Report

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To what extent do therapists in adult psychiatry involve the children of mentally ill patient(s)?

Abstract:

The aim and scope of this study was to examine to what extent the mentally ills' therapists involve children. Nine therapists from the psychiatric policlinic at the hospital in Namsos, Norway were interviewed. The selection of interviewees was done in order to ensure representation across the complete range of professions involved. An interview guide consisting of 12 pertinent questions was developed and employed. The results show that the informants claimed there were no known procedures for exploring the children's situation. All of the therapists reported that the sick parent(s) had brought up their personal concerns for their children in the course of treatment. Five of the informants confirmed that they had at times invited the children to participate in conversations with their parents. Only two of these had done this more than once. The explanation for why children are so seldom involved can be stringent environmental control factors, uncertainties, fear of generated increased workload, or of undertaking a more complex treatment process. Perhaps treatment in adult psychiatry is primarily focused on the mentally ill target person alone. It seems that it's socially unacceptable to examine children's circumstances in the course of treatment.

Key Words: children at risk, children of mentally ill, maltreatment, prevention

Introduction

In Norway there are approximately 100,000 children with one or both of their parents suffering from mental illness (1). Many adults who at any given time are receiving psychiatric treatment have daily care of children. A vast number of international follow up and longitudinal studies show that children growing up in environments in which one or both of their parents are mentally ill, will themselves run a higher risk of acquiring developmental disorders and illness (2; 3; 4; 5). The greatest problems arise where mental illness degrades emotional relationships. Attachment theory as described by Bowlby (6; 7) is essential for the understanding of the impact of complex, unpredictable traumas in children's lives. In the course of the past decade there has been increased focus on this issue in the media, popular social debate and politically, with the goal of establishing a holistic and interconnected treatment program

Research results from various studies involving children of mentally ill all confirm that the illness can reduce parents' ability to care for their children. Rutter (9) claimed that as early as in the 1950s one could clearly see evidence of a connection between parents' mental illness and children's developing illness and problems. According to Clausen & Huffine (8) the mental illness in one or both parents will *"often impair the child's normal development"*. When one family member becomes ill, consequences arise for the entire family. Stress research over the past years has documented that exposure to stress over time, especially in

the early childhood years, increases the risk for acquiring illness (10; 11).

Several programs which attempt to address the needs of children of mentally ill parents, both on an individual and group basis have been carried out in Norway. Among these are: "You are not the only one" (a one year follow up group for children with mentally ill parents) from Blakstad Hospital in Asker, BAPP (a ten week follow up group for children between eight and twelve years with mentally ill and / or drug addictive parents) in North Trondelag and Children's Forum (CF)[1] at Namsos Hospital run by psycho-educative principle, where the focus lies on emotional processing and education. CF is an obligatory program about offering information and responding to questions from children ages 2 to 18 whose parent(s) are receiving in house treatment at the adult psychiatric clinic in Namsos. The objective is to provide gains in children's knowledge and understanding, stress reduction, expose needs that need to be addressed and offer follow-through support. Intervention is based on the presumption that having the opportunity to talk acquire knowledge about the mental illness and its disturbing consequences will contribute to protecting children from harm. Increasing parents' and children's competency is a primary objective here.

The vast majority of parents appreciate that their therapist talk to them about their children and they acknowledge that their illness reduces parenting skills and that that in turn requires family intervention especially tailored to their needs.

It isn't always the case that these children develop mental illness, however it is known from experience that children of mentally ill are at risk, and that they can be *"subject to harm".*

[1] We use Childrens Forum (CF) for the norwegian concept "Barnas Time"

Lov om psykisk helsevern § 21b (12) lays the responsibility to comprehend and recognize the need for further intervention by child care services on health care professionals working within the framework of the law. If parents, for whatever reason, lack the ability to cope with the situation or seek assistance, then it is the responsibility of other adults to intervene on behalf of the parents as well as their children. The health care system's mandate is to treat the suffering and prevent the development of illness among those at risk. Knowledge demands responsible action. Children should be protected and all adults share the responsibility.

