Training Pack

Accompanies the film

Being Seen and Heard: The Needs of Children of Parents with Mental Illness

Contents

Acknowledgements 3
1 Introduction 4
2 Contents of the video 5
3 Guide for trainers when using the video 17
4 Suggestions for training group exercises 22
5 Talking with families, children and young people 23
6 The evidence 31
7 Organisations that can provide further help or support 32

Acknowledgements

Written and directed by Dr Alan Cooklin and produced with the generous support of Camden & Islington Mental Health and Social Care Trust, Camden & Islington Family Service Unit, the Camden Area Child Protection Committee, the Royal College of Psychiatrists, and virtuall.org: the London Mental Health Learning Partnership. Video and accompanying materials produced with the technical support of Team.

Editorial team: Sue Balmer, Deborah Hart, Dr Gillian Rose and Dr Ann York.

With grateful thanks to Dr Adrian Falkov, who contributed his time and expertise to this project.

1 Introduction

The film *Being Seen and Heard: The Needs of Children of Parents with Mental Illness* and this training pack complement existing materials, and will broaden and enrich training opportunities for all professions and disciplines. The investment in time, effort and resources is justified because there is now a wealth of evidence documenting that:

- Parents constitute a substantial proportion of mental health service users.
- Being a parent with mental illness is especially challenging.
- Children in these families are at greater risk of a range of mental health problems and adverse life experiences.
- Improving the mental health and well-being of mental health service users who are parents is very important for the individual, and brings great benefits for their children. Their general development and well-being will be enhanced.

Many parents cope exceptionally well with their childcare responsibilities, even if they have a severe mental illness. Their illness does not automatically imply that they cannot look after their children. The majority of parents with mental illness do not abuse their children (and the majority of those who abuse children are not mentally ill). It is important that the parent's ability to meet the needs of all children is routinely considered, including ensuring their safety.

A proportion of parents are not able to care for their children adequately, despite their best efforts and additional support provided. Alternative care arrangements need to be considered for these children.

Investigations into serious child abuse, including when a child was killed by a parent, have found that a key factor was the absence of inter-agency working, rather than an absence of individual service provision. Child agencies had a limited understanding of parental mental illness and adult services lacked an appreciation of the experiences of children.

Addressing the needs of children and parents with mental illness is, therefore, an important issue for all mental health, social and primary care services, implicating earlier intervention, mental health promotion and more effective cross-service and inter-agency collaboration.

Some adults who, in childhood, cared for a parent with a mental illness report high levels of abuse, neglect and isolation, which as children they found hard to disclose.

2 Contents of the video

Brief pointers to trainers

The video is divided into two parts. Training groups may wish to view the two parts in separate sessions.

Part 1

- the referral and the questions professionals need to consider
- children and young people describing their experiences
- children and young people describing what they need from professionals
- children and young people's views about what they need when their parent is admitted to hospital

Part 2

- techniques for talking to children and young people on their own and with their families
- clips of a special project that works with children in a group
- key messages

Hand-outs

The hand-outs on the following pages can be used as part of a professional training session. Participants may find them helpful to organise their note-taking. To help you organise your training session, the approximate time (from the opening credits) at which each video segment referred to on the handouts starts is listed below.

		Approximate start time	Hand-out page
Part 1			
	a	4 minutes	6
	b	6 minutes	7
	c	8½ minutes	8
	d	14 minutes	9
	e	18 minutes	10
	f	22 minutes	11
	g	27½ minutes	12
	h	30½ minutes	13
Part 2			
	a	32 minutes	14
	b	37 minutes	15
	(Special project)	45 minutes	(no hand-out)
	c	58 minutes	16

Part 1a The referral: questions that professionals should consider

You might like to organise your notes under the following headings:

1. Are there children in the family?

2. Who is looking after them?

3. Is their care good enough?

4. How is the illness affecting these children?

5. Is the family adequately supported?

6. Are the children safe?

7. Do the children have someone to talk to?

Part 1b What children and young people think, say and feel

You might like to organise your notes under the following headings:

1. Ricky feared hospital would make his mother worse

2. Feared that he could 'catch it'

3. Most parents try to protect their children

Part 1c What children and young people think, say and feel

You might like to organise your notes under the following headings:

1. Matthew worried a lot about his mother

2. He wanted to visit her even though she was unwell

3. He wanted a room in hospital where he could feel safe

4. Visiting a parent in hospital can reassure the child

Part 1d What children and young people think, say and feel

You might like to organise your notes under the following headings:

