



Module 2: The Impact of Parental Mental Vulnerability on Children



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Susie is 11 and her school attendance is irregular. When in school, she is often tired and she is often very untidily dressed and her hair looks dirty She is quite a “bossy” girl and has difficulty making friends. Some of the younger children feel bullied and intimidated by her, and the school is getting more and more worried about her behaviour.

Mum is a single parent and has twice been invited to come to school to discuss Susie’s behaviour and attendance, but she has not turned up on either occasion. An Educational Welfare Officer (EWO) is allocated to the case and, on making a home visit, discovers that Mum is suffering from bipolar illness. Mum has medication but does not always take it, which results in good and bad days and accounts for Susie’s erratic attendance. The reason for Susie’s bossy behaviour also soon becomes apparent as she needs to “boss” mum to get her to take her medication, and as well as looking after Mum’s well being. She is trying to be a parent to her 9 year old brother Jake

(<http://www.rpsych.ac.uk/mentalhealthinfo/mentalhealthandgrowingup/parentalmentalillness/susiestory.aspx>)

1. What do we mean by mental vulnerability?

The term mental vulnerability does not seem to be widespread in psychiatric literature (Zubin & Spring 1977). When working with parents we use this term, as the attribution of a mental illness to parents is usually associated with high stigma for parents and mostly provokes trial, anger or fear from the side of parents. **This term is less stigmatising and more easily accepted by the affected parent. However we are aware that – especially regarding schizophrenia and/or bipolar disorders the term “illness” might also be useful.** it is highlighted that especially regarding the better understanding for children the term “illness” might be used in parallel way; taking into account the importance for children to relate these diagnosis to somatic illnesses”. The discussion reflects the challenging field that on the one hand stigmatisation and taboo should be reduced, on the other hand somatic models might facilitate easier processes of understanding for the children.

1.1 Vulnerability

In the diathesis–stress model, a biological or genetic vulnerability or predisposition (diathesis) interacts with the environment and life events (stressors) to trigger behaviors or psychological disorders. The influence of genetic factors, however, might be quite diverse, as Boggarts & Lußcz (1999) could show regarding different diagnosis. The greater the underlying vulnerability, the less stress is needed to trigger the behavior problems or disorder. Even so, someone with a diathesis towards a disorder does not necessarily mean they will ever develop the disorder. Both the diathesis and the stress are required for this to happen. This theory was created by (Holmes & Rahe, 1967)

This stress model has been reformulated in the last 20 years as the stress–vulnerability–protective factors model, particularly by Liberman (2007, 2009) in the field of psychiatric rehabilitation.

Which implications does the stress-vulnerability have for children? Especially if both parents show high signs of vulnerability, high emphasis should be put on the strategy to decrease stress factors for the children.

1.2 Talking about mental vulnerability

As professionals, we meet parents when their parenthood - regarding some diagnosis – might be in danger. Usually we experience that such danger is correlated with some medical diagnosis of a mental illness but also many of the parents whom we meet during our everyday work do not have a diagnosis; and as a result they themselves might not always recognise their problem as a mental illness or are not motivated to seek help. Just a few parents associate their reduced capability to cope in everyday parenthood with their possibly reduced psychological resources. The mental illness always makes the affected parent more vulnerable towards stressors, compared to the non affected parent, even in the times when they are free of the symptoms

Vulnerability itself, in terms of a salutogenetic approach (Antonovsky, 1967) also indicates that parents and children living in the context of mental illness and one or even both parents are able to actively “do” something to remain or become healthy again.

The term mental vulnerability covers emotional, cognitive, social and behavioural disturbances, which sometimes fulfil the criteria of mental illness. The spectrum is wide, from “mild” illness such as anxiety disorders, to substance abuse and more “serious” diagnoses such as bipolar disorders or schizophrenia. It is optimistic and has to be emphasized that even in cases of low vulnerability, strengthening the parent and the child is possible.

1.3 The term vulnerability – a euphemism?

We want to make clear that by using the term “vulnerability” it is not our intention to “cover” a mental illness. As mentioned above, this enables parents to shift their attention away from the concept of “mental illness” and its burden - including its social stigmatisation, towards a concept of empowerment and resilience. This concept of vulnerability also includes people

who show signs of mental vulnerability (e.g. high irritability, reduced tolerance of frustration) which might not fulfil the criteria of mental illnesses. Therefore, the concept of vulnerability is broader than the concept of mental illness, even though also in our materials certain interchangeability will be observable due to

- a) the historically and scientifically accepted term “illness”
- b) high degree of overlapping of the terms

Because of this concept both terms might be in a parallel way in some chapters.

1.4 What do we understand by mental illness in the context of mental vulnerability?

Significant changes, aberrations from normality, within the area of psychological functions (emotions, cognition, perception..) can be interpreted as indicators of mental illness. Despite the above mentioned discussion of the term “vulnerability”, the definition and classification of mental disorders is a key issue for mental health and for users that is and providers of mental health services. Most international clinical documents use the term "mental disorder." Major categorisation systems (ICD-10, 1991) for the German area, DSM IV TR (APA, 2000) based on approaches of the American Psychiatric Association) **describe symptoms in order of better understanding within the professionals (to compare diagnostic criteria)**

As most of the professionals in the KIDS STRENGTHS project are not primarily familiar with mental diagnostic processes and do not have a knowledge about symptomatology, the most common diagnoses will be described in order to obtain a better understanding of the situation of children. Taking into account that any diagnosis in the mental health field always opens discussion about norms, socio-cultural contexts, it seems obvious that diagnosing a person as mentally ill or mentally vulnerable with all its consequences is or should be a very serious and thought through process.

However within a diagnostic process the diagnoser (mostly) perceives symptoms and subsumes them under a “label” (e.g. depression). This can be assessed as a working hypothesis. Sometimes it would be necessary to correct the working hypothesis according to the better understanding of the symptoms and sources. (No wonder that it can happen, that diagnoses also can be changed.)

A diagnostic process is always a process of dialogue, with the professional taking into account that both child and parents are faced with

- unknown people (diagnoser)

- strange situations to be assessed (tests, games)
- unusual questions and tools.

Diagnostics processes also have to include the perspective and assessment of resources, strengths and also aspects such as love or being proud to be a parent.

