Indication for Psychotherapy in Offspring of a Parent Affected by a Chronic Somatic Disease (e.g. Multiple Sclerosis)

B. Steck a  F. Amsler a  A. Schwald Dillier a  A. Grether a  L. Kappos b  D. Bürgin a

Departments of a Child and Adolescent Psychiatry, and b Neurology, University of Basel, Basel, Switzerland

Introduction

Somatic illness in a parent is a risk factor for psychiatric disorder in children [1–5]. A significant physical disease in a parent has an impact on children’s development and psychosocial functioning.

Stressful life events require coping strategies from both parents and children. Coping and long-term adjustment to a chronic illness include the effort and the time needed for each individual, and for the family as a group, to integrate the physical, psychological and social consequences of the disease into the intrapsychic and interpersonal reality [6].

Integration of heterogeneous psychic functions in children and adolescents depends on the complexities of their development, which is influenced by constitutional, environmental and maturational factors and their mutual interaction. For Anna Freud ‘integration serves healthy growth provided the elements synthesized by it remain within the limits of an expectable norm. It is the hallmark of the synthetic function that, while doing its work, it does not distinguish between what is suitable and unsuitable, helpful or harmful for the resulting picture. Thus, every step on the developmental line, besides being a compro-

Key Words
Multiple sclerosis  ·  Indication for psychotherapy  ·  Children’s coping  ·  Family  ·  Semi-structured interviews

Abstract
Based on the transcripts of video-recorded, semi-structured interviews with 41 offspring (aged 6–18 years) of parents with multiple sclerosis, we evaluated the indication for psychotherapy. These results were then compared with the previously determined coping ability of each child/adolescent. Psychotherapy was indicated for 22 out of the 41 children/adolescents. There was a significant relation between the indication for psychotherapy and the children’s inability to cope with the parental disease. The present findings confirm the risk of mental health problems in children of somatically ill parents. In our sample, half of the children and adolescents were estimated to benefit from individual psychotherapy, which might enhance their ability to cope with the parental illness.

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mire between conflicting forces, also represents an amalgamate of beneficial with malignant ingredients’ [7, pp 128–129]. The task the child faces is to make sense of the experience of parental illness, then integrate the experience in an adaptive way into his or her ongoing development.

Children’s coping capacity depends on their age, gender, developmental state, personality and defensive structure. The illness concepts and their cognitive and affective coping strategies are specific to each child. They change with age and development. Risk, protective and resilience factors influence the coping abilities of children. In particular, parental factors such as aggravation of the disease, associated emotional distress, depression or cognitive impairment may negatively influence children’s coping behavior.

Our previous research [8, 9] also indicates that there are significant gender-specific interactions between the patient and his or her partner in terms of their coping, the level of neurological impairment and associated depression. The ability of children to cope with a parent’s chronic somatic disease seems to be determined by the coping style of the healthy parent, and particularly by the coping pattern of a healthy parent of the same gender. Identification with the healthy parent seems to be essential for child development. The healthy parent of the same gender is the most important person for imitation and role modeling. Identification with the ill parent may lead to psychopathological problems such as psychosomatic symptoms and hypochondrial complaints. Multiple fears of loss, death, separation and transmission of the disease as well as depression, learning problems and relationship difficulties are other frequent manifestations of children and adolescents with a parent affected by a somatic illness [10].

The literature on the evaluation of an indication for psychotherapy in children and adolescents is sparse. Anna Freud stated that ‘childhood is a process sui generis, a series of developmental stages in which each manifestation has its importance as a transition, not as a final result’ [11, p 136]. One factor is essential, i.e. ‘the child’s ability to develop does not remain fixated at some stage before the maturation process has been concluded’ [11, p 136]. Indications for psychotherapy are based less on psychopathological manifestations themselves than on the bearing of these manifestations on the maturation process within the individual child’ [11, pp 148–149]. Emphasis is shifted from purely clinical to developmental aspects.

According to Freud, neurosis is severe and therapeutic measure have to be taken ‘if a child shows a faulty knowl-

edge of the outer world, far below the level of his intelligence; if he is seriously estranged from his own emotions, with blank spaces in the remembrance of his own past beyond the usual range of infantile amnesia, with a split of his personality, and with motility out of ego control’ [11, p 148]. ‘Since the decision to seek advice for the child normally lies with the parents, an infantile neurosis is more likely to be brought for treatment when its symptoms are disturbing to the environment. The parents will be guided in their assessment of the seriousness of the situation by the impact of the child’s neurosis on themselves’ [11, pp 134].