1. Many children and young people may feel responsible for making their parent feel better

2. Some may have their own ways of noticing when their parent is becoming ill

3. Many children and young people may feel isolated and feel that they cannot join in with others of their own age

4. Academic success does not mean that a child or young person is coping

5. Children and young people will not always welcome formal counselling, but will often need to talk to someone

6. Some children and young people may feel they have gained some benefit from the experience of their parent's mental illness

Part 1e What children and young people think, say and feel

You might like to organise your notes under the following headings:

1. Often no one explains anything to children and young people

2. Professionals must ask children what is happening to them

3. Like Ricky, Diane thought she might catch the illness

Part 1f What children and young people think, say and feel

You might like to organise your notes under the following headings:

1. Frightened and having no money for food

2. Many children protect and care for their parents over many years without any help

3. Many children become caught up in their parents' abnormal beliefs

Part 1g What children and young people say they need

You might like to organise your notes under the following headings:

1. Children and young people need a good explanation

2. They need a chance to ask questions

3. They may have important information to offer the professional

4. Children and young people need to be looked after, not left to do the looking after

5. The professionals need to talk to each other, both across professions and between agencies

6. Children and young people need one keyworker who is known to them

7. Children and young people need to know who they can call at any time

8. They may feel better if their parent is being looked after in hospital

9. Foster carers may need special training

10. They need a positive response when they ask for help

Part 1h Extra needs when parents admitted to hospital

You might like to organise your notes under the following headings:

1. There needs to be a dedicated space in hospitals for parents to meet children

2. In-patient staff need training to help both the children and their parents

Part 2a Talking to children on their own

You might like to organise your notes under the following headings:

1. Allow enough time, and do not rush either yourself or the child

2. It can help to use a quiet, visual game

3. You do not need to use a 'special' voice. Be yourself. Speak in a simple, straightforward manner

4. Follow the topic chosen by the child, and return to your topic in a few minutes

5. Listen carefully to what the child says, even if it seems irrelevant

Part 2b Talking to children with their family

You might like to organise your notes under the following headings:

1. Inaccurate information can lead to misunderstandings

2. Normal childhood behaviour may be misinterpreted as illness

3. Professionals must be truthful, but also offer hope

4. Although two parents with the illness does increase the risk, a child is still more likely not to develop the illness than to develop it

5. Good relationships in the family help to protect children and young people

After this section, you will see an example of working with children as a group within a special project

Part 2c Key messages

You might like to organise your notes under the following headings:

1. Do not assume that someone else has talked to a child or young person

2. Different professionals and agencies must work together

3. The welfare of children is everyone's responsibility

3 Guide for trainers when using the video

Children and young people's experiences of parental mental illness

Issues illustrated in the video	Where to locate in the video and name of child/parent
The loss of close intimate contact with a parent	Refer to Ricky (part 1b) and Matthew (part 1c)
Neglect and/or violence, including verbal, physical and/or sexual violence	Refer to Diane (part 1e) and Carly and Jessica (part 1f)
Ambiguous expectations/demands; e.g. one parent making demands that contradict those of the other parent, or contradictory demands from the same parent at different times	Refer to Carly (part 1f)
Invasion of the child's thinking and feelings by exposure to the parent's delusions and hallucinations	Refer to Carly (part 1f)
Fears for the parent's safety	Refer to Ricky (part 1b), Matthew (part 1c) and Chineye (part 1d)
Fears for the parent's future as a couple (if there are 2 parents), for the future of the family, and about who will look after him/her	Refer to Sabrina (part 1d)
Contradictory expectations, i.e. that the child be 'grown up' and 'a carer' at home but a child at school	Refer to Sabrina (part 1d)
Rejection, harassment and/or bullying by other children at school or in the neighbourhood	Refer to Ellie and Becky (part 2a)
Self-isolation, through stigma and fear of rejection	Refer to Sabrina (part 1d)

Other common effects on a child's or young person's life

Issues illustrated in the video	Where to locate in the video and name of child/parent
Isolation of the family through stigma	Refer to Carly and Jessica (part 1f)
Lower standard of living and financial hardship	Refer to Carly and Jessica (part 1f)
Being separated from parent/s and usual daily routine	Refer to Carly and Jessica (part 1f)
Experiencing different and potentially confusing care patterns if looked after by others	Refer to Carly and Jessica (part 1f)
Experiencing separation from other family members, e.g. siblings, if children cannot be cared for together	Refer to Carly and Jessica (part 1f)
Disruption of education	Refer to Carly and Jessica (part 1f)
Underachievement in education and reduced life chances as a consequence	Refer to Carly and Jessica (part 1f)

