

## **Messages children need to hear from parents with a mental disorder:**

- 1) My [diagnosis/disease/symptom] is not your fault.
- 2) You can't fix it, it is not your job.
- 3) You are not responsible for taking care of me.
- 4) I still love you.
- 5) If I can't take care of your needs, I will make sure that I will find another adult who can (be specific about what needs and who will meet them).
- 6) You are not alone. Many adults care about you (make list of who). You may talk to them whenever you need to.
- 7) It is OK to have whatever feelings you have about this (may have to help child identify and name feelings, find outlets for expressing them such as drawing or physical activity).
- 8) It is OK to ask for what you need.
- 9) It is OK to ask questions about things you do not understand (reasons for absences, moods, meetings, appointments).

## PERSONALITY DISORDERS

### Red Flags for Workers:

- Is there consistency in blaming others/ circumstances when the parent had/has a key role in the situation?
- Is there available/reported history of childhood physical abuse, sexual abuse, neglect, or other trauma (i.e., multiple early hospitalizations, death of parent during childhood)?
- Is there available/reported history of criminal acts and/or violence?
- Are there attempts to “split” the professionals, or sudden shifts, seeing others as “all good or all bad”?
- Does the parent’s primary focus *remain* “Who turned me in?”
- Is the parent’s primary concern about getting their own needs met, especially if these are minor?

### Strengths and Protective Factors:

#### Parent-child relationship:

- Has attachment to child been established despite PD disorder?
- Is parent aware of and responsive to limitations in parental capacity based on their PD diagnosis?
- Is parent realistic about child’s capacity for self care and self control?

#### Functional capacity of parent to meet child’s needs:

- Is parent’s personality disorder in the mild range?
- Is parent able to sustain adult partnership, and/or form supportive relationships with other caregivers?
- Is there no additional Axis I diagnosis (mood, anxiety, substance use, etc.) impacting parent’s functional capacity?

- Is parent in treatment with minimal negative impact on parental abilities /availability?

#### Developmental needs of child

- Is the child developmentally able to understand and minimally cope with their parent's personality disorder diagnosis and treatment needs?
- Is parent minimally realistic about child(ren)'s limited capacity to meet the *parent's* needs?
- Is there minimal parental awareness of and capacity for age-appropriate consistency in expectations and discipline?

### **Safety and Risk Factors:**

#### Parent-child relationship:

- Is there little or no demonstrated ability to nurture or give affection to the child?
- Are they unable to think about the child's needs as separate from their own?
- Is there little demonstrated capacity for empathy, lack of awareness of how their behavior impacts their child's response to them?

#### Functional capacity of parent to meet child's needs:

- Are the parent and child displaying a pattern of role reversal, with the parent's primary goal to get someone to take care of them?
- Is parent's goal to satisfy their own needs, at the expense of others, even taking pleasure in harm to others?
- Is there charming, engaging behavior that results in manipulation of others for their own ends?

#### Developmental needs of child:

- Is there inability to tolerate developmentally normal behaviors such as crying?
- Is there evidence of "having a right to do what I want" with their child?
- Is there exaggerated concern for themselves, rather than parenting, displaying an attitude of entitlement?

Secondary Considerations:

- Is parent's management of their personality disorder adequate to minimally sustain services?
- Are there extended family and community resources that continue relationship to help with needed resources for follow through with treatment, such as transportation and childcare?
- Are there treatment resources currently positively engaged with the parent?
- Is there history of multiple providers due to parent's personality disorder characteristics, such as splitting or blaming?
- Is there history of long-term dependence upon providers, without potential progress?
- Are there cut-offs from major relationships/support systems due to parent's personality disorder characteristics?

**AXIS II PERSONALITY DISORDERS Cluster A Traits:**

*Withdrawn, cold, suspicious, or irrational*

**PARANOID PERSONALITY DISORDER LOOKS LIKE:**

- Suspicious and quick to take offense; may read hidden meaning into innocent remarks
- Few confidants

TIPS:

- Rarely presents for treatment/drops out often
- Meds not helpful due to noncompliance/suspicion regarding their purpose
- If acutely harmful to self or others, then short term anti-anxiety or anti-psychotic meds may be tried
- Needs honest, concrete approach that is client-centered
- Delusional beliefs cannot be challenged or argued away
- Focus on support and straightforward conversation (watch jokes or subtlety)
- Avoid requests for releases of information unless critical

