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Talking about parental substance abuse with children: eight families' experiences of Beardslee's family intervention

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ABSTRACT

Background: Many children are affected by parental substance use disorder. Beardslee's family intervention (BFI) is a family-based psycho-educative method for children of mentally ill parents, used in psychiatric practise in several Nordic countries. The method has also been used to some extent when a parent suffers from substance use disorder. **Aims:** The aim of the study was to explore the family members' experiences of the BFI when a parent has a diagnosis of substance use disorder, to gain new knowledge about the process of the BFI in this area. **Methods:** Ten children and 14 parents were interviewed about their experiences 6 months after a BFI. The interviews were analyzed by qualitative content analysis. The children's psychological symptoms were measured by the Strengths and Difficulties Questionnaire at baseline and after 6 months. **Results:** Increased openness about the substance use disorder in the families was a recurrent theme throughout the material and a central issue reported in the children's experiences. The children had a high level of psychological symptoms according to the SDQ at baseline, but the majority of them felt that the BFI made a positive difference in their families and for themselves. The parents reported improved wellbeing of their children. **Conclusions and clinical implications:** Positive experienced effects for children and parents are reported in families with parental substance use disorder, with possible connection to use of BFI. The present study suggests that Beardslee's family intervention is applicable as a preventive method for children in families with a parent suffering from substance use disorder.

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Background

Parental substance use disorders (alcohol and other substances) are known to affect the wellbeing of children. Emotional, cognitive, and behavioural problems are more common among the children of parents with substance use disorder compared to the general population, through all developmental stages (1). According to a Swedish register study, 4% of all the children born between 1987–1989 had at least one parent who had been treated as an inpatient for substance use disorder, before the child had reached the age of 18 (2).

A number of interventions have been developed to provide support to families or children (3,4). Parenting programmes, group interventions for families, couples, or children, interventions for mother–infant, and home visit programmes are examples of the intervention frameworks, aiming at improvement of parenting skills, children's coping strategies, or a mother's interaction with the infant, or providing peer support.

Few interventions focus on communication about the parent's substance use disorder with their children. This is often a taboo issue within families, probably because substance use disorders are highly stigmatized in society and because of self-stigmatization, which is common among the persons with substance abuse and results in avoidance,

withdrawal, and secrecy (5,6). Parent's denial of the substance use disorder can also lead to silence in families. Furthermore, Swedish legislation obligates the healthcare staff to pay attention to children's needs regarding information and support when a parent suffers from mental health problems or substance use disorder.

Beardslee's family intervention

Beardslee's family intervention (BFI, in the US Family Talk Intervention), was developed by William Beardslee and colleagues for use as a tool in public health services. It is a psycho-educative, family-based method to encourage communication about parental affective disorder within families. It has been shown to have positive long-term effects for the children and parents, including improved parental child-related behaviours and attitudes, child-reported understanding of parental illness, and children's internalizing symptoms (7,8). Adaptations of the method for low-income and culturally diverse populations have been successful (9,10). In Swedish clinical practise, the BFI has been used in families with a variety of parental diagnoses, such as affective, anxiety, and psychotic disorders, and has been shown to be safe and feasible for use in psychiatric care. The children's wellbeing and knowledge about the parent's illness were

reported to improve, and both parents' and children's feelings of guilt to decrease (11). In families with dual parental diagnosis, psychoeducation is provided concerning both diagnoses.

The main purposes of BFI are to prevent mental health problems and to promote resilience in children of mentally ill parents. Strengthening parenting, helping parents to talk about the illness, and to enhance other protective factors (such as school, friends, interests, and other supportive adults) for their children are the main strategies to reach the goals (12,13). Listening to each child is a crucial part of this process. Other important elements of BFI are reducing guilt and shame to facilitate communication, and providing psychoeducational material linked to the family's own experiences. The method is manualized.

BFI consists of five sessions with the family, beginning with two sessions with the parents or a single parent. The parents are given the opportunity to talk about their experiences of the illness and their view of each child's wellbeing, including their perspective on the child's experience of the illness. In the next stage each child is interviewed individually. This is followed by a further session with the parents, including feedback from the interviews with the children and planning for the family session. During the family session the parents themselves talk about the illness with their children and answer the children's questions. The professionals' role is to promote dialogue between the family members.

The method has also been used to some extent when a parent suffers from substance use disorder, but we are not aware of any research reports of BFI being used in this area.