Possible responses from the child

Issues illustrated in the video	Where to locate in the video and name of child/parent
Attempts to fill the care space left by parents by taking care of parents and/or siblings	Refer to Carly and Jessica (part 1f) and Chineye (part 1d)
This can sometimes result in a child becoming dictatorial or bullying	Refer to Jessica (part1f)
Self-blame and taking undue responsibility for the problems in the family or for the parent's illness	Refer to Jessica (part1f)
Confusion about how to interpret the ill parent's behaviour, particularly in respect of the parent's anger. Confusion about whether it is the illness that causes the anger, or something the child has done	Refer to Ricky (part 2a), Carly and Jessica (part 1f) and Diane (part 1e)
Increased compliance in response to the parent's unpredictability	Refer to Jessica (part 1f) and Diane (part 1e)
Loyalty to the parent, through guilt and fear about the situation	Refer to Jessica (part 1f)
Withdrawal and isolation	Refer to Sabrina (part 1d)
Depression, low self-esteem and/or a fatalistic acceptance of their life situation	Refer to Carly and Jessica (part 1f)
Attempts at disassociation from the problem, particularly if another sibling is 'taking control'	Refer to Carly (part 1f)
Violent and/or other self-destructive behaviour	Refer to Carly (part 1f)
Copying the parent's symptoms and/or behaviour, particularly in eating disorders	Refer to Carly (part 1f)

What do children need?

Issues illustrated in the video	Where to locate in the video and name of child/parent
To have a frank discussion about their parent's illness so they can think about the situation more objectively, and to have their questions answered honestly and openly	Refer to Chineye and Sabrina (part 1d), Diane (part 1e) and Carly and Jessica (part 1f)
To know that there is an adult who will act as their advocate	Refer to Chineye and Sabrina (part 1d), Diane (part 1e) and Carly and Jessica (part 1f)
To know that their situation is not uncommon	Refer to Chineye and Sabrina (part 1d), Diane (part 1e) and Carly and Jessica (part 1f)
To have access to a place or a group where they can mix with other children and young people who have had similar experiences	Refer to Sabrina (part 1d)
To be helped to develop their understanding of mental health problems, and for any belief that they are responsible for the illness to be identified and challenged	Refer to Ricky (part 1b), Diane (part 1d) and Diane's family (part 2b)
To discuss their fears that they might 'catch' the illness now or develop it later	Refer to Ricky (part 1b), Diane (part 1d) and Diane's family (part 2b)
To be helped to develop an understanding of how mental health services are organised and what treatment the parent is receiving	Refer to Matthew (part 1c)
To be helped to recognise when their parent is becoming ill, to understand the behavioural signs that show he or she is becoming ill and to know how to access help	Refer to Chineye and Sabrina (part 1d)
To understand what is and what is not acceptable behaviour from an adult	Refer to Sabrina (part 1d)
To know that their knowledge and experience of their parent's illness will be listened to and taken into account in terms of care planning	Refer to Sabrina (part 1d)
To know that their contribution to the care of their parents has been recognised and respected	Refer to Sabrina (part 1d)

To have daily life re-established	Refer to Sabrina (part 1d)
To experience all the professionals concerned with both adults and children working together	Refer to Sabrina (part 1d)
Help and support with education, training and employment	Refer to Sabrina (part 1d)
To have recognition and acknowledgment of any positive benefits of their situation	Refer to Sabrina (part 1d)

4 Suggestions for training group exercises

Divide into groups of about four people

1. Devise an explanation about schizophrenia, using no more than eight sentences, for:
   (a) an adult patient
   (b) an adult relative

   Work out the actual words and phrases you would use, then discuss them in your group.

2. Devise an explanation about a mother who has to go to hospital for an operation to remove a benign cerebral tumour. There is a significant risk to her life. The explanation should be suitable for:
   (a) a 5-year-old girl
   (b) an 8-year-old boy

3. Repeat exercise 2, but replace the explanation about the mother's tumour with an explanation of schizophrenia, using your experience from exercise 1.

4. Role-play the explanations devised in the above exercises, either in small groups or as a large group. In each case, choose one member of the group to play the child, one to play the professional and 2 or 3 to act as observers who take notes. Be sure to allow plenty of time for discussion at the end, especially of the participants' experiences.

