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## RESEARCH ARTICLE

# Social Workers' Support Skills for Parents with Mental Disorders: A Qualitative Descriptive Study in Child-Welfare Social Workers

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### Abstract:

#### Background:

In Japan, a half to one third of child abuse cases involved parents with mental disorders. However, support skills for these parents have not been established.

#### Objective:

This qualitative descriptive study aimed to describe child-welfare social workers' support skills for parents with mental disorders.

#### Method:

Eight social workers were interviewed, and each was asked to identify four cases (32 total cases); two were successfully supported, and two were not. Descriptions of support goals and content were extracted from transcripts, coded, and categorized.

#### Results:

Almost half of the parents with mental disorders identified in this study were diagnosed with addictive or personality disorders. Social workers supported parents in the following goals: "being able to consult when the need arises," "living conditions with minimum level of safety and comfort for children," "living arrangements suitable for the family," "independence of the family," and "growth of children." Social workers supported more comfortable and realistic living arrangements for each family and supported them to live independently. The social workers supported the parents with the following support skills: "assessment of the needs of the family," "assessment of and support to relationships with parents," "assessment and support of growth of children," "assessment and support in child-raising by parents," "assessment and support for the stability of medical condition of parents," "support through cooperation with other related agencies," and "continuing support for being an independent family."

#### Conclusion:

Social workers had many ways of assessing/supporting parents with mental disorders. However, social workers must be more sensitive to medical conditions and collaborate more with psychiatrists.

**Keywords:** Mental disorders, Child abuse, Parenting, Social workers, Support skills, Child welfare.

## 1. INTRODUCTION

The number of child abuse cases reported has been increasing in Japan [1]. Families in which children are abused are supported until the children reach 18 years old under the Child Welfare Act in Japan. Many related agencies are members of a formal support network of child abuse under the law, cooperate with each other, and provide support for

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families with potential child abuse. The social cost of child abuse in Japan in the fiscal year 2012 was at least ¥1.6 trillion (\$16 billion), almost equal to the total amount of damages from the 2011 Tohoku Earthquake and Tsunami in Fukushima Prefecture [2]. Despite this high cost, Social Workers (SWs) working in child consultation centers in Japan, which are the main management and support agencies for child abuse, are in charge of many families with cases of child abuse; each center reaches over 100 families per SW [3]. In child welfare facilities, the number of families with severe problems has been increasing, and parents with Mental Disorders (MD) are a severe problem [4]. The SWs in child welfare fields have heavy caseloads and must support more difficult cases including MD.

There is strong evidence that parents with MD are more likely to abuse their children [5]. Based on data from several reports in Japan, a half to one third of child abuse cases involved parents with MD [6]. Children living with parental MD are at greater risk of adverse outcomes [5]. However, research on parenting with MD in Japan is minimal [7], and support skills for parents with MD have not been established.

In the field of child welfare, clarifying support skills for parents with MD will be useful for child welfare SWs. This study aimed to describe support skills for parents with MD by child welfare SWs.

## **2. MATERIALS AND METHODS**

### **2.1. Research Design**

This study was a qualitative descriptive study [8], which is the method of choice when desiring straight descriptions of phenomena.

### **2.2. Interview Participants**

Of SWs working in child welfare fields in a local government, those who have supported parenting of persons with MD for 10 years or more were interviewed in a city near Tokyo. The researcher contacted the manager in charge of research for child welfare department, which included maternal and child living facilities, child consultation centers, and child welfare offices. Eight had SWs who met the inclusion criteria. Three were working at maternal and child living facilities, two were at child consultation centers, and three were at child welfare office. First, research documents were sent to them and then the research was explained by telephone. Next, the research was explained face to face, and interviews were conducted.

### **2.3. Data Collection**

The interviews were semi-structured and conducted using an interview guide. We asked participants to select four cases in total: two cases judged as providing successful support and two judged as unsuccessful. We asked participants to provide the following: (1) case summary, (2) reasons why they judged their support as successful or unsuccessful, and (3) the contents of support including assessment and behaviors. The interviews lasted one to two hours each. The length of time for the interview in each case was  $20 \pm 5$  minutes (range 13-32). The interview data were recorded and transcribed.

### **2.4. Data Analysis**

First, summaries of support by SWs in 32 cases were compiled. Next, a qualitative descriptive analysis was conducted on the interview data. The descriptions about goals or contents of support were extracted from transcripts, and the descriptions were segmented according to each meaning. Each segment was coded and labeled for content related to two research questions: "What were the goals of your support?" and "How did you provide support?" We subcategorized and categorized data based on the similarity of codes.

