

Promoting children's resilience to parental mental illness: engaging the child's thinking

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SUMMARY

The negative effects of parental mental illness on children are not dependent on the parent's diagnosis, but are related to that parent's behaviour, the responses of other key adults (both familial and professional), and the degree to which development of the child's resilience has been encouraged. Parental mental illness can be responsible for serious interruptions in a child's cognitive and emotional development, which in turn can have implications for their future mental health. Resilience can be promoted by relatively simple interventions, but these require the active participation of both adult- and child-focused professionals involved with the family, particularly those concerned with the parent's treatment.

DECLARATION OF INTEREST

None.

In a previous article (Cooklin 2010), the effects of parental mental illness on children were summarised as fears for themselves and fears for the ill parent and/or for the family (Box 1). Other effects on the child's life included:

- lowered standard of living, with financial hardship
- possible separation of the child from the parent/s if the child is placed in care, with differing and potentially confusing care patterns as a result
- disruption of education, underachievement and reduced life chances.

In *Parents as Patients*, the Royal College of Psychiatrists (2011) stresses that children and young people need not only to influence services in a general way, but that they can also play a positive role in and contribute to the decisions about their parent's care. The report states that (p. 17):

'Many young carers have multiple responsibilities, such as caring for several members of the family; mediating family conflicts; seeking out help for the "looked-after" person (Grant 2008),

and that

'Their caring role can restrict opportunities for social networking and peer relationships and reduce time spent on leisure activities. Young carers themselves may have physical health problems, emotional and educational problems and may suffer from stigma by association with the parent who has mental health or substance misuse problems. They may fear professional involvement as it can lead to separation and/or public hostility, and are less likely than other carers to receive a carer's assessment (Stanley 2003).

Article 12 of the United Nations Convention on the Rights of the Child states that children have a right to be listened to and have their views taken into account on matters that affect them' (p. 17).

Perhaps more importantly, the authors of those publications have explicitly listened to what children and young people have said. As Bilsborough (2004) reported, of ten demands of mental health professionals by young carers from the Liverpool Barnardo's programme, 'Introduce yourself', 'Tell us who you are and what your job is' and 'Give us as much information as you can' were top of the list.

There is evidence of increasing concern, both nationally and in selected international services, that the needs of children and young people who

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BOX 1 Impacts of parental mental illness on children

Fears for themselves

- That they will develop the illness
- That they will be blamed for either causing the illness or for failing to protect their parent
- That they face contradictory expectations: to be 'grown up' and 'a carer' at home but a child at school, or contradictions between the expectations of different parents or even within the same parent between his or her 'ill' and 'healthy' self
- That they will be bullied, singled out and/or stigmatised openly by other children and more subtly by adults, on account of their parent's illness
- That they will lose or fail to regain the closeness they may have enjoyed with the ill parent

Fears for the ill parent and/or for the family

- That the ill parent will not be cared for properly, may not recover, or may get 'worse'
- That the parent/couple/family will not survive, and the child will be taken into care
- That the family will become the object of shame and stigma

have mentally ill parents must be addressed. In Australia, the national children of parents with mental illness (COPMI) services are an explicit recognition that this group of children and young people require specific attention. In the UK this need was given some priority by the 'Think Family' initiative. Although this initiative was later partly withdrawn following a change of government, the Social Care Institute for Excellence report *Think Child, Think Parent, Think Family* (2009) is still accepted as providing national policy and implementation guidelines. However, the responses of professionals, and in fact the stress in nearly all reports and recommendations, is on:

- professionals working together – often without defining what they should in fact do if they do work together
- doing things *to* children and young people, rather than engaging their active participation.

Thus, many interventions aimed at helping these children have focused on the care network. In this article, the goal is to consider what may enhance children's capacity to be aware of their need to protect themselves and to distance themselves from the invasive elements of the parent's emotions and behaviour, i.e. what may promote the children's resilience. The term resilience in relation to an individual's psychological functioning was first used by Werner (1971, 1982). The original focus of the study of psychological resilience by Garmezy (1973, 1974) was of factors in the children of parents with schizophrenia that might protect them from developing the illness. Psychological resilience in children has been defined as their capacity to successfully adapt to adversity, despite challenging or threatening circumstance, owing to their individual characteristics (rather than shared cultural factors), which may be specific to particular kinds of adversity, such as parental mental illness, trauma or loss (Rutter 2008; Masten 2009).