**SCHIZOID PERSONALITY DISORDER LOOKS LIKE:**

- Has restricted emotional range
- Seems indifferent to criticism or praise
- Tends to be solitary, cares little for social relationships
- avoids close (including sexual) relationships

TIPS:

- Respect boundaries, go slow with rapport
- Be aware they see little reason for social interaction and if placed in groups, will be silent
- Unlikely to seek treatment unless highly distressed; will interact for help primarily for short term, pressing needs

## **AXIS II PERSONALITY DISORDERS CLUSTER A TRAITS CONT'D**

### **SCHIZOTYPAL PERSONALITY DISORDER LOOKS LIKE:**

- Appears peculiar or strange to others because interpersonal relationships are so difficult
- Lacks close friends
- Uncomfortable in social situations
- May show suspiciousness, unusual perceptions or thinking, eccentric speech, and inappropriate affect

### **TIPS:**

- Since reality is distorted (similar to Paranoid Personality Disorder), confrontation is not helpful
- Warm, supportive approach particularly when displaying extreme social anxiety
- When under acute life stresses, expect mistrust and suspicion

## **AXIS II PERSONALITY DISORDERS: CLUSTER B TRAITS:**

*Dramatic, emotional, attention-seeking; moods labile and often shallow; intense interpersonal conflicts*

### **ANTISOCIAL PERSONALITY DISORDER LOOKS LIKE:**

- Irresponsible, often criminal behavior
  - beginning in childhood or early adolescence, with truancy, running away, cruelty, fighting, destructiveness, lying, and theft
  - as adults, may also default on debts or otherwise show irresponsibility
- Acts recklessly or impulsively
- Shows no remorse for behavior

#### **TIPS:**

- Little motivation for voluntary change, pressure comes from legal or significant others
- Threats/confrontation decrease cooperation, increase resistance
- Strengthen focus on life issues/goals by appealing to self-interest
- Conflicts with authority and risk to others are predictable, related to severity and chronicity

### **BORDERLINE PERSONALITY DISORDER LOOKS LIKE:**

- Impulsivity with recurrent suicide threats or attempts
- Affectively unstable, showing intense, inappropriate anger
- Feels empty or bored
- Frantically tries to avoid abandonment
- Uncertain about who they are
- Lacks the ability to maintain stable interpersonal relationships

#### **TIPS:**

- Benefits from structured skill affect management groups
- Depending upon severity/chronicity, expect ongoing lengthy treatment, including day/partial hospitalization, during extreme difficulties in daily/life functioning
- Interpersonal instability impacts employment stability
- Need for acute meds when severely depressed, for brief reactive psychosis, to stabilize thinking or aid anger management
- Responds to support, structure, and clarity

## **AXIS II PERSONALITY DISORDERS: CLUSTER B TRAITS, CONT'D**

### **HISTRIONIC PERSONALITY DISORDER LOOKS LIKE:**

- Overly emotional, vague, and attention-seeking
- Needs constant reassurance about attractiveness
- May be self-centered and sexually seductive

#### **TIPS:**

- Primarily motivated by situational stress, quick to come for help and prone to exaggerate symptoms, circumstances, problems
- Suicidal behavior/threats though common, need to be evaluated, not ignored
- If medications are used for affective/mood disorders, there is increased risk of abusing meds for self-destructive or otherwise harmful behavior
- Needs matter-of-fact, realistic, supportive approach with clear limits concrete direction

### **NARCISSISTIC PERSONALITY DISORDER LOOKS LIKE:**

- Self-important and often preoccupied with envy, fantasies of success, or ruminations about the uniqueness of their own problems
- Sense of entitlement and lack of empathy may cause them to take advantage of others
- Vigorously reject criticism
- Need constant attention and admiration

#### **TIPS:**

- Poor motivation for change
- Likely frequent hospitalizations for severe episodes of impulsive or self-destructive behavior
- Needs clear structure, limits regarding entitlement behaviors

**AXIS II: PERSONALITY DISORDERS: CLUSTER C TRAITS:**

*anxious and tense, often over-controlled*

**AVOIDANT PERSONALITY DISORDER LOOKS LIKE:**

- Timid, easily wounded by criticism so that they hesitate to be involved with others
- May have no close friends
- Fear the embarrassment of showing emotion or saying things that seem foolish
- Exaggerate the risks of undertaking pursuits outside their usual routines

**TIPS:**

- May withhold vital information due to discomfort in interview
- Likely to display poor self esteem and negative view of options/ability
- Does best with familiar experiences, support through predictable experiences
- More effective approach is to limit risks/social involvement, rather than pushing to try new areas, new skills

