Parental loss of a child to mental illness and the resulting grief is a relatively unacknowledged phenomenon. This study aimed to capture the process through which parents journey in the face of their child’s mental illness. Conducting a series of focus groups, the authors sought to further the understanding and the needs of these families. They identify seven themes from initial awareness to the formation of a new stability. Identification of this grief process is an important step that can heighten practitioners’ awareness so that future interventions and support systems can be developed to help these families deal with their pain and burden.

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THE RELATIONSHIPS between parents and children are unlike any others between human beings. Children often represent the fulfillment and expression of pure love. With their potential capacities to play, to dream, and to create, children represent both a connection with the past and hope for the future to many parents. Thus, the loss of a child is unlike any other kind of loss and grief reactions in parents after the death of a child are more intense than after the death of other family members (Rando, 1986).

When the loss is seemingly ongoing or chronic, and when that chronicity may be punctuated by remissions that cruelly inspire hope, the experiences must be devastating for families. This experience is what families face when they learn that their child has a severe mental illness. Advocates in the National Alliance for the Mentally Ill (NAMI) family movement posit that the effect of a mental illness can make families feel “under siege.” These families need an equal measure of empathy and understanding, as do families who are dealing with a child’s death from cancer.

Yet parental loss of a child to mental illness is relatively unacknowledged in the nursing research literature. Given the paucity of nursing and other professional research concerning this phenomenon, this qualitative research study aimed to capture the process through which parents journey when they are faced with the mental illness of their child. The study consisted of a series of focus groups that were done in partnership with a community support group in eastern Pennsylvania. The objective of this focus group activity was to explore, describe, and further the understanding of the needs of these families at risk so that future interventions and support systems can be developed to help them deal with pain and burden.

GRIEF AND THE ADJUSTMENT TO Bereavement

There is wide variation in the way that people grieve and in the time required to get through the process of bereavement (Sanders, 1989). Moreover, grief can be complicated by various factors. “Normal” grief and mourning is described as having stages or phases. Rando (1993) posits that these do not occur in a neat chronological order, but rather the individual shifts between each phase. These shifting patterns are individual and depend on the mourner’s unique personal characteristics and their unique circumstances. The first phase is characterized by avoidance during which the per-
son receives the devastating news of death or terminal illness. Bewilderment, denial, and disbelief feelings of emotional numbing and unreality characterize this phase. The second phase is one of confrontation in which the bereaved individual encounters the reality of their loss. This phase is characterized by waves of intensely negative affect, sadness, weeping, loneliness, anxiety, and often is accompanied by vegetative symptoms such as anorexia or insomnia. Some bereaved people experience guilt, blaming doctors or others for failing to provide optimal care for their loved one. They may withdraw from social relations and become preoccupied with memories of the past.

A third phase of accommodation is characterized by a gradual diminution of the above symptoms and the person begins to come to terms with the loss. They gradually become reestablished and adapt to their loss and begin to reinvest their energies into a new reality—a reality in which someone and all that someone brought with him or her is missing. They reconfigure a new identity for themselves within this new reality while they also begin to resume their daily activities (Worden, 1991; Rando, 1993).

The theory of chronic sorrow, as proposed by Eakes, Burke, & Hainsworth (1998) suggests that periodic, recurrent, pervasive sadness characterizes a normal response to various loss situations. In this framework, feelings of grief are revisited whenever a disparity is experienced between what could have been and what is. Events that revive the sense of disparity can evoke feelings of grief, with the potential for a long-term cycle of seemingly unresolved grief.

Another view of the work that families do to resolve loss of the ideal child in relation to chronic physical illness (Knafl & Deatrick, 1986) suggests that families adjust to this loss via a process of normalization, in which they incorporate the management of the illness into their ongoing family lifestyle. In doing so, the family essentially minimizes the seemingly extraordinary circumstances with which they are faced and they develop new routines. The new behaviors are considered normal for and by the family itself. It is not clear wither or not similar processes are in operation in families who have children diagnosed with mental illnesses.

The grief responses of parents to the death of children is well documented in the literature, but the loss of a child has been conducted with populations other than those experiencing loss due to mental illness. Most of the empirical research on grief has been conducted on grief associated with death or with bereavement associated with chronic physical illness. One exception is Atkinson (1994) who compared grief among parents who had an adult child with schizophrenia and parents who had lost an adult child through death or head injury. She found that parental loss of a child through schizophrenia led to a pattern of chronic grief punctuated by the exacerbations and remissions of the characteristic course of the mental illness. Given the push for community over residential care and the accelerated closure of public and private psychiatric hospitals she called for more research into the impact of such grief and its effects on family dynamics.

