

Research Article

How Adult Psychiatry Professional's View Children

Afzelius M*, Plantin L and Ostman M

Department of Social Work, University of Malmo, Sweden

*Corresponding author: Afzelius M, Department of Social Work, University of Malmo, S- 205 06 Malmo, Sweden

Received: October 24, 2015; Accepted: December 02, 2015; Published: December 09, 2015

Abstract

Background: Children of parents with a mental illness need support from adult psychiatric services. Efforts have been made to enhance the knowledge of practitioners in this field so that they may work in a more family- oriented manner and to include children in the therapeutic services they provide.

Aim: This study investigates how adult psychiatry services works with families and children when a parent has a mental illness.

Method: Twenty-four Swedish professional care providers were interviewed individually or in focus groups. Data was analyzed using an inductive content method.

Results: Although the professionals knew that their patients had minor children, they still prioritized the individual relationship they had with the parent. Few efforts were made to include both children and families in the treatment offered, and when this happened it was done at the professional's own discretion.

Conclusion: Despite the mandatory Swedish obligation to pay attention to a patient's children, our study showed that professionals tend to fall short in this regard. Adult psychiatry services needs to strengthen family -oriented work in order to provide support to such children.

Keywords: Minor children; Parents with mental illness; Adult psychiatric services; Family therapy

Introduction

Approximately one-third of patients admitted to inpatient psychiatric care with a mental illness have minor children [1-3]. A parent's mental illness impacts other family members, including their children. The latter are especially vulnerable as they depend on their parents for their upbringing. These children have to deal with the implications of their parents' mental illness in their daily lives [4,5], although parents can have difficulties in talking about their illness with them [6]. Seldom are children included in discussions about the illness between the parent and professionals from psychiatric services [3].

According to research, growing up with a parent with a mental illness constitutes a risk factor [7-9], especially with regard to children developing their own mental health problems [10,11]. Children themselves have expressed the desire to know more about their parents illness [12,13]. Furthermore, children often assume considerable responsibility in taking care of their parents [13-15], and it is not uncommon for children to perceive themselves as being a cause of their parents mental illness [16,13].

There is increasing evidence of positive effects that results from treating families in accordance with a systematic model when a parent has a mental illness [17-19]. When children can conceptualize their parent's mental illness as something separate from themselves, resilience increases [20]. In order to realize this important step for children, professionals can use interventions that focus on meeting the needs of children as well as their parents [21]. Still, research has identified a number of difficulties that arise when adult psychiatric services works with a patient's family, including not identifying the patient as a parent, the absence of policy guidelines and a lack of skill

in doing family work [22-25].

In Sweden, professionals in psychiatric services have several mandatory obligations to pay attention to minor children in households where a patient may have a mental illness. The first of these is the obligation, according to the Social Services Act, to report to Social Services if the child is in of need protection, that is, if professionals suspect mistreatment or neglect [26]. The second is to assess the child's need for information, advice, and support, as regulated by the Health and Medical Services Act [27], in cases where a parent suffers from a mental illness. Involving a patient's children and family into treatment requires family- oriented work [24].

In the south of Sweden where this study took place, the management of Psychiatric Services has attempted over the past 15 years to incorporate a child's perspective into adult psychiatric therapy by having a children's representative at every unit [28]. They are responsible for attending to the situation of mentally ill parents with children as well as supporting other colleagues who are treating such patients. For the latter task they have conducted in-service training on child development and the special needs of children whose parents have a mental illness. Psychiatric services management has also supplied compliance guidelines corresponding to the relevant Swedish child assistance laws. They indicate procedures for identifying and supporting patients and their children by increasing the use of models like the Beards lee Family Intervention [29] and Let's Talk about Children [30]. The objective of these interventions is to initiate open communication about parental mental illness within the family, as well as prevent mental health problems for the children of that family. The administrator in the Psychiatric services office is responsible for implementing these guidelines.