2. Mental vulnerability/illness as a stress factor for children

It is estimated that 1 in 4 of us, at some point in our lives will experience episodes which fulfil the criteria of a mental illness. (WHO 2008, The Royal College of Psychiatrists) Underestimated and forgotten, are strong words which describe the situation of children living in the context of mentally vulnerable parents – with exception of children in the context of substance abuse (alcohol) The sensitivity towards the needs of children living in the context of mental vulnerability has no long history, but also depends on different diagnostic groups. Fatal events or severe neglect of children in this context (e.g. EUFAMI Conference 2009) have lead professionals and society to raise awareness of this group of children.

Children in the context of a mentally vulnerable parent can be assessed in terms of the same severity of distress and impact as living with a chronically and severely ill parent. The big difference is that most somatic diseases (diabetes, cancer, heard disease) are more socially accepted and patient are mostly compliant and feel “sick”. Also for the children it is very clear that they are not responsible for the illness of their parents. Mostly the surrounding shows understanding for the patient and the children. In contrary, the children living in the context of mental vulnerability blame themselves for the “not being well” of the parent. Very often these feeling would be pronounced due the blaming from the site of the affected parent or other adults (grandparents, father, mother) if they support their parents could also be „punished“.

Data shows that 30% to 60% of people with a severe mental illness have children. Did you know that 1 in 12 children has a parent who is unwell in this way? The mental illness is highly stigmatised despite the fact that during the past few years socially accepted and modern forms of mental vulnerability have appeared: burn-out syndrome, depression. The more we move into schizophrenia, bipolar disorder, substance abuse, borderline personality disorder the less we will find public knowledge and awareness.

3. Contacting families

Most professionals from different fields (e.g. kindergarten teachers, early childhood professionals) working with children report insecurity, discomfort, and even anxiety when getting into contact with mentally vulnerable parents. Lack of information about the mental illnesses, the symptoms, coping mechanisms and the impact on the child wellbeing are the main reasons for these “feelings”. More and more the professionals are aware of it, and usually ask for appropriate information (unless they work in specialized mental health services)

- *What does mental vulnerability/mental illness mean and what kind of consequences do the diverse diagnoses show?*

The second group of questions focus on their perceptions and possibilities of identifying what they perceive:

- *Can I (as a professional) perceive and observe possible changes and symptoms when I work with families or children?*

The third kind of questions that are arising focus on the child (probably connected with the fourth question)

- *What does it mean for the child?,- what can I as a professional do?*

- *What kind of help do the children need?*

The structure for this module therefore, follows these four questions strongly.

4. Mental vulnerability/illness – What are we talking about?

Mental illnesses are common to all countries and cause immense suffering. Their distribution all over the world is for some of them (for example: schizophrenia , bipolar disorder) equal, but for other (anxiety disorders, alcoholism) very different. People with these disorders are often subjected to social isolation, poor quality of life and increased mortality. These disorders are the cause of staggering economic and social costs. (WHO 2008)

Millions of people worldwide are affected by mental, behavioural and substance abuse disorders. For example, estimates made by WHO in 2002 showed that 154 million people globally suffer from depression and 25 million people from schizophrenia; 91 million people are affected by alcohol abuse disorders and 15 million by drug use disorders.

Data shows that symptoms of mental vulnerability in the general population seem to be increasing. The number of women taking their pension on the basis of invalidity based on

depression is dramatically increasing. This also means that **more and more** children, at least during certain periods of their lives, live in the context of ill or severely affected mothers and fathers. There cannot be one mono-causal national model to explain this observed increase of mental vulnerability. Reasons for the increase of mental vulnerability have been hypothesised on all levels of the bio-psychosocial model of mental illnesses: increased distress, increased parental challenge, economic crisis, need for mobility, pressure, demographic changes, family changes etc.

Up until 2020, depression is likely to be the second most prevalent illness, according to WHO data. On the other hand, mental vulnerability in the parent, mainly the mother, can be seen as one main predictor of developmental disturbances within children (Laucht, 2009).

However, one of our young ten year old boys described his experiences relating to his own mother, who tried to commit suicide and was found by the boy (10j) himself: “there are too many parts to the puzzle, sometimes they do not fit together and the frame does not give enough safety and security”.

5. Why do we assess mental vulnerability as a chronic distress factor for children?

Even though mental illness is comparable to chronic somatic disorders some specific factors have to be highlighted which play a key role for burdening the children

5.1 Duration

Based on the main diagnostic criteria (ICD-10, DSM IV) mental illnesses are defined by a certain tendency to be chronic, e.g. symptoms last longer than six months. On the other hand, empirical data shows (Chaudron et al., 2006) that **just** after three months of living within the context of a mentally vulnerable system, children will show first signs of distress and developmental disturbances. The **intensity of symptoms in most of the disorders could increase with during the time**. Experience shows that most vulnerable episodes last longer than six months. It is well known that it takes three to seven years for an affected parent to recognise and admit their emotional, social or behavioural problems as a possible mental illness. During this time (and sometimes longer) children have to live in this context, especially if parents do not seek help or if the children do not show „symptoms“.

5.2 discrete, hidden symptoms

A second factor which contributes to mental vulnerability being assessed as a chronic stressor is that sometimes the symptoms are not so severe, not so deviant, being “hidden within the walls of the home”. They could be explained as a consequence of normal life circumstances: for example, a mother’s sadness years after divorce or losing her job) and in that way as something normally assessed. Children also might obtain help, if the parents recognize that they themselves need help.

5.3 lack of reality check - normal social isolation of small children

Small children do not have a “reality-check” available because due to their age they could live “isolated” within their family. Their parents are the only and the main “attachment person” representing “normality”, with minimised possibility of corrective feedback (including the risk of a “folie á deux” where the child might follow the perceptive system of the parents: For them it might seem normal that the window blinds are always closed, that their mother or father do not go to the playground etc.

5.4 Sudden interruption of everyday life, instability of relationships

The predictability of behaviour and situations give children the feeling of safety and security. They live more or less relaxed. Symptoms of parental mental illness might endanger this predictability: father has to go to hospital, the son finds the mother in bed not waking up due to a suicide attempt, the ambulance arriving. Normally children are not prepared for such situations and usually these situations overwhelm their coping mechanisms and strategies. Unless parents abuse alcohol, the unobservable causes for behavioural changes make children more afraid: the mother does not leave bed, the mother light up all over candles etc. The unpredictable changing of interaction patterns causes feelings of insecurity. The father promised to go out with Sarah, but it does not happen. Peter shows his mother something that he made, and she starts to shout at him. Lisa found her mum sleeping on the floor. Insecure attachment could be one impact of unpredictable caring behaviour.

