Can a child of a parent who has a severe mental illness or a substance-abuse issue, or a combination of the two, provide a satisfactory living environment for a child to adequately develop competent levels of psychosocial functioning. The components of psychosocial functioning that were discussed in this study included: Cognitive, Behavioral, Emotional, Social, and Physical. In this study, it is being hypothesized that there will be no significant difference in the levels of psychosocial functioning among children raised by at least one parent that has either a substance-related disorder, a mental health disorder, or a co-occurring disorder. It is also being hypothesized that there will be a significant difference in the level of psychosocial functioning of children with parents with any or all of the dysfunctional components mentioned and the children with parents with no dysfunctional components. In school district of 6000 students, 1200 parent/child pairs will be recruited into 4 specific groups. Group #1, will consist of 300 parents that were never diagnosed with a mental health disorder, or a substance-related disorder. Group #2, will consist of 300 parents that were diagnosed with mental health disorder, but never a substance-related disorder. Group #3 will consist of 300 parents who were never diagnosed with a mental health disorder, who were diagnosed with a substance-related disorder. Group # 4, will consist of 300 parents that have been diagnosed with both a mental health disorder and substance-related disorder. Each group will be put through a series of instruments and measures to determine their levels of psychosocial functioning in each of the 5 categories mentioned previously.
It has been well researched that children of substance-abusing parents are at a higher risk of suffering from psychosocial functioning difficulties than children of non-substance-abusing parents (Straussner & et al., 2006). It has also been well researched that the children of parents with a mental illness are at a higher risk of having psychiatric and behavioral problems, as well as an overall lower level of psychosocial functioning than children without parents with a mental illness (Pretis & Dimova, 2008; Mowbray & et al., 2006). More recently, a combination of substance-abuse and mental illness has been being researched. This research has revealed that children with parents suffering from co-occurring disorders are at an elevated risk of psychosocial difficulties and multitude of risk factors, such as substance abuse, psychopathology, violence, and many more (Leichtling & et al., 2006). When researchers refer to the issues related to the children’s psychosocial functioning, they are referring to such variables as cognitive, emotional, behavioral, social, and physical difficulties (Peleg-Oren & Teichman, 2006).

Many studies have indicated that children of substance-abusing parents experience problems in their cognitive development compared to the children of non-substance abusing parents, which can be seen in the differences in the levels of intellectual functioning (Peleg-Oren & Teichman, 2006). Studies suggest that the prenatal substance use of mothers, negatively affect their children’s intellectual development (Kelley & Fals-Stewart, 2002). According to Straussner and his colleagues (2006), children who have diminished cognitive abilities are typically unable to interpret their parent’s behaviors as a result of their substance use. According to Mowbray and his colleagues (2006), having a mother with schizophrenia has been shown to primarily affect the child’s cognitive development. Many mothers with mental illness reported that their children suffered from attention deficit hyperactivity disorder (ADHD) as well as other types of learning disabilities (Mowbray & et al., 2006).
According to Peleg-Oren and Teichman (2006), children with substance-abusing parents are at a high risk of suffering from problems in their emotional development. These problems are due to the high stress induced on the family by the substance-using environment, which has been shown to lead many of these children to such emotional issues as: high levels of depressive symptoms and anxiety, low self-esteem, and feelings of guilt and loneliness (Peleg-Oren & Teichman, 2006). Children of parents with mental illness were reported to having higher levels of depression and bipolar disorder than children of parents with no diagnosed mental illness (Mowbray & et al., 2006). Mowbray and her colleagues (2006), conducted a study that showed that parents with co-occurring disorders, consisting of both a mental disorder and substance-related disorder, are at a high risk of bestowing upon their children emotional psychosocial issues, including: schizophrenia and schizoaffective disorder, major depression disorder, and bipolar disorder.

Another psychosocial issue that has been extensively researched is behavior. According to Straussner and his colleagues (2006), children of substance-abusing parents experienced higher rates of problems in their behavioral development than children of non-substance abusing parents. Researchers have indicated that these children demonstrate higher levels of immaturity, impulsivity, as well as irresponsible behaviors in comparison to children of non substance-abusing children (Straussner & et al., 2006). The research was similar for children of parents with mental health problems. According to Mowbray and her colleagues (2006), children of mentally ill parents have been seen to demonstrate a higher level of behavioral issues than children of non-mentally ill parents.

Research has shown several setbacks in the social development of children raised by substance-abusing parents (Peleg-Oren & Teichman, 2006). Peleg-Oren and Teichman (2006)
described many of these children acquiring a limited social life, due to increased social isolation as a result of feelings of shame and secrecy. According to Mowbray and her colleagues (2006), children of mentally ill parents demonstrate lower levels of overall functioning, higher levels of social avoidance, lower levels of self-esteem, and poor social adjustment ability. These children are also seen to develop many negative behaviors during their social development that leads to social isolation (Mowbray & et al., 2006). The social aspects faced by children of substance-abusing parents have been extensively researched and has been viewed in the context of social competence.