When professionals in adult psychiatry adopt a more sensitive approach and invite the parent's family and children to participate in the treatment, such benefits as reduced family burden and improved relationships within the household can be achieved [18]. However, the attitudes of professionals towards including a patient's children in adult psychiatric care are complex. Mayberry and Rupert found that some workers believe the patient's mental illness would increase if family was invited into the therapy or the relationship with the patient might be disrupted [24]. The professional's role and prior training may also influence their attitude about working with families [31].

The aim of this study is to investigate how professionals in adult psychiatric outpatient services who work with affective disorders deal with children and others in the family when a parent has a mental illness. We also examined the way professionals identified parents with mental illness and their attitude towards supporting both the families and the children.

Material and Methods

Design

Specialist psychiatric care in the south of Sweden is subdivided into special clinics that provide inpatient and outpatient services within a given region. Professionals were recruited from two adult psychiatric clinics that treat people with affective disorders. One clinic was responsible for the psychiatric care of individuals with affective disorder in a catchment of 130,000 inhabitants. The other unit covered a smaller municipality with 32,000 inhabitants. Both clinics participating in this study had almost a similar organization: an outpatient unit with interdisciplinary treatment teams made up of psychiatrists, psychologists, social workers, nurses and physio- and occupational therapists, with all members of the team responsible for the treatment of patients in the services. Treatment mostly consisted of medical intervention and individual therapy.

In order to explore how professionals work with children and families we collected data in two ways: through focus group discussions and by conducting individual interviews. Focus groups are group discussions [32,33], while the aim of individual interviews is to obtain a participant's interpretation of a specific phenomenon [34,35]. Focus groups promote the study of mutual experiences and identities but when topics are sensitive or hindering factors such as hierarchical professional barriers exist, a combination of both approaches may be useful [36].

The head of one psychiatric outpatient service recommended eight practitioners, whom had shown an interest in child and family work, for our study: four participants for interviews and four for a focus group. A contact person chosen by the head of the other unit suggested two interdisciplinary team members and a group with social workers for the study. Sixteen professionals were recruited in all: 15 participated in three focus groups, and one was the subject of an individual interview.

Procedure

Four focus group discussions and five individual interviews were conducted. Both the focus group discussions and the individual interviews were semi-structured, using questions like: How do you work with parents? When and if you meet families, do you have a

specific method? What are the factors that make you invite the children and families to participate together?

The interviews lasted from 36 to 85 minutes (mean time: 59 min). They were conducted by the first author, who led the focus group discussions as well, the latter with the support of the second author. The interviews all took place at the psychiatric units. To encourage the participants to engage in the discussion, the focus groups began with the presentation of a vignette. It described a married father suffering from anxiety and suicidal ideation living with two minor children (a 12-year-old girl and a 16-year-old boy). The father suspects that his wife is having an extra-marital affair. This results in loud quarrels and ends with the wife leaving the house for several days. The father has been in psychiatric inpatient care but has now been allowed to go home on leave. The initial question posed to the group was: "How would you work with a family like this?". At the end of the session, each participant had the opportunity to present a short summary of the discussion in accordance with Wibeck [37].

Participants

In total, 24 individuals participated in the study: 5 participants in individual interviews (3 women, 2 men) and 19 (16 woman, 3 men) in a total of four different focus groups, made up with 4 to 6 people each. The participants belonged to different professions: 9 social workers (one also worked as a manager), 5 psychologists, 5 nurses, 2 physiotherapists, 2 psychiatrists, and 1 occupational therapist. Their average age was 52, and the length of time they had worked in their profession ranged from 4 months to 40 years. The vast majority had had some form of therapeutic education, and 7 persons held graduate degrees in psychotherapy, with specializations in psychodynamic therapy, cognitive and behavioral therapy, and family therapy.

Analysis

The analysis of the individual interviews and the focus group discussions was summarized and the findings presented together. An inductive content analysis concentrating on manifest content guided the analysis since the study had an explorative approach [38]. All interviews were recorded and transcribed verbatim by the first author and names were coded to assure anonymity. Each interview was closely read, reread, and listened to on audiotape several times [34]. An open coding was made in which notes related to the aim of the study were collated. Preliminary categories were formed in order to describe the data and were compared with the transcribed material for confirmation. Categories were grouped to provide a more comprehensive view of the material, and then dichotomized into two main categories. All authors collaborated in this process through a number of discussions and revisions.