5.5 Mental illness as a family secret

One of the big differences for the children – e.g. compared to kids living in the context of parental chronic somatic illness - is that the family but sometimes the child by itself tends to keep the mental vulnerability as a family secret, as it is taboo within society.

Lack of information about a parent's mental illness and the taboo to speak about it, fails to provide the child with an adequate attribution. Each child tends to interpret their parent's reactions in relation to themselves, to their own behaviour, especially if the feeling of responsibility is reinforced by sentences like "It is you, who makes me sick! Because of you is the mother in hospital" They will usually attribute their parent's anger or sadness towards their own "possibly incorrect" behaviour. This can be assessed as a first "seed" to developing feelings of guilt and eventually future depression or anxiety disorder.

Mental illness as a family and society secret has a double consequence:

- a. Within the family: the child does not know what is going on, even though they feel that "something is not as it should be" and
- b. For society: Lack of awareness about the mental illness means that the child is left alone without the possibility of getting help from the surroundings.

5.6 Intensity of the symptoms of mental illness

Perceived distress is not primarily connected with a diagnosis of mental illness, but rather with the severity of symptoms. The more severe symptoms appear, the more they are different from normal behavioural patterns, the higher their negative impact on the child. As a consequence symptoms of schizophrenia or bipolar and borderline disorder appear to have a higher negative impact on the protective factors of the child. In some cases the life experience for the child in this context could reach the criteria of posttraumatic stress disorder

5.7 Age of the child

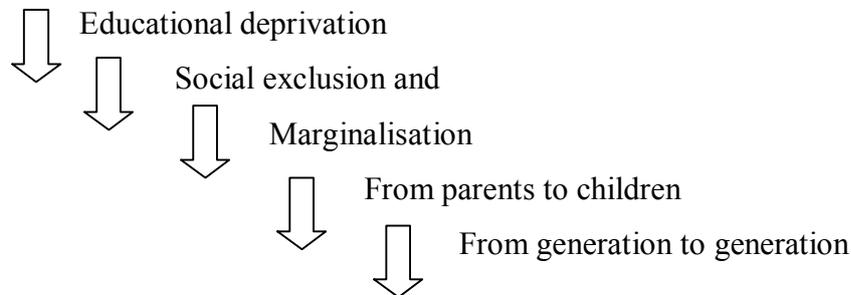
Another factor of distress is the age of the children: the younger the child, the higher the negative impact relating to its protective resources. One reason for this is that the small child lacks other supportive (social) systems, as well as that the normal neuro-genesis in conditions of higher stress level will be in danger, reducing the biological resources of the child, making it more vulnerable causing the basis towards the child's reduced biological resources.

5.8 Both parents are mentally vulnerable?

Two vulnerable parents obviously show greater impact on the child than only one (even if there is a supporting social network). In such cases the probability of inheriting the genetic (biological) vulnerability and at some point in the lifespan experiencing mental problems, lies between 40-50% (e.g. in parents with schizophrenia)

However, Tytti Solantaus highlights that the way that this vulnerability is transmitted cannot only be seen in terms of genetic predisposition. Solantaus describes a possible cascade of transmission steps

The transmission of mental disorders (Solantaus 2009)



To summarise, mental vulnerability in at least one parent always has to be seen as a system distress, affecting all other family members, especially young children. From the above mentioned reasons their reflecting and coping mechanisms are in danger of being overwhelmed.

On the other hand practical work with mentally vulnerable parents shows that, the parents (the healthy and affected one) do not usually recognise their children's distress. Most of them report that

- their children do not perceive what is happening with the affected parent,
- their children do not feel the changes in the family system, and even that the parents try to "play" normality.
- children might feel responsible for the disorder

Such underestimation of the ability of the children to "feel and see" the changes in their family also comes from professionals, leaving children alone with their burden, without professional help. However in praxis we see, that (partly with exception of parents with alcohol abuse) that very often the professionals in the field of psychiatry „use“ children as therapeutic **factor for their parents.**

However, as children are active constructors of their own reality, as their (sensors) perceptive systems are mostly alert, they are able to perceive the power of (unexpected) emotional or behavioural changes within their parents. The first step in our work is to sensitise parents, to make them aware that their children: even if they are not able to verbalise their situation, very early in their lives, at the age of 3-4, are able to perceive these changes. Because of that it is

very important to increase the sensitivity of the parent (affected and the healthy one) towards the need of his/her child, particularly in the turbulent times of severe symptoms and increased mental vulnerability of themselves or their partner.

6. How do children react?

The manifested symptoms (reactions) of children towards chronic stress (caused by some severe chronic somatic illnesses or chronic increased mental vulnerability) are very similar, but generally unspecific. This unspecific nature of symptoms is also a reason for not recognizing the suffering of the child, also on the part of the professionals. The age of the child contributes much more to possible disturbances than the given diagnosis of the parent(s) (Pretis & Dimova 2004).

Children might react with different coping strategies (see module 3 regarding “role-taking”). Furthermore the reactions to a high extent depend on the age, gender, temperament (see module 4).

In their **first years of life**, children might react based on e.g. disturbed emotional regulation: increased crying, delays in developmental expressive language, cognitive delays. At the **beginning of pre-school or kindergarten** disturbances regarding social-emotional behaviour in kindergarten or academic performance in school can be observed. Every child in every family system is different. Approaching/contacting families is always a highly individual, tailor-made process.

7. What do children retrospectively report?

Many of the studies regarding the experiences of children living with mentally vulnerable parent/s show similar results. They report feelings of helplessness, (Wagenblass, 2001) and being left alone (Marsh & Dickens 1997), sometimes they felt guilty and responsible for what is going on in their family or with affected parent, they feel insecure and anxious and overwhelmed.

It is important to emphasise that with regards to psychological health the child has to have the opportunity

- not just to understand that mother is depressed and father is drinking or having hallucinations,

- to be able to differentiate illness-related behaviour from (healthy) normal range behaviour of the parents.
- but also has a right and space to express healthy feelings of anger, parental deception, disappointment, sadness, which has to be done under support and help from professionals.

