Chapter #18

KIDSTIME AND MINDFUL SCHOOLS: SOCIAL INTERVENTIONS FOR CHILDREN AND ADOLESCENTS FROM FAMILIES AFFECTED BY PARENTAL MENTAL PROBLEMS

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ABSTRACT
About one in five children lives with a parent with a mental illness. These children usually face many obstacles like stigma, social isolation and feelings of guilt. Many of them take a role as a young carer, thus taking over more responsibilities within and outside the family than they can really bear.
The workshop will introduce children of parents with mental illness (COPMI) as a group and explain the impact of parental mental illness on children. We will provide examples of approaches that can help children in this situation, using the Kidstime Workshop model as a case study. We will describe the approaches of the Kidstime practice model and explain how a combination of family therapy and systemic therapy influences, together with drama, can create an effective multi-family therapy intervention.
It will describe the impact of the Kidstime model and highlight the evidence in support of preventive approaches, as well as the barriers to securing investment for these interventions. The workshop also shows a concept of how to better address mental health in school context. In this way it supplies a generic approach to raise resilience within a whole school project. The workshop will conclude with recommendations for practice.

Keywords: parental mental illness, resilience, stigma.

1. INTRODUCTION

Dr. Miguel Cardenas and Henner Spierling present the Kidstime model: a multifamily-based social intervention with lots of creative elements for building children and families' resilience. Kidstime has been put into practice for several years in Spain and Germany, so there are multiple experiences and case studies to share – also, there is some evaluation data that may be presented.

Moreover, Mindful Schools is a whole school approach, funded by the EU as an ERASMUS+ project that empowers schools to address the topic of mental health within school contexts and to create a school atmosphere that strengthens resilience amongst students, their families and school staff.

Having a parent with a mental disorder increases the risk of social and behavioural problems in childhood and mental health problems in adolescence. In Australia, approximately twenty percent of children grow up in a home where at least one parent is diagnosed with a mental health problem (Maybery, Reupert, Patrick, Goodyear, & Crase, 2005), while in England this figure is estimated to be around two million (Parrott, Jacobs, & Roberts, 2008). In Spain, although we do not know the number of children living with parents with mental disorders, by population, the figure would probably be slightly lower than that of England.

2. SUMMARY OF KEY FACTS AND STATISTICS

• Over 3,8 million children in Germany live with a parent with a mental health problem

• Average of 4-8 children in an average classroom will be in this situation.

• 20–25% of the school population, similar figures in other EU-countries

• 70% likely to develop a mental health condition.

• Parental mental illness is one of the 10 adverse childhood experiences (ACEs), which has a lifetime impact on both physical and mental health.

• Parental mental illness (PMI) is a root cause of many other ACEs.

• WHO identifies PMI as one of the most important public health issues of our generation.

• Intervention late after the onset of an ACE is less likely to be effective.

• By focusing on clinically diagnosable mental illnesses, interventions are often too late to address ACEs.

• Many of the young carers (80%) are not identified, while rising thresholds for acute support are exacerbated by significant reductions in early intervention spending by local authorities.

Research into adverse childhood experiences, known as ACEs, identifies parental mental illness as one of the ten most powerful sources of toxic stress in young people. The presence of mental illness in a parent is known to negatively affect a child's cognitive and language development, educational achievement and social, emotional and behavioural development. It can lead to anxiety and guilt coming from a sense of personal responsibility. Where there is severe mental illness in a parent and no second parent who is well it can lead to neglect or abuse. These children are also at greater risk of bullying, a lower standard of living and financial hardship.

Data on the impact of the parents´ disease on their children are scarce and the usual intervention models usually lack prevention programs for this type of family. Often these boys and girls present stress associated with the fact of assume the role of caregiver of the father or mother with a mental disorder, especially in single-parent families. People with a mental disorder are one of the most stigmatized groups in our society, especially those with schizophrenia. These families often do not ask for help out of fear, guilt, or stigma about mental illness.

