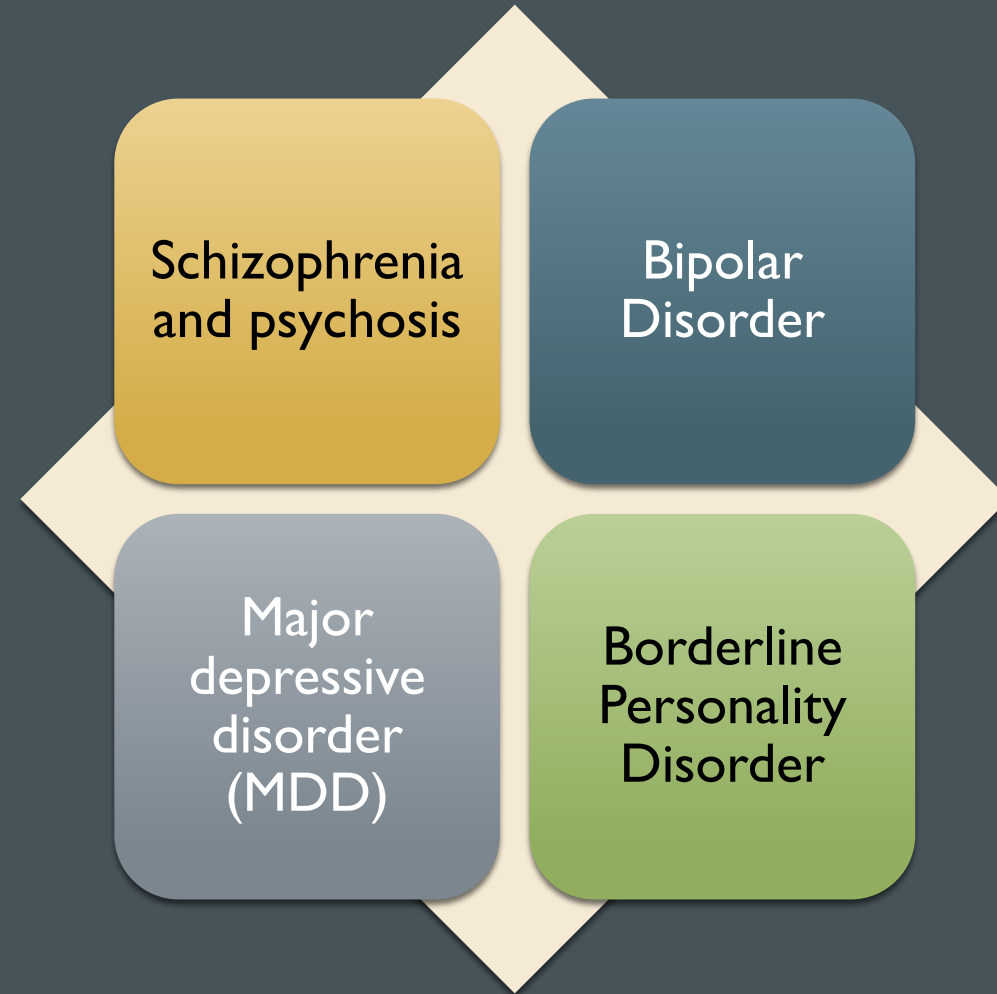

EFFECT OF PARENTAL MENTAL HEALTH ISSUES ON THE CHILD



DEFINITION OF MENTAL ILLNESS

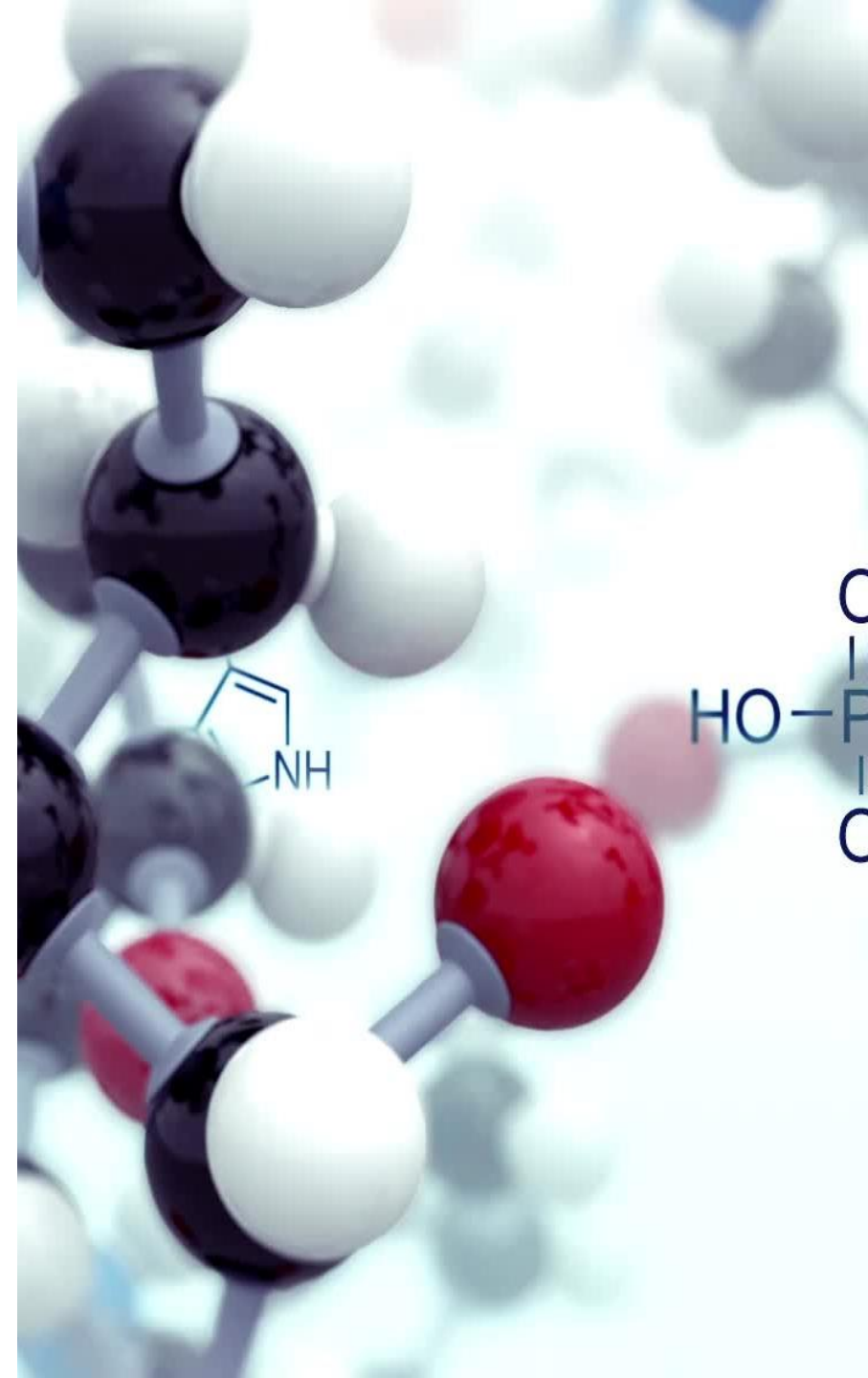
- This lecture will be considering the impact of serious mental illness on the child:
 - Schizophrenia
 - Bipolar disorder
 - Major depressive disorder

RECAP – WHAT
ARE SERIOUS
MENTAL HEALTH
CONDITIONS
AND WHAT DO
THEY ENTAIL?



DSM-5: KEY FEATURES OF SCHIZOPHRENIA

- The diagnosis of schizophrenia has expanded in DSM-5. **Criterion A** now includes five items:
 1. Delusions.
 2. Hallucinations.
 3. Disorganized speech (e.g., frequent derailment or incoherence).
 4. Grossly disorganized or catatonic behaviour.
 5. Negative symptoms (i.e., diminished emotional expression or avolition)
- At least two of the five symptoms must be present for at least one month. One of the two symptoms must be delusions, hallucinations, or disorganized speech.
- Negative symptoms, which impair function the most, are now officially recognised.