**DEPENDENT PERSONALITY DISORDER LOOKS LIKE:**

- Needs approval of others so much they have trouble making independent decisions or starting projects
- May agree with others when they know others are wrong
- Fear abandonment, feel helpless when alone, miserable when relationships end
- Easily hurt by criticism
- Will volunteer for unpleasant tasks to gain favor

**TIPS:**

- May be outwardly compliant but passive in follow-through
- Strong need for constant reassurance and support
- Frequent physical or somatic complaints
- Acute anxiety/depression from fears of abandonment or challenging limits to independent functioning
- Risk of abuse of sedatives or overdose with drugs
- Antidepressants and anti-anxiety medications may be used for acute life stresses
- Short-term, solution-focused contact to reduce dependency
- ‘Cheerleading’ for self-confidence and assertiveness

## **AXIS II: PERSONALITY DISORDERS: CLUSTER C TRAITS CONT'D**

### **OBSESSIVE-COMPULSIVE PERSONALITY DISORDER LOOKS LIKE:**

- Perfectionism and rigidity
- Often workaholics
- Tend to be indecisive, excessively scrupulous, and preoccupied with detail
- Insist others do things their way
- Have trouble expressing affection
- Tend to lack generosity, resist throwing away useless objects

### **TIPS:**

- Most live normal lives, needing help when overwhelming life issues challenge their behavior and way of thinking
- May be acutely stressed with technological or other work changes to which they cannot adjust
- Responds best to help with current difficulties and increased coping skills
- Too rigid and unable to adapt to others' ways of doing things for group involvement

## ANXIETY DISORDERS (INCLUDING PTSD)

### Red Flags for Workers:

- Is there a history of past traumatic events for which parent continues to demonstrate present distress?
- Is there sleep avoidance and/or medication failure regarding traumatic nightmares?
- Are parent's PTSD "triggers" or symptoms of dissociation leading to injury (or demonstrated potential injury from history) to child?
- Is parent's PTSD symptoms acute or severe such that significant time is lost (dissociation), leading to failure to provide minimally adequate supervision or parenting?

### Strengths and Protective Factors:

#### Parent-child relationship:

- Was attachment between parent and child established prior to traumatic events leading to PTSD?
- Is attachment continually demonstrated to child despite diagnosis?

#### Functional capacity of parent to meet child's needs:

Is parent able to manage his/her disorder so that it does not limit engagement with child's activities/other support system?

#### Developmental needs of child:

- Is parent insightful about managing his or her symptoms or treatment, so that projection of fearful "world view" is limited?
- Is parent encouraging of child's appropriate developmental risks and independence?

## ANXIETY DISORDERS (INCLUDING PTSD)

### **Safety and Risk Factors:**

Parent-child relationship:

- Does parent or child report significant periods of “lost time” or personality switches (“good mommy/bad mommy”)?

Functional capacity of parent to meet child’s needs:

- Is parent’s social anxiety limiting parent’s ability to spend time needed with child for minimal care-giving?
- Are parent’s PTSD “triggers” or symptoms of dissociation leading to injury (or demonstrated potential injury from history) to child?
- Is parent severely anxious or consumed with symptoms, so that child’s daily needs are not prioritized?
- Is child endangered by parent’s periods of dissociation (car accidents, forgetting needed medical treatment, missing days for school attendance)?

Developmental needs of child:

- Is parent’s social anxiety directly impacting parent’s ability to sustain relationships critical to the child’s well-being?

### **AXIS I ANXIETY DISORDERS LOOK LIKE:**

- fearful, worried, anxious
- preoccupied with fears about future anticipated social, physical or emotional experiences
- unable to forget/relives past traumatic events
- isolates or avoids places/people/situations as ways to manage/control intense fears or anticipated reactions

### **TIPS:**

- Panic, phobia and trauma survivors' symptoms can seriously impact ability to deal with daily functioning, including work performance
- Irrational or exaggerated fears will not resolve with confrontation;
- Challenging catastrophizing *may* be helpful depending upon severity and duration of symptoms
- Needs encouragement for treatment follow-through, including medication compliance;
- Support and recognition of past strengths helpful

## MOOD DISORDERS

### Red Flags for Workers:

- Does parent display extremely depressed mood, fatigue, or other symptoms for more than two weeks, especially without identifiable cause?
- Is there a marked change in housekeeping, personal care, or other coping related to loss of concentration or energy?
- Is there unusual irritability, grandiose or excessive behavior?