The need to work across disciplines and agencies in the best interests of children is not in dispute, and in some situations children do require that rapid and effective safeguarding action is taken. However, as can be deduced from the content and tone of the aspirations of the young people quoted by Billsborough (2004), they want to be personally involved in any interventions directed at either their parent/s or themselves, and they want their own thinking to be taken seriously (Box 2). This is not surprising when one considers the weight of care, responsibility and thinking which may have been demanded of them for prolonged periods as a result of their parent's illness. From over 200

children and young people who have attended the Kidstime project (to which I will return later in this article), compelling anecdotal evidence has demonstrated that when a child's views are both listened to and acted on, at times even a relapse in the parent's illness may be successfully aborted. In one case presented at the Nordic Forum (Cooklin 2011), two sisters of 17 and 15 called the crisis team to ask for help as they believed that their mother was about to relapse. The mental health worker reassured them that she was symptom free, but they later insisted and their mother was seen by the team psychiatrist, who agreed with their suspicions. Thus, the attending psychiatrist allowed the view of the children to prevail over the opinion of the mental health worker, and the parent's medication was urgently reinstated.

The fear of 'catching' the illness

Genetic and environment interactions

Many children will have heard comments about mental illness such as that 'it runs in families'. Subsequent comments and discussions, even by well-meaning adult family members and friends, as well as peers, commonly compound the child's fear and confusion about their own predisposition to develop a similar illness to their parent. The

BOX 2 What children say they need

In a series of audits in the UK, Scandinavia and Australia, children have consistently prioritised their needs as follows:

- 1 A 'two-way' explanation of the parent's illness which provides clear, understandable, but substantive information, while heeding and taking account of the child's own knowledge about the parent's condition.
- 2 Access to a neutral adult with whom the child can discuss the illness, who can be contacted in times of crisis and who can act as the child's advocate.
- 3 An opportunity for the child to address their fears: that they will 'catch' the illness, that they 'caused' the illness, that the parent may die from the illness and/or that they will not see the parent again.
- 4 Interventions to diminish the child's social isolation: learning that they are not 'the only one' with the problem, meeting other young people with similar experiences.
- 5 Rebalancing the child's 'inverted' role as carer within the family: opportunities to do childish or youthful activities with other young people, sharing the load of responsibility with one or more adults.

All of these are consistent with the list reported by Billsborough (2004).

aggregated data suggest that if a child has two parents with mental illness they have a 30–50% chance of becoming seriously mentally ill (Rubovits 1996), and a child with an affectively ill parent has a 40% chance of developing affective disorder by age 20, compared with a 20–25% risk in the general population (Beardslee 1983; Royal College of Psychiatrists 2011).

However, although some mental illnesses have been shown to be associated with an inheritable vulnerability, Rutter & Silberg (2002) have stressed that gene–environment interactions are as important as direct genetic effects. Particular factors in the child's environment have been shown to significantly mitigate against their risk of developing mental illness. At the extreme end, these include adoption, depending on the quality of the adoptive family. The Finnish adoption study (Tienari 1985, 1994, 2004) has demonstrated that a high-quality care environment can offer a significant degree of protection even to children with a high genetic predisposition to schizophrenia.

Offering an explanation

On the other hand, quite small interventions have been shown to increase children's resilience in ways that can provide them with a significant degree of protection. A number of studies suggest that the resilience of children and young people is significantly enhanced when they receive clear and understandable information about the sources of their adverse experiences (Koocher 1974; Rosenheim 1985, 1986; Rutter 1999; Dyregrov, 2001, 2010; Bostock 2004), and many reports confirm the positive benefits of a neutral, caring adult helping the child to appraise their situation more objectively (Quinton 1984; Shachnow 1987; Rutter 1966, 1990; Cowling 1999). A small study by Falcov (1999, 2004) demonstrated that children who had received just a good explanation of their parent's mental illness scored lower for 'caseness' or signs of disturbance in themselves on objective measures compared with a control group who had received no explanation. In the resilience research (cited above), holding the belief that there is something one can do to manage one's feelings and 'cope' has been found to be a significant factor in the promotion of psychological resilience. Such a 'belief' requires that one has a good understanding of the source of the adversity which one is enduring.

However, questions about how, when, where and by whom this explanation is to be delivered is often the sticking point. Despite the now statutory requirement that all mental health services in the UK ensure (and audit) that the views of children and young people about the care plans for their

parent's treatment are elicited, relatively few children and young people are talked with directly about the nature of their parent's illness.

I therefore invite mental health staff to focus on what they can and should do to assist this group of children and young people by helping them with their own thinking, understanding and feeling about their parent's illness and their own responses, rather than focusing only on structuring or monitoring the child's environment. Although an assessment of a child's resilience in this context has to be principally based on the child's own perception of their well-being and capacity to cope, equipping them with greater knowledge and understanding of their parent's illness is a significant factor in promoting that resilience.

