CHAPTER

4

Talking with children whose parents experience mental illness

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Introduction

> *'Imagine what it's like to be a child whose profoundly depressed mother does not respond at all to a simple "look what I did in school today", or who suddenly switches moods, talking non-stop nonsense for thirty-six hours, and then disappears for months because she has to be hospitalised.*
>
> *Imagine what it's like to be told by your father, before he goes to work each day, to keep an eye on your potentially suicidal mother when you get home from school—but he is so preoccupied that he never really explains what is going on, never asks how you are doing, and neither does anyone else.*
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> *Imagine what it's like to have your mother, who has schizophrenia but won't take her pills, suddenly come thundering into your room to scream at you for sassing her, when in reality it's the voices in her head that are taunting her.'*
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> VICTORIA SECUNDA, 1997

Why talking with children is necessary may seem self-evident, but until every practitioner and parent has this view, clearly and unequivocally, it is important to address this issue.

As well as providing information and explanation for children, talking is also a way of ascertaining whether a child is confused, fearful, having problems, or ill and requiring support or treatment in his/her own right. The multiple impacts and influences of mental illness on children are outlined throughout this book; talking is a good way of ameliorating some of the adverse effects by enhancing children's adaptive capacities.

Furthermore, the nature and extent of children's understanding of parental mental illness has also been hypothesised as having an important link with the quality of the child's adaptation. In an earlier unpublished study, this author examined school-aged children's understanding of parental psychosis (Falkov, unpublished survey). Although not without methodological limitations, the trend was for those children able to provide the clearest (most coherent) accounts of their parent's illness to also show least evidence of emotional or behavioural problems based on measures of mental health problems and self-esteem.

Scherer *et al.* (1996) evaluated the subjective perceptions of 57 children regarding their mothers' mental illness, and reported that the children's perceptions of their mothers' mental health were significantly related to their psychological functioning. Children who reported their mother as having more psychiatric symptoms had lower perceived self-competence and less social support.

Working with a sample of 36 families in which a depressed parent and children (aged 8–15 years) lived together, Beardslee *et al.* (1997) compared two preventive interventions consisting either of a single lecture and discussion about depression for parents only, or provision of 6–10 sessions of clinical work involving children, parents and family. The authors concluded that results for both groups yielded benefits, but that the more intensive intervention demonstrated the additional advantages of linking information about mental illness to the individual life experiences of all family members, and of directly involving children to achieve longer-term (preventive) effects.

One of the 'givens' of children growing up, of development, is the process of 'making sense'—of self, surroundings and interactions (relationships). This is a lifelong process which forms the foundation for successful adjustment and adaptation to the inevitable and unplanned hurdles of life. So why should we not endeavour to ensure routine explanations which facilitate children's 'making sense', especially in circumstances of adversity?

For one thing, this presents a dilemma. On the one hand, it seems obvious that providing an explanation about difficulties is a good thing. Children are vulnerable and innocent. They need to be protected from negative influences, adversity and evil forces. However, as adults 'get close' to the actuality of talking about difficult things, they face the possibility of children becoming upset—the very thing they are trying to protect them from. Children's distress is difficult for adults to cope with. Potentially painful issues can be easier to avoid. Talking with children could:

- upset, frighten, embarrass, damage, worry or confuse them
- provide information they do not need or should not receive
- be unnecessary because they are too young, they do not notice or they will not understand
- affect the parent–child relationship in a problematic way
- upset, embarrass or distress parents
- lead to children's removal from the care of their parents
- challenge professional knowledge and skills
- jeopardise the 'therapeutic' relationship
- strain scarce resources
- breach 'confidentiality'.

The stigma associated with mental illness also generates strong reactions—fear of the unknown, uncertainty, shame and vulnerability (Laurance, 2003). A collusive relationship between media and society reflects and perpetuates unhelpful myths and stereotypes. So the combination of parenthood, madness, and innocent, vulnerable children is a potent mix. Perhaps this is why the splits and separations between mental health and children's services and agencies have been maintained for so long. How can society support and protect vulnerable children *within* families in which parents are mentally ill?

Talking is one of the ways. Talking is the tool which enables and facilitates the process whereby the hidden is made visible, fears are addressed and myths challenged. Talking requires acknowledgement both of the presence of children in vulnerable circumstances and of their vulnerability. It challenges the notion that the way to protect is through silence. It is the link between exposure to adverse events and circumstances and internal thoughts and feelings. It is the 'glue' that supports the 'making sense' process.