### **2.5. Ethical Considerations**

The objectives of this study, voluntary basis of participation, confidentiality, and autonomy were explained to participants orally and in writing. Written consent was obtained before each interview. This study was approved by the Research Ethics Committees, Faculty of Medicine, Osaka University (16283).

### 3. RESULTS

#### 3.1. Demographic characteristics of participants and cases.

The eight SWs were two men and six women aged  $50.8 \pm 6.7$  years old (range: 42-60).

Of the 32 cases, 30 involved mothers with MD, 1 was a father, and 1 was a case where both parents had MD. Diagnoses of 32 cases are shown in Table 1. Diagnoses were duplicated in six cases. Almost half of the parents identified with MD were diagnosed with addictive or personality disorders.

**Table 1. Diagnoses of cases supported successfully or unsuccessfully.**

Diagnosis (multiple diagnoses)	Supported Successfully	Supported Unsuccessfully	Total
Schizophrenia	4	4	8
Mood disorders	2	3	5
Addictive or personality disorders	8	10	18
Anxiety disorders	1	0	1
Adjustment disorders	1	1	2
Others	2	2	4
Total	18	20	38

Note: 6 cases had two diagnoses.

#### 3.2. Goals in Support Perceived by SWs

SWs supported parents with MD in the goals of “being able to consult when the need arises,” “living conditions with minimum level of safety and comfort for children,” “living arrangements suitable for the family,” “independence of the family,” and “growth of children.” Categories were explained with a transcript of interview data (mother or father with MD, diagnoses, case ID, main interventions provided, and factors contributing to success or lack of success).

##### 3.2.1. Being Able to Consult When the Need Arises

SWs judged their support as successful when parents could consult when the need arose. On the other hand, SWs judged their support as unsuccessful when parents could not consult and shut out the support of SWs.

###### 3.2.1.1. Successfully Supported

The mother hit her 5-year-old son when he was out of control, like peed in his pants (physical abuse). She also could not care for her son during psychogenic hyperventilation (neglect). When I met her for the first time, she spoke very little. We cannot support the person until they say what is troubling them. Now, she says everything to me honestly, even unimportant things. I can help her. By talking a lot, she came to organize past events (mother; addictive disorder; No. 6; individual counseling, accompany on visits to psychiatrist, and counseling by therapist; factor contributing to success was changes in the mother).

###### 3.2.1.2. Unsuccessfully Supported

The mother often had acrimonious quarrels with the father (domestic violence). She left him and moved in temporarily to this facility with her a few months' old son and 2-year-old daughter. In the facility, she was beginning to feel that the staff were talking badly about her to her children and were watching her. Therefore, she wanted to leave. However, I could not agree with her intention. I discussed this several times. She left, and now, I cannot contact her (mother; schizophrenia; No. 19; individual counseling, accompany on visits to psychiatrist; factor contributing to lack of success was the symptom of illness).

##### 3.2.2. Living Conditions with Minimum Level of Safety and Comfort for Children

SWs judged their support as successful when the children were living with a minimum level of safety and comfort..

###### 3.2.2.1. Successfully Supported

The father had been abused physically in childhood. The father hit his 5-year-old son as punishment (physical abuse). The parents could not take the son to nursery school due to their disability (neglect). The father refused home visiting services at first. However, the parents gradually accepted the services. One or more staff members visit their

home every day, so that we can assess enough information from all staff members and prevent crisis situations (father and mother with schizophrenia; No. 25; individual counseling, teaching parent skills, home visiting service, extending social support, providing respite time to parents, financial support, and arranging medication and rehabilitation service; factor contributing to success was using services as much as possible).

### **3.2.2.2. Unsuccessfully Supported**

The mother had experienced domestic violence by a partner and moved to the facility with a few months' old son. She went to a pub with a few months' old son and did not care for him because of her alcohol addiction (neglect). She had many difficulties in the facility. She signed a contract to rent an apartment and left the facility by herself. She could not care for the child enough. So, I wondered if I could provide better support (mother; addictive disorder; No. 27; individual counseling, and financial support; factor contributing to lack of success was the symptom of illness).

### ***3.2.3. Living Arrangement Suitable for the Family***

SWs judged their support as successful when the living and/or visitation arrangements were suitable for the family which means that parent(s) and child/ren lived together, or parent(s) and child/ren lived separately but met in a comfortable way. SWs believed that living at home is better for children than living at child welfare facilities, and living with a father and mother is better than living with a single parent. However, living separately is sometimes better for parents as well as children. They chose suitable arrangements for each family.