Professionals faced with concern about the fate of these children may sometimes offer therapy or counselling to a child without first exploring the child's own thinking and opinions about what this may mean to them. Many of the children in the Kidstime project, as well as reports from the Barnardo's group (Bilsborough 2004), have challenged the common assumptions of some professionals that children might need greater access to counselling and other therapeutic resources. These children have stressed that they want to see a greater awareness of their needs and problems in the minds of both the professionals and the public, rather than themselves being singled out for 'some form of therapy or counselling'. This of course does not mean that some children will not need or want therapeutic intervention, either with their family or on their own, at some point in the future. However, an offer of therapy as a first response may seriously misjudge the child's perception of their predicament. For example, a child's role as carer has meant that they may have had to take on great responsibility for family matters which they need to have acknowledged. Therefore, the response of professionals needs to be more that of a friendly 'colleague' or a respectful uncle or aunt, than the formal and inevitably hierarchical role in which a therapist or counsellor may be perceived by the child.

Children identifying with the ill parent

Many children who have a mentally ill parent strongly identify with that parent: they see themselves in and model themselves on the parent. Of course, most developing young people identify with the parent of the same gender, but if a parent has a mental illness the identification is likely to be enhanced and to cross gender boundaries. A child who is concerned about and preoccupied with an ill parent is likely also to become preoccupied with

the details and nuances of that parent's thinking and behaviour. As the child's mind is filled with thoughts about the parent, they may become hyper-alert to the slightest similarity between the parent's thinking and feelings and their own. Although many children in this situation may say that they are determined not to become like the ill parent, this statement is often itself predicated on an assumption that this may occur. Thus the child or young person may need to be helped to separate from some aspects of the parent's mindset before they can adequately engage in their own thinking. The kinds of explanatory discussions described later in this article are targeted at helping the child or young person to achieve some distance from the parent's emotional life and behaviour so that they can develop their own thinking. Offers of therapy or counselling may be misconstrued as confirmation that the child will follow in the parent's – ill – footsteps. This has to be distinguished from the need for someone to talk to, as identified by Shachnow (1987), Quinton & Rutter (1984) and Cowling (1999), the offer of which can often be introduced in the course of an 'explanatory' discussion.

Therefore in the range of interventions presented here, a key focus will be the role of explanations discussed with the child.

What does the child and young person require protection from or help with?

The social needs for support in daily living, caring for the parent and maintaining the child's education have been well defined in the Social Care Institute for Excellence guidelines (2009).

Despite the universal need to make sense of the parent's behaviour, children of different ages and from different cultures and/or family compositions (lone parents, only child *v.* availability of 'safe' alternate parent, members of extended family and siblings) will to some degree have different needs. However, there are two specific areas in which the children child will need either protection or remedial help:

- interference with their cognitive and emotional development as a result of distortions in their interactions with the ill parent caused by the illness;
- invasion of their thinking by delusional or severely distorted beliefs expressed by the ill parent.

Both of these factors are likely to be enhanced if the family is socially isolated and stigmatised, and perceives the world outside the parent-child relationship as hostile.

Parental mental illness and the interruption of key developmental processes

Recent evidence from practitioners of Marte Meo educational counselling (Øvreeide 2011) has confirmed the findings of earlier studies (Trevarthen 1979, 1993, 2001) that the congruence of early verbal and non-verbal responses of a child's primary carer is critical in the child's development of a capacity to label their own emotions and responses. This is almost synonymous with the development of a capacity for mentalisation (Sharp 2008). When a parent reacts with withdrawal or with ambiguous responses to a child's early overtures, this developmental process can be seriously interrupted, and a pattern of parent-child interaction may ensue which further detracts from the child's ability to think about emotional relationships, rather than just react to them in an often erratic and impulsive manner.

Engaging children in understandable discourses with the ill parent, as well as with others, can be a first step in promoting the child's mentalising ability. Although explanation of the parent's illness with the child has been repeatedly stressed in this article, it is not a single end goal. Explanation, as a platform of discussion, opens a whole range of discussions about relationships in general, as well as specifically about the parent's illness. Within that 'educational' framework, a child can feel freed up to think about many wider issues in family relationships and thinking. On the other hand, common intervention strategies directed solely at the illness of the parent have been reported to compound the difficulties experienced by some children in developing this capacity, particularly if they are offered no explanation or an explanation which is incongruent to their experience (Cooklin 2006c).