Ethical considerations

Participation was voluntarily, and all informants were assured that they could withdraw from the study at any time. Oral and written information was distributed in advance, and an informed consent form was signed prior to the interviews. The study was approved by the Regional Ethics Review Board in Lund (Dnr 2013/137).

Results and Discussion

Two main categories resulted from the analysis: 1) establishing a trustful relationship with the patient, and 2) fulfilling legal obligations

towards the child. All participants spoke of coping with the tension between these two categories.

Establishing a trustful relationship with the patient

Subcategories were as follows: a) establishing a care relationship, and b) protecting the care relationship.

Establishing a care relationship: It was important in the initial stages of a contact to “create some kind of attachment”, that is, an alliance with the patient. As one of our participants described it, “Sometimes you are more forthright and sometimes you are more cautious, depending on how you perceive what this person can tolerate; and as in all psychotherapy, you don’t jump straight in because first you try to create an alliance, and then gradually you can be more forthcoming”.

Many interviewees described the relationship between the professional and the patient as a process in which the patient was in a defenseless state and in need of trust in order for the contact to be productive. Questions about the family or children were not considered appropriate unless there was a particular issue that attracted the professional’s attention. Some described how inviting the patient’s family to join a session could create a dilemma, i.e., concerns about sharing information about the patient with family members, and how information about the patient provided by family members could negatively affect the relationship of the patient with the professional.

Protecting the care relationship: The interviews showed that professionals weighed attention they gave to their patients’ children against the importance of maintaining their own relationship with the patient. In some situations our informants said they wondered how such children coped with their situation; but although they noticed it, they took no action, as when they were trying to convince the patient accept treatment, and at the same time the patient’s children needed support. Some participants assumed that a patient might be upset or feel insulted by questions concerning parenthood and children; and if the informant suggested contacting Social Services, on behalf of their children, it might increase the parent’s level of stress. Some of the interviewees believed that a short period of mental illness would not affect the children, and so children should therefore not be included in the treatment. One commented: “There are many who want to keep things for themselves, and I think this should be respected, even though there can be limits if children are involved. If you’re affected a lot... and you think that there’s a problem in the relationship with the child, then it’s important. You have to weigh each case on its merits”.

Our informants stated that there generally was little direct contact with the patient’s family or children. They stressed the importance in their view, that patients be given individual treatment, and how this could, in fact, could benefit the children. “One helps the children indirectly. By helping the father and the mother through psychotherapy, you unburden them of their inner conflicts, which give them more time for their children”.

The interviewees reported feelings of inconvenience and unfamiliarity in inviting and working with the patient’s children and family. Some of them had skills in family therapy and family interventions, but they seldom used them. However, a knowledge about family work helped them think and deliberate in a more systematic way when treating patients: “I allow myself to use my

theoretical thinking to put the patient in their wholeness”.

The participants described being aware of the child’s perspective, but they lacked the knowledge of what it meant in practice. Some saw it as a demand from the organization and not something that they themselves wanted to do. They assumed that other members of the interdisciplinary team were more qualified in that area than they were.

Fulfilling the obligations towards the child

This category reflected the interviewees’ experiences of taking a family-focused approach when meeting a parent with a mental illness who had minor children. Subcategories were as follows: c) looking for warning signs, d) inviting the children and families needs flexibility, time and collaboration.

Looking for warning signs

Those we interviewed were conscious of the patient’s children and their obligations toward them when they met with the patient. This was expressed in terms of “warning signs” that could appear for example, when a parent had severe mental illness combined with “situations where the adult uses the child as a parent.”

In situations such as these, the interviewees listened closely to what was said about the relationship between the parent and the child and how the atmosphere in the home was perceived. The informants assessed the patient’s overall situation and considered such factors as their socioeconomic status, and whether or not the patient had a healthy partner or was a single parent. These assessments were conducted throughout their therapeutic contact with the patient.

