Supporting Parents with a Mental Illness to Engage in, and Benefit from PCIT: Challenges and Opportunities.

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Abstract
A significant proportion of children around the world live in a household where one or both parents are experiencing a mental illness (Zalewski, Goodman, Cole, & McLaughlin, 2017). Parental mental health is known to be intricately connected with children's psychosocial functioning, and with the attachment relationship between parent and child (Barlow, Smailagic, Huband, Roloff, & Bennett, 2014; Calam & Wittkowski, 2018). Parent training programmes such as Parent-Child Interaction Therapy (PCIT; Thomas, Abell, Webb, Avdagic, & Zimmer-Gembeck, 2017) are well placed to treat externalising and internalising presentations in young children. And intervening to meet the needs of the child can also have positive outcomes for the parent in a number of areas (Forehand & Sullivan, 2017; Timmer et al., 2011; Zimmer-Gembeck et al., 2018).

However, delivering a manualised programme can be challenging when both the child and the parent/s have complex needs (Woodfield & Lambie, 2019). Many factors (parental, child, familial, contextual) need to be considered, and concurrent treatments carefully planned to support parents to succeed at undertaking PCIT alongside interventions for their own well-being (George, 2014). Furthermore, PCIT therapists need to strike a careful balance between maintaining fidelity to the PCIT protocol and making adaptations to meet the needs of the parent with a mental illness (George, 2017).

This paper outlines the research literature relating to parental mental illness and child wellbeing, and the challenges facing agencies tasked with meeting the needs of both children and their parents. It will consider the complexity across four domains: the parent, the child, the parent-child relationship, and the wider family system and other service providers. Drawing on clinical experience and the research literature, solutions to common PCIT challenges with this client group will be suggested.

Background

Parental mental illness is common - around one in every five Australian children (Maybery, Reupert, Patrick, Goodyear, & Crase, 2009) and 15-20% of New Zealand children (Craig et al., 2013) live in a household where a parent is experiencing a mental illness. In presenting to services, these parents are often engaged in an arduous 'double journey' of recovery: their own psychological treatment, alongside developing new parenting strategies to meet their child's needs (George, 2014). Unfortunately clinical care is often poorly co-ordinated for these families (Zalewski et al., 2017), and can result in ill-timed engagement in PCIT, excessive demands on parents, and/or insufficient support for parents. All of these factors can contribute to attrition from PCIT, which can be taxing for parents, especially in the initial stages before benefits have been derived.

Meeting the physical and psychological needs of a young child can feel overwhelming and unrelenting for any parent. It requires the parent or caregiver to demonstrate many self-regulatory and relational capacities including emotional regulation; an ability to mentalise (i.e. understand the mental state of) oneself and one's child in order to respond to their needs effectively; and the capacity to maintain a warm and firm parenting stance in the face of the child's challenging behaviour. George (2017) outlines specific parental factors that

can have a detrimental impact on children. These include holding negative attributions relating to the child; a lack of parental self-efficacy; parent difficulty regulating their arousal and emotions; and dysregulated parental behaviour in the form of aggression, fright or collapse; as well as high criticism and hostility; harsh punishment; inconsistent discipline; low warmth; low involvement; low encouragement; and low supervision. The absence of, or diminished positive parental capacities can also have a negative impact on children, including reduced parental reflective capacity or mentalising; low attunement and sensitive responding; and limited strategies to promote child emotional regulation. Johnson, Hawes, Eisenberg, Kohlhoff, and Dudeney (2017) describe various supportive emotion socialisation behaviours (ESBs) such as regular discussion of both parental and child emotion. The authors also describe non-supportive ESBs such as avoiding emotional discussion, invalidating a child's emotions, punishing or trying to quickly terminate emotional expression, and dismissing emotions as undesirable. According to Johnston et al. (2017), in a family with non-supportive ESBs, a child's emotional regulation skills will likely be under-developed, and child emotions may remain un-soothed and may escalate and trigger stressful parent-child interactions.