The beginnings of a capacity for mentalisation, as well as the cognitive ability to understand and retain an explanation, are also going to be affected by the child's neuropsychological development, as well as the environmental experiences which will have impinged on the latter (Fonagy 2004; McCrory 2010). In the 150 children and young people seen in the Kidstime programme, children who were either pre-verbal or had poorly developed language skills at the time of, for example, their parent's first hospital admission, seemed to continue to manifest higher levels of anxiety about the ill parent. Despite being subsequently able to learn and comprehend an explanation of the illness, they often seemed unable to connect this to their earlier experience which was without a scaffold of words (further details available from the author on request).

The need for a child to learn to identify their own emotions and experiences is universal across all social contexts and cultures. However, their opportunities to achieve this will be dependent on their age, abilities, culture and family form:

- a child with a good relationship with a 'non-ill' parent may be significantly protected from this problem;
- good relationships with siblings may also offer a significant protective factor;
- in cultures in which children are not encouraged to express their feelings, the child may be particularly dependent on an outside supportive adult (such as a teacher or young carer's worker) to overcome this potential deficit;
- a child with well-developed language skills, particularly if they are in a context where these can be used, such as a young carer's group, will have more potential to develop resilience than a more isolated child with poor or undeveloped language skills.

Invasion of the child's thinking

Although no argument is needed to suggest that it will be detrimental for children to take on the delusions expressed by an ill parent, it is as much, if not more so, the process whereby these delusions are adopted by the child which place the child at emotional and developmental risk, rather than the content of the delusions themselves. Although a '*folie à deux*' represented in truly fixed delusions would be rare, many children and young people have reported that in times of acute stress and confusion they have 'seen' what their parent may have described, adding 'even though I knew it wasn't there'. The content may be foreboding or frightening, such as claims that an evil process (e.g. the Devil) is controlling events, or it may engender an overall fearsome and suspicious stance by the child when, for example, a parent claims that they are being watched, or that their thoughts are being read by the television, the police or the government. However, for a child to adopt such views may depend on several factors such as those listed in Box 3 (see also the fictitious vignette in Box 4).

In the vignette in Box 4, it is unlikely that the children actually took on or experienced the mother's delusions. It rather suggests a survival strategy adopted by the girls, which meant that they temporarily took on their mother's overall belief system when it conflicted with the beliefs of others. Naturally, the mother's threatening behaviour as well as the daughters' concern for her, will have greatly heightened their level of

BOX 3 Factors influencing the child's thinking

- The child is intensely identified with the ill parent
- This identification may have become enhanced by attachment difficulties (Weinfeld 2008), particularly anxious attachment
- An alternative parent is either not available or is distanced from or kept outside of the closeness of the ill parent-child relationship
- Either there are no siblings to counter the intense parent-child attachment or they are also caught up in the delusional perspective
- The child perceives the ill parent as powerful and at the same time requiring protection by the child or the child will 'lose all' if they do not subscribe to the parent's world view

anxiety, which in turn would push them towards such a strategy.

A similar strategy is described by Carly (then aged 20 and with twins of her own) in the teaching film *Being Seen and Heard* (Cooklin 2006c). She describes being woken in the early hours by her mother, claiming that her body was covered in bugs. Although Carly states on camera that 'We got so confused we could even see them', she later clarifies this statement as feeling that their minds were taken over by their mother's to the degree that they would believe that they saw whatever their mother told them – 'although I knew they weren't really there.'

Types of intervention

Here, interventions which mental health staff can either implement themselves or seek to have

BOX 4 Vignette of invasion of the child's thinking

Ayo was aged 39 and had two daughters, Sarah (aged 13) and Elizabeth (aged 11). Her marriage to their father had broken up 5 years previously. Although it was not possible to clarify how much acrimony had existed, or whether there had in fact been violence on either side, Ayo described her ex-husband – Sebastian – as in league with the Devil, and for his part he appeared to fear her and keep his distance. Ayo had had the girl's family name changed by deed poll to Christ, and proclaimed loudly and publicly that Sebastian was not their father, but that they were daughters of Christ. This of course added pressure on the girls to accept their mother's definition because not only were they totally submissive to any of her wishes, they also had to endure the school roll-call under their new name. The local authority was very concerned about the girls and referred them to the local child and adolescent mental health services (CAMHS). The girls, however, remained steadfast in defending both their mother and the version of the truth that she propounded. Although they were seen as very 'odd' at school, they were not actively bullied as other girls were generally in fear of them. The situation seemed to remain stuck, with increasing concern for the girls' welfare on the part of the local authority.

Eventually, Ayo was admitted to a psychiatric hospital under a compulsory treatment order, after becoming violent and threatening towards neighbours and local shop-keepers. The girls were accommodated by the local authority, and once Ayo was in hospital, Sebastian contacted them, showing affection and concern. After about 3 weeks in local authority care and several visits from their father, the girls disclosed their fear of their mother and acknowledged that they had 'bought' her definition of reality as a survival strategy.

implemented in partnership with other statutory or voluntary organisations are put forward.