The focus in this chapter is on implications and opportunities for all staff, especially (but not exclusively) those working in the range of adult mental health services. Who should say what, when, and how?

Talking with children—the need to engage parents

Providing children with the opportunity to talk about their experiences will be a significant contribution to supporting their present and future emotional health (Absler, 1999). Infants, children and adolescents have thoughts, feelings and anxieties about everything that does, or does not, occur in their environment, particularly in relation to the adults with whom they have the closest contact. They are acutely sensitive, and respond to and make sense of the experiences within their developmental capacities; infants and children have active emotional and social lives from the moment of birth (Absler, 1999).

Both children and parents need to be a part of the talking process. Discussion should address any parental concerns about talking with children in an honest and open way, emphasising the benefits for the child and parent of talking more openly and considering the possible impacts on children. There should be recognition of the fact that parents do worry a great deal about their children and want the best for them; in some instances there are serious inabilities to meet children's needs, but in the majority of situations children are not removed from their parents' care. Early consideration of children's needs with provision of support for parents can reduce the likelihood of children needing to be removed from their carers.

Children do worry about their parents but may be anxious about asking questions for fear of upsetting them. They need opportunities to feel safe enough to ask questions, express fears and talk openly with their parents/carers in order to make sense of their experiences. By helping children express themselves, they are unlikely to be harmed, and this will help them to understand more about worries or difficulties and to develop more effective coping strategies.

Refusal to talk

Some parents may refuse to talk about their children. While trying to respect a parent's wishes, it is important to explore the reasons for refusal—the source of the denial/anger/anxiety. A better understanding of parental fears and dilemmas may facilitate more open discussion.

Persistent refusal to talk about their children, together with denial of any impact on them and an inability to obtain any information about the children from other family, friends or agencies must be seen as a serious concern, especially if associated with poor insight and compliance and a history of difficulties in engaging with services. Childcare professionals should be consulted if there are any concerns about child safety and welfare, and where there is evidence of:

- persistent negative views expressed about a child
- continuing emotional unavailability, unresponsiveness and neglect
- inability to recognise a child's needs and to maintain appropriate parent–child boundaries, including involvement of the child in the parent's symptoms or abnormal thinking
- continuing use of the child to meet parent's own needs
- distorted, confusing or misleading communications with the child

- continuing hostility, irritability and criticism of the child
- inconsistent and/or inappropriate expectations of the child.

The talking process

In order to provide information, promote understanding and facilitate harmonious relationships within families, effective engagement is crucial. Some stages in the process include:

1. Recognition of the patient/client as parent
2. Acknowledgement of the presence of children and their individuality
3. Engaging and forming a relationship with parent/carer and child—a collaborative process (talking not telling)
4. Clarity about practitioner's role
5. Establishing what parents and children know about their illness
6. Supplementing existing knowledge with relevant information while facilitating more open discussion between parents and children
7. Enabling children to ask questions, and empowering parents to respond confidently
8. Practitioner qualities: respect, empathy and warmth, honesty and active listening skills.

Children's experiences and adaptation will be influenced by the:

- extent of problematic parental symptoms and behaviours (intensity, frequency, duration and severity of illness)
- intensity and duration of exposure to parental dysfunctional behaviour
- degree of genetic loading for a particular disorder
- extent of associated psychosocial adversities such as separation and parental discord
- degree of psychosocial distress experienced by the child (subjective perceptions and attributions)
- availability of alternative caring adults and associated family and social supports
- extent of child's responsibility in looking after parent.

When should talking happen?

In general, the earlier parents and children are actively involved in talking with each other the better. Timing is always important, and practitioners must judge, according to circumstances (including children's safety), when to facilitate discussion. However, even in an acute crisis the provision of an explanation to a child about the actions that professionals will be taking represents good practice and can have lasting benefits for children.

While consideration of individual and family needs should occur routinely at the point of first referral or contact, opportunities exist at all stages for joint involvement and intervention (Falkov, 1998).

Parents not known to a mental health service

A first meeting with children and parent(s) is an important opportunity to establish a positive relationship. The practitioner can then be seen as an important adult within the family's social network. A detailed conversation may not be necessary. It is much more important for the children to be helped to feel part of events through having been spoken with directly.