#### **3.2.3.1. Successfully Supported**

Before the mother gave birth, she became homeless and her treatment was interrupted. Therefore, the baby grew up at an infant welfare facility and she was admitted to a psychiatric hospital and the treatment was restarted. Before hospitalization, she started a relationship with the baby's current father (not biological father). Staff in the facility supported the baby well. Eventually, the baby could visit with parents, with the assistance of the grandmother, and then could live with the mother and father. The baby grew a lot at home. Living at home is better (mother; schizophrenia; No. 13; individual counseling, childrearing the baby in facility, referral to psychiatric treatment, financial support; factors contributing to success were psychiatric treatment, and collaboration with grandmother).

#### **3.2.3.2. Successfully Supported**

The mother experienced domestic violence by her previous husband and left him. She was believed to be codependent on her 16-year-old boy and he committed violence against her and his younger brothers (domestic violence). The oldest son lived with grandparents stably and met the mother regularly. The mother lives with her other two sons. I do not think that it is best for the child lives with the mother. The family needs an adequate sense of distance from each other. The adequate distance allows them to live comfortably (mother; adjustment disorder and personality disorder; No. 14; individual counseling, providing support for children and mother by therapists, providing respite time to mother, involving grandparents, financial support; factor contributing to success was support by grandparents).

### ***3.2.4. Independence of the Family***

SWs judged their support as successful if the family was able to live independently.

#### **3.2.4.1. Successfully Supported**

The mother hit her 4-year-old twins when she became irritated (physical abuse). I supported sending her twins to nursery school to reduce her burden of childcare. She began to work at a part-time job. She sometimes complained to me about work, but she continues to work and has a connection to society (mother; personality disorder; No. 17; individual counseling, providing respite time, and referral nursery school; factor contributing to success was change in the mother).

### ***3.2.5. Growth of Children***

SWs judged their support as successful when the children grew normally. Normal growth was indicated by living independently, adjusting socially, and living as typical children.

### **3.2.5.1. Successfully Supported**

The mother had been abused in childhood. She had sometimes physically abused her daughter in early childhood, and had slit her wrist in the front of her daughter (physical and psychological abuse). She became extremely irritated when she found out that her daughter had emailed her friend at midnight, and she threatened her then 12-year-old daughter with a knife. Since then, her daughter has been living with her grandparents and the mother has been living alone. Several staff have provided counseling continuously to this family from since the daughter was 3 years old. Her daughter is almost 18 years old. The daughter found work at a big company. The daughter wants to live separately from her grandmother's home and live with a boyfriend in the future (mother; depression; No. 29; regular counseling to mother and child separately, and financial support; factors contributing to success were changes of the mother and child).

However, SWs judged their support as unsuccessful when the children could not be typical children.

### **3.2.5.2. Unsuccessfully Supported**

The daughter was 4 years old with developmental issues. The mother loved her child but had low self-esteem. When the mother drank and could not take her daughter to nursery school, she blamed herself and tried to jump from the balcony of the apartment in the front of her daughter (psychological abuse). I have supported the mother and the daughter. One day, I visited home and asked the daughter, "What do you want to eat for dinner?" The daughter said, "Frozen food is okay." When the mother did not prepare lunch, the daughter said, "Mother is not wrong." I thought they were experiencing role reversal (mother; depression, adjustment disorder, and personality disorder; No. 20; individual counseling, referral to special training program for children with developmental issues, and referral nursery school: factor contributing to the lack of success was the child's developmental issue).

## **3.3. Support Skills Used by SWs For Parents with MD**

SWs supported parents with MD with the following support skills: "assessment of the needs of the family," "assessment of and support to relationship with parents," "assessment and support of the growth of children," "assessment and support of child-raising by parents," "assessment and support for stable medical condition of parents," "support by cooperation with other related agencies," and "continuing support for being an independent family."

### ***3.3.1. Assessment of the Needs of the Family***

SWs first assessed the needs in parents and children, in order to have a rough idea of goals of support.

The mother came to the facility with her 2-year-old child. The child said to me the next day, "I could have slept on a futon (Japanese bed)." They slept on the floor without a futon at home (mother; anxiety disorders and obsessive-compulsive disorder; No. 2).

The mother said, "We hope to live together one day." The daughter persisted in many things. The mother taught her the general rules of society. However, the mother could not stop drinking, and the daughter had mental retardation. I assessed that the mother could not live with the daughter (mother; addiction; No. 30).