8. The needs of children in the context of mentally vulnerable parents (specifically see module 4: Fostering resilience)

- a. Children need to feel safe and secure. For any professional working with children therefore the first question is: what can I as a professional do to increase the feeling of safety and security for the child?
- b. Children need information and understanding. The associated question for the professional is: how could I in an optimal way inform and sensitise the parents and the broader family system to the vulnerability in the given family system? How could I increase the awareness of the needs of the children? Within the methodological files concrete exercises are described. Children need their needs to be met and satisfied. How can I as a professional contribute to ensuring that the parents are better able to perceive and satisfy the needs of the child and if this is not possible, that the needs of the child are met by means of other supporting systems?
- c. Children need age appropriate tasks and challenges. There is the risk that children in the context of vulnerable parents take on responsibilities which are not appropriate to their age - “parentification”

9. Parenthood and mental vulnerability

Even though 25% of custody cases in court are connected with mentally vulnerable/ill parents, this does not automatically mean that mentally vulnerable parents are not able to bring up their children. Individual assessment of safety and security, attachment, age appropriate stimulation, provision of norms, rules, and values, together with compliance and seeking or acceptance of support or help are essential indicators for good (enough) parenthood. However: **CHILDREN SHOULD NEVER BE USED AS A STABILISING FACTOR OR (EXTREMELY IMPORTANT) PSYCHOLOGICAL MEDICATION, SUPPORT FOR THE SICK PARENT/S.**

Within the field of alcohol abuse this recommendation seems to be recognized in public, in other situations (e.g. regarding missing compliance) it is observable that child welfare or child protection systems show difficulties or hesitate to implement necessary services for children.

However, experience shows that even in rich communities with a lot of supportive systems (medical, social or educational) children are at high risk of being forgotten because in many of the cases supporting systems focus their attention primarily towards needs on the affected parent. Furthermore – in case of episodic symptoms, decompensation – assistance might be timely limited.

10. Children in the context of parents suffering from depression (based on DSM IV TR, 2000)

The major approach within this module regarding diverse forms of mental illness or in a more general context “mental vulnerability” is based on the Diagnostic and Statistic Manual (DSM) of the American Psychiatric Association (APA). However, to be able to describe diagnostic criteria better for professionals, not primarily working in the field of psychiatry, symptoms (didactically) are group around 4 categories (taking into account, this reflects a pedagogic heurism): *Feeling, Thinking, Behaviour and Body-reactions*.

10.1 Symptomatology (Didactically structured overview of criteria)

FEELING

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). (In children and adolescents, this may be characterized as an irritable mood.)
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day

THINKING

- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- Diminished ability to think or concentrate, or indecisiveness, nearly every day

BEHAVIOUR

- Psychomotor agitation (higher level of activeness) or retardation nearly every day
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt nearly every day

BODY REACTIONS

- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 of body weight in a month), or decrease or increase in appetite nearly every day.
- Insomnia or hypersomnia nearly every day

According to the DSM-IV, a person who suffers from major depressive disorder must either have a depressed mood or a loss of interest or pleasure in daily activities consistently for at least a two week period. This mood must represent a change from the person's normal mood; social, occupational, educational or other important functioning must also be negatively impaired by the change in mood. A depressed mood caused by substances (such as drugs, alcohol, medications) or which is part of a general medical condition is not considered to be major depressive disorder. (...) Further, the symptoms are not better accounted for by bereavement (i.e., after the loss of a loved one) and the symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

10.2 The impact of depression on children in daily life

Within the context of a major depression for the affected parent it might be possible to react in a very sensitive way towards the emotional needs of a child. A mother reported, that during an episode of major depression “nothing mattered for, including her children.” However during episodes of remission she empathically took care of her children.

Especially regarding the available “energy/motivation” level of parents with depression children show high sensitivity: Motivation and energy will not be available constantly and children will be faced with unexpected and unexplained loss of energy, motivation and responsiveness in their parents: “Sometimes my mother/father will react, sometimes not, how can I be sure, when she/he will satisfy my needs?”. Due to this inconsistent parental responsiveness or sometimes negative responses (Keep quite, don't disturb me), most of (small) children tend during a time to give up and run the risk of insecure attachment behaviour.

Sometimes the mother or father will react on contact wishes of the children, sometimes he or she will stay in bed for days and weeks. Small children are therefore confronted with behaviour which, from the perspective of a child, is very difficult to anticipate. For the child him or herself therefore it is not evident if his or her needs will be satisfied or not. Sometimes it will be possible, sometimes not. There are no clear signals in which cases this will happen. Many times children could be left alone with their existential needs. **This unforeseeable**

irregularity or insecurity might activate a child's alarm system, and their level of activation should therefore be higher.

Furthermore these children might be faced with suicide attempts – including being subject to highly traumatic situations (ambulance, worries about the mother/father...)

10.2.1 Playing the emotional coach for the depressive parent

Noticing that their parent's reactions are slow or missing, the mostly older child or single child will try to reinforce his or her activities, to stimulate the parent to be active and happy (unless there is a health attachment person available). Very soon the child will observe that its effort causes no changes in the behaviour of the mentally vulnerable parent. They could try harder and harder to stimulate their affected parent's reactions; their invested energy will be increased. The missing response could be disappointing. Feelings of helplessness or sadness are expected consequences. We are deeply convinced that in juvenile depression, a higher mental vulnerability of a parent plays an essential role within pathogenesis.

10.2.2 Protecting by taking on the responsibilities of the affected parent - Parentification

Very early in their young age, children recognise that due to their parent's lower activity the everyday structure at home does not function. Within the next phase they will start, if there is nobody to do so, to take care of their own needs, sometimes also their siblings as well as the affected parent. This can be also observed in e.g. schizophrenia or bipolar disorders but also alcohol problems. Our experience shows that a child of 5 years could take the responsibility of reminding their mother to take her medication in the case of worsening symptoms. Responsibility for the psychological health of the loved parent is a very big burden for the child (or even other adults), especially because it might last over many years.

10.2.3 Early developmental problems

Working with the children of mentally vulnerable parents we see in many cases early developmental problems in an absence of organic reasons.

As a result of exposure to emotional deprivation in the case of depression as well as schizophrenia, we can see increased disturbance in expressed language within the first years. Findings show that children in the context of depression tend to cry more often (Milgrom et

al. 1996), that they show less explorative behaviour (Field et al. 1996) and also that they do not react appropriately e.g. on verbal stimuli prompting from their parents with depression.