- **Criterion B** for schizophrenia gets more attention in DSM-5: “Level of functioning... is markedly below the level achieved prior to the onset”.
- The previous specifiers for schizophrenia (paranoid, disorganized, catatonic, etc.) have disappeared; now, specifiers are related to the illness course (“first episode” versus “multiple episodes”; state of remission; etc.).
- “Currently in full remission” is a specifier. People can and do get better from schizophrenia. (DSM states that 20% of people with schizophrenia have a “favourable course”.)
- The DSM authors explicitly comment about “decrements” in cognitive function in people with schizophrenia, which frames the condition as a brain disease.
- Similarly, there’s a note that “unawareness of [schizophrenia in the patient] is typically a symptom of schizophrenia itself rather than a coping strategy.”

CATATONIC SPECIFIERS AND NEW CATATONIC DISORDERS:

The catatonic subtype has been eliminated. However, a catatonic specifier has been added and may be used with depressive, bipolar, and psychotic disorders.

This recognizes that catatonia occurs across several categories of disorders, without necessarily indicating psychosis.

In addition, there are two new catatonic disorders: Catatonic Disorder due to Another Medical Condition and Other Specified Catatonic Disorder.

KEY COGNITIVE AND BEHAVIOURAL FEATURES FOR DIFFERENTIAL DIAGNOSIS

- **Delusions (positive):**

- Firmly held erroneous beliefs or misinterpretations of perceptions or experiences.
- Fixed and unchangeable beliefs.

Frith (1996) proposes that these stem from an inability to integrate perceptual input with prior knowledge.

Morrison (2001) argues that they stem from biased information processing and dysfunctional beliefs about the world, individuals jump to conclusions based on minimal information.

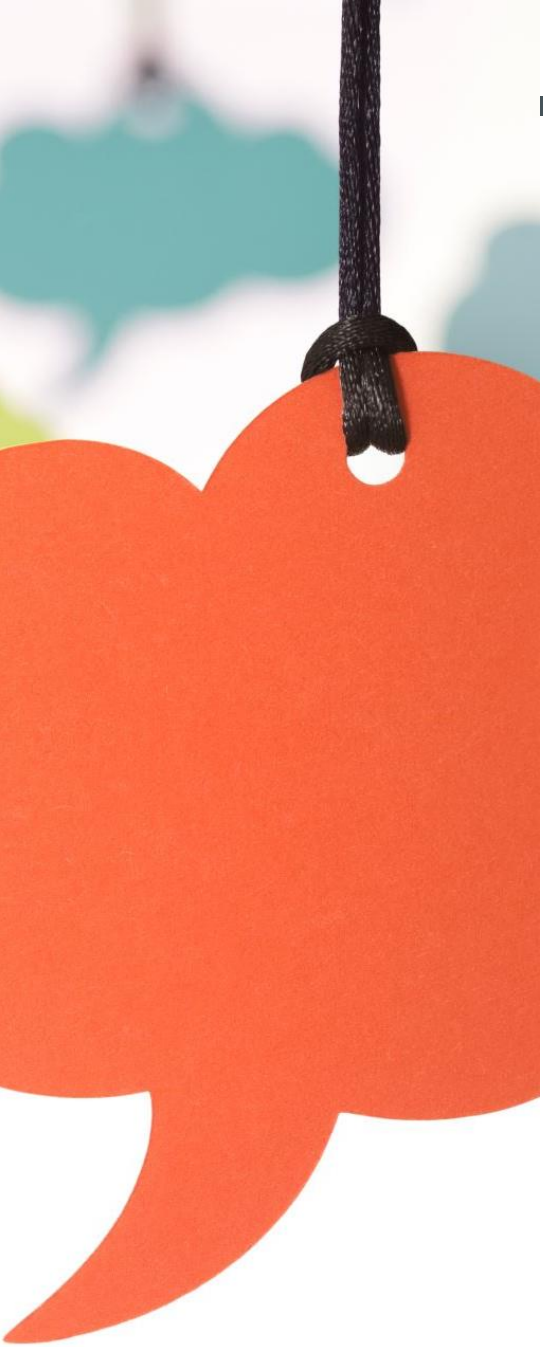
Types of delusions range from persecutory, grandiose, delusions of control, delusion of reference, nihilistic delusions and eroto-manic delusions.