Lebovici [12] underlined that the difficulty in the psychoanalytical treatment of children lies essentially in the relationship of the therapist with the child’s parents. Būrgin [13] evaluates three main categories during a diagnostic therapeutic interview: need, motivation and capacity for therapy. Within the relationship between therapist and child/adolescent, an exchange characterized by a dialog and mutual emotional movements, allowing the inner psychic world to appear in the outer world, occurs in the ‘transitional space’ [14].

When evaluating the indication for psychotherapy, the age, gender and developmentally specific features of contact and relational structuring, capacity for communication and expression, as well as the child/adolescent’s way of emotional experience and cognitive assimilation must be taken into account. Is the child able to benefit, to take advantage of the therapeutic relationship? On the therapist’s side, he or she is always influenced by his or her own education, training, references and values.

In this study, 41 offspring (6–18 years old) with a parent affected by multiple sclerosis (MS) were evaluated for an indication of psychotherapy. The evaluation was based on transcripts of video-recorded semi-structured interviews and projective materials. Parental/family criteria (e.g. depression, single parenthood) as well as the resources of parents and offspring were taken into consideration. The results were then compared with the coping capacity of each child/adolescent, quantitatively determined in previous research [9].

**Subjects and Methods**

**Participants**
All patients except one were recruited from the Neurology Department of the University of Basel, Switzerland, where MS patients are treated by a specialized multidisciplinary team.
Psychiatric Interview
A specific semi-structured interview was conducted which lasted an average of 1.5 h and was video recorded.

The following topics were addressed in the interview with all parents.

1. Experience and coping with the disease, at the moment of the outbreak, the diagnosis, in the present time and in regard to the near and far future.
2. Influences of the disease on the relationships within the core family, the partnership, the children and outside the family (enlarged family, neighbors, friends, teachers) and on role and function (professional, parental, social).
3. Experience and coping of their parents with the illness (trans-generational mode of coping).

The following topics were addressed in the interview with the offspring.

1. Experience of the parental disease: knowledge, representations and manifestations of parental reactions and emotions to the disease; influence of the disease on parental role and function.
2. Own experience: preoccupation with the parental disease; representations, fantasies, emotions and fears; losses, restrictions, sacrifices due to the parental disease.
3. Communication about the disease. With whom? Inside the family (sick and healthy parents, siblings)? Outside the family?
4. Influence of the disease on the relationship with the sick and healthy parents, and with siblings.
5. Own health and illness: related representations, feelings and fears; heredity.
6. Psychosocial impact on own development, school, education, profession, social relationships, peers, and on future projects.

Quantitative Evaluation of 7 Dimensions
Transcripts of video-recorded interviews and of projective material included in the interviews [Thematic Apperception Test (TAT) [15]; story stems (according to Bretherton et al. [16], the Scenotest [17], and Squiggles [18]; drawings of parents and self; dreams) were analyzed according to a clinically oriented self-created coding scheme to quantify and describe the following dimensions (dimensions 1, 2, 3 and 4 are modified according to Bürgin [13]). For more details, see Appendix.

1. Criteria concerning psychopathology (n = 68) subdivided into: 31 criteria for intrapsychic aspects (emotions, thinking, communication, ego functions, defense mechanisms), 15 criteria for observable aspects (e.g. symptoms, parentification, precocious behavior) and 22 criteria for projective material (e.g. narratives, play, drawings).
2. Criteria concerning need for therapy (n = 2): the child’s distress and the presence of symptoms.
3. Criteria concerning capacity to benefit from therapy (n = 2): the child’s emotional investment in the therapeutic relationship and his or her capacity to benefit from it.
4. Criteria concerning motivation for therapy (n = 2): the child’s interest in the psychoanalytic dialog and the readiness to express his or her inner world and emotional experience over the course of the interview.
5. Familial/parental criteria (n = 14): e.g. depression, single parenthood.
6. Criteria concerning parental resources (n = 9): e.g. capacity for open communication or to respect interests and activities of each family member.

(7) Criteria concerning children’s resources (n = 9): e.g. mature defense mechanisms, good cognitive functions.

In each dimension, the criteria were evaluated by the interviewer according to a 5-point scale (0, 0.5, 1, 1.5, and 2, where 0 indicates that the criterion is missing, i.e. low numbers indicate weak expression and high numbers strong expression of the criterion). Criteria for dimensions 2 (need for therapy), 3 (capacity for therapy) and 4 (motivation for therapy) are combined to give a single score each.