In Spain, Mental Health Services tend to provide separate follow-up to families between adult mental health services and the child and youth mental health network. There are almost no known experiences on similar multifamily group interventions in this type of families. Most important is the integrated and coordinated manner of working and building connections between the child and youth mental health network with the adult network.

3. RISK FACTORS AND VULNERABILITY TO MENTAL DISORDERS

The fact that having a father or mother with a mental disorder increases the risk in children of presenting problems in childhood (higher incidence of perinatal complications), developing social and behavioural problems, mental health and behavioural problems has been widely studied. suicidal or criminal in adolescence. Additionally, minors often present stress associated with the tasks of taking care of the father or mother with a mental disorder and the change of role, role reversal, especially in single-parent families with severe mental

illness (Huntsman, 2008). These children and adolescents often do not seek help out of fear, guilt, and stigma about mental illness.

There are comparative studies on severe mental disorders that have shown a greater risk of mental decompensation in minors who have a father or a mother with schizophrenia in relation to controls, being more frequent to suffer a pathology of the schizophrenia spectrum during adolescence or the beginning of adulthood (Niemi, Suvisaari, Tuulio-Henriksson, & Lönnqvist, 2003).

The children of fathers or mothers with borderline personality disorder associated with substance use are highly represented in child protection services and have problems in child development (Newman & Stevenson, 2005).

Among children and adolescents of parents with bipolar disorder, there is a higher percentage of behavioural problems, such as aggression, rule breaking, and attention problems (Dienes, Chang, Blasey, Adleman, & Steiner, 2002; Giles, DelBello, Stanford, & Strakowski, 2007).

The sons and daughters of adults with major depressive disorder have more problems in academic functioning, as well as in relationships with peers and with the family, and it seems that altered parental functions play an important role in this problem. Thus, in women with a major depressive disorder who present symptomatic and functional improvement at three and six months after the start of treatment, there is also a reduction in symptoms and an improvement in psychosocial functioning in their sons and daughters (Pilowsky et al., 2008; Swartz et al., 2008).

Greater knowledge of the mental illness on the part of the patient and the family decreases the risk of distress in the minor, while a serious mental disorder with greater severity of the illness and a greater number of decompensations increases the risk (Huntsman, 2008).

The family psychosocial factors that increase the vulnerability of minors are (Maybery et al., 2005; Huntsman, 2008; Logan, Moore, Manlove, Mincieli, & Cottingham, 2007):

- social isolation,
- child abuse,
- mental disorder in both parents,
- living in a single-parent family with mental disorder,
- disadvantaged socioeconomic level,
- young parents,
- substance abuse in the family,
- high family destabilization (bad relationship in the couple)

On the other hand, family psychosocial factors of good prognosis are

- having a mother with good mental health —that is, that the mental illness is in the father—, contact with health services,
- good maternal habits,
- social support,
- a good relationship between the couple,
- positive attitudes towards pregnancy,
- a high socioeconomic status,
- an older age in the infants
- the late onset of the disease

People with a mental disorder constitute one of the most stigmatized groups in our society, especially those who suffer from schizophrenia. Within the family, prejudices towards the disease are also present, in the form of behaviours of shame, secrecy and a feeling of guilt towards the cause of the disorder, causing isolation (Ochoa, Martínez, & Ribas, 2011; Logan et al., 2007).

3.1. Protective Factors

Contact with other people who have a mental disorder, and sharing experiences, facilitates changes in stereotypes (Cooklin, 2010). Some authors suggest that contact and familiarity between the general population and people with serious mental health problems may be the most important factor in reducing stigma. Therefore, carrying out a group intervention with sons and daughters together with fathers and mothers in which mental disorders are discussed openly is a good strategy to combat the stigma of the disease.

Another important concept to take into account in interventions in the population with mental illness is resilience, understood as a dynamic process of an evolutionary nature that allows minimizing or overcoming the harmful effects of adversity and, above all, feeling reinforced, transformed, given meaning to these experiences. In studies of boys and girls who suffer situations of family and social risk such as economic deprivation, abuse, and/or the presence of psychopathology in their parents, common aspects have been detected in those who, despite adverse conditions, have come to have successful personal development. These aspects have been grouped under the name of resilience and among them it is worth highlighting those related to the family, such as belonging to a high socioeconomic level, maintaining the conjugal union, having both parents alive, parental competence and a warm relationship with at least one primary caretaker.