KEY COGNITIVE AND BEHAVIOURAL FEATURES FOR DIFFERENTIAL DIAGNOSIS

- **Hallucinations (positive):**
- Sensory abnormalities across a range of modalities; auditory, tactile, gustatory, olfactory and visual in 70% of sufferers.
- Auditory hallucination is reported the most, with sufferers hearing voices commanding that they act, or `hearing a conversation` (although we know that it is from an internal source). Visual comes next, followed by tactile and somatic.
- Some sufferers believe them to be true, whereas others recognise that they are not. They appear to stem from a `reality monitoring` and/or `self monitoring` deficit.



KEY COGNITIVE AND BEHAVIOURAL FEATURES FOR DIFFERENTIAL DIAGNOSIS

- **Disordered thoughts/speech (positive):**
- Derailment- drifting from one topic to the next.
- Loose associations- drifting from one conversation to another.
- Tangential speech- irrelevant answers.
- Clanging- thoughts driven by word sounds.
- Neologisms- made up words.
- Word salads- no links between words at all.

KEY COGNITIVE AND BEHAVIOURAL FEATURES FOR DIFFERENTIAL DIAGNOSIS

**Disordered
motor
behaviour
(positive):**

Inappropriate
behaviour for
chronological age.

Or agitated
behaviour.

Inappropriate
behaviour for the
context.

Inappropriate
clothing or
hygiene.

Catatonic motor
behaviours.

KEY COGNITIVE AND BEHAVIOURAL FEATURES FOR DIFFERENTIAL DIAGNOSIS



- **Negative symptoms:**
- Common for schizophrenia, but less so for the other psychoses.
- Diminished emotional expression (affective flattening).
- Avolition (lack of goal orientated behaviour).
- Alogia (lack of verbal fluency).
- Asociality (social withdrawal).

WHAT WOULD IT
BE LIKE TO BE A
CHILD WITH A
PARENT
SUFFERING FROM
SCHIZOPHRENIA?





PSYCHOSIS OR NEUROSIS?

- A neurosis refers to a disorder of affect or mood, such as anxiety, panic, phobias and depression. People suffering from neurotic disorders are treated with sympathy and understanding.
- Psychosis on the other hand is outside of most people's comprehension and refers to a detachment from reality. Symptoms may include hallucinations (auditory and visual) and delusions, thought disorders etc.

MOOD DISORDERS

Most people with a mood disorder suffer only from depression

- This pattern is called unipolar depression or **Major depressive disorder (MDD)**
 - Person has no history of mania
 - Mood returns to normal when depression lifts

Others experience periods of mania that alternate with periods of depression

- This pattern is called **bipolar disorder**

SYMPTOMS COVER FIVE AREAS OF FUNCTIONING

Emotional symptoms	Motivational symptoms	Behavioral symptoms	Cognitive symptoms	Physical symptoms
• Feeling “miserable,” “empty,” “humiliated” • Experiencing little pleasure	• Lacking drive, initiative, naturalness • Between 6% and 15% of those with severe depression die by suicide	• Less active, less productive	• Hold negative views of themselves • Blame themselves for unfortunate events • Pessimistic	• Headaches, dizzy spells, general pain

DIAGNOSIS- MDD (DSM5)

DSM-5 Checklist

Major Depressive Episode

1. The presence of five or more of the following symptoms during the same two-week period, including at least one of the first two symptoms: • daily depressed mood for most of the day • daily diminished interest or pleasure in almost all activities for most of the day • significant weight loss or weight gain, or daily decrease or increase in appetite • daily insomnia or hypersomnia • daily psychomotor agitation or retardation • daily fatigue or loss of energy • daily feelings of worthlessness or excessive guilt • daily reduced ability to think or concentrate, or indecisiveness • recurrent thoughts of death or suicide, a suicide attempt, or a specific plan for committing suicide.
2. Significant distress or impairment.

Major Depressive Disorder

1. The presence of a major depressive episode.
2. No history of a manic or hypomanic episode.

Dysthymic Disorder (One Form of *Persistent Depressive Disorder*)

1. Depressed mood for most of the day, for more days than not, for at least two years.
2. Presence, while depressed, of at least two of the following: • poor appetite or overeating • insomnia or hypersomnia • low energy or fatigue • low self-esteem • poor concentration or difficulty making decisions • feelings of hopelessness.
3. During the two-year period, symptoms not absent for more than two months at a time.
4. No history of a manic or hypomanic episode.
5. Significant distress or impairment.