Inviting the children and families needs flexibility, time and collaboration

Only a few of the interviewees started their treatment sessions by proposing that the patient bring the family and the children to next session. However, most families stayed away, and those who came could show up at the next session or unannounced. In these cases the professionals assumed that the family was ambivalent about coming. Other informants made their own assumptions when inviting children and family. These were situations such as a patient’s suicide and the wish to support the family members; or when the practitioners noticed that the patient’s handling of their mental illness was overwhelming family life. Some of our informants had their own recollections of growing up with a parent who had a mental illness. Several of the informants turned to social workers on the interdisciplinary team for guidance when discussing whether to invite children and family members to be a part of the treatment plan before asking the patient about it.

When children and families were present at a treatment session, our informants said that they had to spend a great deal of time motivating the patient to involve their family members. Some patients were reluctant to have them there, and as the therapy continued the informant postponed the invitation. Flexibility was required, both when the family suddenly appeared at a session, and when other treatment rooms were required to accommodate all of them. The interviewees described their hesitancy when providing information or simply talking to a patient’s children, depending on how old they were and to what extent they should be involved in the parent’s treatment.

Having family sessions was more time consuming than individual treatments, and those informants who invited families felt that they did not achieve the organization's requirement that they see a certain number of patients each working day. "Of course that's something one says, that we should take the children's perspective, that we should think in terms of the family. That's right, but then there's the harsh reality, which is something else".

Collaboration with Social Services or the Department of Child and Adolescent Psychiatry was described as rarely taking place and difficult to establish:

I think that during the last ten years that I've been working here I've been the one who has invited them most often, so, on the contrary, they are really bad at doing it [initiating contact with adult psychiatry], both from the child and psychiatry unit and social services; it is beneath contempt. They seldom phone and invite us in; it's always me who invites them for collaboration meetings or what's it called networking.

A problem with collaboration was to find the time to meet, since the professionals' schedules were fully booked. If collaboration was necessary and no time was available to arrange a meeting, then the informant was forced to cancel a session with a patient. The interviews emphasized the dilemma of having to ask a patient to forego their treatment session and reschedule the appointment.

Almost all informants in our study underlined the importance of building a trusting relationship with the patient before talking about the patient's children. In accordance with earlier studies [28], our findings also showed that while the professionals knew that the patients had minor children, the children were not necessarily involved in therapy. Even if guidelines specified that involving the patient's children and family in treatment was obligatory, our informants used their own discretion in dealing with this issue. They said that they tended to focus on the individual patient and exclude the patient's role as a parent, in agreement with Fudge et al. [39], although Wang and Goldschmidt [40] have shown that when parents are invited to talk about their children, they want to do so. Few of the professionals we interviewed were active in inviting children and families, similarly to other recent studies. Maybery and Reupert [23] showed that lack of time to work with families was often a hindering factor, and that it was expected that only the social worker on the interdisciplinary teams was expected to initiate contact with Social Services and conduct family-oriented work [25], which we also found. The most common response from our interviewees when we asked them about taking an active role in the needs of the children was that it was not considered part of their assignment.

Some of our interviewees feared that involving children and family could affect trust and confidence in their relationship with the patient in individual therapy, in accordance with the findings of Oppenheim-Gluckman et al., [41]. Although establishing a care relationship with a patient requires confidentiality [42] and protecting the "best interests" of the patient [43], these considerations may also act to seclude the patient's family. In everyday life, people are part of a family and depend on each other [44]. In some cases confidentiality must be breached in order to protect others (i.e.; children). Such decisions depend on the individual professional's attitude and the situation,

as was stated in our study. This leaves the professional in a complex and high-responsible position [45]. However, families relationships are themselves complex issues that generate ethical considerations prior to the start of therapy [46]. Research on psychiatric patients' experiences of involving family members in treatment reveals that they do want them to be invited [47,48].

When children whose parents have mental illness are included in family therapy, they express to be heard during therapy [49,50]. Several interviewees in our study said they seldom invited children or family members into treatment sessions. Instead, they instead they handled the situation by talking with the patient about them during psychotherapy. Moreover, Korhonen et al., [31] found that professionals in psychiatric services who are trained in family-oriented care have been shown to have increased interaction with the children of their patients. Although some of the interviewees in our study were family therapists, they avoided working with children because they felt uncomfortable doing so and seldom practiced in that area, as has been shown in earlier studies [51-53].