### ***3.3.2. Assessment of and Support to Relationship with Parents***

SWs assessed the characteristics of the relationship of parents, tried to build a consultative relationship with parents, and to support parents' ability to build relationships with others.

SWs assessed problems in relationships with others when the parents recounted different narratives depending on who they were speaking to, were good at lying, shouted aloud when they could not get their own way, had several broken relationships, could not refuse requests from others, spoke in a distorted way, and so on. SWs assessed difficulties in establish consultation relationships with parents when the parents refused involvement and kept relationships superficial.

The mother insisted on her bad health at the hospital. I thought that she did not want to care for her own child. If she is hospitalized, the child will go to a facility (mother; personality disorder; No. 11).

The mother refused our home visits. She said, if I come to the home at 9 pm, she would allow me to meet the child for a minute. Therefore, I visited the home at 9 pm. However, she prohibited me from talking to the child (mother;

personality disorder; No. 23).

SWs try to build consultative relationships with parents by understanding them, accepting them, talking about issues collaboratively, focusing on their strengths, continuing to involve, building relationships with the children, interacting with someone the parent relies on, keeping a comfortable distance with the parent, arranging the environment to support their mental stability, and supporting navigation between related agencies.

She had withdrawn from high school because of bullying, moved around work places, and changed partners. The mother's life was full of trouble (mother; personality disorder; No. 8).

The mother confessed to me, "All I have said is lies." I said her, "Concealing lies was painful for you." She told lies because she wanted to talk to the staff (mother; personality disorder; No. 5).

I became friendly with the child to build a relationship with the mother. I think that it is the best aspect of building a relationship with the parent (mother; depression; No. 22).

Having distance from the parent is important to not make her confused. (mother; personality disorder; No. 8).

### **3.3.2.1. Unsuccessfully Supported**

The mother became angry with the staff. Another staff member came to her and listened to her. Interaction with the mother was not the same among staff members. She became confused (mother; schizophrenia; No. 12).

SWs supported parents' ability to build relationships with others by helping them express their feelings and teaching social rules.

She did not know social rules. I taught her rules so that she can work in the community (mother; addiction; No. 6).

### ***3.3.3. Assessment and Support of Growth of Children***

SWs assessed the growth of children through the occurrence of abuse, relationships with parents, relationships with others, and mental health condition of children.

I received a call from the nursery school that the father had not taken the child because he wanted to scold the child who had shoplifted. I visited home and saw that he hit the child with his fists many times (father and mother with schizophrenia; No. 25).

The child who lived in a facility struggled terribly and used disrespectful language towards to SW, "Come out" and "Leave me soon." (mother; personality disorder; No. 31).

SWs supported the growth of children by being mediators between parents and children, assessing the success of relationship between parents and children, and helping the children live without parents.

The mother wanted the child to go to high school because she did not go to high school and had faced difficulties in her life. She did not want the child to face the same difficulties that she had. I repeated her words to the child. (mother; addictive disorder; No. 21).

### ***3.3.4. Assessment and Support of Child-Raising by Parents***

SWs assessed the child-raising ability of parents, and the effect of characteristics of illnesses and disorders on the occurrence of abuse. Some parents could not control their emotions well and easily became angry. Some could not build emotional relationships with their children.

The father shouts as soon as the child does not do well (father; schizophrenia; No. 25).

The mother is expressionless and seems not to be attached to the child. A lack of emotional relationship between mother and child can have a serious effect on the child (mother; schizophrenia; No. 28).

Due to characteristics of mental disorders, SWs assessed that some parents could not raise children well.

The mother cannot teach her children lifestyle habits such as daily routines, brushing teeth, and eating meals (mother; addictive disorder; No. 21).

The children had an unpleasant body odor. The pediatrician told the mother to be careful in the home to care for children with allergies. However, she is not capable (mother; depression, addictive and adjustment disorders; No. 20).

The mother could not make milk in the right way. She added cold water to hot milk (mother; schizophrenia; No. 25).

The mother did not take the child to hospital to treat a cleft palate (mother; addictive disorder; No. 21).

The mother holds the child and does not let the child go to school (mother; schizophrenia; No. 19).

The child became friendly with a caretaker. The mother thinks that the caretaker says nasty things about the mother to the child (mother; schizophrenia; No. 19).

SWs assessed the ability and relationships of the family as a whole.