Discussion points for the group

1. (a) What might the word 'illness' mean to a child?
   (b) What are the possible consequences of how a child might understand this word?
   (c) How might this have affected a child's thinking in the excerpt of the children's play in the video in which the mother dies because the child cannot collect her blue and white tablets in time? (part 2 'special projects')
   (d) Make a list of other words/terms that you have heard being used by mental health, child mental health or social care professionals. Discuss how these words/terms might be interpreted by children of different ages.

2. Discuss the possible implications – as well as the possible solutions – arising from Chineye's and Carly's wish that their parents should be hospitalised earlier.

Further possible exercise

In small groups (multi-disciplinary or otherwise), discuss how to improve inter-agency working and sharing of information, and come up with three action points.

5 Talking with families, children and young people

Children need to be told about mental illness and how it affects their parent

Most parents with mental illness will struggle to protect their children from the effects of their illness, but however much they try to achieve this, the mental illness is likely to have a significant effect on the child. Some parents may understandably want to protect their children from knowing about their illness. Unfortunately, not telling children does not necessarily spare them anxiety. Many children are extraordinarily sensitive to what happens in their family, as well as to the feelings and attitudes of the adults in the family, even when these are not openly expressed. They are nearly always aware that there is something wrong, even if it is being hidden from them.

Knowing something is wrong is frightening for children. They may worry about their parent and not be able to say. Sometimes, a child may believe that they are not allowed to ask about what is happening. In these situations, it is very common for a child to believe that things are far worse than they are in reality. It is also very common for children to believe that they have caused the problem. If children are not told the truth, perhaps because an adult (parent or professional) wants to protect them, they may end up not being able to trust anything adults say.

A clear explanation of what is happening will reduce a child's anxiety, let them know that they are not to blame and help them trust others around them.

It is important to understand family attitudes and culture

All parents, families and children are different. How they each are affected by, and respond to, the illness will be different. The cultural background and beliefs of the family will also influence how mental illness is experienced, defined and explained. The culture is also likely to have a bearing on the attitudes of the parents to the children. All families have different attitudes about the extent to which children have the right to speak and be heard.

It is crucial that professionals have some understanding of the attitudes and cultures represented in the family, and how these affect how different family members think. It is easy for cultural stereotyping to get in the way of ensuring children get what they need. Professionals must remain culturally sensitive while ensuring that the needs of the children are met.

Parents should be included in decisions

It is important for parents to understand, and if possible to be in agreement about, what the children are being told. Including parents in the process will often support them in their role as parents. Deciding how, when and what to say to the children should emerge from the dialogue between the professional and the service user. It should be a creative process. It is important not to undermine a parent who may already be uncertain about their parenting capacities.

Talking to families

One of the aims is to open up the subject so that the parents and children can talk to each other about the parent's illness. Where possible, it is important to see the whole family together. This can help them to face the problems posed by the illness more realistically. Even if parents can only mention their illness in passing, this can 'give permission' to the children to bring up the subject, if it is on their mind. It may be useful to explain that research shows that gaining a better understanding of mental illness is likely to help protect the child or young person from developing mental health problems themselves.

Talking to children

It is also very important to see children on their own. This will give them an opportunity to voice concerns and fears, or anything else they might not want to say in front of their parents. You need to be clear about the limits of confidentiality. Children need to know that your conversation is private, but not secret, and that you will not be able to keep anything private that makes you think they or someone else may come to harm.

Tips for talking with children and young people

General points

Many professionals from all disciplines are nervous about talking with children. They can be worried about upsetting the child or making the situation worse. However, it is important to encourage children to discuss their experience of having a parent who has a mental illness.

Discussion between adults and children often involves the adult telling the child things or asking questions to which the adult already 'has' the answer. Children may then feel that they have to guess what answers the adult is seeking. It is important that professionals who talk with children about their parent's mental illness allow children to express their views honestly, even if it is to disagree with the professional.

General principles

As illustrated in the film (part 2a)

1 Allow enough time, and do not rush either yourself or the child

Children often sense that adults, especially busy professionals, are rushed or short of time. As a result, children and young people may be less likely to confide worrying fears or events. Therefore, it is important to give yourself as much time as you can, say 45 minutes to an hour.

2 It can help to use a quiet, visual game

Make sure you have paper, coloured pens and some toys. Many children find it easier to think and talk if they draw or play at the same time. You can also use the paper to illustrate your explanation with drawings and diagrams.