Even if the professionals in our study did not meet the children, they did describe of listening for signs that those children were in need of support or protection. When warning signs were noticed, they did not always act upon them, depending on how the relationship with the parent was developing. Brunette and Dean [54] propose that warning signs be used as a therapeutic tool. They urge clinicians to talk to the patient about their concerns and the need to report them, and play an active role in collaboration with Social Services in helping to explain mental illness and its impact on parenting. By doing this in a respectful way, the clinician's alliance with the parent might not be disrupted. Our findings, that practitioners more often pay attention to warning signs than they do provide information and support to children and families, were also found in a study by Liangas and Falkov [55].

Our informants noticed that mentioning contact with Social Services to their patients brought about increased stress. Other studies reveal that patients avoid talking about their children because they fear losing custody [56,57]. One study by Bournell [58], indicates that parental mental illness is viewed in stereotypical way in social work, and is often stigmatized as a risk factor for child protection, as another study confirms [59]. Earlier studies have also shown that families suffering from a parental mental illness differ in their need and for support [54], just as families in general. Providing families with individualized support that involves family members in collaboration with both the formal and informal network has been proven to be effective [60].

Collaboration with other actors was rarely mentioned in our study. It was expected that the social worker's role, within the psychiatric services organization was to initiate contact with Social Services and conduct family-oriented therapy, as seen earlier by Slack and Webber [25].

It is known that family involvement has a positive impact not only on a person suffering from mental illness and that person's children [29]. Children involved in family interventions reveal increased knowledge of their parent's mental illness and fewer concerns about them [61]. Studies indicate a growing willingness on the part

of families and professionals to include families in adult psychiatry [46,62], although establishing this perspective is a slow process [18], as our study confirms. Needed are the systematic implementation of family work and the child's perspective [22], resources for broadening the therapeutic approach through the use of structured models [63], and flexible ways to handle confidentiality. Although the central concern for professionals is establishing a trusting relationship with the patient, family-sensitive work also has obligations to fulfill towards children. Today parents with mental illness are more involved in their children's lives than twenty years ago, as advances in psychiatric treatments and deinstitutionalization enable patients to handle their mental illness outside hospitals [64]. In order to assess whether a patient's children need supportive or protective social services, family relations have to be talked about as apart of treatment and should not be dismissed out of hand by invoking confidentiality [44].

Methodological considerations and limitations

The professionals who participated in our study were recruited by staff leaders in adult psychiatric clinics and not by random selection, which might indicate that participants were chosen because they had a special interest in the issue. However, an effort was made by the authors to include all the professions working on an interdisciplinary team. Since we wanted the focus groups to provide us with information from everyday treatment situations, we chose participants who were already known to each other, in accordance with Kitzinger's advice [65]. However, we cannot be certain whether the focus group discussion created this open atmosphere, or if the informants in the focus groups were in a vulnerable position because the interviews we conducted related to matters of how professionals handled a mandatory obligation. After some of the focus group discussions, informants said the discussion was thought-provoking and important. Even if individual interviews allowed participants to say what they thought, uninfluenced by the presence of other participants, we do not know whether our participants did this, since the interview situation is related to context and communication [66].

There are some limitations in this study. First, all the professional groups providing psychiatric services were not equally represented in the focus groups (two of the focus groups consisted of only social workers and a nurse). Furthermore, the first author has worked for many years in adult psychiatric services, and this which could have had an impact on the data analysis. Discussions with the other two researchers were carried out during the different phases of the analysis in order to counteract the possible effect of the first author's pre-understanding. The data gathering could have been accomplished by other methods, such as by observing an interdisciplinary team or studying case material in medical journals. This was not possible due to the project's restricted resources.