Quantitative Evaluation of Coping Capacity
For previous studies on coping capacity, see Steck et al. [8, 9]. All interviews with parents and offspring were evaluated by two trained, clinically experienced raters, according to a detailed coding scheme. For further analysis, the mean of the two raters was used; in cases where the difference was larger than one point, a consensus was reached in collaboration with the interviewer.

The coding system is clinically oriented and aimed at transforming all of the detailed information acquired into large content categories. This information – following a code manual – was then summarized. We used a 5-point scale for (each of) the patient, the partner and the couple, describing the following 5 dimensions: (a) impulse-defense balance; (b) capacity for dialog on a cognitive and emotional level; (c) flexibility/rigidity of representations; (d) course of the interview, capacity to use the interviewer, and (e) coping with the disease (integration of a–d). Low numbers indicate a low degree and high numbers a high degree of coping with the disease. The mean of all 5 dimensions was calculated to obtain the coping index (CI). Only the CI of the patient, the partner, the couple and the children was used for further analysis. Because the CI was – as expected – age-dependent, we used an age-standardized Z score for further investigation (more detailed information in Steck et al. [8, 9]).

The internal reliability of the CI scales was high (Cronbach’s alpha higher than 0.95 for the interviews with the parents, and higher than 0.93 for the interviews with the offspring), indicating a high concordance of the underlying subscales (a–e), which are essential parts to the assessment of the coping.

The overall intraclass correlation coefficient [19] of the assessment of the patient was 0.74, of the partners 0.65, and of the children 0.67. These values are, according to Rosner, situated in the range of 0.6–0.8 considered to be good to very good. The coping scale reflects a global clinical judgement, based on the content of and the observation during the interview, as well as the raters’ subjective impressions.

The following statistical methods were applied: intraclass correlation for interrater reliability according to Rosner [19]; scale consistency with Cronbach’s alpha, Pearson and Spearman correlations, regression analysis, and analysis of variance. All significance tests were calculated 2-tailed.

Results
Demographics and Clinical Data
The 17 male and 24 female patients have a mean value of neurological impairment of 4.1–5.5 [Kurtzke Expanded Disability Status Scale (EDSS)] [20], indicating a more or less severe disability. The distribution of off-
spring according to age and gender and within the two age groups is comparable.

Psychopathology, need, capacity and motivation for therapy were not age dependent (t test: no significant differences between the two age groups). The internal reliability of the dimension ‘psychopathology’ was high (Cronhbach’s alpha >0.93). No significant correlations were found between psychopathology, need, motivation or capacity for therapy and age, gender of offspring, disease variables (e.g. age at the diagnosis, course and duration of illness), or neurological impairment (Kurtzke EDSS [20]) of the ill parent (tables 1 and 2).

**Psychiatric Interviews**

The results are presented in 4 parts: (1) descriptive statistics of the 7 dimensions; (2) coping capacity results (CI); (3) associations between the dimensions, and (4) associations between the dimensions and the CI.

**Descriptive Statistics**

The criteria concerning psychopathology (dimension 1) with the highest score are of intrapsychic nature (defense mechanism with psychic inhibition, overwhelming or rigidly suppressed emotions, hopelessness/helplessness/loneliness, poor self-representation, destructive aggressiveness) or are observable items (symptoms, e.g. fears, parentification, or precocious behavior).

Among the dimensions 2, 3 and 4, need for therapy (dimension 2) gives the highest score, followed by capacity for therapy (dimension 3) and finally by motivation for therapy (dimension 4).

Of the family/parental criteria (dimension 5) – with a potentially negative influence on parental and children’s coping – depression/suicidal ideation scored highest, followed by single parenthood, no alternative relationship/social isolation, parental communication incapacity and unresolved traumatic experiences in the parents’ own past history.

With respect to parental resources (dimension 6), concern and respect for the child’s emotional and developmental needs and for family members’ interests and activities are assessed highest, followed by parental perception of the psychosocial impact of the disease on children, and parental ability to take advantage of appropriate information and to give age-appropriate information to children about the disease.

Good cognitive functions and mature defense mechanism range highest within the criteria of offspring resources (dimension 7), followed by the child’s significant relationship with another person and own creativity.