**METHOD**

We chose focus groups as the method for this study. Focus groups are a way of listening to people and learning from them during which there is not only lines of communication between the researchers, but also among the participants themselves (Morgan, 1998).

**Sample**

Following Morgan’s (1998) recommendation for a participant size of no more than 6 to 10 (p. 71), our sample consisted of 8 participants (four dyads) who were parents of children diagnosed as having a mental illness. They were recruited by way of announcements made with the help of facilitators of five community groups whose mission is to provide social and emotional support for family members of mentally ill relatives. All of the couples were married and each had one child who had a diagnosis of schizophrenia or a major affective disorder that had required hospitalization. The ages of their children at the time of the focus groups ranged from 17 to 31 years. Because the intent of the study was to concentrate on the individual participants’ recollections concerning their experiences with the life event of having a child with mental illness, participants were not asked to elaborate on their child’s diagnosis, and that data was not collected. Rather they were asked to discuss and to share their feelings with each other.
**Data Collection**

Again consistent with Morgan’s recommendation that a typical small focus group project consists of three to five groups (1998, p. 77), we conducted four focus groups of 90 minutes each were held in the same location over a 4-week period. A final follow-up session with the same participants was conducted after 3 months. The principal investigator initially acted as the moderator moving more into the background as the members began to take over the groups themselves. The research assistant acted as an assistant moderator, taking field notes, making notes of nonverbal communication, and spot checking the taping equipment. With the exception of the final meeting, each of the 90-minute sessions was audiotaped and transcriptions of these were downloaded to computer disks. Questions and interviewing schedules for the focus group activity surfaced from discussion and negotiation among key family members and the research team during the first group. Family members were trained at these negotiation sessions by the principal investigator in how to conduct groups for maximum results. In turn the family members then led the focus groups and it was from this series of focus groups that the data were collected.

The basis behind this approach was our conviction that persons with lived experiences are the experts in those experiences. As such, they are the individuals who are best able to formulate informed questions and answers concerning those experiences, as well as surface possible solutions to problems that might arise with respect to coping with those experiences. In addition this method allowed the participants to be an integral part of the research process, flattening any potential hierarchical relationship between university “expert” and the actual experts. Although Morgan (1998) makes a point of stressing that focus groups are not support groups, the our research team believed that support groups can be a source of action research that can use focus group methods. Furthermore, by making the participants coresearchers, this participatory approach also began to demystify, share, and teach the participants the research process, thereby empowering them to eventually conduct their own grass roots research and action.

**Data Analysis**

After each group meeting the principal investigator and assistant held a debriefing discussion of initial impressions and made notes of this discussion. They then reviewed each audiotape, separately and together, making an initial list of the most important themes that surfaced and in what ways these themes differed from what they expected. Subsequent debriefings after the next three focus groups concerned differences in what occurred between them and earlier groups. The total data yield was 7.5 audiotaped hours. Management of data was facilitated by the use of a computer program. The tapes were transcribed and the results of the transcriptions were initially analyzed for patterns and trends and initial quotes that answered specific questions were highlighted. Given that these NAMI families are engaged advocates, data proved extremely information rich and redundancy was achieved early in the analysis. A computer file was developed and each of the highlighted quotes that answered specific questions concerned with the participants experiences with their children’s mental illness were grouped under that question. Categorization schemes, themes, and formats were negotiated with professional colleagues and with the study participants.

**Limitation**

A potential criticism may arise in that this sample was small and may not represent typical experiences, however, the intent of the study was to elicit information rich exemplars and to describe a process. Moreover, the criteria of transferability were met in that NAMI reports similar instances of family grief in their own studies (Burland, 1998). Thus these data seem to resonate at least with reports of other NAMI family members.

**Scientific Rigor**

**Trustworthiness**

We followed the criterion of trustworthiness in qualitative research as described by Lincoln and Guba (1985) and Sandelowski (1986). Validity, credibility or truth value, was enhanced by the first author’s direct and repeated involvement with the participants throughout the data collection and through the testing and retesting of inferences about what they had said until we achieved consensus about the meaning of what they had said. A field journal and daily record of thoughts helped to make any biases explicit. An ongoing struggle with data collection and analysis was a tendency to
become emotionally drained during the course of this study. This was resolved by debriefing on a regular basis with a colleague who served in the capacity of mentor for the study’s duration.