10.3 What are the major support strategies for children in the context of depression?

- a. **Treatment of the parent(s)' depression** is therefore the first and major step towards the well-being of the child. By this the source of its burden will be reduced. It always has to be stressed that depression is an illness which in the majority of cases can be very successfully treated. One complete remission is possible (absence of symptoms). A combination of **medication , psychoeducation and supportive psychotherapy shows the best results.**
- b. Children in the context of depression need joy, responsiveness (?), situations where they can express their emotions. For the daily work this means to activate healthy family members or family network partners to create islands of joy, fun, optimism, activation. Worries free islands.
- c. Information: In the very beginning it has to be explained to the child that the vulnerability of the mother or the father is not connected with his/her behaviour. That he or she is not guilty. That her/his behaviour is not connected with their father/mother's tiredness , irritability or crying disease.
- d. **The child should be allowed to express his or her feelings, to be loud, to sing, to dance, to run, to cry, to be angry** (in the best case not in the presence of the affected parent as this behaviour of the child could also represent a stressor for the parent).

11. Children in the context of parents suffering from bipolar disorder (DSM IV, 2000)

11.1 Symptomatology (Didactically structured overview of criteria (manic episode)

The **current diagnostic criteria for bipolar disorder** is that Bipolar disorder describe a heterogeneous illness--one that comes in many different forms. The frequency and intensity of mood swings (between depressive and mania) varies greatly from one person to the next. The symptoms of depression have already been described under 10.1.

FEELING

- o A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least one week (or any duration if hospitalization is necessary). The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or

- relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features
- inflated self-esteem or grandiosity, potentially including grandiose delusions

THINKING

- flight of ideas or subjective experience that thoughts are racing
- distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

BEHAVIOUR

- more talkative than usual or pressure to keep talking
- increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
- excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

BODY REACTIONS

- decreased need for sleep (e.g., feels rested after only 3 hours of sleep) or persistent difficulty falling asleep

The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition.

The DSM-IV TR characterizes Bipolar Disorder as a condition in which the patient has significant mood changes that last from weeks to months at a time. Patients will experience at least one manic episode where the mood is an elevated one; followed by a period of normalcy or balance for at least two months before an onset of a major depressive episode. These mood changes cannot be due to schizophrenia, schizoaffective disorder, psychotic disorder or delusion disorder. The mood changes also cannot be a direct result of substances taken, such as sleeping pills or prescribed amphetamines. However substance abuse (alcohol) could be present during especially manic episodes.

11.2 The impact on children in the context of bipolar disorders

Facts: The lifetime prevalence and bipolar (specifically bipolar 1) disorder is often assumed to be about 1%. If children live in the context of 2 parents with bipolar disorder, every second child might develop symptoms.

Children in the context of bipolar disorders are faced with switching extreme affective mood states, which might be reinforced by possible alcohol abuse. Even when very young, most children report that they clearly note the changing behaviour of their parents: one child aged 6 told us that the father very often goes to the restaurant and invites the children for drinks or ice cream etc. Then he knows: it is starting again. Children might observe changes, when parents e.g. use words and phrases or ask strange questions, which they would not use during stable phases. In manic phases children are confronted with activation and their parent's activities: going out, not sleeping, being loud, irritable and even aggressive.

In the very beginning this behaviour could be funny for the child, getting what he/she likes, but the intensity of the reactions makes however mostly to be it frightening. But after a time it is very exhausting for the child, especially if the child is small and forced to follow the parent's activities. Very soon he or she will notice that when mum or dad does not comply with his or her promises, their needs are not met. Their lives could be in danger. Parents might forget to care for the child adequately or to feed it, or to follow basic security rules (for example, being outside in the cold weather for a long time without coat, gloves). The everyday life is without structure. The higher level of intolerance could be followed by aggression towards the child, especially if the child tries to correct his/her parent.

As the affected parent seems to lose „control“ and might perform strange actions, children sometimes feel shame. If the child denied participation, does not follow the activities of his/her parents children mostly will be faced with verbal aggression.

And after some time all this can turn into the complete opposite. Parents shouting, laughing, singing, being generous, but also act aggressively. During the depressive phase - then they might become tired without energy, without motivation. The sadness is at the face, in the movements (see depression).

The child is left alone (if there is no other adult in the family). Its needs in the both phases could be neglected. Reactions can be contradictory and for the child, difficult to understand, between high levels of irritability and expressed emotions e.g. in terms of explosive behaviour till sadness, depression.

This unpredictable behaviour is for the child difficult to follow. The impact for the children is the extremely unpredictable behaviour and parental behaviour crossing personal limits of the child. Children in this context might show symptoms of generalised anxiety disorders and insecure attachment.

11.3 Guidelines of intervention

- a. It is the most important goal to initiate medical treatment for the affected parent. However this is difficult, as the affected parent does not feel „ill“, despite national legal problems to treat a person without his/her consent.
- b. For professionals it will not be possible to work with parents within an acute manic episode – due to reduced self-reflection.
- c. Parents in an acute manic phase will usually not be able to comply or keep therapeutic contracts as missing compliance is a major symptom of a manic episode. From a professional point of view, any contract with parents in this acute manic phase has a high probability of failing. If there are no healthy others in terms of grandparents, healthy partners or supporting social network **The child should not be left alone with a caring person in acute manic episode** children in such situations could be in danger. **The child should not be left alone with a caring person in acute manic episode:** because of **high probability that the welfare of the child is in danger**. If the child lives alone with the affected parent, staying with the grandmother or the neighbour or in foster care, as a temporary solution, could protect the wellbeing of the child. The child has a “right” of clear structures and routines even in the times of parent’s manic episode. They give them the necessary emotional and physical safety.
- d. It is the most important goal to initiate in-patient treatment for the affected parent. However this is difficult, as the affected parent does not feel „ill“, despite national legal problems to treat a person without his/her consent.
- e. If the child is older, a “crisis-plan” for any situation could be prepared to give the child a feeling of control within unexpected situations which are risky for him/her. E.g.: what can I do when my mother or father wants to go out with me at night? Where to go? Whom to call when the mum or father behaves in a strange way?
- f. Children will need (age appropriate) understanding and information that the changes in their mother/father’s behaviour are caused due to the changes in the brain functioning ..
- g. Professional “contracts” have to be focused on the healthy parent, informing him/her about:
 - a. Importance of satisfying the needs of the child, his/her duty of protecting the child
 - b. Possible supportive interventions for the child and family system
 - c. Information about the prognosis, treatment, and sometimes also diagnosis of the partner’s changed behaviour.
 - d. The legal situation: When can a person be forced to undergo (medical) treatment against his/her will.

- h. If no healthy parent is available, the child welfare/protection systems has to be activated
- i. In bipolar disorders the genetic linkage is very high: therefore any additional stress for the children should be avoided.