Some children may not be able to answer questions directly, but will be keen to be a part of any discussion about the parent's illness. Indirect approaches can be helpful; for example, asking one family member about another's behaviour or feelings. Such children may subsequently begin to contribute to the conversation once they have seen their parent being able to talk more openly about previously unspoken issues. Sometimes the converse may occur when a parent anxious to protect a child, has avoided any discussion but hears a child talking about illness-related matters that have been 'overheard', thus demonstrating a capacity to cope with such matters. Such a situation can often bring great relief to a parent and facilitate further discussion.

Parents already known to a service

Consideration of the social and family contexts of the ill parent/carer will have provided information about parental concerns regarding children and ways in which mental illness may be affecting the children or the carer's parenting abilities. These conversations will also have enabled practitioners to emphasise the importance of considering the needs of the children.

Meeting a child and family in crisis

When a crisis occurs, including parental hospitalisation, basic principles still apply; judgements will need to be made about the extent of involving the child, balanced against safety requirements. There may be uncertainty about circumstances which precipitated the referral, or about parental diagnosis. The aim of the meeting will be to gather basic information as part of the assessment. Childcare and safety issues may be a priority. If a disturbed parent/carer is to be admitted to hospital urgently, then it is important to ensure the presence of a trusted adult with the child. Once decisions have been taken, an explanation (appropriate to the child's age) should be given about forthcoming actions for parent and for child.

Approaches to managing children when a parent is hospitalised

In order to meet children's needs when a parent is hospitalised (Falkov, 1998), staff looking after a parent and those caring for the children should:

- *Be open and honest.* Children will have an awareness of what is happening, including the absence of their parent/carer. They may have observed all that occurred, or overheard conversations while in another room or while hurriedly being taken to neighbours, friends or family. Pretending nothing has happened may be especially confusing. They need to be kept informed.
- *Provide explanations.* A truthful statement/description appropriate to the child's age, but without minute detail, is sufficient. Use of language which the child can understand is important. The ill parent could be described as sad, confused, upset, needing a rest, stressed, mixed-up inside etc. Describing what happens while their parent is in hospital—talking, being looked after, medication etc.—is also helpful.
- *Emphasise that the child is not to blame.* They should be told this.
- *Help to minimise disruption and maintain daily routines for children.* 'Special time' (extra attention) is helpful.
- *Support opportunities for contact.* Children visiting parents in hospital according to parental well-being, in an appropriate and safe setting can reduce children's distress. Other ways of maintaining contact include letters, phone calls and photographs.
- *Recognise changes in behavioural patterns.* Children will worry, have fears/anxieties, be confused. This may manifest in a wide range of observable behaviours and hidden distress. For example, disrupted sleep or routines, uncharacteristic quietness/inaccessibility, poor appetite, clinginess, bed wetting, demanding or disruptive behaviour, anger, irritability, tearfulness, stomach aches, nightmares etc.
- *Alert school and teachers.* Inform them that the child may need extra support, attention or praise.

Talking at a distance

It is possible to engage parents and their children despite geographic separation. The importance is twofold: given the distances in a large country such as Australia, which has relatively poor service provision in rural areas, technology (telemedicine) can promote and support local services while not itself becoming or being seen as a barrier to involving children when a parent has a mental illness. An example of one such discussion is provided in the following vignette.

Lachlan, a 9-year-old boy, was referred by his local child and adolescent mental health services worker to the telepsychiatry service at the Children's Hospital Westmead. He was having difficulties at school—getting into fights when teased about walking with a limp. His nickname was 'limpie', and he was increasingly reluctant to attend school. Despite additional classroom support, he was under-achieving in his learning.

Lachlan's mother had a history of schizo-affective disorder, with twelve admissions to hospital. She was less worried about Lachlan being teased, but preoccupied with the teacher's descriptions of his difficulties in concentrating.

Lachlan thought he had been referred to get help with 'liking school more', and he wondered 'Am I ADD?'.

As part of the assessment, an attempt was made to ascertain Lachlan's understanding about his mother's illness and her support for such a discussion. It appeared that they had been helped in the past to talk about the mother's difficulties. Lachlan described it as follows:

> *'I'm not sure about a name (for the difficulties), but she sleeps a lot. She gets a needle (Depot injection) and takes her mls (fluid/syrup)—like medicine—but she doesn't like the mls. She also has pills—(I) don't know the name. She changes when she gets unwell; goes a bit cuckoo (in her head) sometimes—when she doesn't take her mls—thinks someone's trying to poison her, like Grandad, or that people in the family aren't really her family. Freaks me out a bit. I try to forget about it. (I'm) not sure if it's an illness— not a clue. Her mind runs away from her sometimes … imagines things that haven't happened. (She) packs a suitcase and leaves her sense, her worries in the suitcase. The truth is in the packed suitcase and she thinks about the stuff that's not real. She's upset. Living in the gutter of her imagination.'*

Who should talk?

