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Working in a family therapy setting with families where a parent has a mental illness: practice dilemmas and strategies

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There is strong evidence supporting the benefits of family work, for both parents and children, in the treatment of parental mental illness. However, there has been only limited research on the implementation of family work in settings outside the mental health sector, such as family therapy or family counselling services, where mental illness may not be the primary presenting issue for a family. This article reports on a qualitative study that explored the experiences of family therapists working with families affected by parental mental illness. The article focuses on dilemmas clinicians faced integrating discussions about parental mental illness into family sessions. The findings support the need for clinicians to have appropriate training in family work related to mental health issues and also to develop the skill set needed to actively introduce, negotiate and explore the topic of mental illness with families.

Practitioners points

- Developing knowledge, language and confidence in talking about mental illness may assist clinicians to raise discussions about parental mental illness in family sessions.
- Training in evidence-based interventions for working with children of parents with a mental illness may provide a tool for clinicians in family sessions.
- Clinicians must be attuned to the 'emotional readiness' of parents and children to discuss parental mental illness. Developing readiness may take time.

Keywords: mental health; family work in mental health.

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Introduction

Having a parent with a serious mental illness can have a negative impact on the health and well-being of all family members. Children, in particular, may be vulnerable to poor emotional or social outcomes (Maybery *et al*., 2009; Mowbray *et al*., 2006; Siegenthaler *et al*., 2012). Families where a parent has a mental illness (FaPMI) may also be at risk of a range of social problems, including poverty, homelessness or family conflict (Beardslee *et al*., 2007; Mowbray *et al*., 2006).

There is, however, strong evidence for the benefits of a family-focused approach to the treatment of mental illness, both for parents and children. Family-inclusive work can promote positive family functioning, reduce the incidence of children developing a mental illness and improve care of children in the family (Beardslee *et al*., 2003, 2007; Falloon, 2003; Reupert and Maybery, 2010; Siegenthaler *et al*., 2012; Solantaus *et al*., 2010). There is also evidence that family work may improve outcomes for parents with serious mental illness, such as schizophrenia or bipolar disorder (Asen, 2002; Pharoah *et al*., 2006), as well as more prevalent conditions such as depression (Leff *et al*., 2000). Family work may incorporate a range of strategies. Often it does not involve contact with the whole family, rather the focus is on training mental health workers to support clients in their parenting and to coach them to talk to their children about mental illness (Solantaus *et al*., 2010). Other initiatives are more intensive, often based on a therapeutic model and involving all family members directly (Asen, 2002; Cowling and Garrett, 2012; Nicholson *et al*., 2007). Psycho-education about mental illness is included in most interventions and there is consistent evidence of positive outcomes for children to be gained from teaching them about parental mental illness. In particular, education programmes have been shown to increase children's understanding of their parent's behaviour when they are unwell, so as to reduce their own sense of self-blame (Beardslee *et al*., 2003, 2007; 2003; Siegenthaler *et al*., 2012). Where psycho-education is conducted in the context of a family session, discussions are likely to incorporate a focus on each family member's unique experience and perspective of mental illness and the family's capacity to communicate their concerns or stresses (Solomon, 1996).

Most research on family-based approaches to working with parents who have a mental illness has occurred in a mental health setting (Beardslee *et al*., 2003; Cowling and Garrett, 2009, 2012; Siegenthaler *et al*., 2012). Missing from this research is an exploration of the ways

in which parental mental illness has been addressed or incorporated into therapeutic responses in other settings. In particular, there is limited research in settings where mental illness is not the presenting issue for families or where families present with complex issues. This is often the case in frontline counselling and welfare services where families affected by parental mental illness may present to services with a range of issues including family conflict, substance abuse problems, family violence, experiences of trauma among family members, child behavioural problems or couple relationship issues (Golding, 1999; Hegarty, 2011; Weaver *et al*., 2003). Even in the context of other issues, however, parental mental illness is likely to be a factor influencing family well-being, given the pervasive impact of mental illness on couple and family relationships (Ackerson, 2003; Foster *et al*., 2011).