Aim of the study

The aim of the present study was to explore the family members' experiences of the BFI when a parent has a diagnosis of substance use disorder, to gain new knowledge about the process of the BFI in this area. A further aim was to measure the children's emotional and behavioural problems before and after BFI.

Materials and methods

To explore the family members' experiences of the BFI, we conducted qualitative interviews (14) and analysed them using Qualitative content analysis (15). Measurement of the children's psychological symptoms with a validated instrument was a complement to the qualitative data. They were measured by the 25-item Strengths and Difficulties Questionnaire, SDQ (16). The problem scales describe emotional, conduct, and peer problems, and hyperactivity, which are rated on a 3-point scale (0 = not at all, 1 = somewhat, 2 = fit well). According to data from the US, the normative ranges of parent scores for children aged 4–17 years for low, medium, and high difficulties are: 0–11; 12–15; 16–40 for total difficulties, 0–3; 4; 5–10 for emotional symptoms, 0–2; 3; 4–10 for conduct problems, 0–5; 6; 7–10 for hyperactivity, and 0–2; 3; 4–10 for peer problems (17). British mean scores of self-report of children aged 11+ are 10.3 for total

difficulties, 2.8 for emotional symptoms, 2.2 for conduct problems, 3.8 for hyperactivity, and 1.5 for peer problems (18). In a Swedish community sample, mean total score was 6, according parents' assessment. The optimum cut-off of the total score was 11 (19).

Settings and informants

The families were recruited among the clients of a clinic for substance use disorders and at Social services' department for treatment of families, in a county in Northern Sweden. The families lived in urban areas. Eight families were consecutively invited to participate in the study as the BFI was about to start and they all accepted. The same professionals conducted the BFI in a family recruited to the study, by giving written and oral information. They were nurses and social workers, which are the most common professions among those who conduct BFIs in Sweden. The professionals conducted the BFIs during their training course in the method, with several occasions of supervision during the interventions to ensure fidelity to the manual. In all families, BFIs were conducted by two professionals, which is common practice in Sweden.

Criteria for inclusion were that a parent in the family had a diagnosis of substance use disorder of any kind, having under-age children, and that the family had agreed to take part in a BFI. The eight parents with a substance use diagnosis will in the following be referred to as IP (Identified Patient Parent), and the other parents as NIP (Non-Identified Patient Parent).

The first author met with the IPs for a baseline evaluation to confirm the diagnosis of substance use disorder, and for screening for other psychiatric diagnoses by using the Mini International Neuropsychiatric Interview (20). Six IPs had a diagnosis of alcohol use disorder, two had opioid use disorder, iatrogenic in one case. All but one had suffered from the disorder for several years. Seven of the IPs had an additional psychiatric diagnosis. Six IPs have had past depression episodes and/or anxiety syndromes; one of these had an ongoing depression. One IP had bipolar disorder. Seven IPs had ongoing psychopharmacological treatment with antidepressant or mood stabilizing medication. One IP was diagnosed with ADHD according to the medical records. Five of the IPs were in remission, while three were using alcohol at the baseline (see Table 1).

Ten children from five families were interviewed. They were between 8–15 years old; seven of them were girls. In three families, the parents did not want their children to be interviewed, the parents considered that there had been enough sessions for the children already. Four of these six excluded children were under the age of 8 years. Seven IPs (four mothers and three fathers) and seven NIPs were interviewed.

Data collection and analysis

The parents filled in a SDQ for each child at the baseline and at the 6-month follow-up. Children who were 11 years or

Table 1. Family and informant facts and characteristics.

| Families (n = 8) | IP (n = 8) | NIP (n = 8) | Children (n = 16) |
|----------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------|---------------------------------------------------------------------------------|
| 32 informants at baseline | 1 drop-out to 6-month follow-up | 1 drop-out to 6-month follow-up | 6 drop-outs to interviews, 2 to SDQs |
| Mean age of the parents = 39.4 years Range = 29–55 years | Female/Male = 5/3 | In one case: grandmother with custody | Female/Male = 9/7 Mean age = 9.8 years Range = 4–15 years |
| All the families had contact with Social services before the BFI | 6 IPs: alcohol 1 IP: illegal drugs 1 IP: prescribed analgesics | 1 NIP with bipolar disorder, according to the parent | 2 children in one family with ADHD, according to the parents |
| 2 'whole' families 2 IPs without custody of the children, but met them regularly | No one worked: 3 on sick leave 2 on sick pension 3 unemployed | All worked | All went to school/pre-school 2 children in one family with conduct problems |