WHAT WOULD IT BE
LIKE TO BE A CHILD
WITH A PARENT
SUFFERING FROM
MDD?



WHAT ARE THE SYMPTOMS OF MANIA ?

■ Five areas of functioning –

Emotional symptoms	Motivational symptoms	Behavioral symptoms	Cognitive symptoms	Physical symptoms
• Active, powerful emotions in search of outlet	• Need for constant excitement, involvement, companionship	• Very active – move quickly; talk loudly or rapidly • Flamboyance is not uncommon	• Show poor judgment or planning • May have trouble remaining coherent or in touch with reality	• High energy level – often in the presence of little or no rest

DIAGNOSIS

DSM-5 Checklist

Manic Episode

1. A one-week (or longer) period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, for most of the day, nearly every day.
2. Presence of at least three of the following: • inflated self-esteem or grandiosity • decreased need for sleep • increased talkativeness, or pressure to keep talking • flight of ideas or the experience that thoughts are racing • distractibility • increase in goal-directed activity or psychomotor agitation • excessive involvement in activities that have a high potential for painful consequences.
3. Significant distress or impairment.

Bipolar I Disorder

1. Presence of manic episode. Or, if current episode is hypomanic or depressive, history of manic episode(s).
2. Significant distress or impairment.

Bipolar II Disorder

1. Presence or history of major depressive episode(s).
2. Presence or history of hypomanic episode(s).
3. No history of a manic episode.
4. Significant distress or impairment.



WHAT WOULD IT BE LIKE
TO BE A CHILD WITH A
PARENT DIAGNOSED WITH
BIPOLAR DISORDER?



PERSONALITY DISORDERS

A personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

DSM 5, 2013, p.645.

PREVIOUSLY...DSMIV-TR

- 10 personality disorders in 3 clusters:
- Cluster A: Odd/eccentric: Paranoid, Schizoid & Schizotypal
- Cluster B: Dramatic/Erratic: Antisocial, Borderline, Histrionic & Narcissistic
- Cluster C: Anxious/Fearful: Avoidant, Dependent & Obsessive-compulsive
- Prior to DSMIV the diagnosis was very unreliable!
- DSM-5 has two sections on PD's.
- We are concerned specifically with Borderline PD.

BORDERLINE PERSONALITY DISORDER (PART OF CLUSTER B)

Very common in clinical populations and very hard to treat. It is also associated with suicide.

Core features are impulsivity instability in relationships and mood.

Attitudes and feelings towards other people can change rapidly from idealisation to anger.

They are overly sensitive to small signs of emotions in others and often do not have a clear sense of self.

Their potentially self-damaging behaviour can include gambling reckless spending indiscriminate sexual activity and substance abuse.

They do not like to be alone, fear abandonment, demand attention, and experience chronic depression.

They may also engage in self-mutilation.

However, over 10-15 years they usually no longer meet the criteria and certainly by the age of 40.



WHAT WOULD IT BE LIKE
TO BE A CHILD WITH A
PARENT DIAGNOSED
WITH BORDERLINE
PERSONALITY DISORDER?



EXPERIENCE OF THE CHILD

The child is dependent on the parent and so will be particularly exposed to challenges.

Children recognise when their parent is experiencing a period of poor mental illness.

They often witness and experience dangerous situations: such as the parent being physically abusive.

However, children can also experience episodes when the child is neglected and the parent is physically and mentally absent.

Parents with serious mental illness can often become delusional and bring the children into their delusions.

CONT'D - ATTACHMENT

The relationship between the parent and child will be affected, and often the child will not know whether it is safe to engage with the parent, or whether they are safer to keep their distance.

Children often report being able to engage with parents when they are not experiencing a psychotic episode but needing to withdraw when it is unsafe.

THE CHILD AS THE CARER

Children of mentally unwell parents often become the main carer. Needing to support their siblings and often their parent.