This article reports on a study about the experiences of family therapists working with FaPMI. In the article we explore the challenges and dilemmas clinicians may face when raising mental illness discussions with families or when integrating interventions known to improve outcomes for families affected by mental illness into their family work. We focus particularly on work with families when parental mental illness is not the presenting issue, even where there is a known diagnosis of mental illness. It is anticipated that the findings of this article will be of use to professionals across a range of health and welfare settings who may be working with parents or families affected by mental illness. It may also be of interest to those working in the adult mental health sector.

Method

This project was undertaken at the Bouverie Centre, a family institute located in Melbourne, Victoria, Australia. The Centre has its origins in family therapy but also works with a broad range of organizations to introduce family-inclusive practices. The Bouverie Centre sees families from range of backgrounds but has a particular focus on families affected by trauma, family violence, child and adolescent behavioural and mental health problems, sexual assault, mental illness or brain injury.

A group of clinicians working at the Bouverie Centre formed a team that met regularly to discuss ways to improve their work with FaPMI. The team included four family therapists as well as the coordinator of a state-wide project that aims to improve outcomes for

FaPMI in the mental health sector (the Victorian Government FaPMI strategy). Two people on the team were specialists in FaPMI (one family therapist and the coordinator of the FaPMI strategy). The team operated as a reflective practice group in which clinicians met to discuss families with whom they were currently working in order to share experiences, reflect on practice challenges, draw on the expertise of other clinicians and the FaPMI specialists and explore ways to integrate current evidence on FaPMI interventions into their family work.

The project ran for 12 months from September 2011 until August 2012 and the team met once or twice per month. Clinicians involved in the team were assigned cases, through existing intake procedures, where parents were known to have a mental illness. Through the course of the project twenty-two families were seen by members of the project team. The number of sessions families attended ranged from one to thirteen, with an average of five. Families had a parent (father or mother) with one or more of a range of diagnoses, including severe depression, post-traumatic stress disorder, borderline personality disorder, bipolar disorder, dissociative disorder, schizophrenia or delusional paranoid disorder. In several cases one or both parents also had a drug or alcohol problem. All these parents had at least one child aged under 18 years. In eight of the twenty-two cases (36%) the primary presenting issue was a concern about the impact of parental mental illness on the family. In all other cases, the families presented with a range of other issues including concerns about the children's behaviour, concerns about the impact of parental hospitalization on children, conflict between parents and children or conflict between parents. It was originally envisioned that therapists would work in teams of two in order to provide opportunities to share knowledge and reflect on the clinical work. Due to practical constraints, however, only nine families out of the twenty-two (40%) were seen in co-therapy teams: the rest were seen by one clinician.

While we have provided general information about families seen by clinicians as part of this project, it is the clinicians, not the client families, who were the research participants. Providing details of the families seen by the clinicians is intended to illustrate the range of experiences clinicians had over the course of this project. Our objective was not to measure outcomes for families but to reflect systematically on the challenges clinicians encountered in their work with these families. As such, and to maintain client privacy, we speak about

families in very general terms and provide no details of ages, gender or number of children in the families.

The family therapy interventions utilized by clinicians in this project drew on a number of theoretical models or approaches. These included relational trauma theory (Scheinberg and Fraenkel 2001), attachment theory (Byng-Hall, 1995), Milan systemic theory (Selvini-Palazzoli *et al*., 1978, Rhodes, 2008), narrative therapy (White and Epston, 1990), solution focused therapy and strengths based practice (de Shazer, 1988; Furlong *et al*., 1991), as well as structural family therapy (Minuchin, 1974). Clinicians at the Bouverie Centre also work broadly in a single session therapy approach, which involves collaborating with clients to set an agenda for each session and to check in with the family during the session to ensure the agenda is meeting their needs (Young and Rycroft 1997). The therapeutic approach taken by the clinicians could also be considered a post-modern approach (Perlesz and Lindsay, 2003) in that clinicians were interested in working with families to understand the ways they construct experiences of mental illness but, when it was helpful, were also willing to draw on more objective processes such as the delivery of education and information that aimed to inform the clients about mental illness.