In spite of the enormous need, there are few studies, national or international that clearly states to what extent children of mentally ill adults are involved in treatment. Swedish studies (13; 14) confirm the neglect of children within the field of adult psychiatry. Hestmann, Vikan & Husby, (15) concludes that intervention on behalf of children of psychiatric patients is the exception rather than the rule. Kufås, Lund & Myrvoll (16) claimed that in spite of extensive documentation of risks involved concerning children of psychiatric patients, adult psychiatric treatment lacks practical knowledge of how to help these children. Håkonsen (17) was critical to the manner in which adult psychiatry took into consideration the needs of parents and children who were admitted for treatment. One study carried out by Meijde, Aashamar & Knibe (18) exemplifies how little consideration is given to children. They concluded that therapists were overprotective of their patients and unable to perceive their role in counseling their children. Within the hospital realm focus was almost entirely on the patient. Many therapists expressed fear of loosening the alliance with their patient if the children's situation was brought up in therapy. The parent role was therefore shunned. Other possible explanations offered were the fear of losing trust, and that it could add to the destructive feelings of guilt already experienced by the patient. Time restraints and rationalization demands within the policlinic also presented obstacles for involving children. It's possible

that the therapists were more focused on the children *in* the patient than the child *of the* patient. It's almost as if the child's perspective is lacking in psychiatric care. Experience worldwide point toward the benefits of as early as possible intervention prior to the manifestation of health problems (19). This is especially true in cases where there is a genetic predisposition. The earlier the onset of an unhealthy development, the less optimistic is the resulting prognosis. The foundation for a solid mental health starts in early childhood. The government's strategic plan for ensuring good childhood and adolescent health "Sammen om barns psykiske helse" (20) places special emphasis on early intervention and coping skills.

Falkov (21) pointed out the importance of noting which adults with mental illness had children and that there is an obvious need for a balanced involvement of several agencies "*in relation to child protection*". Success depends on proactive cooperation between "*child and adult service if traditional and historical interagency, specialty and geographic divides are to be bridged*". Sammen om barns psykiske helse (20) stresses the need for documentation of sound methodology in the field of preventive psychiatric health care. Research and growing knowledge may build a sound foundation for effective intervention.

Therapists play an important role as they in fact stand in the gateway of reaching these children, discovering them and eventually referring them to appropriate health care professionals such as public service nurses, BAPP, or other suitable service providers. The primary goal is to ensure a good mental health for children so that they can be equipped to deal effectively with the challenges they may face in their lives.

Rundskriv IS- 5/2006 (22) recommends the establishment of routines and procedures that screen the population of adult mental health care recipients in order to find out who have children, describe their situation and necessary follow-through intervention.

There appears, however, to be considerable gaps in this field, and as the situation in Central Norway was unknown to us, we endeavoured to reveal how therapists and other healthcare professionals relate to their patients' children. We conducted an interview study among therapists at the psychiatric policlinic in Namsos Hospital with the aim to examine to what extent the therapists involve the child(ren) to the mentally ill. In an attempt to narrow these gaps we attended to the following question

To what extent do therapists in adult psychiatry involve the children of mentally ill patients?

Method

Nine therapists from the psychiatric policlinic were interviewed at Namsos Hospital. The sample group was determined by the desire to secure the representation of all involved professions. In those professions where there were more than two therapists, a random selection of one was taken. We chose a qualitative approach in order to secure information about the therapists understanding and subjective experience of their situation. An interview guide consisting of twelve questions was put together. The answers were written down and read aloud to each informant for approval before proceeding to the next question. The interview guide was based on what we considered to be relevant for our area of inquiry, exemplified by the following questions: The informants were questioned about their education, position, when they finished their basis education and the time span of their work experience in adult psychiatry. Have any of your patients now/previously been care-providers for children? Are there to your knowledge any procedures or admittance protocols for probing about the children's situation at your current place of employment? Are there routines that either promote or discourage the involvement of children? Do you know of any intervention programs for the children of parents with psychiatric disorders and/or chemical substance

addictions? Do you feel you have sufficient competence in relation to including children? Do you believe that discussing parental roles and functionality can be detrimental to the therapeutic relation to your patient? Have you ever invited children to a conversation together with their parent(s)? Have you ever invited a child alone for a conversation? Have the parents themselves ever mentioned their concerns for their children in lieu of their illness? The interview took on average approximately 30 minutes.

The informant group consisted of five men and four women. There were two psychologists, two social workers, one specialized nurse in treating handicapped individuals, two registered nurses and two psychiatrists. The interviews were carried out in the period from October to November, 2006.

Results

The average time since the therapists completed education was 22 years, and on average their experience in the field of adult psychiatry was 19 years.

