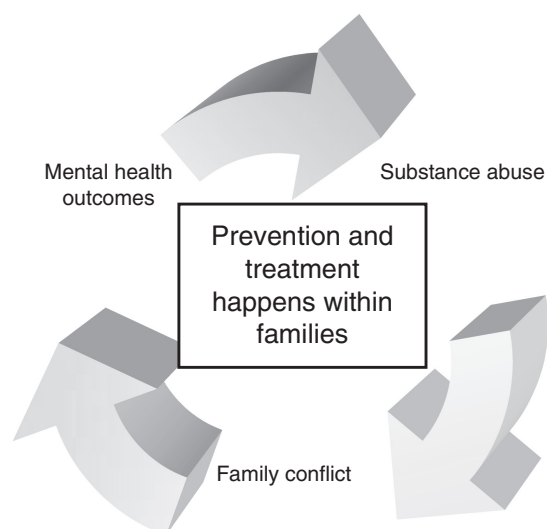


Figure 9.2 Prevention of, and Treatment for, Mental Health, Substance Abuse, and Family Conflict

evidence that excessive family conflict negatively affects mental health disorders and substance use, we lack knowledge about specific pathways (find more discussion on this point in the Future Directions section, below). Thus, the arrows connecting family conflict, mental health outcomes, and substance abuse are designed to illustrate a co-occurrence and not a linear progression.

A review of the literature divulges that both prevention and treatment models for each of the four mental health diagnosis categories discussed in this chapter (depression, anxiety, substance abuse and dependence, and schizophrenia) are all strikingly similar. They all conclude that family interventions are more successful than other interventions (e.g., individual, group). Therefore, as opposed to discussing prevention and treatment in all four domains of mental illness discussed in this chapter, the discussion below will highlight some of the commonalities of specific aspects of prevention and treatment models used to address these areas of mental health.

Prevention and treatment models for depression, anxiety, substance abuse, and schizophrenia all consider the challenges and needs of engaging in family therapy. These models define the roles that family members have in supporting prevention, treatment, and recovery processes. For more than two decades, researchers have realized that environmental factors, such as family, are critical in terms of recovery from substance abuse and posthospitalization for a person with schizophrenia. Family has also been identified as a critical, necessary component of the treatment of depression and anxiety (Hughes & Asarnow, 2011; Maid, Smokowski, & Bacallao, 2008).

The goals of prevention and treatment programs center on improving various interaction skills to better manage family conflict in order to avoid mental health problems. For example, the intentions of many of the programs are the following: (a) prevent initiation of disorders by

identifying subclinical symptoms, (b) increase resiliency in children, and (c) improve skill building for families. Specifically, these interventions increase the parents' awareness of the impact of poor mental health on children and their spouses and improve communication skills within the family (Gladstone & Beardslee, 2009).

To achieve these intentions, prevention and treatment programs use a variety of approaches. Communication skill building is an effort to allow families to better understand the experiences of depression and to assist children in reducing self-blame for parental symptoms and ancillary behaviors (Gladstone & Beardslee, 2009). Commonalities across these successful interventions include "social support, detailed education on clinical aspects, direct guidance, and training in coping skills" (McFarlane et al., 1995, p. 679). The notion of many intervention and prevention studies in schizophrenia is to reduce family conflict, increase family warmth, improve family communication through communication training, and improve problem-solving skills (Lopez et al., 2004; McFarlane et al., 1995). Furthermore, high levels of family warmth seem to have positive implications for the prevention of relapse in people with schizophrenia. "Identifying family behaviors associated with warmth may contribute to identifying family strengths" (Lopez et al., 2004, p. 437).

Given that family conflict and dysfunction is often a major factor contributing to the disorders discussed (anxiety, depression, substance abuse and dependence, and schizophrenia), treatment modalities that include the family can be challenging. However, several rigorous, clinically based interventions have demonstrated that family-based treatment (a) increases treatment retention and attendance (over other types of standard treatments in substance abuse and dependence treatment), (b) increases engagement by heavy-using and resistant adolescents

into treatment, (c) increases engagement of homeless and runaway youth (Rowe & Liddle, 2003), (d) reduces substance abuse compared with other treatments (Waldron, 1997), and (e) reduces substance abuse during the course of treatment (Waldron, Slesnick, Brody, Turner, & Peterson, 2001). In addition to recognizing that families have a critical role in inhibiting and preventing mental health disorders, these interventions have also demonstrated that family relationships, in both adolescent and adult treatment processes, are vital to enhancing treatment outcomes (Heath & Stanton, 1998; McCrady & Ziedonis, 2001). Because family engagement in substance abuse treatment has shown so much promise, researchers continue to observe clinically sound ways to improve a wide variety of treatment outcomes. Furthermore, investigations of family-based treatment of comorbid substance abuse and other mental health issues, including school attendance and performance, have provided evidence of the importance of family intervention (Rowe & Liddle, 2003). Family functioning, in terms of this literature, includes a decrease in family conflict, an increase in family cohesion, and an improvement in parenting styles (Rowe & Liddle, 2003; Waldron et al., 2001). Additionally, family-based interventions decrease the risk of relapse with people recovering from hospitalization for schizophrenia (McFarlane et al., 1995). In fact, family-based psycho-educational models have been shown to be more effective than either individual treatment or medication alone (McFarlane et al., 1995).