You may want to try the Squiggle game, originally developed by Donald Winnicott. It is an interactive game which can be used between an interviewer and a child. The interviewer and the child each draws a 'squiggle' (an uncontrolled small scribble – best done with the eyes shut) and invites the other to turn it into a drawing. Some children will have their own favourite game which

they will want to teach the professional. Whatever the game, it is important to try to keep the atmosphere as calm and controlled as possible, so that there is the possibility of conversation, for example between 'turns'.

3 You do not need to use a 'special' voice. Be yourself. Speak in a simple, straightforward manner

It is particularly important to be simple and clear in what you say and ask. Children of mentally ill parents may have been trying to understand very complicated or confusing kinds of communications. They will often have had to guess at what their parent really meant. This may make them particularly sensitive to professionals who are not clear and candid.

4 Introduce yourself and say why you are meeting

Find out what the child or young person knows about or has heard about you, where you work and what you do. Make sure the child knows your name and agree what you will call each other. Let them know how long you will be meeting for. It is also helpful to ensure that the child knows how to contact you in the future, if necessary. Reassure the child that you will be able to visit his/her family to talk again.

If either parent is present, check with the parent in front of the child that the child has permission to discuss their parent's illness. However, if the parent is too ill to give permission, and there is no other adult family member available, then it is important to explain to the child why it has not been possible to ask their permission. Either way, confirm with the child or young person that you will want to see them with their parent as soon as possible, in order to review what you have discussed.

Be clear about the limits of confidentiality (see 'Talking to children' above) and that, although your conversation is private, you have to tell someone if you are worried that they or someone else might be at risk of harm.

5 Follow the topic chosen by the child, and return to your topic in a few minutes

It is important to show a genuine interest in the child and their life as a whole, rather than just their worries. Try to avoid 'problem-focused' conversation as much as you can, and certainly at the beginning of the conversation. When you bring up the parent's illness, a good starting point can be to ask the child or young person what they already know, or what explanations they have come across by themselves. Avoid the temptation to talk about what you believe are their sources of distress and worry, because you might not be right.

Try to hold in your mind the important issues about the parent's mental illness that you think the child or young person needs to understand. You can then allow the child to divert you – often repeatedly – but you can then return to the topic when a suitable space allows.

6 Listen carefully to what the child says, even if it seems irelevant

It is especially important that after you have said something, you listen carefully to the child's response and are willing to spend time discussing it and clarifying the child or young person's point of view, before moving on to the next point.

Some children and young people may tell you complex and convoluted stories, which you may at first feel are off-track or irrelevant. While it is important to keep in your mind and not forget the key issues that you need to discuss with them, if you follow the child's thinking you might find a more appropriate opening for the discussion.

By the end of the discussion, you need to check that the child's understanding of their parent's mental health problem (or situation) is close enough to what you were trying to explain. Just like adults, children are unlikely to be reassured by false optimism. Therefore, invite and take seriously any questions. If you are asked anything that you don't know the answer to, be honest and say so, but say that you will find out and then **do so**. It may be that no one has the answer – for example, how long a mother or father will be in hospital. In which case, be honest, but discuss the likely possibilities.

7 *Ending the conversation*

Let the child know when you have about 5 to 10 minutes more left, so that they can ask you anything else. Tell them how they can contact you if they need to.

Interviewing: more specific approaches

The following nine points may be helpful to the professional who is relatively unfamiliar with discussions with children and young people. However, it is only one possible guide, and should not be allowed to undermine successful practices already used by particular professionals, or other approaches that feel more in keeping with the professional's personal style.

Point 1: Emphasise their positive abilities and interests

Begin by focusing on conversation about the positives, such as asking about their abilities and interests. Show a genuine interest in the child. Comment on their toy, book or T-shirt. However, beware of forced jocularity and assumptions. Do not make assumptions about what they may be interested in, as can sometimes happen when professionals are anxious, as for example: '*…so which football team do you support?*'

Example:

It's better to say something like:

'*So what kinds of things do you like to do when you haven't got to think about these grown-ups?*'

Also, rather than 'presuming' empathy or sympathy, which the child might not want, it is better to adopt a stance of congratulating their achievements in a non-patronising way. So rather than saying:

'*You must have been very worried about your Dad being ill*'

it might be preferable to say:

'*How did you find a way to manage all these situations so well?*'

Try to engage the child in a 'thinking' conversation where they are actively engaged with you, and actively listening and contributing. Finding a topic that engages you both can take time, especially with young children, but making the effort to do this will help. It may also be important to acknowledge any possible benefit the child or young person has gained from the experience of the parent's mental illness (see Sabrina, part 1d)

Point 2: When introducing the subject of mental illness, be careful not to make assumptions about how the child or young person may have experienced it; be 'behind' rather than ahead of the child

Resist the tendency to try to guess at, or even 'suggest', what the child is thinking or feeling about the situation in their family. It is preferable to ask a child to explain. If you do not understand something they are trying to express, admit it and ask them to help you.