Everyone should talk. All practitioners have a responsibility to identify parents with mental illness, recognise their support needs and acknowledge the needs of their children. In the United Kingdom, the Royal College of Psychiatrist's Report (2002) describes roles and responsibilities for all psychiatrists and their teams. Such discussions will vary according to setting, circumstances, purpose and child factors (safety, age and experience). For example, staff in adult mental health services do not have sufficient training in the assessment of child development and mental illness. It would not be appropriate to expect a comprehensive assessment to be undertaken. However, given that all staff would wish to do the best for their patient/client, it is important that they recognise which of their patients are parents, and to acknowledge their role as parents. Furthermore, when the opportunities arise, adult mental health services staff should acknowledge the presence of children, and initiate discussion with them. This is a conversation. It is important that such conversations are not pathologised but are seen as a good practice, common-sense issue. If staff acknowledge anxiety or uncertainty about how to talk with children, this presents a good opportunity for training in order to develop appropriate skills to talk with children (Falkov, 1998).

However parents, too, have a responsibility to talk with or to participate in a process of talking with their children. Many do, and for those who wish to but for various reasons struggle to, an important opportunity exists for collaborative partnerships between parents, practitioners and children.

How to talk with children

Laetitia was 11 years old when I met her. Her mother had a diagnosis of chronic schizophrenia with at least eight hospital admissions since her birth. Laetitia, clearly an able child, had become withdrawn and distracted at school following her mother's latest admission, and her changed behaviour together with a decline in school grades had led to this referral. She was telling me about the circumstances of her mother's latest admission. She spoke in a matter of fact way and showed little of the anxiety and hesitancy which many children display when asked about their parent's illness. As a single parent and only child, they spent a great deal of time together. Laetitia was directly and extensively exposed to her mother's suspicious, at times flamboyant and disinhibited behaviour, for which she often took direct responsibility in managing, and in alerting appropriate adults. However, she also described her mother in warm and affectionate terms: 'We do things together. She cooks for me. Sometimes she checks my homework. I know she's got an illness. It's not her fault. It's just (that) she stops her medicines and usually I can tell her to take them. But not always—then she gets sick again.'

Laetitia particularly trusted her mother's mental health nurse, with whom she had a good relationship and who had encouraged her to call if ever she was worried about her mother. This is what she had done on the morning of her mother's latest admission.

On her way to school with friends, Laetitia had noticed her mother, some distance away, walking down the central reservation of the busy high street, dressed only in a short nightie and attempting to direct traffic. Laetitia quickly left her friends (telling them she had forgotten a book at home) and went to her mother, whom she quickly and firmly guided across the road and back home. She rang her mother's mental health worker. When she arrived at school later that day, her intensely curious peers had numerous questions. In a calm, unflustered way she informed them that her mother was simply 'on her way home from a pyjama party'.

The most difficult part, she told me, was getting her mother home: ‘I took her hand—held it tight. I told her “I’m taking you home. If you don’t come home I’m calling the police.” I know my Mum didn’t want that—the last time they locked her up. They thought she was drunk—she wasn’t; it’s the illness, she’s sick, manic-depression’.

The purpose of involving children in discussion might include any one or a combination of the following:

1. acknowledgement of child (having a conversation)
2. explanation (providing information for a child about parental illness)
3. facilitating parent–child communication about parental mental illness (enhancing understanding)
4. assessment and treatment of a child if necessary.

