

THE CHILD AS THE PRESENTING SYMPTOM, AND WHAT HAPPENS WHEN THINGS GO WRONG?

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SUMMARY

In this paper I wish to draw attention to Balint's concept of 'the Child as the presenting symptom' and ask whether this concept is relevant to us as psychiatrists.

What arises is whether this concept might illuminate situations where there is serious mental illness in the family, and whether the presentation of a child to a doctor might be indicative of mental illness in the family.

If such an interpretation is possible, then there are important clinical implications, since at present, all UK government guidance, based on the analysis of many high-profile cases where children have been severely abused, is that the needs of the child are paramount, and thence it may be that, whilst quite dramatic intervention may well occur in order to protect the child, perhaps the mental health needs of the parents might be somewhat overlooked. Examples of the interplay between child and parents in the context of mental illness are given, and the present way in which children within families where there is mental illness are cared for is described, also considering the consequences for the parents.

Key words: *Balint's concept – children - mental illness*

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Introduction

The concept of 'the Child as the presenting symptom' was first described by Michael Balint in his book 'The Doctor, The Patient, and the Illness' (Balint 2000). Balint was a psychoanalyst, and he is best remembered for his development of 'Balint Groups', which are groups for general practitioners, run on the lines of group psychotherapy, in which doctors would meet to discuss, with the help of an expert facilitator, cases which in some way are causing them trouble in their own emotional response to the sick person. Such groups are a very core part of General Practitioner training, and today, the Royal College of Psychiatrists have made such groups a central part of the training of psychiatrists.

It was while running such groups that Balint discovered that often, when a child was repeatedly brought to see a general practitioner, it was often found that the parent, usually the mother, also needed therapy, and that such therapy was usually of an emotional, psychological nature. The parent

would not have presented herself, and indeed often the psychological problems of the parent might be totally hidden from the doctor's view. In other words, the parent might present as completely well; an efficient mother dealing efficiently with the child's illness. Balint, in his book, describes a mother who frequently presented her child to the doctor with acute asthma, always acting very efficiently in dealing with the illness, but in fact, it only took a small prompt, in the form of a question by the doctor as to how she was feeling that the mother burst into tears, and disclosed how depressed she actually was. Nor is the depression simply because of the stress of dealing with a sick child, it may be very indicative of other tensions within the family, including marital difficulties between the parents and other issues of illness or even abuse within the family.

Thus, 'the Child as the presenting symptom' presents us with a possible tool to look within the family and explore the family dynamics. I can certainly think of cases, within my years as a

general practitioner when a child presenting with recurrent sore throats has turned out to be an acceptable way in which a family can enter the doctor's surgery and from then, if asked, express their deep seated concerns to a doctor.

So, could this also happen in more serious, psychotic, mental illness?

The concept of the child as the presenting symptom is usually referred to in cases of 'neurotic illness', however, it is the purpose of this paper to suggest that the such a presentation may also regard more serious psychotic illness, and in any case, where children are involved, an assessment of the whole family dynamics of the situation must be part of the examination of the case; and this for a number of different reasons.

In the first place, often, in families where one of the patients has a psychotic mental illness, Leff (Kuipers 2002) has shown that high expressed emotion is a common feature of the family psychodynamics.

Secondly, while many parents who have mental illness are devoted parents, in some cases some mentally ill parents might put their children at risk of serious abuse.

Definitions of Child Abuse

1. "Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to the child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces an illness in a child."

2. "Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development.

It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person.

It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction."

"It may involve seeing or hearing the ill-treatment of another.

It may involve serious bullying causing children to frequently feel frightened or in danger, or the exploitation or corruption of children.

Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone."

3. "Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways."

4. "Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.

Neglect can occur during pregnancy as a result of maternal substance abuse.

Once a child is born, neglect may involve a parent or carer failing to provide adequate food and clothing, shelter including exclusion from home or abandonment, failing to protect a child from physical harm or danger, failure to ensure adequate supervision including the use of inadequate caretakers, or the failure to ensure access to appropriate medical care or treatment."

"It may also include neglect of, or unresponsiveness to, a child's basic emotional needs."