Social competence is measured in the social behaviors exhibited in peer settings as well as the quality of peer relationships (Eiden & et al., 2009). In long-term studies of social competence, when children do not effectively acquire social skills early in their development process, they are much more likely to experience many negative social consequences in adolescence and adulthood (Eiden & et al., 2009).

According to Conner and her colleagues (2004), children of substance-abusing parents are often affected from their conception, right on through childhood to adolescence in terms of their physical development. Some of the physical problems that researchers are seeing in children of substance-abusing parents includes: asthma, fetal alcohol syndrome, hearing problems, vision problems, mental retardation, learning disorders, motor skills disorder, communication disorder, and attention deficit disorder (Conner & et al., 2004). Research has revealed consistently, that many of the physical issues mentioned are seen in higher rates among children of substance-abusing parents compared with children nationally. Also, many of these specific challenges presented to the children of substance-abusing parents that cause deficiencies to their physical development have been thoroughly researched. Often times, these children are
exposed to alcohol, other drugs, and cigarette smoke in the prenatal stage of their development, which leads to many health problems at birth and beyond. After the child is born, there are many more obstacles that challenge the physical health of the child, that include: often low income status of drug-addicted parents, low education, parents may have mental illness, instability of caregivers, child abuse and neglect, as well as many other similar factors (Conner & et al., 2004).

According to developmental psychology, the early stages of an individual’s life are astronomically important (Peleg-Oren and Teichman, 2006). It is during the early stages that children develop their personalities, develop their identities, their development of a secure attachment style, as well as their necessary social and coping skills (Peleg-Oren & Teichman, 2006). It is during this period that the child’s emotional, cognitive, behavioral, social, and physical developmental processes are taking place in such places as the school setting, interaction among their peers, and at home with their family. According to Peleg-Oren and Teichman (2006), for a child to achieve normal development, something close to the following must be present: they need a safe and stable environment; they need a warm family that provides acceptance, trust, sense of autonomy, and security. When a normal developmental atmosphere is created for the child, they feel a sense of capability, fulfillment, belonging and are down a path toward adequate levels of psychosocial competence (Peleg-Oren & Teichman, 2006). However, if the child is unable to achieve normal development, they feel inadequate and inferior, have low self-esteem, and in many cases, “intergenerational transmission of substance abuse and other psychopathology” (Peleg-Oren & Teichman, 2006).

In the developmental psychology viewpoint, a family is not measured in terms of the summation of its individual members, their characteristics, or even patterns of behaviors. Rather, a family is viewed as an organism, in which each family member is an aspect of the
organism that interacts and affects each other in the organism, as well as the organism as a whole (Peleg-Oren & Teichman, 2006). Therefore, if the organism is infected with a bad component (a parent with a severe mental illness or substance related disorder) then the other aspects of the organism will be affected and perhaps not receive the necessary resources to meet its needs. In this case, the part that is not receiving what they need, is the vulnerable child who is still developing whether the parent is providing a normal and safe environment or not.

Unfortunately, at a time when the child should be developing all the tools to live a long and substantial life, the children that are living in these inadequate circumstances are generally developing certain types of defense mechanisms and symptoms of numerous types of self-defeating disorders (Peleg-Oren & Teichman, 2006).

Eiden and her colleagues (2009), focused on another type of theory from the discipline of psychology, which is prominently relevant in this issue of psychosocial development in children. In the social learning theory, it is suggested that the symptoms and behaviors displayed by the parents, could have a direct role in predicting child outcomes through modeling of inappropriate behaviors. This issue is different from the one suggested by Peleg-Oren and Teichman, which focused on the normal development environment. The social learning theory suggests that more than more needs to be assessed than merely the environmental status presented by the substance-abusing parent (Peleg-Oren & Teichman, 2006). In the social learning theory, it is emphasized that the parents need to be role models for the children, so they can demonstrate the proper ways to live, interact, and behave (Peleg-Oren & Teichman, 2006).

So, with all of the information provided in the review of literature, including what was just mentioned about the social learning theory, an interesting perspective is brought to light. The question that has been attempted to be answered is as follows, can a parent(s) who suffers
from a severe mental illness or substance-related disorder or some combination, be a part of the family structure and not negatively affect the vulnerable aspects of the structure, which is referring generally to the children. The purpose of this study is to provide more that it may not be in the researchers best interest to focus so much attention what is causing the parent to be less than adequate, but rather focus on what the child is not receiving.