Seven of the informants claimed that there weren't any procedures that included questions probing into children's situation, while two reported that they didn't know. As to whether or not there were routines in the "*system*" that either promote or discourage the involvement of children, the response of several was that they felt the treatment needs of many of these children were not being addressed. One person claimed that CF, innovation and initiatives from the Department promote the involvement of children. The others claimed contrastingly that old attitudes, traditions, time-restraints, revenue generating demands, and the fear of losing the confidence and alliance with the adult patient were all factors which hindered child involvement. One informant claimed that it was discouraging to repeatedly be turned away when referring children to child welfare agencies.

All of the informants were aware of CF and seven of them assessed that it had influenced them to be more cognizant of and focused on children's situation and the parent role, in particular the importance of educating the children about the adult's illness. CF has been operating at Namsos Hospital the past 4 years and is therefore well known there.

The majority of our informants claim that they know of intervention programs for children of psychiatric patients and / or chemically dependent individuals. Among those the following can be mentioned: BAPP groups, public nurses, BUP family units and child welfare agencies. Seven of the informants claimed that there was little or no focus on children's situation in their basis education. Two said yes, that there was a focus on children but it was specifically on the development of disease, research and prevention without being concerned with intervention.

Four of nine claimed that they were sufficiently competent to include children. The five that answered no considered themselves lacking in the ability to communicate with children. They mention the processes that influence children, the language one uses and choice of focus. One put it like this *"children understand more than we give them credit for, but still I'm afraid to err and am apprehensive about what I can talk to children about."*

In the opinion of six of the therapists discussing the parental role and the child's situation was not detrimental to the therapeutic relationship. One informant claimed that there had never been negative feedback from patients whose children's situation had been discussed, the contrary was rather common. Response depends mostly on the manner in which the child's situation was brought up and on the words chosen. The other informants meant on the contrary that bringing this topic up was likely to damage the therapeutic relationship. One therapist claimed: "*In the worst case the patient won't come back."* Another: "*It can stir and already guilty conscience, but I know that if I take the time to see it through they will get over*

it."

Five of the informants answered yes to whether they had ever invited the children to a conversation with the parent(s). Only two had done this more than once. All five therapists, without exception felt it had been a good experience. "*The parents had conceded and that had contributed to a conversation more focused on the illness / problems."* One therapist claimed that it revealed the family's interaction pattern and that everyone was preoccupied with the sick family member. The children's experience according to the informants' perception was that the conversation was good and brought a certain feeling of relief. One said: *"it articulated aspects of the relationship between the sick parent and their child* which were *useful in subsequent treatment sessions."*

Two of the therapists had upon request or in agreement with the parents, invited children to a conversation alone. *"That exposed among other things, that* some *children had played distinct roles for each other and that one of them always had the care provider role in the family."*

All the therapists had experienced parents who, on their own initiative, had brought up the topic of their children's situation in light of their illness. Typically parents expressed themselves as follows: *"Think of how my instability will influence the children and others who are close. Afraid of overlooking the children's needs, and they will be harassed and teased and be subject to the same things I experienced when I grew up.* The therapists also report that many of the parents have guilty consciences because of their illness and lack the capacity to support them in everyday activities. Mothers express their concerns most often, although there are some men who do the same. Some worry about the part heredity may play and some report that they frequently call their mothers seeking support.

Discussion

In this study we have attempted to approach an area in which few studies nationally and internationally have been done. At the outset we had scant knowledge of the extent to which therapists involve children.

Our findings suggest that therapists are more cognizant of children's situation after the establishment of the Children's Forum program at the in-patient ward. Nonetheless, it seems that clinical practice at the policlinic remains unchanged with regard to a systematic involvement of children's experience in coping with their mentally ill parents.

All of the informants claimed that several of their patients are currently, or have previously been, care providers for children. Potential patients are always met with questions as to whether or not they are child care providers. Without exception the therapists in our study claimed that there weren't any admittance procedures for exploring children's situation. This represents a violation of the recommendations given by the Rundskriv IS- 5/2006 (22).

Our study shows that only two of nine therapists had invited children alone to conversations in order to find out more about their situation. This was not to be expected in light of the many reports on parents expressing their concerns for their children. Several therapists seem to feel they have involved the children merely by asking parents about them. After four to five years of experience with CF we wonder whether all of these parents are able to take the perspective of their children and adequately perceive their needs. There is a huge discrepancy between the knowledge the majority of therapists have of the various intervention programs for children of mentally ill parents, and the lack of concrete follow through referrals on their behalf. It seems as if therapists to a certain degree think about the children's situation but

something keeps them from taking active measures for them. In that way this study is in agreement with Meijdes findings (18).