In summary, one can say that psychopathology in a child/adolescent can be assessed by a relatively few criteria. Among the 3 therapy criteria, need for therapy is most frequently observed. Depression in a parent and single parenthood present an unfavorable context, whereas parental consideration for their child’s emotional and developmental needs and good cognitive functioning can be considered as resources.

**Children’s CI**

The CI (table 2) of the total population of offspring is 3.1 ± 0.6; daughters have a slightly higher CI (3.2 ± 0.7) than sons (3.0 ± 0.5); children (6–12 years old) have a CI of 3.1 ± 0.6, adolescents of 3.0 ± 0.6.

The coping value of 3 is slightly above the medium range; there are no significant coping differences between girls and boys, or between the two different age groups.

**Associations between the Different Dimensions**

**Correlation between the Different Criteria of Psychopathology of Children and Their Need, Motivation and Capacity for Therapy.** The intrapsychic criteria (such as overwhelming or rigidly suppressed emotions, disorders of ego function) correlate most significantly with need for therapy (r = 0.50 vs. r = 0.80; p < 0.01). Other intrapsychic criteria (such as communication difficulties, defense

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mechanism of denial) show the highest inverse correlations with capacity and motivation for therapy (r = –0.47 vs. r = –0.58; \(p < 0.01\)).

**Correlations between Psychopathology of Children and Their Need, Motivation and Capacity for Therapy.** We found a significant positive correlation between psychopathology and the need for therapy, as well as between motivation and capacity for therapy. There are no significant associations between psychopathology nor between need for therapy and motivation or capacity for therapy (table 3). It might be important to note that neither the criteria of psychopathology nor of need for therapy can be used to assess motivation or capacity for therapy.

**Cross-Tabulation between the Need for Therapy and Capacity for Therapy.** The score of 22 (54%) children and adolescents is high or medium for both need and capacity for therapy (table 4). The correlation between the need for therapy and motivation for therapy shows similar results (12 offspring have a high score, 10 a medium), as well as the correlation between motivation for therapy and capacity for therapy (19 offspring have a high, 9 a medium score). The criteria of need, capacity and motivation for therapy are considered to be essential in the evaluation of an indication for psychotherapy.

**Correlations between Parental/Family Variables and Psychopathology, Need, Capacity and Motivation for Therapy of Children.** Parents’ self-perception as victims of their illness, which is the sole focus of their concern, social isolation, and unresolved traumatic experience in their past history as well as the emotional or physical abuse of the child all correlate significantly with the child’s psychopathology and the need for therapy (r = 0.40 vs. r = 0.48; \(p < 0.01\)). There are no significant relations between parental/family variables and motivation or capacity for therapy.

**Correlations between Parental Resources and Psychopathology, Need, Motivation, and Capacity for Therapy of Children.** Concern and respect for the child’s own emotional and developmental needs, for family members’ activities and interests outside the family, and receiving psychotherapy themselves all correlate negatively (r = –0.33 vs. r = –0.50; \(p < 0.01\) vs. \(p < 0.05\)) with the child’s psychopathology and need for therapy. Parental social integration correlates negatively (r = –0.034; \(p < 0.01\)) with the child’s need for therapy. Open communication with the child about the disease correlates positively with motivation and capacity for therapy (r = 0.34 vs. r = 0.36; \(p < 0.05\)).

**Correlations between Offspring Resources and Their Psychopathology, Need, Motivation, and Capacity for Therapy.** There are significant (r = –0.042; \(p < 0.01\)) negative correlations between good cognitive function and psychopathology, and significant (r = 0.40 vs. r = 0.47; \(p < 0.01\) vs. \(p < 0.05\)) positive correlations between good cognitive function, creativity, and motivation and capacity for therapy in children. The offspring’s ability to provide coherent narratives and to find creative and positive solutions in their stories correlates negatively (r = –0.31 vs. r = –0.42; \(p < 0.01\) vs. \(p < 0.05\)) with psychopathology and positively (r = 0.32 vs. r = 0.47; \(p < 0.01\) vs. \(p < 0.05\)) with motivation and capacity for therapy.
Associations between the 7 Dimensions and the Coping Capacities (CI) of Offspring

Correlations between Psychopathology, Need, Motivation and Capacity for Therapy, and CI. Psychopathology, need for therapy and CI show a significant negative correlation. The correlations between motivation, capacity for therapy and CI are significantly positive (table 3).