12. Children in the context of parents suffering from schizophrenia

In most training courses, schizophrenia tends to be related to unclear mystic pictures of “splitted person”, in the sense of “Dr. Jeckyll and Mr. Hyde”. It is a synonym for mental disorder. Most professionals who are not working primarily in the field of psychiatry show great difficulties in understanding what schizophrenia is about. In this section therefore, the main focus has to be given towards an explanation of how people with schizophrenia “function” and the impact it has on children. The lifetime prevalence within the general population, all around the world is about 1-2%; Perälä et al. (2007) pointed out, that population based surveys show lower rates. However 13 out of 100 children with at least one affected parent also will develop symptoms.

12.1 Symptoms of Schizophrenia (Didactically structured overview of criteria)

According to the revised fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), to be diagnosed with schizophrenia, three diagnostic criteria must be met:

Characteristic symptoms: Two or more of the following, each present for much of the time during a one-month period (or less, if symptoms remitted with treatment).

FEELING

- Negative symptoms: Blunted affect (lack or decline in emotional response), alogia (lack or decline in speech), or avolition (lack or decline in motivation)

THINKING

- Disorganized speech, which is a manifestation of formal thought disorder. The speech disorganization criterion is only met if it is severe enough to substantially impair communication.
- Delusions: Ideas to be followed, the peoples to speak about him/her..

BEHAVIOUR

Grossly disorganized behavior (e.g. dressing inappropriately, crying frequently) or catatonic behavior

PERCEPTION

- Hallucinations

If the delusions are judged to be bizarre, or hallucinations consist of hearing one voice participating in a running commentary of the patient's actions or of hearing two or more voices conversing with each other, only that symptom is required above.

Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care, are markedly below the level achieved prior to the onset.

Duration: Continuous signs of the disturbance persist for at least six months. This six-month period must include at least one month of symptoms (or less, if symptoms remitted with treatment).

Schizophrenia cannot be diagnosed if symptoms of mood disorder or pervasive developmental disorder are present, or the symptoms are the direct result of a general medical condition or a substance, such as abuse of a drug or medication.

12.2 The impact on children

Experience shows that schizophrenia (alongside bipolar disorder and borderline personality disorder) is one of the heaviest burdens for the child living in the context of mentally vulnerable parent/s. The impact on the life of the child can be assessed as severe, because of the manifested “strange behaviour”: (disorganized) speech, reduced concentration, significant impairment of social functioning, social isolation causes subsequent difficulties in the field of attachment and developmentally appropriate stimulation (Mattejat & Lisofsky 1998.).

Not only small children (lack of ability to check reality if there is not another healthy partner), but also the older ones find themselves in a hostile, frightening, unfair world. He/she understands this only by means of parental interpretation. The reality of the parent/s could become the reality of the child, so called “folie à deux”. If the child remains in this context, if there is reduced compliance or denying of the mental vulnerability there is the great danger of being captured in the world of the psychopathology of the affected parent. It is important to stress that this is no rule. Impact depends on the intensity of the symptoms. It is important to be aware that in such cases, when the children show similar symptoms as the parent, it might be an inducted psychosis (not a schizophrenia in the **child**). **In the case of inducted psychosis, separation from the affected parent will reduce the symptoms by the child.**

Acoustic hallucination (e.g. in terms of imperative voices) paranoid ideas (to be poisoned or to be observed by e.g. secret services do not have to be present all the time but might represent some indicators for the non-psychiatric professional, that symptoms of

schizophrenia could be present. Therefore persons with schizophrenia might react also fearfully.

When the symptoms of the affected parent are severe, this might engage the biggest part of the person's attention; the constant responsiveness towards the needs of the child could be in danger. In such situations the child will be faced with irregular care behaviour, insecure attachment, lack of necessary developmental stimulation. Therefore, cognitive developmental delays (without organic explanation) can quite often be observed, diagnosed especially when children attend kindergarten.

12.3 General strategies for the supporting systems

- a. **Compliance** (readiness to accept own mental vulnerability and to cooperate in the treatment) of the vulnerable parents in terms of medication and communication, can be seen as the main factor against the source of the burden for the child, which best protects the children. This issue is also relevant regarding all other described illnesses.
- b. **Support from other healthy adults:** Even if the symptoms are very not pronounced and the parent might be sensitively responsive, **repeated and sudden worsening of the symptoms** in terms of chronic illness **have to be taken into account**. In such cases **having one stable adult person close to them represents an important protection factor for the child, giving the necessary feeling of security.**
- c. **Information and understanding for the child about the mental vulnerability of the parent suffering from schizophrenia.** Bearing in mind the characteristics of the symptoms of schizophrenia, its ways of manifestation, it is quite difficult to explain to the child what happens with mum or dad. Helpful ideas from the praxis could be to call the vulnerability the "illness of jumping thoughts" (words of 8j Ilse) or that mum **or dad** "lives like in a wrong movie" (words of 6j Markus). In this case it is irrelevant that this explanation is not "correct" from a scientific point of view. It is important for the child to be able to distinguish that, what is manifested in mum or dad, is an illness, independent of their behaviours, independent of them. Detailed information is available in module 3.

- d. **psycho-education** with the affected parent concerning his/her mental vulnerability, treatment options and consequences on the healthy psychological development of the child. This issue is also relevant for all other described illnesses.

13. Children in the context of parents suffering from anxiety disorders

Anxiety disorders are the most prevalent among the general population, and their impact on child well being can often be observed. Approximately 18,1 percent of people in this age group in a given year (in America), have an anxiety disorder (Kessler et al. 2005).

13.1 Symptomatology (Didactically structured overview of criteria)

FEELING

- At least 6 months of "excessive anxiety and worry" about a variety of events and situations. Generally, "excessive" can be interpreted as more than would be expected for a particular situation or event. Most people become anxious over certain things, but the intensity of the anxiety typically corresponds to the situation
- 1. Feeling wound-up, tense, or restless

THINKING

- Concentration problems

BEHAVIOUR

- The symptoms cause "clinically significant distress" or problems functioning in daily life. "Clinically significant" is the part that relies on the perspective of the treatment provider. Some people can have many of the aforementioned symptoms and cope with them well enough to maintain a high level of functioning
- There is significant difficulty in controlling the anxiety and worry. If someone has a very difficult struggle to regain control, relax, or cope with the anxiety and worry, then this requirement is met

BODY REACTIONS

- Easily becoming fatigued or worn-out
- Irritability
- Significant tension in muscles
- Difficulty with sleep

The symptoms are not part of another mental disorder and the condition is not due to a substance or medical issue

13.2 The impact on children

Parental anxiety disorders (depending on the severity of the symptoms) very often show a negative impact on the attachment and explorative behaviour of children. Living in excessive anxiety and worry, parents are not able to provide a secure attachment with subsequent insecure attachment and anxiety in children (Muris et al, 1996). As a consequence parents are mostly overprotective, restricting the child in their explorative behaviour. In terms of the concept of conditioned helplessness, children tend to give up exploring as the reactions of their parents might frighten them. Through the anxiety of the parent, the child creates a picture of a world full of risks and dangers. Lack of experience and competence and social avoiding behaviour can be a consequence.