Social, societal and educational interventions

As already stated, these are not the focus of this article but are nevertheless very important and necessary in diminishing stigma by increasing public and school awareness of, and knowledge about, mental illness. As several of the more vociferous members of the Kidstime project have stressed, it is an increase in this awareness as well as of the effects of both the illness and the stigma on the children of parents with mental illness which they need rather than therapy for themselves.

Family interventions

Family interventions aim to acknowledge the child's role within the family, specifically in relation to the ill parent and their illness.

Family work or family therapy is beginning to become more available within, or attached to, adult mental health services. However, the main approaches have been directed at either helping the non-ill family members to solve problems of managing the illness (Falloon 1984), or at modifying the family environment as a means to diminishing the likelihood of relapse in the ill member (Anderson 1980; Fadden 1997; Leff 1990; McFarlane 2002). In these approaches the most vulnerable members of the family – the children – have generally not been included in the thinking about the family, and in fact the children may not be included at all. Burbach and his colleagues have developed a county-wide service in the UK in which the 'problem-solving' approaches developed by writers such as Anderson, Fadden, and McFarlane, cited above have been combined with a systemic understanding of the family and its development (Burbach 1996).

A number of systemically oriented family therapists have reported on specific therapeutic projects which have included the children (Fredman 2000; Daniel 2005). However, although these approaches have addressed family relationships and how these relationships can accommodate the impact of mental illness, in general they have focused on the impact of particular parental behaviours and the possible meanings which family members may ascribe to these, rather than on explanation of the illness and its consequences. In the past, some therapists have even been coy about fully acknowledging the reality of the illness in the service, avoiding 'labelling' the patient. Although this attitude may be seen as a way to respect the integrity of the ill member, it can in

fact be counterproductive for children, as it can deprive them of a tangible entity on which to base their confused experiences.

Direct interventions for the child

This may include ensuring that the child is supported in school by recognising their dilemma if, for example, they are often absent or late as a result of parental demands. It may also include providing a mentor or counsellor for the child. However, in this article the dangers of offering counselling – unless the child has explicitly accepted the idea of therapeutic help for them – have been stressed, because this may increase the child's unwelcome sense of identification with the ill parent, and also may be seen by the child as defining them as on a similar pathway to the ill parent. Mentors or 'befriending' projects do not have this disadvantage and can be particularly helpful.

A very positive intervention which can be offered by schools, and which has so far been very successfully implemented in a small number of secondary schools, is a weekly support group specifically for children and young people who have a parent with mental illness (BBC Three 2010; R. McCall & F. Dix, personal communication, 2011). This is often arranged during the lunch hour and is not perceived as therapy. The sharing of experiences leads to many children feeling less isolated and therefore less subjected to stigma. It can also help them to resist and support each other against any bullying about their 'mad parent' to which they are often subjected.

Who should do it?

Some adult mental health staff may see all the above as outside their expertise or responsibility, and is therefore the province of 'someone else's responsibility'. The problem is that a similar view is often held by all in the different health and social care fields, and although community mental health workers may often not see the children because they are at school when they visit, a greater awareness of the children's needs could encourage them to visit in the after-school window of 15.30–17.00h. Dunn (1993) demonstrated that at the time of the study there was evidence of consistent underreporting of both physical abuse and neglect by – as well as in respect of – this group of children. Although this is an old study, it has not to my knowledge been replicated, and many young carer's groups report that children often do not trust the available services and will try to hide their parent's problems or disturbed behaviour. A significant proportion of children continue to be missed by the safeguarding services,

principally because these children become adept at hiding sources of concern in favour of loyalty to the family. Furthermore, most local authorities may be handicapped by a combination of a lack of information about and understanding of mental illness and its possible role in subjecting children to emotional abuse, together with uncertainty about how to intervene. They may in turn assume that such intervention will be provided by CAMHS. In reality, CAMHS will see a tiny proportion of the children affected by parental mental illness, few of whom will meet their referral criteria. As already discussed, most children in this category will be highly resistant to referral to a mental health service.

In fact, it may often be the case that only adult mental health staff will be in a position to sufficiently explain the nature of the parent's illness. Although this article is not suggesting that adult mental health staff become 'children's' workers, there are a number of roles in which only they may be able to adequately contribute (Box 5).