### Strengths & Protective Factors:

#### Parent-Child relationship:

- Is there demonstrated attachment (i.e., support, empathy) with the child?
- Are there significant periods of remission from the mood disorder?
- Is parent insightful of mood disorder and actively committed to treatment?

#### Functional capacity of parent to meet the child's needs:

- Is parent's mood disorder in the mild range, minimally impacting daily functioning?
- Does parent's mood disorder respond to medication, if prescribed? (Includes parent's ability to tolerate prescribed medications)
- Are there other caregivers the parent/child routinely accesses when needed?

#### Developmental needs of child:

- Is parent's course of treatment demonstrating minimal vegetative symptoms (eating, sleeping, energy, concentration)?
- Are mood episodes of brief duration, with quick recovery?
- Is parent able to remain supportive of child despite depressive symptoms (negative cognitions, irritability)?

## MOOD DISORDERS

### Safety and Risk Factors:

#### Parent-Child Relationship

- Is parent withdrawn from child, isolated from family/friends when symptomatic?
- Is there history of lengthy absences from childrearing (hospitalizations, child placed with relatives)?

#### Functional capacity of parent to meet child's needs:

- Are parent's vegetative symptoms (eating, sleeping, energy, concentration) moderate to severe?
- Are mood episodes lengthy, with poor recovery?
- Is parent's excessive or grandiose behavior primary in failing to meeting child's basic needs or exposing child to further abuse/neglect?
- Are the parent's acute symptoms (insomnia, hypersomnia, memory, fatigue) contributing to a pattern of failed treatment appointments for the child?
- Are the parent's acute or chronic symptoms a significant factor in noncompliance with necessary prescribed medications for the child?

#### Developmental needs of child:

- Is child 3 or younger or parent under 18?
- Does child have special needs or temperament consistently requiring patience and concentration?

### Secondary considerations:

- Is parent able to sustain short term memory, energy, and concentration for services to address child welfare goals?

### **AXIS I MOOD DISORDERS LOOK LIKE:**

- A period of abnormal mood,
  - *either* sad, cannot enjoy life, trouble eating, sleeping concentrating; negative thoughts about self worth, excessive guilt, or suicide;
  - *or* may be abnormally happy, with rapid speech and underlying agitation; talkative, distractable

### **TIPS:**

- Depression can look like/be mistaken for lack of motivation
- Dysthymia can look like/be mistaken for being a negative or pessimistic person
- Diminished ability to think/concentrate, and indecisiveness impacts work
- Fatigue and chronic sleep problems impact daily functioning
- Supportive validation and encouragement to follow through with therapy and medication treatment are most helpful.

## **Depression in Men**

- Some researchers question accuracy of present criteria for men, recommending revisions for males
- Male experience of symptoms and coping with depression look/present differently: more willing to acknowledge fatigue, irritability, loss of interest in work or hobbies, sleep disturbances than feelings of sadness, worthlessness or excessive guilt
- Higher reported alcohol and drug abuse which can mask depression
- Four times as many men die by suicide in the US
- Impact of loss for elderly males of work, productivity

(National Institute of Mental Health: Real Men Real Depression (RMRD) Campaign, 2005)

## **Depression in Women**

- After 14, twice the rate of depression Impact of abuse and poverty is greater on women than men
- Highest rates are for unhappily married women
- Pregnancy, abortion, and menopause do not show increased rates of depression
- More likely to report feelings, seek help
- Women survivors of heart attacks who are under 60 at greatest risk (40%) for post-heart attack depression (males 22%) (Mark Dombeck, 2006, “Heart Attacks and Young Women = Depression”)
- African American and Hispanic women are twice as likely to be depressed as African American and Hispanic men

(National Institute of Mental Health, 2005, except where noted)

# SCHIZOPHRENIA

## Red Flags for Workers:

- Does the parent think they are under the control of outside forces or their thoughts inserted by/heard by others?
- Is the parent withdrawn/isolated due to symptoms, flat (non-expressive) affect, or poor self-care?
- Does the parent's speech manifest "loose associations," i.e., connections between topics are tangential, hard to follow?

## Strengths and Protective Factors:

### Parent-child relationship:

- Is parent's illness sufficiently manageable that parent is not displaying "bizarre" behavior or thinking in social situations significant to the child?
- Does parent identify their role as parent as an important one, to which they are committed to being effective?