In addition to engagement with these eight individuals we established credibility by repeatedly going back to them and eliciting their validation of themes, categories, and understandings. As previously mentioned transferability or “fittingness” occurred when findings fit the reported experiences of other NAMI families. As well as examining NAMI documents and their web site, we also enhanced transferability through sharing some of the data with other psychiatric nurses, patients, and other families from the NAMI Family to Family Program. All found the experiences reported by our participants as consistent with their own experiences.

We strove for reliability, dependability, or consistency by ascertaining that the group remained focused on its purpose and by achieving redundancy.

A colleague at another university, who has worked reciprocally with us in the past, conducted inquiry audits, which included: the examination of the process of the investigation, including raw data; data reduction and analysis products, such as coded field notes; data reconstruction products, such as patterns; and journaling, consisting of methodological reminders and reflexive notes. Examination of these components constitute an audit trail for this study. The inquiry audit was conducted at the midway point in the data analysis and additionally when the data were completely analyzed. Referential adequacy was accomplished by storing a selection of raw data that was later retrieved near the conclusion of the study. It was then analyzed and compared with similar data analyzed as part of the full data set.

FINDINGS

Early Nightmares

Parents related the existence of a moment of awareness that they described as the beginning of a nightmare. These moments of awareness conformed to Denzin’s (1989) description of the illuminative, minor epiphany of which he says: “It is not a turning point moment, yet it brings to the surface and illuminates . . . .” (p. 130). These illuminative instances occurred at times during which the participants first began to feel that something was not quite right and ranged from a gradual perception to a sudden realization that there was something very wrong with their child’s behavior. A series of small steps constituted the actual process of awareness. These were an initial questioning, the realization itself, and feelings of impending crisis. The mother of a 17-year-old girl who was 10-years-old when she became ill narrates the initial questioning that followed her daughter’s suicidal verbalizations:

Mom: She said, “I just want to die. I just want to die.” And that was a red flag for me. I was like, “This isn’t typical for (child), you know, a 10-year-old to be wanting to die? What’s going on?

The above narrative represents an example of one parent’s trying to cope with something that was common to those experiencing the same beginning moments of awareness that came during the early nightmares. She engaged in rational questioning as a response to what appeared to be a situation that was unfamiliar to her.

This kind of questioning may represent one component of an awareness process in which parents try to reorient themselves to their situations or to adapt by way of a cognitive revision of their assumptions. When parents could no longer engage in questioning they came to accept that something was indeed wrong. The mother’s narrative below represents the actual recognition that her son’s behavior had become aberrant:

Mom: He seemed to be upset with his inability to be able to control himself and that caused him to get mad at himself. When he did something wrong, he would destroy toys, his clothes. He really never did anything so much to other people as to property. So he was being destructive and he seemed to be very upset with himself because he couldn’t be what he thought he should be. He didn’t seem to be able to do what we asked him to do and that would make him upset. It was like trying to fit together pieces that just wouldn’t fit—for both of us. Gradually, he just seemed to have an inability to be able to accomplish having appropriate behavior. So it dawned on us and we hated that dawning, that dreadful realization—something’s not right.

Subsequent to the moment of actual cognizance that something was not right, the parents’ remarks reflected an almost universal forewarning or foreboding of worse things yet to come, as in the following:

Mom: We had ups and downs, her temper, her moods, it would just get so extreme. She’d just get so violently mad.
You know, like she kicked a hole in the wall a week before we took her [to the hospital]. And that night, she just got out of control, so terribly upset. Because, that night, she was like, “How can I kill myself?” And I think that—that night, I thought, “She’s going to find a way.”

Invariably the parents tried to rationalize or make sense of the situations for themselves in some way, either by giving their children the benefit of the doubt or assuming that they were in some way deficient as parents and had to compensate for it in some way. When these attempts to compensate failed and they sensed an imminent crisis they were faced with making decisions that they dreaded.

**Action**

Parents came to the decision that they must act in ways different from what they were currently engaged in. One parent who experienced a gradual awareness that something was not quite as it should be was reluctant, at first, to believe in her own perceptions. But she took a proactive approach and tentatively validated her intuition by validating with others:

Mom: And I just thought, “I can’t keep going through this. She needs some help. You know, this counseling every week was not working.” And one of my best friends, she works with emotionally disturbed children, elementary age children from the school district at this school where I was teaching. [She] had been hearing about this every day every night. So, she came over, and we both assessed the situation and decided that she (the daughter) needed some help.