Parental mental illness and psychological distress (e.g. fatigue, distress, preoccupation) can impact parenting behaviour (e.g. attunement with the child), and have been linked to an increased risk for children's emotional and conduct difficulties (Barlow et al., 2014). Maternal insecure and unresolved attachment status predicts disrupted child attachment, likely mediated by poor parental reflective functioning or mentalising of their child (Slade, Grienenberger, Bernbach, Levy, & Locker, 2005). This is turn is linked to poor child socio-emotional functioning and child conduct problems (Fonagy & Luyten, 2018), thereby adding further challenges to the family system. These can include maternal anger, confusion and fatigue; high levels of family turmoil and conflict (parent-child, inter-parent, and sibling); emotional difficulties for siblings; and a reversal in family hierarchy over time, with a gradual abdication of parents being in charge (George, 2017).

Problem Statement

Parent training approaches for the treatment of childhood conduct problems are some of the most effective psychosocial interventions in child mental health (Scott & Gardner, 2015) and can benefit both the child and the parent's well-being (Forehand & Sullivan, 2017; Timmer et al., 2011; Zimmer-Gembeck et al., 2018). However, retaining parents in these effective programmes can be challenging, with attrition rates from PCIT ranging from 27% to 67%, and high maternal stress implicated in drop out from programmes (Barnett et al., 2017). PCIT is somewhat unique from other parent training programmes, in its provision of individualised real time coaching of parents with their child, which - when delivered responsively - may support parents to remain engaged (Barnett et al., 2017). This ability to individualise coaching presents both opportunity and challenge when providing PCIT to parents currently experiencing a mental illness. That is, a sensitive, effective treatment is needed, one that balances fidelity to the manualised PCIT protocol with responsiveness to the needs of both the child and the parent (George, 2017). The therapist needs to hold at least four domains in mind, i.e. the parent (level of well-being, attachment style, personal and parenting capacities); the child (attachment style, psychosocial functioning), the nature of the parent-child relationship, and the family system or wider context (parental hierarchy, other caregivers and family relationships) (George, 2014). Providing PCIT to families in which there is parental mental illness often also presents a systemic challenge: parent and child treatment teams and support systems are often delivered in isolation from one another. There is opportunity for PCIT to bridge these systems.

Solutions

The above discussion has focussed on five main areas of challenge in offering PCIT to families in which parental mental illness is present. For each challenge, recommended ways of working or opportunities for enhancing PCIT's responsiveness will now be offered.

Importantly, most of the recommendations serve two critical functions – they aim to fully mentalise the parent and family system, and to provide attuned clinician responsiveness. This process offers the parent a corrective attachment experience and a 'felt sense' of what the parent is being coached to provide for their child. Stated plainly, as therapists we do for the parent what they will go on to do for their child. We consider these elements essential to retaining families in PCIT and supporting them to derive optimal benefit.

1. 'Double Journey'

It is crucial to co-ordinate care and take parent needs, child needs, and the needs of the parent-child relationship into consideration (Zalewski et al., 2017). While PCIT's live coaching provides a natural opportunity for this within each session, we propose extending this 'dual focus outside of the PCIT suite. We advocate for regular, close liaison and collaboration between the parents' mental health clinicians and PCIT therapists to ensure mutual understanding of current parental well-being and personal therapeutic work, and the parenting work being undertaken (George, 2014). It is critical that demands upon the parent do not outweigh their resources and supports. Systemic collaboration provides the opportunity for sharing of psychological information (e.g. parental triggers and coping strategies); coordinated timing of parent and child treatment elements; and apt utilisation of available supports (e.g. adult emotion regulation skills groups, adult community support workers to enhance parental support networks). Establishing teams specifically to facilitate systemic co-ordination and collaboration, such as services for Children of Parents with a Mental Illness or Addiction (COPMIA) is likely to be helpful where these are not already available.

Another opportunity to extend parents with a mental illness further support is to have two PCIT therapists working with the family. This approach, while resource intensive, is in keeping with other therapies which are tasked with meeting complex client needs (e.g. Dialectical Behaviour Therapy (Linehan, 1987)). Where two therapists are seeing a family, one therapist can take the child aside at the end of the session, allowing the parents a short debrief of the session and a brief time to share any information not intended for the child to hear. Having two therapists available also increases continuity for families with less postponement of sessions due to one clinician's absence. It allows for enhanced case management between sessions - shared between therapists - such as supportive text messages, emails or phone calls. And it can make this intensive (and rewarding) work more sustainable for therapists.