Example:

So, rather than saying:

'*You must have been very sad/worried/frightened to see your Mum looking so low/upset/frightened'*

it might be preferable to say:

'*So when you saw Mum like that, what was it like?*'

and if she says:

'I don't know', or *'nothing really'*,

it may be better to take a step back from the child, by asking a more impersonal question and offer a range of possible answers. These can be easier to answer, because they do not face the child with so much anxiety about what you are seeking or will accept.

Example:

'*Well, was it the sort of thing that might make a daughter/son more cross, more sad, or more worried?*' (see below)

Point 3: When you are asking questions, frame them so that they are easier for the child to answer than to say 'I don't know'

Children worry about giving 'wrong' answers to adults, and often assume that there is a correct answer to the question that the adult wants to hear. Emphasise that there is no right or wrong answer.

Example:

'*So what did you think* (or even more anxiety-provoking: 'What did you feel?') *about your Mum not getting up to make your breakfast?*'

It might be easier for the child to answer:

'*When your Mum didn't get up to make your breakfast, do you think you were more worried about her, more cross, or just very hungry?*'

Point 4: Children and young people may find it easier to respond to a generalisation rather than a personal question which may make them feel anxious

So, rather than saying:

'*You must feel very responsible for your Mum's upset'*

it may be preferable to say:

'*Did you know that many kids in this situation seem to feel as though **they** are responsible for caring for their parents, rather than the other way round – it's strange isn't it…* (perhaps adding) *…of course, that may not have happened to you, but it does to lots of children*.'

Point 5: Make no interpretations or presumptions about a child's experience; ask them

The previous points have already highlighted the importance of not making assumptions or interpretations. Given time, patience and a demonstration that you are prepared to wait for the child to think and speak, rather than 'thinking for' them, children of all ages will attempt to articulate even their most complex ideas.

Professionals who 'suggest the meaning' of what the child is trying to say may 'kill off' the child's own attempts to clarify his or her own thoughts. On the other hand, if a child consistently talks about, or draws repetitive images and seems 'stuck', you might suggest that these images have given you a 'funny' idea, and ask if he or she wants to hear about it. Occasionally a child will say firmly 'no', in which case this should be respected. If the child says 'yes', then you could say:

Example:

'*You have drawn a lot of pictures of what look to me like a mum or someone getting hurt, or very upset* (whatever it is), *so it does make me think some things – do you want to know what I think?'*

If the child says 'yes', you could say

'*Well, it made me think, maybe you think this could happen to your Mum, or you are worried that it might.'*

If they say:

'*No! I just drew them because...*', you should probably say *'Oh...right...',*

but sometimes they may say:

'*Well, it has happened to my Mum'*

Then it's important that you do not seem surprised or shocked, but say something like:

'*Would that be something we could talk about together or do you want to keep it private?*'

If the child **does** insist it should be private, despite having let it slip out, then you might need to say:

'*OK that's for you to decide, but imagine you did tell me about it, what do to you think might happen then?*' in order to convey that it could be okay to talk about it.

Point 6: Challenge the child's expectations of compliance to adults

This goes against some of our preconceived views of children's ideas, and also against children's expectations of how they will be expected to behave. It requires a change of tone in the conversation with a child, and often a change in how we think about children.

Why is this important? Unless a child or young person feels that they have the right to have their own opinions, and that they will be listened to and respected (even if you do not agree with them), then they will not be able to engage with you in a 'thinking' manner. The child's main need is to be helped to think about a parent's mental illness with a concerned adult.

One way to approach this is to seriously encourage the child to tell you about something they're better at or know more about than you, and then both question and respectfully debate their point of view. It could be something as simple as how some girls think boys are a disruptive influence in the class.

Example:

If the child is a girl:

'*Do you think you will never want boys in the same class*?'

and if the answer is 'yes', you could add:

'… but some girls do seem to change their mind about this when they get older… have you noticed this?'… 'Why do you think that happens…?'