Signs that a child may be being abused include a number of behavioural indicators. These include; Inexplicable falling off in school performance, sudden apparent changes in personality, lack of concentration, restlessness, aimlessness, being socially withdrawn and fearful, being overly compliant, acting out, aggressive behaviour, poor trust in significant adults, regressive behaviour, onset of wetting (by day or night), onset of insecure, clinging behavior, running away from home, arriving in school early and leaving late, suicide attempts, self-mutilation, eating disorders, cover-up clothing, being unusually tired, constant hunger, low self esteem, and poor social relationships.

The signs and indicators of abuse for disabled and non-disabled children are fundamentally the same. However, for disabled children they are

sometimes more subtle. There may be fewer behaviours, fewer signs and sometimes different indicators, there are more possible explanations, they are harder to untangle – especially if there are communication differences, and they are more easily explained away by the impairment, by the illness, by the medication, by the suggestion that “It’s always been like this.”, as attention-seeking behaviour and as self-inflicted.

Mental Illness, parents and their children

Parental illness may markedly restrict children’s social and recreational activities.

Mental and physical illness in a parent - children may have caring responsibilities inappropriate to their years - leading them to be worried and anxious.

If they are depressed, parents may neglect their own and their children’s physical and emotional needs.

Some forms of mental illness may blunt a parent’s emotions and feelings, or cause them to behave towards their children in bizarre or violent ways. Unusually, but at the extreme, a child may be at risk of severe injury, profound neglect, or even death.

The adverse effects on children of parental mental illness are less likely when parental problems are mild, last only a short time, are not associated with family disharmony and do not result in the family breaking up.

Children may also be protected when the other parent or a family member can help respond to the child’s needs.

Child protection is everybody’s business and all NHS mental health services have existing statutory responsibilities for child protection.

While mental illness can be compatible with good parenting, some parents with a severe mental illness are at risk of harming their children.

Very serious risks may arise if their illness incorporates delusional beliefs about the child, and/or the potential for the parent to harm the child as part of a suicide plan.

Staff in adult mental health services caring for a parent must always consider: the child’s needs, the potential for physical and psychological harm as a primary task of the CPA) and as part of multi-agency risk assessment processes. Risks should also be considered for patients who are not parents but are in contact with children e.g. patients with child siblings or grandchildren.

Concerns about patient confidentiality should never delay acting as soon as a problem, suspicion or concern about children becomes apparent.

Some Figures

The National Confidential Inquiry into Suicides and Homicides (NCISH) reviewed 254 homicide convictions between 1997 and 2004 in England and Wales where children were killed by their biological or step parents. Of these, 37% (94 out of 254) had a mental disorder including 15% with depressive illness or bipolar affective disorder, 11% with personality disorder, 8% with schizophrenia or other delusional disorders a 5% with substance or alcohol dependence.

In the Local Safeguarding Children Boards’ evaluation of serious case reviews 14 of the 50 cases identified mental illness as a significant factor. A study by Falkov (Falkov 1995) (Falkov 1997) of part 8 reviews of child deaths where abuse and neglect had been a factor in the death, showed clear evidence of parental mental illness in one third of cases. This led to a training pack, Building Bridges, being commissioned by the Department of Health (Mayes 1998).

Children, parents, and Substance Abuse

In Britain, one third of people with severe mental health problems have a substance misuse problem and a half of service users in Drug and Alcohol Services have a mental health problem, with alcohol misuse being the most common form of substance misuse (Banerjee 2002).

The Social Care Institute for Excellence (SCIE) research briefing 6 (August 2005) produced 6 key messages about how parenting capacity can be affected by parental substance misuse (drugs and/or alcohol) and how this might be managed. They are as follows:

- The misuse of drugs and/or alcohol may adversely affect the ability of parents to attend to the emotional, physical and developmental needs of their children in both the short and long term;
- A number of policy and practice documents are available governing the provision of services to support parents who misuse substances;
- Research has tended to focus principally on substance misusing mothers rather than fathers, and drugs rather than alcohol.

Residential programmes which include the children have been demonstrated to be effective;

- Studies often fail to evaluate the impact of substance misuse on parenting capacity relative to other aspects of disadvantage, such as poverty, unemployment or depression;
- Parents are worried about losing their children, so confidentiality is considered to be a requirement for support services;
- Children often know more about their parents' misuse than parents realise, and feel the stigma and shame of this misuse, but also fear the possibility of being separated from their parents and taken into care.