The importance of explaining parental mental illness

Explanation of parental mental illness to children and young people and the kind of relationships with professionals that this activity may foster has advantages beyond those already discussed:

- it engages the child's thinking and as a result may diminish their more automatic emotional responses to irrational parental behaviour;
- it is respectful of the child's position as carer and can lead to a two-way discussion of what the child already knows or has concluded;
- it can more easily avoid the dangers of the child feeling patronised, which this group of children in particular object to so strongly;
- it can encourage the child to begin to trust the professional, and may in the long term disclose therapeutic needs which can be responded to more appropriately.

Many adult patients as well as their relatives complain that they do not receive an adequate explanation of their own, or their relatives', illness. In a recent exercise conducted in a mental health community team in London, the team members were asked to define a detailed explanation of schizophrenia – its causality, course and treatment – in pairs. In the resultant discussion, team members were unable to agree on what, how and by whom such an explanation should be offered to either patients or relatives about the patient's illness (further details available from the author

BOX 5 Role of adult mental health staff in helping children

- Being available to and/or ensure that all staff members feel confident to explain about the parent's illness and treatment to the child of a parent admitted to an acute psychiatric facility
- Ensure similar arrangements for less acute admissions or community treatments
- Liaise with and give detailed explanations and encouragement to social workers as well as to staff running young carer's groups
- Offer to support local school projects with advice and/or to attend one of the groups to answer general questions (Shah 2004)

on request). Anecdotal evidence suggests that this is not an uncommon situation. In addition, many mental health staff may shy away from trying to offer an explanation to children, fearing that their lack of training disqualifies them from engaging with children, and workers with children commonly do not feel competent to discuss or explain mental illness. It is therefore not surprising that children and young people generally receive even less explanation, and that such explanations as they receive are often banal, non-specific and may give little or no real information, or may even lead to misunderstandings which further compound the child's anxiety.

As already explained, an important goal of explaining to the child about the parent's illness is to help the child to view the parent from 'outside', and therefore to diminish identification with the ill parent. This goal has important implications for the kinds of explanations which may enhance this process, rather than increasing identification, which will be discussed later. A survey of a group of young people, with a parent with mental illness, in a large secondary school, identified the ill parent's face (angry, sad or 'confused/mad') as the their key indicator of the illness (BBC Three 2010; R. McCall & F. Dix, personal communication, 2011). The work of the Marte Meo group (Øvreeide 2011) has shown how the facial responses of a parent are a key factor in the development of attachment to the parent, which is likely to be congruent to Sharp & Fonagy's (2008) finding that a preoccupied and mentally ill parent will often not have the emotional capacity to respond emotionally to their child in a way which can promote the child's capacity to mentalise. Therefore, if the child's main indicator of illness is the parent's face and associated emotions, the child risks not only being further confused by the parent's behaviour but also

may experience arousal of developmentally earlier patterns of interaction with that parent. The nature of the explanation therefore needs to offer the child a different and less immediately emotive image, through which the child can perceive the parent's illness. For this reason we have generally tried to help the children and young people to understand a generic stress/vulnerability model of mental illness, using very simplified neurophysiological diagrams and exercises. An example of this approach is illustrated in the online supplement to this article. The goal is to help the child associate the parent's illness more with a set of images of neurophysiological internal processes, rather than just with the parent's emotional responses.

Approaching explanations of parental mental illness with children at different developmental stages

The goals of explaining parental mental illness – whether with a child on their own, with their parents or in a group of children or families – are:

- to allow the parent's illness (including the possibility of relapse) to become discussable and therefore cease to be an unmentionable fear for the child'
- to define the parent's illness as a more 'technical' event and therefore something which lessens the child's identification with the parent; this approach tends to objectify the child's experience of the mental illness, which in turn may assist a child in distinguishing the illness from their own experience
- to help the child to discriminate between 'normal' parental behaviour and 'illness' behaviour (although many children in this situation are remarkably adept at this discriminatory skill)
- to allow specific recognition of the child's contribution to the parent's care from professionals and familial adults.

To achieve these goals the explanation needs to be the following.

- 1 Technical, i.e. in a medium close to a topic the child may be familiar with from school – such as in a science subject.
- 2 Process, i.e. providing the child with a framework within which to understand the process of illness development, rather than statically listing signs and symptoms of a particular diagnostic category. The latter is important because many parents may dispute their diagnosis, and because many mental health problems may not be easily or consistently categorised in the same manner. Parents are much more likely to accept a process description.

3 Two way, i.e. it needs to promote a sharing of ideas between child and professional, and juxtaposition of the differences, so that the child can begin to construct their own image of the parent and their illness.

4 Differentiated, i.e. it needs to help the child clearly differentiate mental illness from common (and often dramatic) perceptions of physical illness.