Point 7: Encourage challenge and contest (but not combat); conversation may appear both 'silly' and playful, but can be serious underneath; avoid insincere 'forced' jocularity

This follows from the need to demonstrate to the child that they can disagree with you, as above, by gently and good-humouredly encouraging debate with the child. Do not be phased when the child disagrees with you. It is also important that you resist the temptation either to try to win an argument or to humour the child in a manner that could appear to be patronising.

The goal is to help the child think, not to elicit feelings. A child will show what they feel as and when he or she chooses.

If a child can begin to reflect on the topics talked about with a professional, often they will have achieved the first step in mastering their worries about whatever this issue is.

Example:

If the child is contemplative:

'So maybe my Dad just thinks everyone is against him 'cos he always thinks the worst will happen.'

It may help to encourage the child's internal debate, for example with:

'Could be…or I suppose maybe there could have been some times in his life when he did feel got at, but did you know that some illnesses in the mind can make people feel that everyone is against them?'

What does not usually help the child is for the professional to be a 'detective' trying to 'get to the bottom of' what the child feels about it all. They will show rather than tell what they feel, as and when they choose.

Point 8: Try to find some aspect of the situation about which a child or young person can make their own choice

Children and young people may have felt totally helpless in the face of a parent's erratic behaviour, or alternatively may have had to be totally in control. Either way, the hospitalisation of a parent, change in care arrangements for the child or other sudden changes resulting from the parent's treatment may leave them feeling confused, lost and desperate.

It is likely that many decisions will have been taken without the child being consulted. If the professional can recognise this by trying to find some – however small – decision in which the child or young person can participate, this may lead to them feeling less helpless, and as a consequence, feeling more mastery over themselves.

If there is a significant decision to be taken, such as where the child is to stay during a parent's hospitalisation, the construction of a 'pros and cons' list with the child can be very useful. This allows the professional to offer suggestions for pros and cons, while the child actually retains some mastery over the decision.

Point 9: Use drawings or other visual aids and/or a quiet visual game (see Squiggle game used in part 2) with a child or young person, both to explain illness and understand the child's perspective

Most children and young people are helped by being able to draw their own image of what is being explained (of the brain and nerves, some diagram to link the body, the mind and the feelings, etc.) in order for them to gain sufficient mastery over the idea for them to be able to consider it. However, rowdy play may not be helpful to the child or young person. They might use it simply to

try to keep distressing thoughts or feelings at bay, and may then become overwhelmed by the same thoughts or feelings later. Furthermore, if you allow the situation to become rowdy, the child may actually feel less safe, despite the fact that they are the ones initiating the rowdiness.

It is also important that games do not take over to such a degree that there is no real possibility for a child or young person to talk, especially if it is the professional who is most anxious about what needs to be discussed!

6 The evidence

Aldridge, M. & Wood, J. (1998) *Interviewing Children: A Guide for Child Care and Forensic Practitioners*. Chichester: John Wiley & Sons.

Cooklin, A. (2001) Eliciting children's thinking in families and family therapy. *Family Process*, **40**, 293–312.

Cooklin, A. (2004) Talking with children and their understanding of mental illness. In *Parental Psychiatric Disorder: Distressed Parents and Their Families* (2nd edn) (eds M. Göpfert, J. Webster & M. V. Seeman). Cambridge: Cambridge University Press.

Falkov, A. (1999). Adressing family needs when a parent is mentally ill. In *Approaches to the Assessment of Need in Children's Services* (eds H. Wood & W. Rose). London: Jessica Kingsley.

Falkov, A., Mayes, K. & Diggins, M. (1998) *Crossing Bridges: Training Resources for Working with Mentally Ill Parents and their Children. Reader for Managers, Practitioners and Trainers* (Commissioned by the Department of Health). Brighton: Pavilion Publishing.

Garley, D., Gallop, R., Johnstone, N., *et al* (1997) Children of the mentally ill: a qualitative focus group approach. *Journal of Psychiatry and Mental Health Nursing*, **4**, 97–103.

Göpfert, M., Webster, J. & Seeman, M. V. (eds) (2004) *Parental Psychiatric Disorder: Distressed Parents and Their Families* (2nd edn). Cambridge: Cambridge University Press.

Jones, D. P. H. (2003) *Communicating with Vulnerable Children: A Guide for Practitioners*. London: Gaskell.

Jones, D. P. H. & Ramchandani, P. (1999) *Child Sexual Abuse – Informing Practice from Research*. Abingdon: Radcliffe Medical Press and Department of Health.

Ramchandani, P. & Stein, A. (2003) The impact of parental psychiatric disorder on children. *BMJ*, **327**, 242–243.