If perhaps the focus of research is placed on more on these components, perhaps something can be done to help the children in future generations. The literature that was reviewed in this study was influential in guiding the specific hypotheses chosen. In the present study, it is being hypothesized that there will be no significant difference in the levels of psychosocial functioning among children raised by at least one parent that has either a substance-related disorder, a mental health disorder, or a co-occurring disorder. We also hypothesize that there will be a significant difference in the level of psychosocial functioning of children with parents with any or all of the dysfunctional components and the children with parents with no dysfunctional components. These findings will provide leverage for future research studies to place more attention on the children and their developmental deficiencies, rather than on the parents and their role in creating these developmental deficiencies.

Methods

Procedure

To obtain the four groups, 3 assemblies will be conducted. Assembly 1 – will be conducted at the elementary school, consisting of grades 3-5. Assembly 2 – will be conducted at the middle school, consisting of grades 6-8. Assembly 3 – will be conducted at the high school, consisting of grades 9-12.
In each of the 3 assemblies, the format will be laid out nearly identically in how it will be conducted. Each assembly will include all of the children that attend the school accompanied by at least one of their parents or guardians. Also, each assembly will begin with a general overview of the purpose of the study. However, when the overview is conducted, the participants will only be provided the information they need; avoiding the possibility of jeopardizing the reliability of the study will be given significant consideration. The assembly for the elementary children will be done in the same format, however with different components due to their less developed cognitive ability and capabilities than that of the older children.

There are several important components that these assemblies will serve for this study. First, it will lay out the path that will be traveled by the participants chosen for the study. Second, it will make everyone feel comfortable that everything is going to be securely maintained by confidentiality and the code of ethics. Third, that everyone that is going to be considered for this study will have to sign the consent form for themselves and their child. Fourth, each parent will fill out a short and simple form that will be attached to the consent form. Basically, this form will include demographic information about them and their child (gender, age, race, ethnicity); this form will include several questions that will put each parent into 1 of 4 possible categories: 1) never been diagnosed with anything, 2) only been diagnosed with a substance-related disorder, 3) only been diagnosed with a mental health disorder, and 4) has been diagnosed with both a substance-related disorder and a mental health disorder.

The form will consist of several extra questions that will be based on which of the four categories that the parent ended up in. These questions are designed to increase the validity of this stage in the process, to verify the legitimacy of each participant. For instance, some questions focused on the individuals who classified themselves as never being diagnosed with
anything. These questions were designed to check whether the individual doesn’t meet criteria, or they have never been diagnosed but probably should have been. The other questions focused on the other 3 groups, to make sure that the timelines would all match up with their mental health and/or substance history and the age of their child. For example, if their child was 8, and they have been sober for 12 years, then they would clearly not be relevant to this study. The focus of this study is on the developmental deficiencies encountered by the children as a result of their parents’ current disorders.

They may answer that they had been diagnosed with a substance-related disorder, but it would not accurately represent the nature of this study.

After the 3 assemblies are completed, all of the forms will be sorted through. All of the ineligible participants will be removed from contention, while the eligible candidates will be placed into 1 of the 4 possible categories. After this process was complete, meetings were set up in 60 minute intervals with the parent and child pair. During this 60 minute session, the parent and professional would complete a bio-psychosocial assessment that would be obtained from the Placer County Behavioral Health Managed Care Network. At this time, the child would be nearby completing a child/adolescent version of the same assessment instrument, provided also by the same professional supplier. This was also crucial because it effectively filtered out the pairs that did not legitimately meet the criteria for one of the 4 categories. Following this screening/assessment process, the research team was able cut down the number of pairs into four equally numbered categories.

Participants
The location that was chosen to conduct this study was in Bonaville, New York. The Bonaville school district consists of approximately 6000 students in grades K – 12. For this study, at least 1200 parents will try to be recruited into four specific types of groups. Although many parents have more than one child, for the purpose of this study only one will be the focus of the statistical components.

The participants will be chosen based on four types of criteria. Each of the four groups is hoped to consist of at least 300 parent/child pairs. The first group will be comprised of 300 parents that were never diagnosed with a mental health disorder, or a substance-related disorder, and did not meet the criteria for either during the screening process. The second group will be comprised of 300 parents that were diagnosed with mental health disorder, but never a substance-related disorder, which will be confirmed in the screening process. The third group will be comprised of 300 parents who were never diagnosed with a mental health disorder, who were diagnosed with a substance-related disorder, which was also be confirmed during the screening process. The fourth and final group will be comprised of 300 parents that have been diagnosed with both a mental health disorder and substance-related disorder, as was confirmed during the screening process.

Measures

Cognitive Functioning

The *Stanford-Binet Intelligence Scale: Fourth Edition* (SB: FE), is a standardized test that measures intelligence and cognitive abilities in children and adults, from age two through mature adulthood. Therefore it fit well in this study, as all 1200 children completed the Stanford-Binet Intelligence Scale: Fourth Edition. The *ADHD Rating Scale – IV* (ADHD – IV), is a tool
that was used for detecting whether the children and adolescents (ages 5-17) in the study would meet the diagnostic criteria for ADHD. The scale contains 18 items and takes 10-20 minutes to administer.