Although there is no specific prescription for such explanations, the above principles have been found to be useful in engaging the thinking of many children of different ages. The online supplement offers a range of sample explanations and exercises which professionals can either use verbatim or as part of explanations which they have developed themselves.

The focus has tended to be on an information-processing model to demonstrate how different factors may make it too difficult for an adult to manage being overwhelmed with different thoughts or feelings. The resulting 'mental state' is then used to explain depression or overexcitation, confusion and misperceptions of reality that lead to acute confusion and delusions, and even the sudden changes in emotional responses of people with personality disorders.

Online Fig. DS1 shows a highly simplified neurophysiological diagram of the brain, spinal cord and a sensory and motor nerve, which many children find easy to engage with (Cooklin 2012). This may be because it is close to the medium of learning with which they are familiar. This model has been found to be easily assimilated by most children from about age 9, and in fact many parents have also found it useful. Younger children can also take in a more simplified model of functioning. However, it seems that younger children engage more easily if a more action-oriented visual form of teaching is used. One example of this is to create a model of the brain on the floor, with different children 'playing' different parts of the brain. Each child then 'speaks' the activity of their part of the brain, and the group acts out different sounds before, during and after the treatment of a mental illness.

The film '*When a parent has a mental illness*' (Cooklin 2009) published on the internet by the Royal College of Psychiatrists, also offers a child-friendly explanation and discussion, presented by a young person who was herself a young carer for many years.

With all age groups the increased risk is acknowledged, but it is stressed that having friends, enjoying school and talking about any worries to a trusted adult can diminish that risk.

Specific projects for children of parents with mental illness/children and their families

Young carer's groups

There are now approximately 350 young carer's groups operating in England and Wales. Many are generic – that is, they cater for children who are carers of parents with all illnesses. A smaller number are specifically for children of parents with mental illness. There can be a problem with this lack of differentiation, in that children of parents with mental illness rarely receive proper recognition for their contribution from the ill parent, and may even be blamed for causing the illness. In addition, these children will often experience severe disruption of their attachment relationships with the ill parent, which is unlikely to occur in the case of parental physical illness.

Nevertheless, young carers' groups often offer the only respite and freedom from the caring role, and many children have described them as 'lifesaving'. Groups usually meet weekly, and offer fun activities such as going skating, swimming or to the cinema. They also act as a social reference group in which the children can identify with each other and share experiences, as well as providing discussion or outreach intervention to varying degrees.

The main weakness of these groups is that often the workers find it difficult to adequately liaise with mental health services, and therefore cannot (or feel that they cannot) offer a substantive explanation to the children and young people. This is often compounded by common attitudes in mental health teams or in-patient services, where the staff may see themselves as solely 'the patient's person'. Adult mental health teams may as a result be reticent about offering adequate information on the grounds that they believe it will compromise the confidentiality due to their patient. This is one reason why it is particularly important that mental health services reach out as outlined under 'Direct intervention for the child'.

Young carer's groups are commonly run by voluntary bodies, such as Family Action or the Princess Royal Trust for Carers, but funded by local authorities. The Children's Society offers a coordinating function and runs an annual residential Young Carers Festival.

Few of these projects offer direct intervention between the young person, the ill parent and their illness. They are therefore unlikely to engage parents to a significant degree, particularly in relation to helping the child gain an adequate understanding of the illness.

The Kidstime project

The Kidstime project in Camden and Islington has developed over the past 12 years (Cooklin 2005, 2006a,b, 2006, 2010, 2012). As part of the evaluation of the initial project, two other projects (in Hackney and Westminster) have been developed during the past 2 years. The goals of these projects are the following.

- To help the children and young people to gain understandable explanations of their parents' mental illness and the behaviour in the parent which may be associated with this.
- To address the children's various fears, confusion and lack of knowledge about mental illness and its treatment.
- To help the parents who have mental illness to find a medium within which the illness and its impact can be discussed between themselves and their children.
- To help the parents to access or rediscover their pride, confidence and competencies as parents.
- To help the children to experience their parents responding in a more positive manner.
- To encourage the children and young people to feel freer to engage in pleasurable age-appropriate activities.

The Kidstime project workshops originated in 1999, partly as a result of the experiences of similar workshops for adults and their relatives over the previous 10 years (Bishop 2002). Bishop *et al* had noted that nearly all interventions for the families of patients with mental illness were exclusively concerned with the adults, and that the most vulnerable members of the family – the children – were largely ignored. The workshops were originally called 'What Shall We Tell the Children', as an expression of the discomfort which many parents felt about the task of trying to explain their mental illness to their children. The workshops were later renamed Kidstime – a suggestion from some of the child participants – as a recognition of the primacy of the needs of the children to be addressed in the workshops. As the workshops developed, both the children and the parents participated in the production of the training film *Being Seen and Heard* (Cooklin 2006c) and the children later participated in an 'explanatory' short internet film (Cooklin 2009).