Correlations between Parental/Family Variables and CI of Offspring. The criteria of unresolved traumatic experience in the past history of the parents, as well as their social isolation and the lack of a relationship with a significant other person show a significant negative correlation ($r = -0.41; p < 0.01$) with the CI of the child.

Correlations between Parental and Children's Resources and CI of Children. The parental ability to take advantage of information and to give age-appropriate information to children about the disease, their mutual coping and their own psychotherapy, as well as the offspring's good cognitive function all show a significant positive correlation ($r = 0.33$ vs. $r = 0.46; p < 0.01$ vs. $p < 0.05$) with the CI of the child.

Discussion

The aim of this study was to investigate whether individual psychotherapy was indicated for children of parents with a chronic somatic disease such as MS. A second objective of this study was to assess the relationship between the indication for psychotherapy in the child/adolescent and his or her capacity to cope with the parental disease.

Descriptive Statistics

Psychopathology

Our results demonstrate that a relatively small number of the intrapsychic criteria (defense mechanism with psychic inhibition, overwhelming or rigidly suppressed emotions, hopelessness/helplessness/loneliness, poor self-representation, destructive aggressiveness), and even fewer observable criteria (symptoms such as fears, parentification, or precocious behavior) reflect the child’s psychopathology. We evaluated over 60 criteria, summarized into 3 categories. The question arises whether the present instrument to determine psychopathology should not be simplified.

Family or Parental Criteria

Depression and suicidal ideation show the highest score. Studies of depressive disorders have clearly documented a higher prevalence in MS patients [21, 22]. Psychological distress affects not only the chronically ill patient but also the caregiver [23–25]. There is ample evidence of the association between parental mental disorders and children’s adjustment [26, 27]. The quality of the emotional availability of the healthy parent may however compensate for the inattentiveness of the ill parent. In their studies of parents with mental health problems and their psychosocial impact on children, Leinonen et al. [28] show that the effects of parental mental health on child adjustment are mostly mediated through the other parent’s quality of parenting.

Parental Resources

Other researchers obtained similar results (e.g. concern for children’s needs and activities, parental perception of the illness effects on children, importance of information). Power [29] identified well-adjusted families with a parent affected by MS, and found that their members took care of their own needs and engaged in activities outside the family. The availability of appropriate information, open discussion about the treatment and disability of the patient without feelings of shame or anxiety, and early intervention are important factors facilitating family adaptation to the disease. According to Arnoson [30], families who manage the intrusion of MS into their lives most effectively learn how to make a place for MS in the family without giving it more space than it actually needs. The family learns to accommodate to the demands of MS without allowing the illness to consume more of the family’s emotional, financial or physical resources than it absolutely needs. If MS is allowed to become the primary focus of the family, important developmental and emotional needs of family members are ignored and the entire family system is disrupted. Children should be given an opportunity to receive age-appropriate and individual information about the disease [5, 31]. They need to be able to distinguish between their fantasized causes (e.g. having brought the illness onto the parent through their own destructive affects) and the real etiology [4].

Offspring’s Resources

Other studies confirm our findings on children’s resources: thus, the quality of the child’s relationship with compensatory caregiver(s) may be a key variable that allows the child some respite and perhaps even some escape from risk [32]. Children who have both the ability and opportunity to develop significant relationships with alternative persons experience their parents’ illness very differently than children who have exclusive, negative
and/or conflictual relationships with overburdened parents [27, 33–36].

**Coping of Children (CI)**

In this group of offspring, there were no significant age- or gender-specific differences in the coping capacities of children and adolescents. In our previous study [9], which included 82 children in the age range of 3–26 years, we found gender-specific differences in their coping abilities with daughters coping better than sons, independently of the gender of the MS-affected parent. The main factor contributing to this difference may be the size of the sample (twice the number of offspring in the previous study).

**Associations between the Dimensions**

**Correlation between the Different Criteria of Psychopathology of Children and their Need, Motivation and Capacity for Therapy**

Our data indicate that the intrapsychic criteria of psychopathology (i.e. defense mechanism with psychic inhibition, overwhelming or rigidly suppressed emotions, hopelessness/helplessness/loneliness, poor self-representation, or destructive aggressiveness) are most relevant to the evaluation of need, motivation and capacity for therapy. This finding is meaningful as it confirms the possibility of evaluating the developmental process of the child, i.e. its inhibition or impairment, on the basis of these criteria and underlines the importance of an individual assessment of each child/adolescent by a psychologically trained specialist.