Factors influencing success in talking with children include:

- Recognition of the child’s age and developmental stage as well as cognitive abilities. Using language appropriate to a child’s age is important. For example, with younger children, rather than describing myself as a child psychiatrist, I explain that I am a ‘talking doctor’—someone who is interested in talking with children and asking questions, not doing injections or operations.
- Acknowledging their apprehension. Many children find it difficult to talk in unfamiliar settings, to people they have not met before. The presence of their parent or trusted adult is important, as is sufficient privacy, appropriate to setting and age of the child.
- Starting with neutral, non-threatening topics such as toys, hobbies or issues of interest to the child. Introduce difficult topics gradually. Establish the purpose of the meeting, and empower the child to be able to seek clarification (‘I don’t understand the question’) or to not answer the question (too difficult). Explain that the child is not alone in this (‘I’ve met other children whose parents have mental health problems/illness’).
- The ability to establish a dialogue with a child will allow for gradual checking out of what the child knows about a parent’s illness, the words and language used (the illness, stress, muddles in mummy’s head, depression, mental sickness). Rather than feeling under pressure to provide an explanation for the child, effort and energy should be devoted towards engaging sufficiently so that the child provides useful information and words which can then be incorporated and elaborated in further dialogue.
- Observing (and using) children’s reactions and non-verbal cues as clues to the child’s level of anxiousness, distress or fatigue. Younger children tire very quickly. A 10-minute conversation may be more productive than a lengthy, drawn out session.

- Being open and honest.
- Being prepared to express uncertainty or lack of knowledge: ‘I’m not sure about that but I can find out’.
- Being positive. It is important to acknowledge that talking about mental illness is difficult, and to comment on how well the child is doing. Explain that the discussion is not a test like at school.
- Using props—age-appropriate toys and drawing materials can facilitate discussion. Children can sometimes speak well about difficulties while engaged in an activity. Let parents know (if they are present) that this is fine and that the child is not being rude or not concentrating.

Children are loyal to their parents and will therefore need to know, and see, that their parents are supportive of such conversations. The best way for this to happen is for parents and children to be together, especially in the early stages, so that shared conversations can become the norm rather than the exception. Most younger children will want and need a parent or other trusted adult to be present. Older children may vary in their wishes, and adolescents should certainly be given the opportunity to talk on their own. If the purpose of the discussion is for explanation, then it would be helpful for the ill parent and/or partner to be present.

What to say

> *‘… the more painful a new event is for us, the more important it is to talk about it with our children and that it is better to talk badly about things than not to talk about them at all.’*
>
> (Tisseron, cited in Keeley, 2000)

Children’s questions (David, aged 6-and-a-half)

1. ***What’s Mum’s illness called?***

   My mum has difficulties with her mood and her feelings. When Mum worries and feels sad, things she says make me know. Sometimes Mum gets angry. I remember when Mum threw the cup (at) Uncle Trevor and the cup hit the window. Mum gets cross when I don’t do as I was told and (she) shouts. Sometimes Mum speaks things that doesn’t make sense, and don’t sleep, and she shouts. Mum imagines things that aren’t real. Mum thinks people is against her, and she shouts around the house. She always moves the furniture around the house.

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2. ***Will Mum get completely well?***

   I want my my mum to be well properly.

3. ***Will Mum get ill again?***
4. ***List of worries***

   I worry about leaving Mum and go(ing) to a foster mum. Sometime I ask my mum if she is okay because I am worried and I just make sure if she's alright. I asked my mum because I worry if she's becoming sick again. I worry because I think that if my mum keep being sick all the time it makes me very unhappy, because I like being at home all the time and I like my mum to look after me.

5. ***What helps Mum stay well?***

   Mummy said if she stop worrying that will keep her well. Mummy said if she don't smoke drugs she will stay well. Mummy said if she takes her tablet it will keep her well. Mummy said help from her nurse when she has problems—having someone to talk to keep her staying well.

Explanation about mental illness

Providing an explanation about mental illness for children must occur in the context of the parent/carer–child relationship and at a pace which reflects the level and quality of engagement between family members and practitioners. That children wish to have information about their parent's illness has been clearly demonstrated, as has the willingness of both parents and children to talk about their experiences (Falkov, 1998). Talking should be seen as part of the parent–child relationship—a continuing process, rather than a one-off event. So practitioners should aim to facilitate this joint process by the various approaches described in this chapter.

However, despite the clear wish for information to be provided for children, little work has occurred around children's understanding of parental mental illness as an initial step in developing effective, age-appropriate interventions. A qualitative, group approach was undertaken by Garley *et al.* (1997) in a study designed to elicit subjective experiences of children (aged 11–15 years) living with a depressed parent. Analysis of the transcripts revealed four key themes or areas of particular concern to the children, with a number of sub-themes:

1. Understanding the illness
   - personal concerns
   - illness attributions

    - quest for information
2. Recognising the signs
3. Impact of hospitalisation
4. Managing the illness
    - coping with impact of illness on self
    - coping with impact on their parent
    - perceptions of what is helpful for parent
    - recommendations for other children whose parents are depressed.