13.3 General guidelines for intervention

Insecure attached children have in most cases at least one insecure parent. This is not due to biological determination but due to the “anxious” processing of the information about the world and life”. In the case of small children (pre school age) supporting interventions are most effective when both - parent and the child - are involved. A few strategies therefore can be seen as successful:

- a. Strategies of taking small steps with the parent and the small child, with much patience needed on the part of professionals. For people suffering from anxiety the biggest problem is to cope with new experiences. They are afraid of new, unknown situations. The more challenging the situation, the higher the fear of starting and trying it. It could be easier to convince parents to try new experiences if offered in small “dosage”, because the risk might be lower. Professionals should:
 - encourage the parent to try very small new steps of changes
 - Understand their insecurity and the parent’s “lack” of cooperation, especially at the beginning of the interventions. Positive reinforcement for the parent and child with each small step works on their self confidence.
- b. Information for the parent about the importance and need of their child actively discovering the world. In relation to cognitive reframing, most parents do recognise that self-efficacy and autonomy are two major steps towards adulthood. Based on insecurity and anxiety being the main symptom of the anxious disorder, they delay giving the child the chance for development towards independency: in one, in two, in three years. Thus they will argue that the child will then be more mature or will be better able to understand possible risks and dangers (from their point of view).
- c. psycho-education with the affected parent concerning his/her mental vulnerability, treatment options and impact on the psychological development of the child. Most

parents will be able to acknowledge that if they themselves feel safe, the child will be able to become more autonomous. They do understand that conditioned helplessness and anxiety for their own life might show significant impact on the lives of the children: e.g. in terms of social contacts, kindergarten, school performance and autonomy in general.

14. Children in the context of a personality disorder

The field of personality disorder also tends to be a big challenge for professionals. As the term personality disorder is not very well known and the boundary between so called “normal” behaviour and personality disorders sometimes tends to be weak. **There is a general tendency towards over-diagnosing. Generally, the features of personality disorders can be seen as a continuous matrix of personality qualities which show high stability** in terms of time, situation and **resistance towards therapy**. In most cases, the first signs of personality disorders occur retrospectively, although they can be identified already in early childhood, it is more likely in adolescence. It was already mentioned that personality disorder, especially its Borderline type (besides schizophrenia and bipolar disorder due to its emotional instability has a strong negative impact on the well being of the child. The extent of genetic vulnerability and environmental factors is still under discussion: a higher ratio of environmental factors is hypothesised (Boggarts & Lußcz, 1999)

The American Psychiatric Association (APA) defines personality disorders as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the culture of the individual who exhibits it" (DSM IV, 2000).

(...) These behavioral patterns in personality disorders are typically associated with severe disturbances in the behavioral tendencies of an individual, usually involving several areas of the personality, and are nearly always associated with considerable personal and social disruption. Additionally, personality disorders are inflexible and pervasive across many situations (...).

The onset of these patterns of behavior can typically be traced back to late adolescence and the beginning of adulthood and, in rarer instances, childhood. It is therefore unlikely that a diagnosis of personality disorder will be appropriate before the age of 16 or 17 years. (...)

Diagnosis of personality disorders can be very subjective; based on however, inflexible and pervasive behavioral patterns often cause serious personal and social difficulties, as well as a

general functional impairment. Rigid and ongoing patterns of feeling, thinking and behavior are said to be caused by underlying belief systems and these systems are referred to as fixed fantasies or "dysfunctional schemata".

The DSM-IV lists ten personality disorders, grouped into three clusters:

Cluster A (odd or eccentric disorders)

- **Paranoid personality disorder**: characterized by irrational suspicions and mistrust of others.
- **Schizoid personality disorder**: lack of interest in social relationships, seeing no point in sharing time with others, misanthropy, introspection.
- **Schizotypal personality disorder**: characterized by odd behavior or thinking.

Cluster B (dramatic, emotional or erratic disorders)

- **Antisocial personality disorder**: a pervasive disregard for the law and the rights of others.
- **Borderline personality disorder**: extreme "black and white" thinking, instability in relationships, self-image, identity and behavior.
- **Histrionic personality disorder**: pervasive attention-seeking behavior including inappropriate sexual seductiveness and shallow or exaggerated emotions.
- **Narcissistic personality disorder**: a pervasive pattern of grandiosity, need for admiration, and a lack of empathy.

Cluster C (anxious or fearful disorders)

- **Avoidant personality disorder**: social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation and avoidance of social interaction.
- **Dependent personality disorder**: pervasive psychological dependence on other people.
- **Obsessive-compulsive personality disorder**: characterized by rigid conformity to rules, moral codes and excessive orderliness.

14.1 Personality disorder definitions ((Didactically structured overview of criteria)

According to DSM-IV-TR the diagnosis of a personality disorder must satisfy the following general criteria, in addition to the specific criteria listed under the specific personality disorder under consideration.

- A. An enduring pattern of inner experience and behavior deviating markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
1. **THINKING**: (perception and interpretation of self, others and events)
 2. **FEELING** (the range, intensity, lability instability and appropriateness of emotional response)
 3. **BEHAVIOUR** interpersonal functioning and impulse control

- B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
- C. The enduring pattern leads to clinically significant distress or impairment in social, occupational or other important areas of functioning.
- D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.
- E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
- F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

14.2 The impact on the child in the context of a personality disorder (specifically regarding parents with borderline personality disorders)

The impact of personality disorders on children – to a high extent – depends on the type (as described above). However, in general is mostly correlated with the rigid pattern of personality problems in time and situation. The risks to a child, from its early childhood, therefore will depend of the kind of personality disorders.