The workshops, which are for children and young people who have a parent/s with mental illnesses – together with their parents – are held monthly. They are run by a team of mental healthcare workers, social care workers, a children's drama practitioner and voluntary workers, and last 2.5h after school. They begin with a short seminar for

the children and parents together, in which some aspect of mental illness, or questions about it, are discussed. This is followed by separate groups for the children and for the parents. The children's group starts with games and warm-up exercises, then the children tell stories about family life, commonly prompted by the seminar. They are helped to dramatise these stories and the resulting plays are filmed. The parents and children then gather as a single group to eat pizza and watch the filmed plays. Finally, there is a group discussion of what the children have produced and of issues raised in the parents' group.

Outreach work for individual families is also provided by the projects, particularly in response to matters which have been elicited during a particular workshop. Details of the operation of the workshops are provided in the manual (Cooklin 2011) and an initial evaluation (Martin 2011).

The Kidstime project can accommodate about 8–9 families per session, but as some families come for short periods and may return for a few sessions, about 15 families can be worked with by the project at any one time. Although the work is focused particularly on the child's understanding and the parent's support for that understanding in the context of the family relationships, there is also close liaison with local young carer's programmes. These are complementary in that they can expand the child's 'out of family' experiences and further promote peer relations.

Other multifamily approaches

Reports of other multifamily approaches that focus on the parents and the children together, and therefore on their relationships with each other as well as with the illness, are few. Valdez *et al* (2010) have reported a pilot study of the 'Keeping Families Strong' intervention for families in which the mothers have depression, using predominantly cognitive-behavioural techniques. Explanation of the illness does not appear to be a prime focus of this intervention, partly because they mainly work with very young children.

Conclusions

This article has presented a range of responses to the needs of children of parents with mental illness, as a sequel to the previous article which predominantly identified the hazards faced by these children. The article has focused on relatively small interventions that may enhance children's development of resilience – interventions which mental health staff can implement themselves or assist other professionals who have taken on this responsibility.

It has been stressed that most children and young people of parents with mental illness are likely to be antagonistic to offers of psychotherapy or counselling, although they may readily engage in offers of an understandable explanation of their parent's illness. This explanation can help the child to achieve some separation from over-identification with the ill parent, particularly if the explanation is clear and helps the child to develop an image of the process of the illness. The content of possible explanations has been elucidated, and a variety of contexts in which the child may be offered this help defined.

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MCQ answers

1 c 2 d 3 e 4 b 5 e

MCQs

Select the single best option for each question stem

1 Mental illness in one parent is associated with a:

- a 30–50% chance of the child developing major mental illness
- b 40% chance of developing affective disorder
- c 70% chance of developing minor adjustment problems by adolescence
- d 20–25% chance of developing affective disorder
- e risk of mental illness which is no different from that of the general population.

2 The promotion of resilience to the impacts of parental mental illness on children is likely to result from:

- a keeping the child off school if ever they are upset
- b sending the child to respite foster care whenever the parent shows emotional upset
- c protecting the child from other children who are unsympathetic
- d ensuring that the child has an understandable explanation of the illness and its treatment
- e ensuring that the child believes that the parent suffers from a physical rather than a mental illness.

3 Current training curricula ensure that:

- a children's social workers are fully *au fait* with the facts of parental mental illness
- b general psychiatrists are all equipped to, and ready to, respond to the needs of the children of their patients
- c CAMHS can respond to the needs of children with parental mental illness
- d young carer's workers are trained by adult mental health services to understand the parent's mental illness
- e the child is most likely to gain an adequate understanding of parental mental illness when there is a coordinated approach between adult and child services.

4 Explanations of parental mental illness help the child to gain an objective picture of the illness if the child:

- a can 'feel' for, and empathise with, the parent
- b is helped to understand the parent's illness experience from 'outside'
- c is shown that mental illness is no different from physical illness
- d is told that the medication will cure the illness
- e is allowed to listen only to the ill parent's explanation.

5 Children can develop an adequate resilience to the impacts of parental mental illness only if they:

- a are allowed to identify with, or even experience, the parent's symptoms themselves
- b are placed in foster care
- c are adopted
- d are offered intensive psychotherapy
- e gain an adequate understanding of their parent's illness, its treatment and a positive image of their own role.

CORRECTION**Correction**

Fonagy P, Adshhead G (2012) How mentalisation changes the mind. *Advances in Psychiatric Treatment* **18**: 353–62.

The correct answer for MCQ4 is b.

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