Psychopathology, Need, Motivation and Capacity for Therapy of Children

The greater the offspring’s psychopathology, the greater his or her need for psychotherapy. This is not surprising, as the manifestations of psychopathological symptoms impede the maturation process of the child/adolescent. Yet, there are no significant associations between need for therapy and motivation or capacity for therapy. Why should a child, interested in receiving help, not be motivated? Numerous factors may play a role: in this study, the child met the interviewer for the first time and only once, which may have influenced the motivation. Second, some children thought that their parents needed help first, while others felt they themselves were not entitled to help as their health was not affected. Still others were convinced that in reality no help would be effective, as the disease of the parent took its own destructive course.

The highly significant correlation between motivation and capacity for therapy might be more understandable: these are the children and adolescents who gave the impression in the interview of being able to use an intermediate area of experience, ‘unchallenged in respect of its belonging to inner or external (shared) reality’ [14], in which they expressed and shared their anxieties, distress and concerns, and were thus capable of benefiting from this therapeutic relationship.

Need and Capacity for Therapy as Well as Need and Motivation for Therapy of Children

According to our evaluation a good half of the offspring (22 out of 41) would benefit from a psychotherapeutic intervention. One 15-year-old adolescent was already in individual psychotherapy at the time of the study.

There were no significant correlations between psychopathology, need, motivation, or capacity for therapy and age, gender, disease variables, or neurological impairment of the MS-affected parent. These objective factors are not linked with the child’s psychopathology or need for therapy. So, the child’s internal reality seems to be the essential feature for evaluating the indication for psychotherapy, independent of external criteria like age, gender or disease variables.

**Correlations between Parental/Family Variables and Psychopathology, Need, Motivation and Capacity for Therapy of Children**

Our findings raise the question of whether unresolved traumatic experiences in the past history of a parent may be associated with his or her feelings of victimization and tendency to focus his or her life around the disease. Such an attitude would interfere with parental perception of and emotional availability to their child’s developmental and emotional needs, leading eventually to the emotional or physical abuse of the child. In this context, social isolation may operate as a more or less important factor.

**Correlations between Parental Resources and Psychopathology, Need, Motivation, and Capacity for Therapy of Children**

The most important factors contributing to offspring’s mental health in a situation of parental disease seem to be: that children’s developmental and emotional needs are cared for; that they enjoy freedom to explore own play, interests and activities, and that they are sure their parents are adequately supported by a social network.
Correlations between Offspring Resources and Psychopathology, Need, Motivation, and Capacity for Therapy

Children’s good cognitive function, creativity and capacity for constructive imagination seem to be preventive factors in terms of the development of psychopathological symptoms, and at the same time are important tools in psychotherapy (motivation and capacity).

Association between Dimensions and Coping of Offspring

Psychopathology, Need, Motivation, Capacity for Therapy and Children’s Ability to Cope

Psychopathology and need for therapy seem to interfere with offspring’s coping, i.e. the ability of children and adolescents to cope with the parental disease is negatively affected by their psychopathological symptoms and their need for psychotherapy. Conversely, offspring’s coping is positively influenced by their increasing motivation and capacity for therapy.

Family/Parental Criteria and Coping of Children

The observation that children’s coping is most strongly affected by their parent’s unresolved traumatic experiences and social isolation highlights the importance of addressing parental psychological needs. There is some evidence that mourning of the (often multiple) losses in the past history and in the disease process has not taken place. If parents experience the illness as a traumatic event, children are then confronted with despair, hopelessness and helplessness and a threatening, unpredictable future. It is therefore understandable that children have great difficulty in coping on their own with the parental disease. Helping families to express their grief and to share this as a way of enhancing further psychological development seems to be an essential feature of comprehensive care.

Resources of Parents and Offspring and Coping of Children

Our findings illustrate that appropriate illness information held by parents and children, parent’s mutual coping and psychotherapy, and children’s good cognitive function are all positively associated with children’s coping capacity. The importance of being open to and answering the questions of the offspring about the disease has already been highlighted by Blos: ‘Children are researchers. This ranging curiosity includes their own bodies, how they function, and why things go wrong, as they invariably do. For every question there must be an answer which the child obtains by a mixture of observation, thought, fantasy, previous experience, and prior explanation. But the effectiveness of this research is limited by intruded affect, and the child’s current level of cognitive function, need for defense, and opportunities for observation’ [37, pp 1–17]. The information given to a child should be as simple and accurate as possible and be geared to the child’s capacity for understanding. The process by which information is provided and the child receives it correctly is a complicated one, due not only to the limited cognitive abilities of the young child but also to his or her anxieties, fears and other affects.