As with each of the mental health illnesses discussed in this chapter—*anxiety, depression, substance abuse, and schizophrenia*—poor family functioning (e.g., high conflict, poor communication, abuse, and permissive parenting) seems to be a risk factor for the initiation and maintenance of the disorder. At the same time, the strengths of the family have the capacity to prevent these same disorders

and/or are part of the treatment process. There is likely no other single prevention or treatment entity that can encompass the power of the family.

Specifically, family-based interventions such as multisystemic family therapy (MFT) offer a high level of individualized family- and home-based treatment options that address multiple layers within the context of the individual. These treatments address the individual, the family, the community, and societal aspects that influence development and behavior (Bronfenbrenner, 1989; Henggeler, Melton, & Smith, 1992). Functional family therapy (FFT) also addresses individual problem behavior within the context of the family. The central notion of FFT is to impact individual dysfunctional behavior by improving family relationships and changing family interactions (Alexander & Robbins, 2010). FFT and MFT are similar to one another in that they are both systems approaches that take biological, social, and ecological contexts into consideration. These two frameworks offer intervention strategies that match the BMD's framework of mental illness. Furthermore, the interventions are solidly grounded in the belief that addressing family functioning and family conflict will substantially improve mental health outcomes.

PRACTICAL SUGGESTIONS FOR PROVIDERS AND FAMILIES

Mental health disorders are complex and often difficult to treat. Mental health research receives a great deal of funding from the U.S. federal government in order to determine the most cost-effective, culturally appropriate, and applicable ways to treat and prevent mental illnesses. In all of the areas explored in this chapter, family members play an instrumental role in the prevention, onset, and continuation of many disorders. Families also play an

Box 9.5 It Happens in Real Life: What Is Life Like Now?

The accused killer is currently being held in a state hospital, until the day he is deemed fit to stand trial. He is "incompetent," meaning he is unable to stand trial, unable to understand the proceedings, and unable to assist in his defense. A trial will only happen if his competency improves. His case, and competency, will be reviewed every 2 years. If his level of competency changes, as deemed so by the court or the hospital staff, he will stand trial. It is most likely, however, that he will be locked in the state hospital for the rest of his life. Although he wasn't able to stand trial, his attorneys and the judge agreed that the prosecution provided overwhelming evidence identifying him as the person who committed the crimes. For this reason, in August 2007, just 2 years after the shooting spree, a judge sentenced the killer to 179 years: Five counts of First Degree Murder, 30 years for each of the five individuals who lost their lives (150 years); one count of Child Abuse, 18 years; one count of Armed Robbery, 9 years; Firearm Enhancements on the Child Abuse and Armed Robbery charges, 2 years. He remains in a "medically fragile" state. He is on a minimum of six psychotropic medications a day, and years later is unable to return to a stable state. He wanted help. He asked for help. His family wanted help. They asked for help. No one knew how to support him, how to intervene. No one knew how to effectively communicate—not family, not friends, not medical providers. Lives—multiple lives—were lost that day, and not just those who were killed. Hundreds more were affected: parents, spouses, children, siblings, grandchildren, colleagues, friends, and countless community members. Surely, everyone involved wishes events leading up to this day would have been handled differently. Indeed, it was "one of the worst days in the history of the city."

instrumental role in the recovery. The latest indication for recovery in depression, anxiety, substance abuse, and schizophrenia is family-based treatment. Family members are being retrained in communication skills, problem solving, and parenting. They are also being educated in new ways in regard to mental health disorders. They are being given more information about the disorders and are being given concrete guidance on behaviors that support well-being. Practitioners and families alike can take advantage of free resources on the Internet (see Appendix 9.1) and participate in funded clinical trials. Oftentimes, when participating in clinical trials, families can receive free treatment and providers can receive free, in-depth training.

FUTURE DIRECTIONS

Several future directions in research will help unite existing literature with areas yet to be

thoroughly explored. One area for further understanding is assessing culture within the context of family conflict and mental health outcomes. There is evidence presented in this chapter about the consequences of family conflict on mental health outcomes. However, what is lacking is a better understanding of what family conflict looks like among cultures and how that conflict affects mental health outcomes. For example, Lopez et al. (2004) found that family warmth is a protective factor for relapse to schizophrenia in Mexican American families, while criticism is a risk factor for relapse to schizophrenia in White families. Future research can examine the degree to which different family conflict patterns are associated with mental health outcomes and whether the conflict about mental health is managed differently in different cultures.