The major personal concern was actual or feared parental separation. Other concerns included academic and behavioural difficulties at school, fears about becoming mentally ill themselves, and concerns about cause and prognosis of the parental illness. Various attributions were made regarding the cause of parental illness: low self-esteem, childhood sexual abuse, important bio/environmental factors, and stress. All wished to have more information in order to assist in the struggle to make sense of parental illness. The capacity to recognise deterioration in a parent's mental health was thought to be an important marker for those children who were more able to make sense of their experiences and circumstances living with a depressed parent.

Where alternative carers for children were available in the family, parental hospital admission was felt to be positive; sometimes a relief.

In managing the impact of the illness on themselves, participants valued friends as a source of support, regardless of whether or not they confided in them about their parent's illness. Talking within the study group and sharing experiences related to depressed parents was also felt to be positive. Diverting attention/distraction, reading, watching television and playing sport were other examples of how children coped. In coping with the impact on parents, role reversal and descriptions of the burden for the children were extremely common. Excessive responsibilities and loyalty conflicts were frequently described.

With regard to help for parents, most were aware of the chronic, intractable nature of their parent's mood disorder, and realised that medication was important as a control, not a cure. Discontinuation of medication was a frequently cited reason for relapse, and they attached importance to professional availability to monitor medication.

Questions to think about

Children may understand how their parent's mental illness affects themselves and their parent, but not have a clear or well-articulated concept of 'mental illness'. Some issues and questions to consider when talking with children include the following (Falkov, 1998):

How much does the child know and/or understand his/her parent's illness?

- Is the child aware of changes in the parent or the parent–child relationship?
- What does she/he think caused the illness?
- Does the child understand that his/her parent is ill (is the change in behaviour/mood due to an illness)?

How does the child conceptualise her/his parent's illness?

- Is it an illness, or is it the mother/father being difficult/irritable?
- Is it something to do with the mind/body/brain/stress?
- Does the child see it as something wrong with the brain, or as a response to stress?

How does the child feel about the situation?

- Is the child worried about the current situation (self, parent, parent in hospital, school)?
- Is the child confused?

How does the child perceive his/her relationships?

- How does the child perceive the parent's feelings towards her/him? (Does this change when mental illness is present?)
- Is the child's relationship with the parent changed as a result of the illness?
- How has the child's relationship with other people, including friends, changed?

What are the consequences of the illness?

- Does the illness affect the child's role within the home, and/or school and social activities—taking friends back home, going out and so on?
- What changes for the child when his/her parent is mentally ill?
- Who cares for the child (professionals, family/friends)?
- Is the child in contact with the ill parent—particularly during acute phases?

What, if any, are the responsibilities of the child when the parent is mentally ill?

- Is this role the same as when the parent is well? Does she/he take on a caring role?

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How does the child think about the future?

- Does the child see the parent getting better, staying the same or getting worse?
- Does the child worry about becoming ill her/himself?
- Is the child worried about how long the parent will be in hospital?
- Does the child worry about who will look after the parent and/or the child?

Conclusion

What children tell us can be very distressing and difficult to hear. We need to try to contain our own reactions when we are with the child. It is important that the child does not pick up that they need to protect us from their strong feelings and thoughts. We need to bear in mind that, in order to be helpful to the children we work with, we need to ensure that our needs as workers are always being addressed. This may occur through attending continuing training and professional development, and receiving supervision and support from our colleagues. We need our 'safe place' where we can reflect on and share our reactions to the frequently painful stories we hear (Absler, 1999).

Children whose parents are mentally ill live with the symptoms, behaviours and expressions of mental illness. They see it and feel it, and in the absence of information and an environment in which they can seek explanations, their experience becomes a potent source of fear, confusion and anxiety. Silence is a barrier to 'making sense' and developing strategies for coping. For children, the real madness is living in a situation which generates a whole range of powerful emotions of varying severity at different times, without the capacity, tools or input to make sense of the ordinariness, the chaos and the crisis in everyday life.

Talking with children is therefore an essential part of best practice in the treatment of their mentally ill parents. It is vital, pivotal and not always straightforward to accomplish. It presents a challenge for practitioners, across a range of services and disciplines, and parents to work more closely and effectively together.

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