Conclusions

Our data indicate that somatic disease in a parent is a risk factor for the mental health of children. For half (n = 22) of the 41 children/adolescents, we found an indication for psychotherapeutic intervention. But only a few children/adolescents or families agreed to psychotherapeutic treatment at the final interview or some time after the investigation; to our knowledge, one family underwent family therapy, and 3 children and 1 adolescent individual psychotherapy. Many factors may contribute to the reluctance of parents and/or offspring. Somatically ill patients and their family fear stigmatization through their physical disability, and therefore any psychological or mental health problems which may represent further stigmatization must be addressed with great sensitivity. Parents often have difficulties in acknowledging the effect of their illness on children [38]. The parental need to believe that children are not affected by their own MS prevents them from seeking help [39]. Sometimes parents fear that their child will establish a significant relationship with a ‘strange’ person outside the family, to whom the child will disclose information about the illness situation which the parents tend to keep secret outside the family.

Children perceive their parents’ resistance to psychotherapeutic help and will give up their own need. Conflicts of loyalty, dependency and guilt about his or her parent will not allow a child to invest in and benefit from treatment. Sometimes offspring do not feel entitled to ask for help, as they consider their problems to be minor compared to the difficulties parents encounter with their disease. The importance of the family of the ill parent, the function and competence of the parental couple and the welfare of the children have to be analyzed most carefully before the possibility of therapeutic interven-
tion can be introduced. Each parent, child or sibling will experience different practical and emotional consequences within the context of his/her age, stage of life and culture. The family member as a psychotherapy patient is part of a family unit whose balance, functioning and development has been disrupted [40]. Psychotherapy offers a significant relationship and a meaningful dialog with the intention to meet the need of the child and its family. Psychopathology should be treated in order to improve the child’s relationship within and outside its family and to promote his psychological development. The psychotherapeutic relation aims to help the child/adolescent to deal better with personal suffering and understand what subjective meaning the disease has for him or herself.

The present findings confirm the significant relation between psychotherapeutic indication and impairment of coping in offspring. One might speculate that psychotherapeutic treatment could help offspring to cope better with the parental disease. Our results also indicate the importance of family or parental resources as favorable influences on the coping capacities of children. In focusing on the mental health of children, one must also be aware of the potential opportunities to address the parents’ own psychological needs.

Our results must be considered cautiously. First, the sample size is small and there is no control group. Second, limitations are associated with the heterogeneous nature of the sample, e.g. the implications of the parental disease, the time since onset and diagnosis, and the highly varying duration of exposure of children to the parental illness, although correlations with these external factors did not reveal any significance. Replication with larger numbers involving multiple groups of children is necessary, which would also allow age- and gender-specific differences in indication for psychotherapy to be investigated. Third, generalization of these results is limited, as MS is the only illness represented in this study. Important directions for future research include comparison with families of patients with other chronic somatic disorders. Longitudinal research is needed to understand clearly the interactions between normal developmental variations in children and the risk factors of mental health problems in offspring of parents affected by a severe somatic disease.

**Acknowledgement**

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**Appendix: The 7 Dimensions**

**Psychopathology criteria (n = 68)**

**Criteria of intrapsychic aspects (n = 31)**

- Emotions
  1. Difficulties of regulation
  2. Overwhelming or rigidly repressed emotions
  3. Hopelessness, helplessness, loneliness
  4. Existential fears
  5. Destructive aggressiveness (hate/narcissistic rage)
  6. Auto-aggression

- Thinking
  7. Pseudodebility

- Motor activity
  9. Disorders of form (ruptures, lack of coherence, inhibition)
  10. Disorders of content (irrationality, bizarre contents, narrowing of thinking)

- Perception
  11. Flight into a world of phantasm

- Thinking
  12. Distortion, omission

- Motor activity
  13. Hyper- or hypo-activity
  14. Tics, stereotypes
  15. Motor activity as nonverbal communication

- Tension

- Language
  17. Communication difficulties (cognitive verbal/emotional non-verbal)
  18. Incongruity of verbal/nonverbal communication
  19. Manner, flow of speech (logorrhea, inhibition, slowness)

- Representation
  20. Self-representation
  22. False self
  23. Object representation/relairon (symbiotic, lack of individuation, excessive identification)