Consequent recommendations

A local inquiry into the fatal stabbing of two children by their mother, who had schizophrenia, highlighted a number of safety issues reflected in the actions.

These were that mental health organisations, supported by local safeguarding children boards (LSCBs), should ensure: that all assessment, CPA (care program approach- the main method of monitoring and treating patients with mental health problems in the UK) monitoring, review, and discharge planning documentation and procedures should prompt staff to consider if the patient is likely to have or resume contact with their own child or other children in their network of family and friends, even when the children are not living with the service user. A consultant psychiatrist should be directly involved in all clinical decision making for services users who may pose a risk to children. Safeguarding training that includes the risks posed to children from parents with delusional beliefs involving their children or who might harm their children as part of a suicide plan is an essential requirement for all staff, and attendance, knowledge, and competency levels should be regularly audited and any lapses urgently acted on.

Many important enquiries after serious incidents, such as the Victoria Climbié enquiry (2003) and the 'Baby P' enquiry of this year have emphasized that information sharing is vital.

"Effective action designed to safeguard the well-being of children and families depends upon sharing relevant information on an inter-agency basis." (Source: Lord Laming The Victoria Climbié Inquiry 2003).

Of Victoria Climbié, Lord Laming said "Her suffering and death marked a gross failure of the system and were inexcusable"

In 2009, Lord Laming was asked to carry out another enquiry. His findings were as follows:

- At least 200,000 children live in households with a high risk of abuse;
- Social workers trying to protect them feel demoralised and unsupported;
- In many areas they spend too much time on inadequate IT systems and too little time seeing children;
- New recruits deal with complex cases without adequate training and supervision;
- Police child protection teams are under-resourced and have low status;
- It can take 45 weeks to bring a child protection case to court;
- The government should provide child protection training for council leaders and senior managers;
- Social workers' employers should face disciplinary action over child protection failures;
- A national agency should be set up to oversee the swift and effective implementation of these recommendations;

This, then, are the circumstances in which we operate with regards to mentally ill parents and their children in the UK; the Child's needs are seen to be absolutely paramount, while resources to help the families are not abundant, and staff may be disciplined if they make mistakes. In the meantime, many families remain in desperate need.

So while we aim at safeguarding the child above all, what must we do about the mentally ill parent?

The answer lies in our basic obligations as doctors to the doctor-patient relationship and in such evidence based interventions as case management as well as family interventions such as behavioural family therapy.

The case manager needs to make a complete assessment of the needs of the patient and his family, and the care plan must take into account all interventions that are necessary to appropriately treat the patient's illness, thus promoting recovery. While we optimise medication, we will need to do our best to promote the development of insight and the improvement of self neglect, neglect of others,

impaired mental state, and the reduction of violence.

When patients are discharged from hospital, and when patients are treated in the community, special care must be taken to ensure that it is safe for the children and the parents to live together. Also, all social interventions necessary to ensure that the family, and therefore the children, do not live in poverty, and want.

It is clear that by optimising treatment for the parents, and ensuring continuous treatment and support, we can also contribute to the support of the children. However, risk assessment regarding the patient's capability to live with children and contribute to their care, and the children's safety must remain the first consideration.

Conclusion

So does the issue of 'the child being the presenting symptom' occur also in patients with psychosis?

I would like to suggest that it does, or at least that the same mechanisms are also useful in serious mental illness.

'The child as the presenting symptom' is a useful tool in medical practice because it causes the doctor to look behind the way in which patients present and to seek out underlying causes of distress in the patient's psyche and their families.

Children may present as the first sign of mental illness within families in subtle ways. A head-teacher's concern for the welfare of a pupil

may lead to the identification of a psychotic illness in the mother.

Concerns raised by doctors about the mental health of a daughter may lead to concerns that a child's symptoms may be being fabricated.

Thus, it continues to be very important that the health and safety of the children of our patients be seen as our prime concern, and that our patients should receive the best possible treatment for their psychotic illness.

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Note

I freely acknowledge the help of Martin Orr and Deborah Osborne, Child Protection Leads for Bedfordshire and Luton Partnership Trust, who were extremely helpful in the preparation of this paper, which is based very closely on a powerpoint presentation of their design.

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