2. Family Context

Often mothers attend child mental health appointments and/or parenting interventions alone. This can be due to single parenthood or the way the primary parenting role as been allocated. Mothers contending with child aggression and conduct problems can experience embarrassment, shame, fatigue, and restricted freedom, increased inter-parental conflict, and a subverted parental hierarchy (see George, 2017). For mothers with a mental illness, this can further jeopardise their well-being, increase their sense of isolation, and limit their resources. Conversely, father involvement in child treatment, and parental cooperation in parenting have a positive impact on child outcome (Piotrowska et al., 2017). To reduce maternal burden, enhance systemic supports and to correct the subverted parental hierarchy, we have found it helpful to present PCIT as a two-parent (or two-caregiver, e.g. parent-and-grandparent) intervention insisting on more than one caregiver attending.

According to the standard PCIT protocol, we encourage inter-parental consistency. We also foster inter-parent communication, support and encouragement, using the PRIDE skills as the basis of family validation (for example, encouraging parents to praise each other, and praising this when it occurs). If a parent cannot attend all PCIT sessions due to work commitments, we offer "mini-PCIT" to secondary caregivers (i.e. baseline, CDI teach and PDI teach sessions along with a few coaching sessions). To further support multiple

caregiver attendance, we offer to write letters of support to employers, and provide childcare for siblings during PCIT sessions. Other ways in which we support the family system include offering sibling sessions to improve sibling relationships; offering home-based coaching sessions (particularly if PDI is proving difficult); and attending school meetings alongside parents to provide a consistent home-school formulation and intervention plan. When families are not able to attend sessions, we take the opportunity to have a phone conversation to validate and encourage parents with their 'double journey'.

3. Parental attachment state of mind

We believe the standard PCIT programme with its positive and individualised coaching, and its live bug-in-the-ear support for parents during moments of high emotional arousal (both parent and child) and child behavioural challenge, provides an excellent fit for parents with mental health challenges, many of whom have an insecure or unresolved attachment state of mind. Awareness of parental triggers and coping strategies (e.g. dissociation) allows the PCIT coach to provide sensitive prompts, and we have had feedback from parents that focussing on the PRIDE skills has helped to reduce their dissociation and preoccupation. Standard PCIT provides parents with a positive attachment relationship (with the PCIT therapist) and new relational understandings and skills that may have been absent or limited in the parent's own relational history. PCIT coaching provides the parent with emotional co-regulation; exposure to mentalising and positive attributions about both parent and child; training and coaching in play and pro-social and behavioural management skills, as well as direct exposure to and coaching in authoritative parenting (i.e. both warm and firm). Thus, PCIT supports under-developed parenting capacities to grow, as well as to change old relational models and patterns. For some parents, this is sufficient. For others, with particular attachment states of mind or relational sensitivities or patterns that interfere with their deriving benefit from PCIT, we would suggest small adaptations or augmentations. Importantly, these do not involve departing from standard PCIT content or lengthy delays in the PCIT therapy process, nor do they theoretically oppose PCIT principles. They can be easily integrated into standard PCIT.

Enhanced Coaching: Our approach to understanding the PCIT coaching needs of a parent with a particular attachment state of mind or relational sensitivity draws heavily from two sources. The first is Dr Beth Troutman's (2015) book on integrating behavioural and attachment-informed parent coaching. We incorporate Troutman's (2015) suggestions for matching PCIT coaching comments to a parent's attachment state of mind (e.g. supporting a parent with a preoccupied state of mind to let their child explore the toys and to wait for the child's approach.) We do not have the capacity to complete formal parent attachment assessments, but we listen to parents' language and themes in discussing their own experiences of being parented, and observe the parenting struggles they experience with their child, and try to ascertain their likely attachment state of mind.