Children will often guard their parents, keeping an eye on them to make sure that they are safe.

Siblings will often become very close and support each other as they have a shared experience.

PROTECTING FAMILY PRIVACY

There is often a sense from children that they cannot discuss their family situation with 'outsiders'.

There is often particular pressure from parents that their children cannot discuss the situation with anyone outside of the family.

Why do you think this might happen?

LACK OF UNDERSTANDING

Often children do not know what is going on. Particularly when parents are suddenly absent (because they've been taken into hospital).

Children will often go and live with other relatives but not be informed about the reason why.

They won't have a clear understanding about the illness, particularly if there is an underlying sense of secrecy.

THE CHILD'S FEELINGS

- Experiencing frightening behaviours, being unable to understand the situation, having to look after each other would give rise to many emotions.
- Consider how a child/adolescent might feel in these situations.

THE NEED FOR SUPPORT

Family support: Partners, grandparents and extended family and occasionally the community.

Health services and other services are often not engaged, they often do not notice or provide the support that is needed. Children often feel judged by health services, particularly if their parent has been hospitalised.

HOW WILL THIS IMPACT THE CHILD`S ADULT LIFE

Spend some time considering the impact that this childhood experience will have on the adult.

Think about:

- Health
- Education
- Social implications
- Employment
- Relationships

PARENTIFICATION

- Parentification occurs when a child is expected to take on responsibilities that are beyond their developmental level, such as caring for the emotional, physical, or mental well-being of their family. This can lead to a role reversal where the child becomes the caregiver before they are ready.
 - Signs that a child may be parentified can be –
 - Anxiety about caring role, depression.
 - Unrelenting worry, suicidal thoughts.
 - Overworking, social isolation.
 - Feelings of guilts and shame.
-
- In adulthood, parentified children may have difficulty with relationships, poor boundaries, and anxiety. They may also struggle to form healthy relationships and set boundaries.



ADAPTIVE AND DESTRUCTIVE PARENTIFICATION

When the boundaries between parent and child are severely disrupted it is known as parentification. This happens when the child is used to help with care, support, comfort and closeness.

When a parent has serious mental illness parentification can occur.

ADAPTIVE PARENTIFICATION

- Children are often encouraged to support the family in the home, depending on the family's cultural norms and the developmental stage.
- Supporting with cleaning, cooking, and childcare is often moderate in intensity, and some expectations are usually temporary.
- Often the child is rewarded (pocket money) and receives praise for the work.
- It is often girls that perform these roles. However, this again depends on culture.
- It can develop maturation, personal development, empathy and adaptive coping skills.

DESTRUCTIVE PARENTIFICATION

- Destructive or pathological parentification is harmful. It is usually characterised by poor parental care.
- The child is expected to perform roles that are well beyond the maturational stage of the child. It puts a significant burden on the child and has long-lasting emotional implications.
- The child often perceives these as unfair and a negative challenge.
- They do not receive a reward for this.
- These roles often cause anxiety and depression.
- Children often have to put aside their own needs to cater to the needs of the parent's.

CONT'D

- The relational and physical boundaries are often blurred and violated, particularly as the parent is not able to see the child in the relationship.
- Often the child has to take on adult functions and play a significant role in decision-making and problem-solving.
- Parents often see the child as a friend, an equal, rather than as a child.
- The relationship is often enmeshed and the child struggles with their own identity.

BOUNDARIES

Boundaries between child and parent are necessary.

They support appropriate child development.

And ensure that developmental, emotional needs are met.

The child needs to develop into a secure adolescent, able to decide for themselves and have a good sense of self.

FACTORS THAT
LEAD TO
PARENTIFICATION

External:

- Mental Health issues
- Physical disability
- Cognitive impairment
- Early parenting
- Parental loneliness

CONT'D

Internal:

- Birth order
- Innate traits

EMOTIONAL EXPERIENCES

Fear and Threat

Constant fear of survival

Always vigilant

Not trusting others

Also afraid of their own needs and feelings.

STRATEGIES

Holding and
protecting

Holding and protecting parents whilst also maintaining constant vigilance

Creating

Creating a false self (disconnection, splitting, inner and outer self)

Demonstrating

Demonstrating a strong outward appearance

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