Parents clearly express their awareness of how their mental condition can adversely affect the development of their children. In that regard, the parents are not being taken seriously. Then one may ask why so? The informants give us no clear cut answer. It may be that the framework of the milieu is a dominating factor, uncertainty, or a conscious or for that matter unconscious way to avoid additional work. It may also be a fear of generating a more complex work material.

Approximately half of the therapists claimed to have the competence required to invite children and six of nine meant discussing the parental role in itself bore no negative consequences. Then it seems all the more peculiar that so few take the child's point of view, invite them and listen to their story.

More than half of the therapists feel they lack the competence required to counsel children. Ideally this acknowledgement should spur them to refer the children to appropriate professionals. If CF had been an obligatory treatment program at the policlinic, therapists would more likely refer them there. Then more of these children would be seen and heard, needs revealed, and individual follow-up intervention offered. We base this belief on our experience from CF at the in-patient ward.

The present study shows that the involvement of children is strikingly rare at the psychiatric ward were our informants worked. In that regard preventing the development of illness in the coming generation seems to gain low priority, in spite of sound empirical documentation of the influence parents' mental illness can have on children.

The informants in this study tell that children of the mentally ill aren't included even when

therapists do not fear loss of their therapeutic alliance. The situation may be due to the treatment paradigm which doesn't take the preventive aspect into account. Treatment is focused on the patient to whom it was prescribed. Traditionally, impaired functioning and illness have been the overriding principles for the formation of health care intervention, which in turn has diminished the emphasis placed on mastering and resource focus. Possibly, therapists lack sufficient knowledge of risks facing children and subsequently relinquish themselves from any responsibility for taking appropriate measures. This is especially true in cases where there isn't any explicit expectation that active measures be taken on behalf of the patient's child.

It's almost as there is a social sanction for focusing on the situation of the children. One reason for not inviting children can be that therapists just can't bear to listen to what these children are subject to. Nor is there a tradition to probe further into such sensitive areas. The childrens´s situation seems to be left in silence. Possibly some of the therapists believe their silence is a protective measure. The child´s welfare may then be forgotten in order to secure the welfare of the sick adult. Clemency and isolation can rob the child of the possibility of dealing adequately with their stressful situation. Our study shows that intervention on behalf of children of mentally ill patients is the exception rather than the rule.

An important objective for our study was to gain knowledge of therapists practice on the involvement of children of patients' in house treatment. Eventually we hope to lay a foundation for improvement in the mental care given to these children, for instance increase the consciousness about the children's situation.

The study clearly shows that the degree in which involvement of children is low. In order to improve practice it will be necessary to raise the awareness of children's situation and the availability of suitable intervention programs. A standard admittance form for new referrals

should clarify the responsibilities and obligations for patient *and* child. Their relationship may then be an important focal point of treatment sessions at the policlinic. It is mandatory that therapists become aware of the importance of attending to the needs of both parents and children by establishing arenas where the child's story can be heard and where the whole family is offered necessary help.

Therapists at the policlinic have a unique opportunity to explore children's situation and intervene on their behalf, and on behalf of the children´s mental health it is imperative that this opportunity is fully exploited. The therapists know that the parents are struggling with their mental illness, while this is not always the case for public nurses. He / she will not automatically talk about this subject without prior information or a referral concerning this matter. At the clinic level it is necessary to establish good routines which ensure that all children with presenting needs are involved in the treatment program. Therapists differ in how comfortable they are with discussing the child's situation or counselling them. In that regard it would be most beneficial if those with a genuine interest sharpened their child counselling skills. They must, of course, cooperate closely with the patient's therapist as this may positively influence on subsequent therapy sessions. Through the establishment of mandatory programs for parents and children hospitals will we send a signal to parents that this is a "*normal*" standard procedure, thereby removing considerable resistance in choosing to accept the offer. Up to the present day most hospitals communicates to mentally ill parents that it is in fact difficult and unwanted to talk about their children.

We have, however, to put in mind that results from our study are not necessarily transferable to other arenas/contexts. More studies needs to be are carried out to improve our knowledge and practice in this field. We do not yet know how to organize
adult psychiatry in a way that optimize the needs and possibilities of patient´s children.

In the future we would view those results as a valuable supplement to the results generated here.

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