The mother said to her husband (child's father), "Are you annoyed with me? Tell me 'I love you'." I heard it and think the mother wanted praise from her husband and not from us (mother; depression, adjustment and addictive disorders; No. 20).

The grandmother is old but very smart. She consulted the child's school by herself (father; schizophrenia; No. 18).

SWs supported the family to be able to raise children by teaching them carefully, compensating for care for the children by using services, and coordinating cooperation with other relatives.

I was worried about whether the mother could raise the baby. Therefore, I arranged for her to learn how to raise the baby at a public maternity center (mother and father with schizophrenia; No. 25).

The mother hesitated to use home helpers. I cleaned trash-filled rooms by myself. Then, the mother recognized the merits of using home helpers (mother; depression; No. 22).

I asked for help from the grandmother. However, to avoid too much burden on her, I asked her to tell me anytime when she felt it was difficult (mother; schizophrenia; No. 13).

### ***3.3.5. Assessment and Support for the Stable Medical Condition of Parents***

SWs assessed the medical condition of parents by assessment of diagnoses and signs of worsening symptoms, and supported the parents by helping them see and collaborate with psychiatrists.

I was not overconfident with the diagnosis by the psychiatrist. I assessed the diagnosis by myself (mother; neurotic disease; No. 9).

The mother frequently said, "I cannot be here." She was experiencing withdrawal while the child was inside the room (mother; schizophrenia; No. 19).

The mother said that she could not visit a psychiatrist alone but did not want to go with an attendant SW. I discussed with her and accompanied her on the way to the psychiatrist (mother; personality disorder; No. 5).

The psychiatrist is collaborating with us. We discussed the necessity of hospitalization before the mother's doctor visit (mother; personality disorder; No. 10).

SWs experienced difficulties in collaborating with psychiatrists. Therefore, some SWs judged that their support to the parents was unsuccessful.

#### ***3.3.5.1. Unsuccessfully Supported***

I could not share the mother's unstable condition with the psychiatrist. The mother has committed suicide (mother; schizophrenia; No. 20).

### ***3.3.6. Support by Cooperation with Other Related Agencies***

Families with issues with child abuse and MD require services and support provided by related agencies in many departments. SWs coordinated with other related agencies, held case conferences, shared information on cases, and shared plans and goals for support.

I invited police officers to a case conference and asked for recommendations. A police officer said that we should visit the home and that they would help if something dangerous happened. With the cooperation of police officers, we visited the father to negotiate hospitalization (father; schizophrenia; No. 18).

SWs judged their support as unsuccessful when they could not collaborate well.

### **3.3.6.1. Supported Unsuccessfully**

I think we should have helped the mother to be hospitalized earlier. Despite many agencies being involved with the family, nobody said this and no one could get the mother hospitalized. (mother; schizophrenia; No. 12).

### **3.3.7. Continuing Support for Being An Independent Family**

SWs supported the family to live independently by supporting parental economic independence and supporting them in their roles as parents, having parents and children living together, and continuing to support the family for a long time.

The mother wanted to work. I supported her to gain a mental disability certificate and to be able use professional support for working (mother; depression; No. 29).

We want the parents to change themselves and play roles as parents in the future. All staff of related agencies involve them sincerely (father and mother with schizophrenia; No. 25).

Parents and children need mental preparation if the children live in facilities. I waited until the child would agree reluctantly to stay in a facility, after the child experienced the mother being unable to stop taking drugs on many occasions (mother; addiction; No. 15).

The older sibling meets the mother sometimes. I take time and pay attention to the times when the mother and older sibling live together. (mother; adjustment disorder and personality disorder; No. 14).

I have supported the child for over 10 years (mother; depression; No. 30).

Life is long. The mother may have trouble one or two times in the future. I will continue to support (mother; schizophrenia; No. 12).

## **4. DISCUSSION**

### **4.1. Diagnoses of Mental Disorders and Difficulties in Support**

Of 32 cases picked up by SWs, 30 were mothers. Based on the Japanese government's report, 52.4% of parents who abused children were mothers, and 34.5% were fathers [1]. The current study's sample includes three SWs working at maternal and child living facilities, where only the mother and not the father lives. That is one of reasons why most parents were mothers in the current study. One more possible reason is that parents who are supported by SWs to build a stable family are not the perpetrators of the abuse. If the father is the perpetrator, SWs are likely to support only the mother and children.