Conclusion

Although the obligation of paying attention to a patient's children is mandatory, many of the informants in our study did not fulfill this obligation. Instead, the informants focused on building a trusting relationship with the patient in place of talking about and to the patient's children. Although the process of implementing a child perspective in adult psychiatry has been going on for almost two decades, greater efforts must be made if professionals are to work in a more family-sensitive and child-oriented manner. Children in

families where a parent has a mental illness have the right to be heard and supported by psychiatric services. This is an issue that must not be overlooked by professionals. By combining family-sensitive work with individual therapy on a regular basis, children whose parent is living at home with a mental illness will have their rights better served.

References

1. Maybery DJ, Reupert AE, Patrick K, Goodyear M, Crase L. Prevalence of parental mental illness in Australian families. *Psychiatr Bull.* 2009; 33: 22-26.
2. Skerfving A. Patient earns barn. Om prevalens, in syster och samverkan inom allmänpsykiatri, barn- och ungdomspsykiatri och socialtjänst- Tva registerstudier vid vuxenpsykiatri i Södra Stockholm [Children of Psychiatric Patients: Prevalence, Actions and Collaboration in General Psychiatry, Child and Adolescence Psychiatry and Social Services. Two Registry Studies in Southern Stockholm]. Stockholm: Stockholms län sjukvårdsområde. 2007.
3. Östman M, Eidevall L. Illuminating patients with children up to 18 years of age-a 1-day-inventory study in a psychiatric service. *Nord J Psychiatry.* 2005; 59: 388-392.
4. Gladstone BM, Boydell KM, Seeman MV, McKeever PD. Children's experiences of parental mental illness: a literature review. *Early Interv Psychiatry.* 2011; 5: 271-289.
5. Hedman Ahlstrom B. Major depression and family life: The family's way of living with a long-term illness [dissertation]. Institute of Health and Care Sciences at Sahlgrenska Academy. University of Gothenburg. 2009.
6. Mordoch E. How children understand parental mental illness: "you don't get life insurance. What's life insurance?". *J Can Acad Child Adolesc Psychiatry.* 2010; 19: 19-25.
7. Barker ED, Copeland W, Maughan B, Jaffee SR, Uher R. Relative impact of maternal depression and associated risk factors on offspring psychopathology. *Br J Psychiatry.* 2012; 200: 124-129.
8. Focht-Birkerts L, Beardslee WR. A child's experience of parental depression: encouraging relational resilience in families with affective illness. *Fam Process.* 2000; 39: 417-434.
9. Weissman MM, Wickramaratne P, Nomura Y, Warner V, Pilovsky D, Verdelli H. Offspring of depressed parents: 20 years later. *Am J Psychiatry.* 2006; 163: 1001-1008.
10. Rutter M, Quinton D. Parental psychiatric disorder: effects on children. *Psychol Med.* 1984; 14: 853-880.
11. Oyserman D, Mowbray CT, Meares PA, Firminger KB. Parenting among mothers with a serious mental illness. *Am J Orthopsychiatry.* 2000; 70: 296-315.
12. Stallard P, Norman P, Huline-Dickens S, Salter E, Cribb J. The effects of parental mental illness upon children: A descriptive study of the views of parents and children. *Clin Child Psychol Psychiatry.* 2004; 9: 39-52.
13. Östman M. Interviews with children of persons with a severe mental illness: investigating their everyday situation. *Nord J Psychiatry.* 2008; 62: 354-359.
14. Aldridge J, Becker S. Children as carers: The impact of a parental illness and disability on children's caring role. *J Fam Ther.* 1999; 21: 303-320.
15. Griffiths J, Norris E, Stallard P, Matthews S. Living with parents with obsessive-compulsive disorder: children's lives and experiences. *Psychol Psychother.* 2012; 85: 68-82.
16. Handley C, Farrell GA, Josephs A, Hanke A, Hazelton M. The Tasmanian children's project: The needs of children with a parent/career with a mental illness. *Aust N Z J Ment Health Nurs.* 2001; 10: 221-228.
17. Asen E. Outcome research in family therapy. *Adv Psychiatr Treat.* 2002; 8: 230-238.
18. MacFarlane MM. Family centered care in adult mental health: Developing a collaborative interagency practice. *J Fam Psychother.* 2011; 22: 56-73.
19. Pins of WM, Wynne LC. The efficacy of marital and family therapy: An empirical overview, conclusions, and recommendations. *J Marital Fam Ther.* 1995; 21: 585-613.