In the case of Borderline the child could frequently experience changing partners, changing working and living places, explosive, unexpected emotional reactions - from intolerance to punishment or abuse. The attachment as well as emotional orientation to the child can be very instable. Sometimes parents “forget” the real age of the child, loading all their “adult” problems onto their child, making him or her a friend, a partner. Drug abuse problems or problems with the law are part of the symptoms of some personality disorders. Stable attachment, the feeling of safety and security and responsive parenting will therefore frequently be in danger. Children will usually have feelings of living in an insecure hostile world. Very early on in their lives they could be “forced” to take responsibility for their needs, to become independent. Independency which is not appropriate for their young age. However, the attachment to the parent might be very high, as the parent him or herself might be the only, if very instable, available person for a long time.

14.3 General strategy for the supporting systems

- a. Being in contact with vulnerable people in terms of a personality disorder is a big challenge for professionals. Creating compliance, establishing contact is a continuous investment by the professional which requires high frustration tolerance and clear goals and strategies. **Most parents in this context will not show compliance or acceptance of information that their personality is a risk to the child. Having this in mind their emotional instability to a high extent “impair” long lasting strategies.** In the first

instance, the focus of the professional has to be on the safety and security of the child in terms of needs satisfaction.

- b. However, it is well known that helping and professional structures always seem to be one step behind these families. Thus, if possible, it is necessary to provide stability of attachment to the parents themselves. **However, this requires a lot of patience within a “small steps strategy” - building up trust from the side of the parents as well as the helping systems.**
- c. A detailed analysis of constant resources within the system has to be performed in order to assess whether outside structures such as grandparents or kindergarten are able to provide complementary views of the world for the child.
- d. Including healthy adults in the everyday structure of the child is seen as a high preventive factor (like for all other illnesses).

15. Children in the context of addiction and substance abuse

15.1. Short symptomatology

The DSM-IV-TR, defines substance dependence as "when an individual persists in use of alcohol or other drugs despite problems related to use of the substance, substance dependence may be diagnosed." followed by criteria for the diagnose

DSM-IV-TR defines substance abuse as

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

BEHAVIOUR

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household)
- Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
- Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance

15.2 The impact of parental substance abuse on child well being

Besides personality disorders, substance abuse can be regarded as a major risk factor for the development and needs satisfaction of small children.

Some prevalence figures (<http://www.oas.samhsa.gov/2k7/state/2k7State.pdf>)

- In 2006-2007, 8.1 percent of the U.S. population aged 12 or older had used an illicit drug in the past month
- (US) Nationally, almost a quarter (23.2 percent) of all persons aged 12 or older participated in binge use of alcohol in the past month in 2006-2007
- Tobacco is the second most commonly used substance in the United States next to alcohol. Nationally among persons aged 12 or older, the rate for past month use of tobacco in 2006-2007 was 29.1 percent.
- In 2006-2007, 7.6 percent of the population aged 12 or older was classified with dependence on or abuse of alcohol nationwide in the past year.

Children living in the context of parental alcohol or drug abuse might observe parents lying drunk on the floor, not being able to articulate themselves correctly, they might experience quarrels and high activation during within abstinence phenomena, they **might simply be forgotten by their parent, left alone during the night**. They might just be handed over to another friend of the parent or neighbour if the parent needs to get the next shot. **Organising their necessary daily “shot” is the priority in their life, and because** of that the parents might not be available

- Physically
- in terms of caring behaviour,
- or in terms of parental responsiveness.

Besides genetic and somatic indications e.g. alcohol fatal syndrome or post-natal craving of the child in the context of substance abuse addiction shows that attachment is often disorganised due to the addiction.

Due mostly to changing other people and lack of continuous stimulation, children show deficits in daily life routines and skills. On the other hand parenting is ambivalent and children quickly learn that needs are not satisfied immediately and because of the ambivalent availability of the attachment person there might be the risk that these needs will not be met.

They learn very early on to take responsibility into their own hands, like many children in the context of mentally vulnerable parents.

Problems with authorities and social roles later in the life are due not to the “biological basis”, but as a consequence of this life experience. Unemployment, poverty and physical aggression represent the major threats for the child regarding its safety. However, the impact of alcoholism on children still seems to be underestimated in western society. On the other hand, the risk of relapse is assessed as very high. During treatment, even when relapses are happening, the parents report that their children are the only factor which prevents them from drinking or even suicide in the area of drug abuse. It has to be clearly stated that from the perspective of the support system, children in this context should never, be used as a treatment method for the parent.

15.3 General strategy of the supporting systems

- a. To create a minimally secure basis which ensures safety and meets the needs of the children
- b. To ensure the presence of stable healthy people with whom the child can talk about its worries, to learn healthy strategies which increase the child’s hardiness and self-efficacy and increase the of predictability of supporter’s own behaviour.
- c. Temporary foster care might be necessary if the basic needs of the children are in danger (needs to be cared for in terms of nutrition, daily structures, daily routines).
- d. Set clear limits (also important in other contexts of mental vulnerability/illness)

16. Concluding remarks

There is an ongoing discussion about the terms “mental vulnerability” and “mental illness”. In our modules we decided to use both terms-

- “vulnerability” as it might decrease stigmatisation
- “mental illness” as it is well known and addresses understandable biological models of explanation for the children.

Children of parents with mental vulnerability often report that “their parents remain parents”. As we have said before, that “mental vulnerability” or “mental illness” do not generally relate to a parent’s lack of motivations to be a “good enough” parent. Beside the supporting strategies for the children the parental view has to be taken into account in terms of

- increasing parental responsiveness
- creating basic good compliance
- communicating in a respectful way and
- setting clear limits

However it has to be highlighted, that most of the professionals in the social or educational field will and should not no become “therapists” for the parents. While working with mental vulnerable/ill parents professionals also can reach their own “limits”. Networking e.g. with health professionals will be necessary.

In most cases support and interventions are able to ensure safety and security of the child, predictability and attachment, daily care and developmentally appropriate information, appropriate socialisation within socially accepted norms and rules and laughter. However, a child living in the context of mentally vulnerable/ill parent(s) also means that in some moments of life their safety might be in danger. The **system (healthy partner, grandparents, neighbours or friends or social welfare structures) must always keep this in mind, with the readiness sometimes to take action to ensure the child’s welfare**. Therefore the availability of a stable attachment person is crucial.

There has to be child adequate understanding and clear information that, if the parents do not feel well, there is a largely biologically explainable basis for parts of their behaviour. This behaviour does not have anything to do with the child, but that also parents are responsible for their well-being and sometimes necessary treatment. With this, **the child in the context of parental mental vulnerability/illness has a chance to become strong and resilient**.

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