Almost half of the diagnoses in the current study were for addictive or personality disorders. Regarding death by child abuse, half of the child-raisers were addicted or had personality issues [6], and 10–30% of abused children had parents with alcohol or drug addiction or personality disorder [6]. Substance addiction is recognized as a kind of addictive behavior as well as an addiction to abusive behavior in child abuse [9]. One type of child abuse is a disorder in relationships [10]. Child abuse, personality disorders, and addictive disorder, may have a similar basis, which may be identified at the same time [9]. The similarity of the inner nature of personality or addictive disorders, and child abuse may be likely to emerge at the same time. Moreover, these disorders generally cannot be treated with medication. Therefore, long-term involvement of SWs may be needed.

### **4.2. Goals in Support Perceived by SWs**

Although SWs supported the parents and children living together, they recognized that this sometimes cannot be maintained. SWs supported a more comfortable and realistic living style for each family. This coincides with the definition of family unification in Japan [11]. In Japan, of the children who have parents with MD and live in child welfare facilities, half are likely to be abused by the parents with MD [12]. Twenty percent of mothers in maternal and child living support facilities have MD and take medication [13]. In the current study, some families could not be unified due to worsening medical conditions. SWs must be more sensitive to medical conditions and work to collaborate with psychiatrists.

SWs supported the families living independently, so they supported working for economic independence. In Japan, there was a strong relationship between families with child abuse and low income [14]. Supporting families to live independently is important to prevent child abuse.



### 4.3. Support Skills by SWs For Parents with MD

In the current study, SWs had many assessment perspectives and used many ways of building relationships with parents. The addictive and personality disorders impact relationships with others. Those with severe mental disorders including schizophrenia and mood disorders usually have difficulties in communication. Some of the parents do not visit the psychiatrist or take medication; therefore, the symptoms become worse while parenting [7], as in the current study. With this context, SWs need high-level support skills to build relationships with such parents. Previous research in Japan reported that skills to maintain relationships with people with MD were important [15], and that practitioners used specific support skills to encourage parents with MD to accept support [16]. Building relationships with parents with MD is considered a very difficult and important support skill. There are no systematic training programs about parenting with MD for practitioners in Japan. In other countries, training programs for practitioners did not focus on building relationships with parents [17]. The current study revealed how to assess and how to support building relationships with parents with MD, which may be beneficial in other countries.

SWs assessed and supported the stable medical condition of parents. A national guideline of child abuse in Japan recommended collaborating with psychiatrists to support parents with MD [18]. However, in the current study, SWs found difficulties in collaborating with psychiatrists and failed to support parents. Previous research reported that 60% of SWs in child abuse department recognized good relationships with other child welfare agencies; on the other hand, only 30% recognized good relationships with mental health agencies [12]. SWs in child welfare departments are not usually familiar with mental health services and psychiatrists. Therefore, SWs may consider collaborating with practitioners in mental health departments.

### 4.4. Implications For Practice

The knowledge and skills described in the current study are useful in actual practice. This will be helpful for SWs who work hard and deal with difficult parents in communication. Second, promoting collaboration with agencies between child abuse and mental health departments will be helpful to communicate with psychiatrists about parents with MD. Such smooth communication with psychiatrists may lead to suitable medication and appropriate treatment.

### 4.5. Research Limitation and Future Research

Due to the design of this study, the result cannot be generalized. Next, the participants were mostly mothers. Therefore, support for fathers with MD cannot be described in the current study. Although most of the existent research on parental MD has focused on mothers, fathers have unique difficulties in child-raising [19]. Support skills by SWs for fathers are recommended for future study.

## CONCLUSION

Eight SWs provided 32 cases of parents with MD. Almost half of diagnoses were addictive or personality disorders. SWs supported more comfortable and realistic living styles for each family, and supported the families to live independently. SWs had many assessment perspectives and used many ways of building relationship with parents and supporting insufficient parenting. However, SWs must be more sensitive to medical conditions and work to collaborate with psychiatrists.

## AUTHORS' CONTRIBUTION

M.K. planned the research design and carried out the data collection, analysis, and manuscript preparation. K.Y. participated in research design. All authors read and approved the final manuscript.

## ETHICAL APPROVAL AND CONSENT TO PARTICIPATE

This study was approved by the Research Ethics Committees, Faculty of Medicine, Osaka University (16283).

## HUMAN AND ANIMAL RIGHTS

No animals and humans were used for the studies that are bases of this research.

## CONSENT FOR PUBLICATION

The objectives of this study, voluntary basis of participation, confidentiality, and autonomy were explained to participants orally and in writing. Written consent was obtained before each interview.

## CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

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