20. Walsh J. Children's understanding of mental ill health: Implications for risk and resilience in relationships. *Child Fam Soc Work*. 2009; 14: 115-122.
21. Marsh DT, Lefley HP. Family interventions for schizophrenia. *J Fam Psychother*. 2003; 14: 47-68.
22. Lauritzen C, Reedtz C, Van Doesum KT, Martinussen M. Implementing new routines in adult mental health care to identify and support children of mentally ill parents. *BMC Health Serv Res*. 2014; 14: 58.
23. Maybery D, Reupert A. Workforce capacity to respond to children whose parents have a mental illness. *Aust N Z J Psychiatry*. 2006; 40: 657-664.
24. Maybery D, Reupert A. Parental mental illness: A review of barriers and issues for working with families and children. *J Psychiatr Ment Health Nurs*. 2009; 16: 784-791.
25. Slack K, Webber M. Do we care? Adult mental health professionals' attitudes towards supporting service users' children. *Child Fam Soc Work*. 2008; 13: 72-79.
26. Swedish Ministry of Health and Social Affairs. Social Services Act SFS No. 2001: 453. Stockholm. 2001.
27. Swedish Ministry of Health and Social Affairs. Health and Medical Services Act SFS No. 1982: 763. Stockholm.
28. Ostman M, Afzelius M. Children's representatives in psychiatric services: what is the outcome? *Int J Soc Psychiatry*. 2011; 57: 144-152.
29. Beardslee WR. When a Parent is depressed: How to Protect Your Children from the Effects of Depression in the Family. Boston: Little Brown & Company. 2003.
30. Solantaus T, Toikka S. The Effective Family Programme: Preventive services for the children of mentally ill parents in Finland. *Int J Ment Health Promot*. 2006; 8: 35-42.
31. Korhonen T, Pietilä AM, Vehviläinen-Julkunen K. Are the children of the clients' visible or invisible for nurses in adult psychiatry?--a questionnaire survey. *Scand J Caring Sci*. 2010; 24: 65-74.
32. Morgan DL, Scannell AU. Planning Focus Groups. Thousand Oaks, CA: Sage. 1989.
33. Robson C. Real World Research. 2nd edn. Singapore: Blackwell Publishing. 2002.
34. Kvale S, Brinkmann S. Den kvalitativa forskningsintervjun [Quantitative Research]. Lund: Studentlitteratur. 2009.
35. Warren CA, Gubrium JF, Holstein JA. Qualitative interviewing. In: Handbook of Interview Research: Context and Method. Thousand Oaks, CA: Sage. 2001; 83-101.
36. Mitchell L, Barbour RS, Kitzinger J. Combining focus groups and interviews: Telling how it is; telling how it feels. In: Developing Focus Group Research: Policy, Theory and Practice. London: Sage. 2001; 36-46.
37. Wibek V. Fokusgrupper: om fokuserade gruppintervjuer som undersökningsmetod [Focus Groups: On Focus Group Interviews as a Research Method]. Lund: Studentlitteratur. 2010.
38. Elo S, Kyngas H. The qualitative content analysis process. *J Adv Nurs*. 2008; 62: 107-115.
39. Fudge E, Falkov A, Kowalenko N, Robinson P. Parenting is a mental health issue. *Australia Psychiatry*. 2004; 12: 166-171.
40. Wang AR, Goldschmidt VV. Interviews of psychiatric inpatients about their family situation and young children. *Acta Psychiatr Scand*. 1994; 90: 459-465.
41. Oppenheim-Gluckman H, Chambry J, Loisel Y, Joussemle C, Weiss JJ, Falissard B. How physicians caring for adult patients presenting with a chronic mental illness take into account the difficulties experienced by the children of those patients: Preliminary study. *Ann Phys Rehabil Med*. 2009; 52: 623-637.
42. Wynaden D, Orb A. Impact of patient confidentiality on careers of people who have a mental disorder. *Int J Ment Health Nurs*. 2005; 14: 166-171.