Reder, P. & Duncan, S. (1999) *Lost Innocents: A Follow-up Study of Fatal Child Abuse*. London: Routledge.

Reder, P. & Lucey, C. (1995) *Assessment of Parenting: Psychiatric and Psychological Contributions*. London: Routledge.

Rutter, M. (1990) Psychosocial resilience and protective mechanisms. In *Risk and Protective Factors in the Development of Psychopathology* (eds J. Rolf, A. S. Masten, D. Cicchetti, *et al*), pp. 181–214. Cambridge: Cambridge University Press.

Scott, A., Shaw, M. & Joughin, C. (eds) (2001) *Finding the Evidence: A Gateway to the Literature in Child and Adolescent Mental Health*. London: Gaskell.

Other resources

Crossing Bridges: comprehensive training for staff working with mentally ill parents and their children

Adrian Falkov, Kate Mayes and Marie Diggins

This training resource, commissioned by the Department of Health, has been designed to enhance practice and improve services for families in which mentally ill adults live together with dependent children. The training manual aims to improve individual practice, while encouraging inter-agency collaboration across specialist areas. The key approach of the training works on the premise that children and their mentally ill parents are better supported and protected if agencies coordinate services and interventions. There is an accompanying handbook, which introduces the training and provides information on key topics in adult mental health, parenting and the parent–child relationship, legislation and child development. Available from Pavilion Publishing (1998).

Patients as Parents: addressing the needs, including the safety, of children whose parents have mental illness

Council Report CR105, Royal College of Psychiatrists, June 2002. This is included on this CD-ROM.

7 Organisations that can provide further help or support

ADD Information and Support Service (ADDISS). The ADDISS Resource Centre, 10 Station Road, London NW7 2JU; tel: 020 8906 9068; fax: 020 8959 0727; e-mail: info@addiss.co.uk; www.addiss.co.uk

ChildLine provides a free and confidential service for children; Helpline: 0800 1111; www.childline.org.uk

The Children's Society produces a series of leaflets for children and parents; tel: 0845 300 1128; e-mail: info@childrenssociety.org.uk; www.the-childrens-society.org.uk

CRUSE Bereavement Care. Helpline: 0870 167 1677; for young people freephone: 0808 808 1677; e-mail: helpline@crusebereavementcare.org.uk; www.crusebereavementcare.org.uk

Parentline offers help and advice to parents bringing up children and teenagers. 520 Highgate Studios, 53–79 Highgate Road, Kentish Town, London NW5 1TL. Helpline: 0808 800 2222; www.parentlineplus.org.uk

The Mental Health Foundation has produced a booklet 'The Anxious Child'. 7th Floor, 83 Victoria Street, London SW1H OHW; tel: 020 7802 0300; www.mentalhealth.org.uk

The National Society for the Prevention of Cruelty to Children (NSPCC) produces helpful information for parents and carers. Weston House, 42 Curtain Road, London EC2A 3NH; www.nspcc.org.uk

The National Autistic Society provides information and advice for parents and families. 393 City Road, London, EC1V 1NG; tel: 020 7833 2299; e-mail: nas@nas.org.uk; Helpline: 0870 600 8585; www.nas.org.uk

The Samaritans provide a 24-hour service offering confidential emotional support to anyone who is in crisis. Helplines: (UK) 08457 90 90 90; (ROI) 1850 60 90 90; e-mail: jo@samaritans.org; www.samaritans.org.uk

Manic Depression Fellowship supports people with a diagnosis of manic depression and their families. Castle Works, 21 St George's Road, London SE1 6ES; tel: 020 7793 2600; e-mail: mdf@mdf.org.uk; www.mdf.org.uk

Newpin (New Parent Information Network) offers support to parents with babies and toddlers. Sutherland House, 35 Sutherland Square, Walworth, London SE17 3EE; tel: 020 7358 5900; www.newpin.org.uk

Rethink offers help to people with severe mental illness (not only schizophrenia) and their carers. 30 Tabernacle Street, London EC2A 4DD; national advice line: 020 8974 6814; e-mail: advice@rethink.org; www.rethink.org

Young Minds provides information and advice on child mental health issues. 102–108 Clerkenwell Road, London EC1M 5SA. Parents Information Service 0800 018 2138; www.youngminds.org.uk

www.incredibleyears.com is an American website with research-based and effective programmes for reducing children's aggression and behaviour and increasing their social skills.

© Royal College of Psychiatrists 2004 (registered charity no. 228636)