The second influential resource is adjunctive material from the Circle of Security (COS) programme (Powell, Cooper, Hoffman, & Marvin, 2016). This programme provides a useful visual model of children's attachment needs, and parents' strengths and struggles in responding to them. COS suggests that there are three main areas of parenting response – providing a secure base to support child exploration, providing a welcoming and safe haven that provides mentalising and soothing, and providing warm and firm support to children (knowing when to follow a child's lead and when to take charge). Often, based on their own experience of being parented, a PCIT parent's struggle with one of more of these parenting areas is evident. We often briefly introduce the COS visual model to parents at a parent-only session where we review videotapes of PCIT sessions to enhance parent mentalising, to acknowledge parental strengths, and to support development in areas a parent finds difficult, often by prompting use of CDI and PDI skills. These parent-only sessions are clearly defined and often singular, so as not to impede the trajectory of the manualised programme (McNeil & Hembree-Kigin, 2011).

For a good percentage of our PCIT parents with mental health struggles, we support them to attend the COS psycho-educational group following graduation from PCIT, after carefully clarifying with them the difference between "time in" and "time out", and the usefulness of each. Any parental theoretical or practical questions that arise during the group can be discussed in the monthly PCIT "booster" sessions that often continue for 2-3 months following graduation from PCIT. Family need (and feedback from adult treatment teams) determines the number of PCIT boosters offered.

4. Parent-child relationship

For families with disrupted attachment and behavioural difficulties, we focus on both the behavioural mechanics of the parent-child interaction (using baseline DPICS data and observations of coercive cycles) as well as the observed child attachment style. Standard PCIT and attachment-augmented coaching then targets the identified struggles as discussed above. Notably, this is typically achieved through the use of standard CDI and PDI skills, augmented with observations targeting mentalising and offering positive (child and parent) attributions (e.g. "Your son is really wanting to please you. Your clear command helped him to do what you wanted."). Coaching also draws attention to dyadic attachment struggles (e.g. for a child with avoidant attachment: "He looks unsure. He is looking for your eyes……How reassuring for him to be met with such a welcoming smile."). For an ambivalent dyad with inconsistent parental availability, coaching can help prevent the parent unconsciously keeping the child focussed on the attachment relationship, and therefore remaining hyper-vigilant to parental availability (Troutman, 2015). Coaching for such a dyad could support a parent to understand when to let the child self-regulate and when to provide support. Coaching such a dyad through time out often involves intense emotional struggles, and thus preparatory coaching of parental ESBs may be helpful. Typically we start with supporting child and parent comfort with descriptions of positive affect, gradually building to more difficult emotions such as anger. The COS concept of parents' "being with" their child's emotion (and not trying to fix it or distract away from it) can be a powerful learning experience during coaching.

5. Child

Children's externalising and internalising difficulties develop as a result of multiple influences, and relationships between parents and children involve bi-directional effects – we cannot blame a parent with a mental illness for their child's difficulties (Zalewski et al., 2017). However children of parents with a mental illness are at increased risk for psychiatric disorder (see Barlow et al., 2014) and are often exposed to high parental arousal or emotional states, and unpredictable or inconsistent behaviours (including parenting responses). They are at risk for disrupted attachment relationships and under-developed emotional regulation and pro-social skills, and internalising and externalising presentations (see Zalewski et al., 2017). Standard PCIT is likely to be sufficient for many of these children. Where indicated, the following adjunctive material may be useful: direct teaching of emotional regulation skills (tummy breathing, sensory noticing) to the parent-child dyad so that parents can support practice at home; clinician administered and/or modelled ESBs; age-appropriate child psycho-education regarding parental mental health struggles with the whole family to open this up as a possible topic of family discussion; and assessment of child's mental health status with referral to other services as required. We also consider the child's attachment state of mind, and make adjustments. For example (as suggested by Troutman (2015)) easing the end of special play time for children with ambivalent attachment.

Conclusion

Results from our PCIT clinic indicate that parents undergoing a "double journey" of personal therapy and parent training (PCIT) engage well and derive benefit from PCIT with few adaptations or augmentations (Woodfield & Lambie, 2019). Providing PCIT to families with

parental mental health challenges presents opportunities for systemic collaboration and a 'whole family' approach that takes into consideration the needs of the parent, the family system, the child, and the parent-child relationship. It allows for a privileged therapist-parent relationship which can support significant change in parent and child internal working models of relationship, attributions and attachment behaviours; as well as the growth of many positive parenting skills and child pro-social behaviours.

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