While there is not enough space in this article to engage fully in this debate, we note that there are different views about the benefits of drawing on mental illness diagnostic categories in work with families (Wynne *et al*., 1992). We also acknowledge that it may be problematic to utilize the term illness or impose an objective view of particular diagnoses in therapeutic work with some families (Carr, 1998). As noted above, the clinicians in this study worked on the basis of accepting the research evidence of the benefits of speaking to families and children about parental mental illness (see references in the introduction) but also sought to remain attentive to the language, perspectives and experiences through which families defined the meaning of mental illness through their own lens.

Discussions in team meetings were focused on families being seen by team members over the course of the project. The team utilized a reflective practice approach, incorporating elements of action research (Friedman, 2001; Mendenhall and Doherty, 2005) whereby practice initiatives and strategies were adapted and improved through team-based reflection and further practice (Mendenhall and Doherty, 2005). At meetings, team members would discuss approaches for working with their current clients and ways to integrate new ideas or

processes into their work. In subsequent meetings, the clinicians would then share their practice experience and develop ideas further as needed. In this way, a cycle of action-reflection-action was established.

A researcher attended and digitally recorded the team meetings. Once the project had run for 12 months the researcher interviewed the team as a group, utilizing semi-structured interview techniques to explore the clinicians' experiences of their practice over the year.

Due to time and resource limitations the recordings were not transcribed verbatim. Instead, the researcher took extensive notes during meetings and when listening to recordings. These notes were shared with the team to ensure they were consistent with the participants' recollections of the discussions and to stimulate further discussion. Thematic analysis broadly followed a constructivist grounded theory approach to coding (Charmaz, 2006) whereby a broad set of themes was identified through an initial review of notes and recordings. The researcher looked for general themes in the first instance, focusing on coding actions, interactions, processes and feelings (such as clinicians' experiencing frustration or uncertainty or the process of introducing questions or new discussions to families). In the first round of coding, a major theme emerged around the dilemmas encountered by clinicians. Following this, a second round of analysis involved attending more closely to instances where the participants spoke about dilemmas, challenges and solutions. The researcher wrote detailed notes about these themes, developing analytic memos in the process. These memos were shared with participants who further explored and articulated their meaning through a series of group discussions. The researcher then revisited the notes and recordings to refine and develop the memos. This article was co-written by the researcher and the clinical team. The process of writing enabled further discussion and refinement of the findings.

This project received ethics approval from the La Trobe University, Faculty of Health Sciences, Human Research Ethics Committee.

Findings

Three key processes were identified through analysis of meeting and interviews notes. These are presented below in the order they might arise in the context of the family work. The first is establishing consent from the family to engage in discussions about mental illness. The second is how priorities should be determined in a therapy session

with respect to privileging mental illness over other issues. The third is the nature of discussions about parental mental illness in the context of a family therapy setting and the need to attend to the emotional safety of family members.

Gaining permission for conversations about parental mental illness

In most cases the families seen by clinicians throughout the course of this project did not present to the service for support with issues related to mental illness. As mentioned above, they tended to seek therapy for a range of other concerns, such as problems with children's behaviour, problems with a parent's anger or difficulties in relationships between parents and children. In all cases, however, the clinicians were aware of parental mental illness in the family, as it had been noted during their intake interview.

In families where parental mental illness had not been identified by families as a presenting issue, the clinicians were faced with the dilemma of whether to raise the issue of mental illness or to wait for the family to raise it themselves. This was a recurring theme in project meetings. The clinicians were motivated to talk to families about mental illness but they were also aware that parental mental illness may be highly sensitive for a family and had the potential to invite a sense of blame or shame into the session. The clinicians were also concerned about damaging a trusting therapeutic relationship.

Over the course of the project, the clinicians identified two strategies to introduce discussions about mental illness in their work with families in a way that was sensitive to the family's cues. Firstly, the team worked with the intake service at the Bouverie Centre to develop new questions that would be asked of prospective clients who had a diagnosis of mental illness in their intake interview. The questions were: 'Have you spoken to your children about mental illness?' 'This is something we can help you with, would you like your therapist to talk further with you about this?' Asking this question at the beginning was intended to open a pathway for later conversations.

Secondly, the clinicians began to pay much more attention in their discussions with families to places where the topic of parental mental illness was raised indirectly or in passing. If it was raised, the clinicians took the opportunity to flag the topic by asking a question such as, 'Is your family's experience with mental illness something we could come back to later during the session?' For instance, in one case, a mother referred briefly to her depression in a discussion about her children.