Emotional Functioning

The *Depression and Anxiety in Youth Scales* (DAYS) will be used as a tool to measure anxiety, depression, and social maladjustment in children and adolescents ages 6 – 19. This instrument consists of three scales that were to be completed by three different parties for each individual student. The parent scale contained 45 items, the teacher scale had 30 items, and the self-report scale contained 40 items. Each scale took about 5 – 20 minutes to complete. This instrument is significant to this study, because anxiety and depression were two primary issues reported by researchers as emotional developmental concerns for children of mentally ill, substance-abusing, and co-occurring parents. The *Young Mania Rating Scale* (YMRS) is an 11-item scale will be used to assess the severity of mania in children and adolescents ages 5-17. However, there will most likely be several 18 year olds that will also use this assessment in this study. It takes each child approximately 15-30 minutes to complete. The YMRS has ratings that are based on child/adolescent self-reporting and clinician observation. This instrument was chosen for this study because it does not assess depressed mood, but solely focuses on the manic aspects of bi-polar and whether or not the child seems to be experiencing related symptoms. The *Kiddie Schedule for Affective Disorders and Schizophrenia* (Kiddie-SADS) is an instrument that is to only be administered by a trained clinician. This instrument covers a broad spectrum of most child psychiatric diagnoses, with the exception of pervasive development disorders and personality disorders. This tool is typically used for ages 6-18. The exceptions that had to be taken into account for this instrument had to do with the details of the clinician interview. For younger children, the trained clinician will meet with the parent(s) first, then repeat the interview.
for the child. For the teenagers, the trained clinician will most likely meet with the teenager first, as it was recommended by the test creators. This test is significant to this study, because it measures and detects the degree of schizoid-affective disorders and affective disorders in the children of the study.

Behavioral Functioning

The *General Behavior Inventory* (GBI) is a 73-item self-report screening instrument that will be completed by all the children in this study. Subjects rated their own behavioral indicators, as well as their own behavioral symptoms for hypomanic/alternating mood. The parents were given the Parent Version, General Behavior Inventory (P-GBI). This test was developed out of the child version, which means that it was generating the same types of measures. This instrument will give a good basis for their behavioral functioning and possible impairments that can be statistically compared among the four groups being studied. It may also provide a comparative correlation between parent and child that may support the aspects of the hypothesis that were derived on the social learning theory. The *Conduct Disorder Scale* (CDS) was a 40-item checklist that was specifically seeking all types of conduct disorders for ages 5-22. The types of conduct behaviors that were assessed using the CDS include: aggressive and non-aggressive conduct, deceitfulness, theft, and several kinds of rule violations. This instrument is conducted by using a self-report format. The purpose of the CDS being used in collaboration with the GBI is that the CDS focuses less on overall behavior and zeros in on areas of troubled behaviors and conduct disorders.

Social Functioning
The *Social Competence and Behavior Evaluation Scales* (SCBE-30) is a scale that was completed by the teachers during their direct view of the children in the classroom setting. The SCBE-30 is an average of eight scales that reflect the competency of social behaviors in the classroom, which includes: joyful, secure, tolerant, integrated, calm, pro-social, cooperative, and autonomous. The SCBE-30 provides a great deal of information about the overall social competence of each child, which can then be neatly expressed in statistical figures. The SCBE-30 is less capable in detecting some of the more specific types and degrees of social issues, such as: antisocial behavior, antisocial personality disorders, and social phobias. Therefore, the *Antisocial Behavior Checklist* (ASB) is needed to provide the necessary specific measures to validate the claims of the hypothesis and statistical analysis. The ASB is a 28-item checklist that was used to measure the lifetime of antisocial behaviors of the subjects. This is another instrument that will be administered to both the parent and the child. Several past studies had discussed the correlation between child/parent anti-social behaviors and disorders, which indicate another possible opportunity to support the social learning theory, after the statistical measures of this study, are finalized.

Physical Functioning

A thorough physical will be conducted in collaboration with a licensed physician and the school nursing staff. The purpose of this exam is to measure how physically developed the child is compared to the normal physical progression in terms of their age, gender, race, and size. For instance, if in the statistics of the results section, the children of substance-abusing parents are predominantly undersized for their age. Also, if the statistics in the results section shows that children of non mentally ill and substance-abusing parents are not predominantly undersized for
their age, then this test would support the hypothesis of the study. There has been a special checklist that was created just for the specific components of this present study.

Following the collection of each of the measures described for all the variables of psychosocial functioning, they would need to be calculated. The ANOVA will be used to see if there is any difference between the groups on several variables. The specific types of ANOVA that will be used are known as the one-way between groups model. This type of ANOVA is used to measure a variable among different groups.
References