Regarding the personal characteristics of the boy or girl, some of the resilient aspects consist of having an easy temperament, a high intellectual coefficient, the ability to plan and have problem-solving skills. Resilience is also strengthened by better coping styles, motivation to achieve, feelings of self-efficacy, autonomy and internal locus of control, empathic capacity, adequate management of interpersonal relationships and have a good sense of humour. Some resilient social and educational aspects are having access to a good support network, good schooling and belonging to social and religious groups (Fonagy. Steele, Steele, Higgitt, & Target, 1994; Kotliarenco, Cáceres, & Fontecilla, 1997).

3.2. Intervention Model

The use of a multi-family approach is now recognized as an effective intervention for the prevention of relapses in severe mental disorder and in schizophrenia in particular. It provides a new social context for the family and therefore offers new and positive ways in which family members will think about and respond to the person with the mental health problem. It also allows addressing social isolation and stigma. Mental Health services tend to follow these families separately.

We are aware of systemic interventions with single-family groups, although there are no clear data on multifamily group interventions, which would constitute a valuable opportunity to carry out preventive-type community interventions. Consequently, in the absence of timely preventive interventions, these boys and girls usually begin contact with Mental Health services only when changes in behaviour or school performance or other major problems appear (Cooklin & Barnes, 2004).

Ackerson (2003) published that the existing programs on parenting for the general public, aimed at people who have just had a child, are considered irrelevant and unnecessary for people with mental illness, in addition to having a high percentage of abandonment in this group. Maybery et al. (2005) has conducted focus groups with children and girls with a father or mother with mental illness. These children were asked what types of unmet needs they had. They identified the need to have more information about their family member's mental illness, to be able to be consulted and informed by the health professionals who care for their family member, to have a friend with whom they can talk and help on practical issues, for example, what to do when the relative is hospitalized (Maybery et al., 2005).

In 2013, the WHO launched the General Mental Health Plan 2013-2020, whose action plan focuses on four main objectives: strengthening leadership and effective management of Mental Health, provision of comprehensive Mental Health care services, and social services. Integrated and community-based, implement strategies for promotion and prevention in Mental Health and strengthen information, evidence and research systems.

To guarantee a global response in Mental Health, the plan introduces the notion of recovery, moving from the usual medical model to emphasize the generation of economic resources and opportunities for improvement in education, housing, access to social services and other social determinants of Mental Health (Saxena, Funk, & Chisholm, 2013). The plan stresses the importance of the protection and promotion of human rights and includes a leading role for the provision of community-based services and support. In this way, community Mental Health programs play an important role for preventive purposes.

In this manner, with the purpose of strengthening research, prevention and promoting the creation of programs that help improve community Mental Health and care for people with mental disorders, projects such as Kidstime workshops, which consist of the design of a support and information group for fathers and mothers with mental disorders and for their sons and daughters. These workshops were developed in England in 1999 by Alan Cooklin, a family psychiatrist and his colleagues, in order to help families whose parents have mental health problems. This program is a by now widespread example of the community-type intervention models. The program of Kidstime multifamily intervention, tries to develop and promote resilient attitudes in the whole family, especially in the sons and daughters of fathers and mothers who suffer from a serious mental disorder, with the aim of preventing possible disorders among the child population of this risk group.

This program is an example of the community-type intervention models that have been developed in this area. Kidstime seeks to detect and minimize the impact of the role change that often occurs in these children, such as parental behaviours or the role of caregivers (Spierling, 2020). With this workshop, we want to reduce the anxiety of the impact of the mental disorder, reduce the stigma towards it, and differentiate the role of the sick patient (in crisis) and that of the healthy father or mother (without crisis). It also makes it possible to prevent and identify behavioural or emotional difficulties that the children of these parents may have or possible situations of abuse, while helping to maintain a link between the parents and the Mental Health Services (Cooklin, 2010; Saxena et al., 2013; Cooklin, Bishop, Francis, Fagin, & Asen, 2012). In this way, we work with the family unit in a group format in an integrated and coordinated manner with professionals in Child and Youth Mental Health, as well as professionals from the adult sector in order to assess the global needs and deficiencies of the family.