The clinician took this cue to ask whether the mother had spoken to her children about depression and whether she would like support to have such conversations. This enabled the topic to be identified as something to discuss in future sessions without creating too much disruption to the immediate conversation. In a team meeting, the clinicians noted that asking a question such as this could also occur when the clinician and family were developing an agenda for the session.

This strategy led to several discussions in team meetings about possible questions clinicians could use to open the door to discussions about mental illness. As one clinician said:

> If you ask questions about whether or not you have spoken to children about mental illness it opens a doorway to speaking about parental mental illness and if you don't open this door you may get side-tracked with other issues. So it is about being mindful of opening these doors ... without forcing the session to be about mental health if this is not where the family want it to go. It creates a possibility of it being on the agenda.

The clinicians felt that if they had questions and language at the ready they would be more prepared to initiate conversations about mental illness and less likely to miss appropriate opportunities to raise the topic. A list of potential door-opening questions developed by the team is provided in Table 1.

Determining priorities in the session

A second major dilemma for clinicians in this project was how to prioritize discussions about mental illness in the context of a range of presenting issues. Most families seen by clinicians during the course of this project faced multiple challenges, including family violence in some cases. The clinicians did not always feel confident about the value of introducing mental illness into discussions. They decided to address this concern by exploring strategies for making links in discussions with families between mental illness and other issues. For example, in one case two clinicians worked (as a co-therapy team) with a family where the mother had experienced depression for many years. The presenting issue was the children behaving aggressively towards the mother. This was the primary focus of discussions. But the clinicians decided it was important in this case to identify links between the mother's depression and the children's behaviour. They did this by raising, at an appropriate point in a session, two questions with the mother, 'Is depression getting in the way of you being the

TABLE 1 *'Door opening' questions to invite conversations about the impact of parental mental illness on families*

The therapist plays an active role in signalling to the family that talking about mental illness is okay, that the therapist is comfortable with this conversation and that it is a possible agenda item for discussion. The therapist also conveys that we are interested in every family member's experience of mental illness, as well as their way of understanding and describing it. Some questions might be: • Have you ever had the opportunity as a family to share your experiences and understandings of the illness or difficulties? Do you think talking about this in family sessions at some point would be helpful? • Have you spoken to your children about mental illness? Would you like some help talking about this with your children? What would you like them to understand? Children try to make sense of what they see, hear and think even if they are not told by adults what is going on. What do you think your children understand? Would this be helpful to cover in our sessions? • What do you think your children would say about mental illness if we asked them? • How do you think your children or partner make sense of what they observe when you are unwell?

parent you want to be?' and 'Is depression undermining your efforts to set limits and consequences for your children?' The intention of these questions was to invite the mother to explore her illness as an influence on family processes and her relationship with the children.

Talking about mental illness: therapeutic concerns

Throughout the course of this project, the clinicians gained opportunities to engage with a number of families on the topic of parental mental illness. From these discussions the therapists identified core therapeutic considerations when talking with families about parental mental illness: ensuring emotional safety for the family (such as members feeling free from a sense of blame regarding the mental illness), understanding the family's language and construction of mental illness and providing opportunities for psycho-education (see Table 2 for an overview).

Emotional safety

The sensitive nature of parental mental illness is likely to mean that not all families will be prepared for, or able to consent to, talking about

TABLE 2 *Therapeutic considerations*

- Is it emotionally safe (especially for children) to discuss parental mental illness? Is the parent with the diagnosis prepared to have this discussion and feeling ready? Or are they not ready (perhaps feeling fragile or defensive)?
- Are all family members willing to discuss parental mental illness in the family session? What preparation might be needed to ensure all members are comfortable and safe for discussions to proceed?
- Give a rationale as to why it might be important to discuss mental illness and what the beneficial factors are for children.
- What language does the family use to describe or speak about mental illness? It might be useful to decide on a common language and suitable terms for everyone.
- What is the children's understanding of mental illness? What is their understanding of their parent's behaviour when the parent is unwell? Explore ideas of causality, self-blame concerns and access to information.
- Do family members each have a different understanding or perception of mental illness or their parents' behaviour when they are unwell?
- Psycho-education about mental illness might involve exploring what the partners and children believe about their parent's mental illness as well as providing them with information about mental illness, including the management of the illness and recognizing the signs of illness.
- Give a rationale as to why it is important to discuss mental illness with children and what we know about it being beneficial for them, when done in the right circumstances.
- Be sensitive to the family's and broader cultural beliefs and to the needs of children and parents.