Others experienced a much more intense reaction that resembled a climax during which they felt a shattering tension. It was at that moment when the parents reached an intense clarity of insight and they knew that they had to take action, although they despaired at the necessity of that decision:

Mom: It was pitiful. Oh Lord! I had to call an ambulance. An ambulance come out here and they was—I mean she was just goin’ off. First she standin’ in front of the mirror, she just scratched—whatever the medicine they had on thinkin’ they had her for moodiness, like suicidal or something, but she’s never been that way in her whole entire life. She’s standing in front the mirror just scratching her face, scratching her face—how much she doesn’t like the freckles on her face, she didn’t like the way she looked, and she started lookin’ strange, and all of a sudden she just started screaming and hollerin’—hollerin’ this holler that I never heard before. And I had to lay on her and hold her down, and she was kicking and screaming—and they came and took her. My God, they took her and I let ‘em.

**Overwhelmed**

In each of the participants’ lives they reached a point when they became overwhelmed at having to live with the vicissitudes of watching their children’s descent into mental illness. Before the next passage the mother had related that when there was no escape or avoidance of “the truth anymore” she found herself unable to attenuate the meaning of what had happened. She described the emotional impact of her collapse of defenses:

Mom: I felt shredded emotionally. All of this crashing in on me. this was my baby. I cried all the time. I felt anxious all the time, just really anxious about what was wrong here.

Usually at that particular point of “emotional shredding” parents were so exhausted or frantic that they sought help, but often the process of help itself tended to add to the overwhelming of their coping resources. This mother related her feelings at being faced with the inevitable paperwork of hospitalization:

Mom: No, it was just a bunch of papers. You know, I was so upset that night. I was real upset that night. But it was just a like a paper blizzard, so to say—that you just—I signed things. I was in a daze—and I couldn’t even tell you what I signed, I just signed.

Some parents came to see themselves as strangers in a sense who have been, in cast into a world that was painfully foreign to them and at times unresponsive to their needs, wishes or parental strivings. At the same time that they were feeling emotionally shredded, they also felt a disconcerting emptiness and devoid of power:

Mom: We had no power. We were powerless and very much saddened. I cried. I felt like I was drowning in tears, drowning in the situation. I have someone that I care for and I love that don’t want to talk to me. And at the same time he’s in a facility that I can’t get to him or go to him because it’s locked. I would go (there) and the next thing that I know they’re saying “he doesn’t want to see you.” And then you get escorted out. Drowning. And you wonder, “Well what do I do now?”

**Fear**

The excruciating distress or suffering, that was a result of an all-embracing extreme fear of everything, of what was happening, of the unknown, a
fear of oneself, or of one’s own emotions. The types of fears were not always very precise and centered on what could have been or what could be, but were often “free floating.” Either way, they were exhausting. The following mother found herself walking along a precipice and realizing that she had to make decisions. But she was afraid that she might make the wrong choice and that fear and panic began to feel like paralysis:

Mom: I—I was—I was panicked. I was just panicked. I would just cry. I’d just—I didn’t sleep any, probably, hardly, while she was in. I would just cry and cry. And I couldn’t—and I’d have to go to work, and I just—I—I just spent all my energy trying to figure out what to do. I was so scared.

**Anxijsh**

If the pain of having to listen to and read the narratives of what these parents told us was any indication of what they experienced, it was truly deserving of the word “anguish.” The following description by two parents of how they felt when they had to leave their child at the hospital can stand on its own in communicating this anguish. It needs no further comment:

Mom: Then, we—when we had to leave, I remember—I remember walking down that hall and having to leave her standing there. And we got into the parking lot, and we cried and prayed, prayed together in the car. And I remember it was dark, and it was rainy and cold. And we just prayed and just asked God to help us through this thing. And that’s—that’s what I remember about all that.

Dad: Toughest thing we’ve ever had to do. The toughest thing.

Mom: Well, (Dad) is usually not a real—well, I don’t want to say he’s not emotional, because he has very deep feelings. He doesn’t usually cry. But he—he has cried. I mean, he’s not—and he’s not ashamed of that. But he’s—that night, he bawled, just bawled in the car.

Dad: Like ripping out a part of your life, and your body, your heart and just leaving it, you know? Walking away from it.