43. Verkerk MA, Lindemann H, McLaughlin J, Scully JL, Kihlbom U, Nelson J, et al. Where families and healthcare meet. *J Med Ethics*. 2015; 41: 183-185.
44. Landeweer EG, Abma TA, Dauwese L, Widdershoven GA. Triad collaboration in psychiatry: Privacy and confidentiality revisited. *Int J Fem Approaches Bioeth*. 2011; 4: 121-139.
45. Bennett R, Ashcroft RA, Dawson A, Draper H, McMillan J. Confidentiality. In: Principles of Health Care Ethics. 2nd edn. Chichester, England: Wiley. 2007; 325-332.
46. Romi T, Melamed S. Involving the family of patients with mental illness in treatment: A model for assessment. *J Fam Psychother*. 2007; 18: 11-26.
47. Rose LE, Mallinson RK, Walton-Moss B. Barriers to family care in psychiatric settings. *J Nurs Scholarsh*. 2004; 36: 39-47.
48. Kessing LV, Hansen HV, Ruggeri M, Bech P. Satisfaction with treatment among patients with depressive and bipolar disorders. *Soc Psychiatry Psychiatr Epidemiol*. 2006; 41: 148-155.
49. Moore L, Bruna Seu I. Giving children a voice: Children's positioning in family therapy. *J Fam Ther*. 2011; 33: 279-301.
50. Strickland-Clark L, Campbell D, Dallos R. Children's and adolescents' views on family therapy. *J Fam Ther*. 2000; 22: 324-341.
51. Miller LD, McLeod E. Children as participants in family therapy: Practice, research, and theoretical concerns. *Fam J Alex Va*. 2001; 9: 375-383.
52. Rober P. Being there, experiencing and creating space for dialogue: About working with children in family therapy. *J Fam Ther*. 2008; 30: 465-477.
53. Wilson J. Barnets rost i utredning och behandling [Child-Focused Practice]. Lund: Studentlitteratur. 2011.
54. Brunette MF, Dean W. Community mental health care for women with severe mental illness who are parents. *Community Ment Health J*. 2002; 38: 153-165.
55. Liangas G, Falkov A. Use of structured clinical documentation to identify patients' parental concerns and their children's wellbeing. *Community Ment Health J*. 2014; 50: 646-655.
56. Ackerson BJ. Parents with serious and persistent mental illness: Issues in assessment and services. *Soc work*. 2003; 48: 187-194.
57. Spiegelhoff SF, Ahia EC. Impact of parental severe mental illness: Ethical and clinical issues for counselors. *Fam J Alex Va*. 2011; 19: 389-395.
58. Bournell M. Assessing the capacity of parents with mental illness: Parents with mental illness and risk. *Int Soc Work*. 2014; 57: 92-108.
59. Chang KH, Horrocks S. Lived experiences of family caregivers of mentally ill relatives. *J Adv Nurs*. 2006; 53: 435-443.
60. Kessler ML, Ackerson BJ. Wrap around services: An effective intervention for families impacted by severe mental illness. *J Fam Soc Work*. 2005; 8: 29-45.
61. Pihkala H, Sandlund M, Cederström A. Children in Beardslee's family intervention: Relieved by understanding of parental mental illness. *Int J Soc Psychiatry*. 2012; 58: 623-628.
62. Nielsen N. Evaluation of family therapy. *Nord J Psychiatry*. 2006; 60: 137-143.
63. McFarlane WR. Multifamily Groups in the Treatment of Severe Psychiatric Disorders. New York: Guilford. 2002.
64. Hetherington R, Baistow K. Supporting families with a mentally ill parent: European perspectives on interagency cooperation. *Child Abuse Rev*. 2001; 10: 351-365.
65. Kitzinger J, Barbour RS. Introduction: The challenge and promise of focus groups. Barbour RS, Kitzinger J, editors. In: Developing Focus Group Research. London: Sage. 2001; 1-20.
66. Rosenblatt PC. Interviewing at the border of fact and fiction. Gubrium JF, Holstein JA, editors. In: Handbook of Interview Research: Context and Method. Thousand Oaks, CA: Sage. 2001; 893-909.