- Defense mechanism
  24. Level with psychic inhibition
  25. Level with light distortion of representation
  26. Level with denial
  27. Level with heavy distortion of representation
  28. Defense mechanism with a negative impact on own development

- Disorders of ego function
  29. Disorders of regulation (closeness-distance, drives, needs, wishes)
  30. Disorders of frustration tolerance
  31. Incapacity to elaborate significant conflicts

**Criteria of observable aspects (n = 15)**

- Traumatic experience of the parental or own disease
- Illness as the only focus of concern
- Not age-specific dependency needs
- Not age-specific precocious behavior
Psychotherapy in Offspring of a Parent with a Chronic Somatic Disease

5 Parentification (concrete level, emotional level)
6 Prepsychotic evolution
7 Borderline disorder
8 Symptoms (expressed by offspring)
9 Fears (of separation, death, castration, heredity)
10 Sleep disorders, bad dreams
11 Psychosomatic/hypochondriac
12 Depression, suicidal ideation
13 School or apprenticeship difficulties
14 Peer or relationship problems
15 Accidents
16 Own illness

Criteria of projective materials (n = 22)
1 Narratives of TAT, story stems, Squiggles, Scenotest, dreams
2 Refusal, refusal of white table, criticism of image, irrelevant questions or comments, perseveration (e.g. I don’t know)
3 Negative ending of stories
4 Incomplete or very poor stories, or only in relationship with reality
5 Inability of association
6 Primary process, archaic, psychotic-like, overwhelming, bizarre ideas
7 TAT/story stems
8 Disregard of the stimulation nature of the table/story
9 Avoidance of the themes
10 Persistence of a theme over several tables
11 Strange treatment of affective content experiences
12 Idealistic outlines
13 Play (up to 6 years)
14 Inhibition
15 Inability to play ‘as if’
16 Discontinuity (lack of concentration/preservation)
17 Repetitive scenes of traumatic experiences

Drawings
18 Draws something else (e.g. animals), refusal to draw
19 Line figures
20 Body image distortion/only heads
21 Lack of generation differences
22 Lack of sexual differences
23 Missing hands/feet/giant hands
24 Missing facial features e.g. eyes, no features

Need for therapy criteria (n = 2)
1 The child’s distress
2 The presence of symptoms

Capacity for therapy criteria (n = 2)
1 The child’s emotional investment in the therapeutic relationship
2 The child’s capacity to benefit from the therapeutic relationship

Motivation for therapy criteria (n = 2)
1 The child’s interest in the psychoanalytic dialog
2 His readiness to express his inner world and emotional experience over the course of the interview

Familial/parental criteria (n = 14)
1 Single parent, separated, divorced, widowed, couple conflict
2 Depression/suicidal ideation of parent
3 Both parents ill/several family members affected by MS
4 Course of the disease e.g. acute exacerbation, several exacerbations in a short period of time
5 Illness as the only focus of concern/parent as victim
6 Incapacity to communicate
7 Denial of the disease
8 Secrecy of the disease: inside the family; towards younger children; outside the family
9 Unresolved traumatic experiences in the past history of the parent
10 Disease outbreak or worsening of disease due to pregnancy or birth of a child (e.g. MS); unwanted child, loss of child
11 Emotional or physical abuse of the child
12 No parental perception of the psychosocial impact of the disease on the child
13 Negative aspects of the meaning of the disease e.g. guilt, shame or rigid meaning e.g. sect
14 No significant relationship with another person, social isolation

Criteria for resources of parents (n = 9)
1 The parents’ mutual process of coping with the disease
2 The couple’s satisfactory relationship
3 Their ability to communicate openly on a cognitive and emotional level with the child/adolescent
4 Their capacity to take advantage of appropriate information about the disease, to give age-appropriate information to children about the disease and its etiology
5 Their ability to maintain and respect the interests and activities of each family member inside and outside the family and the developmental needs of offspring
6 The parents’ perception of the psychosocial impact of the disease on offspring
7 Parents’ use of professional help
8 Social integration of parent
9 Parents’ own psychotherapy

Criteria for resources of offspring (n = 9)
1 Mature defense mechanism
2 Good cognitive capacities
3 Creativity
4 Introspection
5 Own psychotherapy
6 Relationship with other significant person
7 Projective material
8 Narratives are coherent
9 Rich in content and fantasy
10 With creative solutions
References