**Guilt**

The parents in this sample, although they all knew that they were not to blame for their child’s condition, nevertheless talked about their guilt. It was difficult to sort out for all of them, how much guilt stemmed from their environments that were still communicating a message of blame, as versus how much simply came from their own feelings of inadequacy as parents. Shame, self-accusation and an unfavorable judgment of themselves as parents as well as a perceived complicity in the ultimate outcome of mental illness were expressed repeatedly in the groups. Although they did not completely “buy into” self-condemnation they did of engage in a degree of self-accusation involving judgments of their actions or inactions. They related the following:

Dad: Because it’s all my fault. You know, I may have been dumb. I did the best I could but it wasn’t enough.

And:

Mom: I questioned myself all the time. I felt like, you know, that I had done something wrong. Why was she like this? Could I have done something to stop this? Should I have done something different? The guilt was unbelievable.

**Sequelae**

Parents described sequelae of the process of seeking help, undergoing treatment, and the aftermath of treatment in words that illustrate that the sequelae do not give closure. Rather, the effects of mental illness have pervasive effects on the family and its functioning. Awareness of the fact that there were problems with their children were accompanied by the feeling that things could get worse, feelings that were reinforced by the treatment process as well as by the behavior of their children.

Dad: And we noticed some of the things along the lines of trust, you know, that (Mom’s) really observed too, you know? She’s not as trusting. You know, the thing with doctors. You know, she doesn’t really like or relate or trust doctors, or anything like that.

And:

Mom: Well, I noticed at the end that she said, when you asked her, “Who do you”—“Who do you rely on now?” “Me. No one else. Not friends, not family, not doctors, not even God.” And I think she’s been—I still think she has some real anger toward God about the whole thing. And again, it’s understandable. But who does she count on? “Me.” And that’s not—that’s not good. That’s not healthy.

Parents expressed that their relationships with their children had changed after a hospitalization or commitment, noting in particular a lack of trust followed by anger. Yet, these parents also expressed an understanding of their children’s re-
sponses, illustrating a capacity to continue to deal with their children in whatever way the present situation required of them. Parents made comments that indicated that, even though their children had changed, they recognized the need to continue to be flexible to meet the needs of their children. The strength exhibited by these parents is seen in the following:

Mom: And she began to see us as “us against them,” because, we put her there. And you know, understandably. I don’t have a problem with her feeling that way. You know, we’ve talked about this, C and I, about her being angry with us. And even though it hurts me, I want her to tell me that she’s angry with me for that, because I—if we don’t know, then we can’t fix it. And—We had a different person in our home. It was a new kid. You know, when you start with your own children, you know what’s been put into them, and you know what makes them tick; but then, when you relinquish—

Dad: She was changed.

Mom: —that child for four months to a new set of people who don’t have your same set of values, who don’t have your same set of what’s right and what’s wrong, then you’ve got a brand-new person coming into your home.

Dad: Yeah. She was changed.

Other person: It altered the family dynamics?

Mom: It altered everything. Everything.

And:

Dad: I regret it today (committing him). I think now we talk more about it. I think there’s a little more trust between us. But I think he’s got anger towards me which I can’t blame him for you know. It’s understandable.

The long term, recurring nature of change requires that families must be flexible, continually adjusting, dealing with uncertainty. Indeed, a two-fold adjustment is necessary, once when the child is initially diagnosed and again, when the child returns home, changed, from a hospital or care setting.

Children changed the ways they related to their parents in ways that indicated that they interpreted treatment as a breach of trust by the parents, yet, difficult as it may have been, parents’ remarks suggest that they understood their children’s reactions and, as this comment illustrates, could even put themselves in the place of their children when trying to deal with the after effects:

Mom: I don’t know that (child) has ever forgiven me. He says he has, but I don’t know if he has. I don’t know that

I could if my mother had done something like that to me. He can’t understand the concern and the frustration that I had in trying to understand what was going on. For a long time, 3 or 4 years after he was discharged, if we so much as drove on the freeway past the hospital, (child) would get upset. And for 2 years, maybe longer, if we had the slightest disagreement, he would say, “Well fine, it doesn’t matter anyway, you’re just going to throw me back in a hospital and lock me away.” And that was really hard to take.

The after-effects of mental illness included altered parenting behaviors changed in response to having a child diagnosed with a mental illness:

Dad: You know, maybe I’m too protective of him now, more protective now, but I don’t know. Maybe I shouldn’t be so easy on him. I don’t know. I feel like he’s been through enough.

There were themes in the descriptions of sequelae that are consistent with post-traumatic stress. In particular, the effects of leaving a child in a mental health hospital lead to vivid, descriptive memories in which locked doors and being forced to leave their child behind are most striking:

Mom: Well, I still have nightmares about it. I—I still have nightmares. Like, I had one last week. And I mean it’s a nightmare. I was going up and down all those halls, the way they’re laid out, and I could hear her and I couldn’t find her. And I got to the room and she was in this room. We could hear her screaming, “Momma, come get me,” and I couldn’t get the door unlocked. And I was hiding from people in my dream. There were people, you know, that worked there, and it was—it was a nightmare. And I still have dreams about it.