mental illness. This sometimes created a dilemma for clinicians around how to ensure all family members were prepared for these discussions, as one clinician explained:

> I feel a bit compromised when the mother is unwell and most of the conversations are with the father and son as she is unable to participate. Yet I know she worries a lot about the impact of her mental illness on her son. So I am not sure of the best way to make sure she is involved and is able to keep her integrity in this process when she is unwell. Should I speak to the father and son separately?

Throughout the project, several clinicians had experiences whereby there was an extended process of working with parents or children to prepare them for discussions about mental illness. For instance, one therapist conducted several sessions over the course of a year with a mother who was very nervous about raising mental illness with her

daughter. This process involved speaking in detail to the mother about what would be discussed with the daughter, what would not be discussed and the potential positive and negative consequences of explaining mental illness to children. In another case, even though the parent was willing to have the conversation, the child did not want to acknowledge what was being said or any negative effects of the mother's illness.

In reflection on these cases in team meetings, the clinicians adopted the term emotional safety to explain what they were trying to achieve with the families. The clinicians sought strategies to prepare individual family members in advance of discussions about mental illness to ensure they felt safe and supported. One option raised to do this was for clinicians to seek permission from parents to have a session with the children alone prior to a family-based discussion about mental illness. This was undertaken during the project by one clinician who found that working with the child separately seemed to build the child's confidence about being able to ask questions about mental illness in front of the parents.

Language and understanding

Throughout the course of their discussions with families, the clinicians in the project became aware that the language clients used to speak about parental mental illness was core to unpacking how both parents and adults understood and also managed parental mental illness. In one family, for example, the children had been taught to use the term sleeping to describe their father's dissociative state. This was problematic because it meant that the children were not aware of what was really going on for their father, given that their understanding of sleeping was based on the type of sleeping they themselves did every night. The children did not fully understand why their father could not engage with them (with affection or attention) when he was dissociative or why he could not wake up. In this case the clinician focused on some simple psycho-education with the children during a family session (and with the parents' permission), teaching them the meaning of the word dissociative and explaining how it was different to sleeping. As occurred in this case, the clinicians found that working with families often involved a process of unpacking the perspectives of each individual to gain a complex picture of how parental mental illness was experienced by the whole family, rather than assuming knowledge of this experience based on

the mental illness diagnosis itself. This process was important for the clinicians as it directed and framed any further interventions or discussions about mental illness, including psycho-education. As one clinician said:

> The thing about it is that even when there is a family with a diagnosis the two parents may have really different meanings they ascribe to that, and the broader system may say 'Well, you are unwell at the moment', and the kids may [see it differently again], like the kids I am working with at the moment, they say, 'Well he [Dad] is just selfish.... So even within families there are different capacities and readiness to have difficult conversations [about mental illness]. So we have to be sensitive to the readiness and the value of having these conversations.

Psycho-education

The clinicians felt they lacked the skills or knowledge to conduct psycho-education about mental illness with families. But they found that the reflective practice group established for this project assisted with this as they could draw from the knowledge of the FaPMI specialists on the team. Where clinicians did deliver psycho-education, they found the context of the family therapy setting to be conducive to a positive session because the families were already oriented towards reflecting on family relationships and processes. This facilitated the integration of education into family discussions, allowing it to be specific and directed towards the needs of each family rather than being a didactic delivery of information. For example, in one case, a mother, on hearing the explanation of depression provided by the clinician, was able to follow on from this by sharing her own reflections on some of the kinds of behaviour her husband displayed when he was unwell. She spoke about how his lack of focus and disorganization affected their relationship and increased conflict in the family. The clinician observed that this new understanding enabled the mother to adopt an attitude towards her husband's depression that blamed him less and was more realistic about what could be expected. In this and other cases, the clinicians felt that the provision of psycho-education was useful in building a framework around which family members could place and make sense of the impact of mental illness on their family relationships. Psycho-education (whether it was structured or unstructured) also created a platform for speaking about mental illness in a way that was less emotionally reactive for the families because the topic was separate from the family itself. Introducing

information or education enabled a conversation that was, as one clinician put it, 'less jammed up by emotional experience'.