4. OBJECTIVES

The main objectives in the Kidstime workshops focus on:

-Help parents suffering from mental illness to find means through the which the disorder and its

impact can be discussed between them and their children

-Help parents access or redirect their pride, confidence, and competence as parents

-Address fears, confusion, and lack of knowledge about the mental disorder and its treatments

-Help children and youth increase their understanding of information about their parents' mental disorder and parental behaviour associated with disease

-That children may experience a more positive response from their parents

These objectives add up to the positive effects of multifamily work in general and especially target the needs of children with mentally ill parents and their families (Behme-Matthiessen & Pletsch, 2020; Asen & Scholz, 2017).

5. METHODS

All methods involved in kidstime aim to encourage children and young people together with their parents to feel freer and to get involved in pleasant activities and to be able to share time together and to connect in a new way.

Especially by the use of drama methods, resilient attitudes are developed and fostered in the whole family and especially in the children of parents with mental disorders. Theatre plays – all led by the children – help the children to find their voice and to free emotions. It also helps to build metaphors and child-friendly explanations on mental illness, which in terms builds resilience. This is also helps to prevent possible disorders in the future.

The structure of the Kidstime workshops includes monthly workshops, which take place in the community, in non-sanitary facilities (such as a social centre, library), with two-hour sessions. These sessions are structured in three parts: a first multifamily part; in the second part, the groups are separated, a seminar is held with the parents and a psychodrama activity with the minors, which is usually recorded on video. In the third part, a closing multi-family group is held aimed at sharing what has been worked on in the separate groups and the video is viewed while a snack is offered. The referral of participating members to the workshops is carried out from the Adult Mental Health Centres, the Child-Youth Mental Health Centres, or from the social services and schools.

The experience provides a transitional space for families and professionals where the professional plays a different role than the therapist. An atmosphere of trust and equality is created and, through psychodrama techniques, using art as a resource, a space is fostered to talk about mental health problems and their impact on family life, emphasizing the impact on minors, to the vicissitudes of families and to find new ways to deal with the problems associated with parental mental disorder. It is a space where parental mental health problems and the needs of children and adolescents are clearly discussed, always keeping in mind the safeguarding of the well-being of minors. The use of play and psychodrama to communicate and teach children to address the issue of mental health, allows them to find a place to meet friends, play games, make movies, eat pizza and understand what is happening to their parents.

6. DISCUSSION

Through the experience, fathers and mothers seem to feel relieved after being able to speak in the group and later explain mental health problems to their sons and daughters. In families, bonds are strengthened by understanding these problems. In forming and finding a safe space and dealing with stigma, at some point, parents use a sense of humour when talking about their mental health issues, putting some distance from them, and expressing that they are ready to talk about it in community. In turn, the workshops allow professionals to work from a different perspective than usual, closer to the families, working together and thus acquiring a better understanding of the situation in each family

The Kidstime workshops are a multifamily group event on a monthly basis, whereas we try to avoid calling Kidstime a treatment or therapy, although it shows therapeutic results. This is particularly because we want to give the message to the children that they are invited to a positive experience (like a party!) rather than to correct something in themselves. This in turn is partly to address the fear of many of these children that they will automatically follow the mental health pathway of their parents, and partly as a way to define the atmosphere or culture of Kidstime as a fun and positive experience, despite the distressing content, which may be addressed. It also changes the definition and expectations of the staff.

There is a number of evaluation done on the kidstime workshops. As a general rule, individual feedback forms are completed by the adults and children after each workshop. A study of the German Kidstime Workshops found that 95% of families (similar reports from adults, adolescents and younger children) submitting evaluations stated they benefited from attending the workshops and wanted to continue attending. All family members stated they had learned something new about mental illness at the workshops and that the workshops helped them to talk about mental illness within and outside of their families. Watching and reflecting on the children's drama film, as well as the multi-family group format (particularly the feeling of solidarity among families) were viewed as helpful catalysts in enabling the open discussion of issues that may have been perceived as being too "shameful" to talk about outside of the group.