And, the poignant description of “the doors” by two parents:

Dad: And outside of that, everything was behind locked doors. I have nightmares about those doors, the doors.

Mom: And all the doors everywhere were locked. ‘Til the day I die, I will remember the locked doors slamming.

Emphasizing the ongoing impact of the memories associated with seeking assistance:

Mom: It was the worst day of my life. I relived that day many, many times.

And, finally, illustrating the stigmatizing as well as enduring effects of a diagnosis of mental illness:

Dad: When a kid is labeled in school, that becomes a part of their life. If they’re bad in class, they’re going to be bad
in another class, they’re bad at home, they’re bad at play because they’re told that they’re troublesome. They’re bad.

**DISCUSSION**

It is clear that the families in this study experienced some of the symptoms of a grief reaction. But they also experienced the symptoms of trauma and they found their loved one very changed. Like the stages of grief that have been outlined in the grief and loss literature, these stages are not progressive, rather members of the family can be in more than one stage at once, or may vacillate between stages. Sometimes, families begin to approach acceptance of the mental illness and a sudden relapse in their loved one’s condition will cause them to feel the same chaos and confusion that they did at an earlier stage. The responses described by family members suggest that they may be experiencing chronic sorrow (Eakes, Burke, & Hainsworth, 1999). Indeed, the report of family members that their child had changed, that there was no going back, suggests that trigger events that maintain the cycle of sorrow were typical experiences of these families. Furthermore, different family members can be in different stages or dealing with different traumatic responses in their own unique ways. Moreover, members of the family may be in an entirely different place with respect to their stages than the person with the mental illness (Burland, 1998). This may lead to tension, difficulties in communication, and on agreeing on what must be done.

The NAMI family movement has long recognized the pain that families endure when faced with the catastrophic event of realizing that a loved one has developed a mental illness. Unlike the traditional view that conceptualizes the family as dysfunctional, NAMI supporters suggest that what families experience is a predictable set of emotional reactions that are quite normal. These responses are reactions to events that the family experiences as being intensely traumatic and disruptive to their lives. Findings of this study suggest that there may be profound differences in the process and outcomes of seeking help for children diagnosed with mental illnesses, as compared with children diagnosed with chronic physical illnesses. Striking examples of difference include forced separation, locked doors, and anger by children toward parents for seeking help. Further study is needed to examine these processes and outcomes.

Similarly, further investigation is needed asking whether or not families of the mentally ill find resolution in ways similar to or different from families of children diagnosed with physical illnesses.

**IMPLICATIONS FOR PRACTICE**

With respect to implications for practice, it is imperative that nurses and other caregivers have a comprehensive understanding of the dynamics of grief and adaptation facing both the family and the patient. Many nurses in advanced practice have been educated in the family therapy model that focuses on dysfunction in family communication and sees the family as needing “repair.” Looking at the family through the lens of a grief model, or an adaptation model such as that advocated by NAMI, provides an understanding that the family is not pathological or dysfunctional. This may reconfigure many of the interventions that service providers have learned. For example, if a family is in intense pain and lashing out it makes little sense to label that family as hostile or dysfunctional and proceed to try to address the members dynamics. Not only is it futile, but it may well alienate the family and patient from caregivers. Such an outcome is tragic because parents are important factors in promoting positive outcomes for their children and mitigating the impact of future environmental and situational stressors. Mindful of parents’ primary influence on children and their development, clinicians would do well to recognize the importance of including parents in the treatment of their child and do everything to make certain that inclusion happens. Understanding the experiences and needs of parents is therefore central to targeting interventions to families in crisis. Interventions should be aimed at providing services that enhance parents’ knowledge, self-confidence, and ability to cope with these experiences. Keeping in mind that families with a child diagnosed with a mental illness face ongoing reminders of the fact that their child is not perfect, nurses need to remember that these families are dealing with the necessity of coping on a continual basis. Nurses can help family members by referring them to programs that have support and educational components. NAMI provides ongoing support groups for families and patients and they have an excellent family-to-family program in which family members learn about the dynamics of mental
illness and about normality of their reactions to the illness. It makes sense that parents whose own pain is acknowledged and who feel supported will be better able to provide support to their children.

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