Discussion

There is a large body of literature supporting family-based approaches to the treatment and management of parental mental illness and there is a strong body of evidence demonstrating the efficacy, in terms of improved child outcomes, of providing psychoeducation for children in these families (Beardslee *et al*., 2003, 2007; Solantaus *et al*., 2010) and in supporting adults to talk to their children about mental illness (Beardslee *et al*., 2003, 2007; Cowling and Garrett, 2012; Solantaus *et al*., 2010). Research on interventions to improve outcomes for children in FaPMI, however, have largely been evaluated in settings where parents have elected to participate and are prepared to engage in sensitive conversations about their children's experience of mental illness (even if permission has been granted following extended discussions with practitioners and researchers) (Beardslee *et al*., 2003; Solantaus *et al*., 2010). This is, of course, by necessity. It would be unethical to compel parents to participate in research if they were unwilling. However, it means that there is only limited research on the implementation of interventions for parents affected by mental illness and their children in settings outside the adult mental health sector. It also means there is limited research on the processes by which professionals might engage parents and families in discussions about mental illness where illness is not the primary presenting issue. This article makes a contribution to this gap in research by exploring some challenges professionals might encounter working with families affected by parental mental illness in a family therapy setting where families have presented with diverse and complex issues.

A consistent, if not implicit, theme across findings from this project is the importance of clinicians spending time reflecting on, and developing, effective ways to engage families on the topic of parental mental illness. Where clinicians were unprepared to introduce these conversations, opportunities to talk about the impact of parental mental illness with families were missed, especially where other problems were more immediately pressing for families. Training in evidence-based interventions for improving outcomes for families affected by mental illness could be part of increasing clinician's preparedness for work in this area. But the clinicians in this project also

found it useful simply to develop a cache of questions and language to draw on to invite or introduce discussions about mental illness into family sessions (see Table 1).

The findings of this project also suggest, however, that even when clinicians feel prepared and have the skills to discuss mental illness, there may be challenges for them in raising these issues with families. Family members, both parents and children, may not feel emotionally ready for the conversations. Being attuned to the emotional safety of all family members and focusing discussions on parents' and children's unique experience and understanding of mental illness (including the language they use to describe their experiences) can be part of assessing readiness to discuss mental illness and may facilitate a safe and productive conversation about the experience of mental illness.

The setting of a family therapy or counselling clinic may offer some advantages over other settings to engaging in conversations with clients about the impact of parental mental illness on family relationships and processes. Families who present to such services are likely to have some degree of preparedness for discussions about family relationships and clinicians are skilled in facilitating these discussions. This may not be the case in other settings. For instance, family relationships and dynamics are less likely to be a focus of service delivery in the adult mental health sector, where the objective is generally mental illness recovery from a more individual perspective. Mental health clinicians are not usually trained in family counselling. There are, however, complexities in focusing on parental mental illness in a family therapy or counselling setting. This is largely because, as noted previously, families generally present to these services with multiple issues and clinicians do not always have a mandate to discuss mental illness. Gaining permission from families to raise the topic of parental mental illness, and determining the priority of these conversations within sessions, can be sensitive territory for clinicians to navigate. Despite this, the outcomes of this project suggest that having a broad range of issues on the table in a family session can facilitate holistic discussions about mental illness and family relationships. These discussions make links between mental illness and other family processes and explore how mental illness may exacerbate other problems in the family. It was beyond the scope of this project to examine family outcomes with respect to this holistic approach. But future research or model development in this area could make an important contribution to existing evidence on improving outcomes for parents with a mental illness and their children.

A limitation of this study is the small sample size and the fact that clinicians involved in the project were all employed as family therapists in one setting. The study does not reflect experiences across a range of organizations. This article is intended as a first step toward broader research into the application of family and child-based interventions around parental mental illness in settings outside of the adult mental health sector. This may have applicability in areas such as the alcohol and other drugs sector, where mental illness may be very prevalent among the client population but is not the primary presenting issue.

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