In Barcelona, a research was made with 65 parents who participated in the workshops. There were administered:

- Self-perception of Social Stigma Scale SSQ
- Rosenberg self-esteem scale
- CD-RISC Resilience Scale
- Inventory of Parenting Practices IPC
- SDQ

Satisfaction survey for children and adults, collecting a total of 173 surveys.

The results showed significant pre-post differences in the "involvement" and "expression of affection" subscales of the Parenting Guidelines Inventory and "Prosocial behaviour" of children measured with the SDQ and in adult self-stigma.

The results showed that Kidstime workshops are effective when it comes to enhancing the affective support of parents towards their children, improving the prosocial behaviour of boys and girls and reducing the stigma of parents affected by mental health problems.

6.1. Intervention in Schools

The Mindful School Project has been developed as a complement to the Kidstime Workshop, and it is based on the kidstime model and philosophy (Cooklin & Barnes, 2021; Frier, 2021). It offers Awareness raising for the whole school staff, lessons on mental illness and mental health plus ideas on how to develop a Mindful School atmosphere to support better the students most at risk when identifying young carers. Within an Erasmus+ project mindful schools has been running in Berlin, Barcelona and Reykjavik for 8th to10th grade in 2022 and is currently followed by a similar Project in primary school in Berlin, Barcelona, Reykjavik and Vienna.

In Barcelona a questionnaire was filled out before and after the lessons by 82 students. Results show, that a majority of almost 75% of the students reported increase in understanding of mental illness. A vast shift was represented by a number of 70% of the students that agreed to the statement that parental mental illness is not rare and thus a relevant issue, while the numbers were 4% before the lessons. There is also a lot of qualitative data from the teachers. The majority found the program helpful in supporting themselves as teachers as well as the students.

Experiences from the school in Reykjavik (Lougolaekjaerskoli) showed that „The introductory event in particular contributes to opening up the long overdue discussion of the topic within the teaching staff. Previously missing tools for students whose parents are mentally ill are communicated within the framework of the project. In the process, professionals are encouraged in the hope that they will be able to adequately support the children and young people." (feedback from teacher)

Experiences from the Berlin school (Green Campus) summarized that Theatre pedagogical exercises within the framework of the workshop offer students the opportunity to communicate their own issues in a playful way, to put themselves in other perspectives and to develop and try out alternative ways for action. Knowledge about support networks and mental illness is built up and deepened in a creative way. (feedback from teacher)

7. CONCLUSIONS

Kidstime workshops have proven to be effective when it comes to enhancing the affective support of parents towards their children, improving the prosocial behavior of boys and girls and reducing the stigma of parents affected by mental health problems. There is evidence that Kidstime workshops strengthen resilience in the face of developmental risks caused by parental mental illness.

The mindful school program aims to empower teachers and other professionals in the school system to support students in general and especially young carers. Evaluation shows that the students' perspective on parental mental illness has changed and their knowledge about it deepened. Safe spaces need to be created within schools to help the students talk honestly about their feelings. The program offers some approaches that can be further implemented in the school culture and should be embedded in wider social networks.

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ACKNOWLEDGEMENTS

The following have participated in this work: Marta Coromina, psychiatrist, Parc Sanitari Sant Joan de Déu; Irene Ardévol, clinical psychologist, CASM Benito Menni-Sisters Hospitallers; Fernando Lacasa, clinical psychologist, Hospital Sant Joan de Déu; Teresa Ribalta, clinical psychologist, Fundación Orienta, Núria Grasses, clinical psychologist, Parc Sanitari Sant Joan de Déu; Miriam Fuentes, clinical psychologist, Orienta Foundation; Carme Saltò, clinical psychologist, Parc Sanitari Sant Joan de Déu; Trini Sánchez, social worker, Orienta Foundation; Olga Pérez Ibáñez, clinical psychologist, Parc Sanitari Sant Joan de Déu.

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