### Functional Capacity to meet child's needs:

- Is parent responsive to prescribed medications?
- Does parent have periods of clarity which include insight into psychosis?
- Is parent responsive to family/support system's limits on embarrassing behaviors?

### Developmental needs of child:

- Are parent's symptoms less severe, with periods of adequate functioning at critical developmental stages for the child?
- Is parent's psychotic symptoms separate from (i.e., not projected upon) child?

# SCHIZOPHRENIA

## **Safety and Risk Factors:**

### Parent-child relationship

- Is the diagnosis Chronic Schizophrenia which is characterized by lack of relatedness to others?
- Have symptoms been acute, hospitalizations needed at critical attachment stages?

### Functional capacity of parent to meet child's needs:

- Are parent's acute symptoms of sleeplessness, withdrawal, or lack of personal hygiene directly impacting minimal parenting capacity?
- Is parent responding to and compliant with prescribed medications?
- Is parent lacking family support due to disorder

### Developmental needs of child:

- Does parent demonstrate or have history of psychotic breaks following childbirth?
- Has parent stopped medications due to pregnancy or breast-feeding?

## SECONDARY CONSIDERATIONS:

- Are parent's psychotic symptoms severe, bizarre, or damaging such that they are a critical barrier to sustaining relationships with other caregivers/support system?

### **AXIS I PSYCHOTIC DISORDERS: SCHIZOPHRENIA LOOKS LIKE, BY TYPE:**

- paranoid—preoccupation with delusions or frequent auditory hallucinations
- disorganized—rapid deterioration, talking gibberish, neglect of hygiene and appearance with prominent disorganized speech and behavior, flat or inappropriate affect
- catatonic—any of the schizophrenic symptoms along with abnormal physical movements, typically slow or retarded to the point of stupor (prevalence now rare)
- undifferentiated—does not meet paranoid, disorganized, or catatonic criteria
- residual—no longer with pronounced catatonic behavior, delusions, hallucinations, or disorganized speech or behavior, but continues to have either negative symptoms or a limited form of odd beliefs, distorted perceptions, illusions, odd speech, or peculiarities of behavior

### **TIPS:**

- Until psychotic ideation is revealed, paranoid type appear the most “normal” in behavior, physical appearance, and self-care, with better daily functioning
- Disorganized type most obviously psychotic;
- More effective medications available, but research continues to find little improvement in ability to function in a parental capacity
- If psychosis managed effectively by medication, may be able to establish limited rapport despite symptoms/lack of insight;
- Typically cannot sustain consistent symptom remission without life impairment

## Suicide Risk Red Flags

- Agitation
- Talking about it
- Hopeless, helpless
- Loss of interests
- Giving things away
- Preoccupied with death
- Suddenly happier, calmer
- More than 10 years of mental health treatment
- Substance abuse in family/history
- Domestic violence in family/history
- Depression
- Recent loss
- Prior attempts
- Ages 15-25; 65+
- Male, single, elderly

### Assessing Risk

- Thoughts of suicide?
- Plan?
  - Availability
  - Lethality
- Reasons not to attempt suicide
  - Children
  - Beliefs
  - Fears
- Acutely agitated?
- Contract for safety
- Existing treatment resources

**SEEK MANDATORY HELP FOR SOMEONE WHO HAS BOTH SUICIDAL THOUGHTS AND AN AVAILABLE PLAN**

24-Hour Toll-Free Crisis Hotlines:

In Iowa:	1-800-332-4224
National:	1-800-448-3000
Substance Abuse:	1-866-242-4111

# **STEPPS Group – For Emotional Intensity Disorder (Borderline Personality Disorder)**

20 weeks therapy; insurance pays

## **Agenda**

- Week 1: Awareness of Filters
- Week 2: Filters
- Week 3: Distancing
- Week 4: Communicating, Part 1
- Week 5: Communicating, Part 2
- Week 6: Challenging, Part 1
- 7-8:30 p.m. STEPPS Open House/Family/SO Night
- Week 7: Challenging, Part 2
- Week 8: Challenging, Part 3
- Week 9: Distracting, Part 1
- Week 10: Distracting, Part 2
- Week 11: Managing Problems, Part 1
- Week 12: Managing Problems, Part 2
- Week 13: A Balancing Act
- Week 14: Setting Goals
- Week 15: Eating and Sleeping
- Week 16: Exercise, Leisure and Physical Health
- Week 17: Abuse Avoidance
- Week 18: Interpersonal Relationships, Part 1
- Week 19: Interpersonal Relationships, Part 2
- Week 20: Wrapping it All Up

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