A second, and quite complex, area of study that warrants a close look is teasing out the pathways of poor mental health and

substance abuse/dependence outcomes and family conflict. Through mostly retrospective evidence, researchers have demonstrated that family conflict negatively affects mental health. What is missing in the literature, however, is an understanding of the impact that mental health has on family conflict; and an understanding of what comes first (is it the mental health that leads to family conflict or the family conflict that leads to mental health). For example, Awad and Voruganti (2008) examined the “burden of care” for caregivers of people with schizophrenia. The burden of care includes economic, physical, social, and emotional consequences, including factors such as shame, guilt, self-blame, and embarrassment. This “burden of care” likely creates conflict within families and between caregiver and patients. In support of this point, Kung (2003) found a positive association between burden of care and family conflicts in Chinese American caregivers. A longitudinal study assessing these factors will allow newfound clarity on the subject and will benefit the development of prevention measures and also provide knowledge of how to manage conflict during the treatment process.

A final area of research (and perhaps for practical prevention programs), is a better understanding of, and an offering of support to, families who have a family member with a mental disorder. Stories like Martin’s (Box 9.3) are tragic and, sadly, not uncommon. Identifying ways to include family members in a network of support services prior to—or exclusive of—the individual receiving treatment would go a long way in gaining an understanding of the family’s needs as a whole and also would provide a unique opportunity to support the individual as well (via his or her family). I wonder if the ending would have been different if Martin’s family had a network of professionals assisting them as they attempted to support Martin through his severe bout of depression.

CONCLUSION

In conclusion, this chapter examines the relationship of mental health and conflict on families. Specifically, this chapter provides definitions and descriptions of four mental health disorders—depression, anxiety, substance abuse and dependence, and schizophrenia; explores the role of race and ethnicity on mental health; explores the relationship between mental health disorders and family conflict; and, finally, offers practical suggestions for providers and families.

While evaluating the relationship between mental health disorders and family conflict, several constructs emerged: (a) marital discord and family conflict, (b) parenting, (c) family violence, and (d) attachment. The literature provides overwhelming evidence that excessive marital discord and family conflict, poor parenting styles—either authoritarian or too permissive—family violence, and developing poor styles of attachment all lead to poor mental health outcomes for children and spouses. Additionally, the literature also provides evidence that parents who have mental health disorders (such as the ones addressed in this chapter; anxiety, depression, substance abuse/dependence, and schizophrenia) are more likely to have children who also suffer from mental health disorders than are parents who do not have these mental health disorders. Finally, the chapter discusses the important role that families have in the initiation, maintenance, and also treatment and recovery of mental health disorders. These disorders occur within the individual, although come about in the context of the family. Therefore, family members have the ability to play a critical role in the treatment process.

Through effective family-based prevention and treatment interventions, we have the capacity to prevent another massive shooting spree, another death by suicide, by people suffering from mental illness. We have a long way

to go in determining all of the nuances of mental health disorders. For certain, however, we know that the role of family is an important one. Future research, theory, and practice need to be integrated in order to develop, evaluate,

and implement effective, culturally relevant, family-based interventions. Theory, research, and practice in isolation will not be sufficient to address the complex family dynamics and mental health outcomes in our society.

Appendix 9.1 Useful Website Resources for Family Members and Practitioners

<i>Organization</i>	<i>Website</i>	<i>Useful Tools^a</i>
Centers for Disease Control and Prevention	www.cdc.gov/mentalhealth	Provides public health information on mental illness; includes data, statistics, publications, and information on resources and organizations
Mental Health America	www.nmha.org	Complete a 3-minute screening tool to assess your own levels of depression, anxiety, PTSD, and bipolar disorders; stay current and get involved with policy making; find treatment, support groups; obtain information on specific mental health areas; and find information in Spanish
National Institute of Mental Health	www.nimh.nih.gov	Offers links to “finding help for mental illness,” multiple publications on vast mental health problems, and NIH-funded studies that are currently recruiting participants
National Suicide Prevention Lifeline	www.suicidepreventionlifeline.org	Provides information on how to help others who are in need; offers a lifeline 1.800.273.TALK (8255), as well as information on warning signs and resources.
Substance Abuse and Mental Health Services Administration	www.health.org	Provides thorough information “Issues, Conditions, and Disorders” common with substance abuse, as well as information on “Types of Substances” and a detailed listing of “Treatment, Prevention, and Recovery” resources; offers helpful links for professionals as well
U.S. Department of Veterans Affairs’ (website specific for mental health)	www.mentalhealth.va.gov	Access information on PTSD, suicide prevention, anxiety, alcohol abuse (along with many other areas of concern); find resources for a free and confidential crisis line phone number (1.800.273.8255, press 1) and confidential online chat: VeteransCrisisLine.net, or text: 838255.

NOTE: PTSD = post-traumatic stress disorder; NIH = National Institutes of Health.

a. Items listed under the “Useful Tools” section are not exhaustive. Each website has an abundant amount of information that is not listed here.

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