Table 2. SDQ, values at baseline, and at 6-month follow-up.

| | Parents (n = 14) baseline | Parents (n = 14) 6 months | Children (n = 6) baseline | Children (n = 6) 6 months |
|--------------------|---------------------------|---------------------------|---------------------------|---------------------------|
| Total score | 12.1 | 9.1** | 14.7 | 11.7 |
| Emotional problems | 3.1 | 2.0* | 4.0 | 2.5 |
| Conduct problems | 2.2 | 1.5* | 3.2 | 2.3 |
| Hyperactivity | 4.5 | 4.4 ns | 5.0 | 4.0 |
| Peer problems | 1.9 | 1.2 ns | 2.5 | 2.8 |

* $p < 0.05$.** $p < 0.01$.

ns: non-significant.

older at the baseline filled in a SDQ as well. The data was analysed by SPSS, using a paired sample *T*-test.

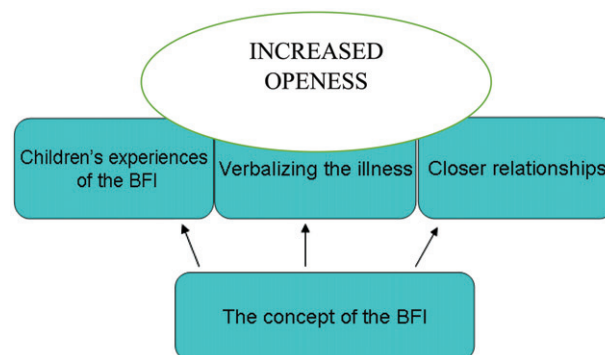
Both parents and children were interviewed at the 6-month follow-up. The interviews took place at the outpatient clinic or in the family's home, and were conducted by the first and second author. Interview guides were used as a support during the interviews. Topics suggested in the interview guide included the informant's experience of the BFI; parents' opinions of the children's participation in the BFI; communication within the family; and the role of the professionals. The questions were as open-ended as possible, in order not to influence the informants' expressions. For example, in the beginning of the interviews the informants were asked to talk freely about their perceptions of the BFI. The interviews were recorded and transcribed verbatim by an assistant.

The interviews were analysed following the principles of qualitative content analysis (15). Every transcript was read by the researchers several times for a thorough line-to-line examination. The text was divided into meaning units as words, parts of sentences, or whole paragraphs. These were condensed and labelled with codes relating to the content. The codes were compared, discussed, and sorted into categories.

Ethics

Written informed consent was obtained from both parents and children, the latter signed by their respective parents. The children who were interviewed were also orally informed and gave consent in the beginning of the interviews. The voluntary nature of the participation was emphasized.

This study was approved by the regional Ethics Committee of Umeå University, Sweden (Dnr 2012-70-31M). The procedures were in accordance with the Declaration of Helsinki.

**Figure 1.** The elements of the BFI–increased openness as a recurrent theme.

Results

Eight families participated and fulfilled the BFI and the 6-month follow-up with the exception of the dropouts presented in Table 1.

SDQ

As shown in Table 2, the children's total scores, emotional and conduct problems, and hyperactivity decreased according to both the parent's and the children's assessments.

Interviews

Four categories were identified: Children's experiences of BFI; Verbalizing the illness; Closer relationships; and The concept of BFI. Increased openness about parental illness within families was found to be a recurrent theme across the material, overlapping with all four categories, and almost all of the informants talked about this issue (see Figure 1 and Table 3).

Table 3. Summary of the results: categories, sub-categories, and codes.

| Categories | Sub-categories | Example codes |
|-------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Children's experiences of BFI | Increased openness in the family | Good to have spoken out, more support and understanding, asking difficult questions, getting answers |
| | Improved wellbeing Improved social life Increased knowledge about the illness | Relief, less worried about the parent, less crying Bring friends home Parents' treatment, diagnosis, heritability |
| Verbalizing the illness | Help to find words that describe the illness Taking children's perspective | Keywords, using words children can understand, abuse as an illness Difficult to hear the children's experiences, necessary to hear, increased understanding |
| | Increased openness in the family | Easier to talk about painful topics, decreased feelings of shame and guilt, relief, honesty |
| Closer relationships | Increased feelings of togetherness | More activities together as a family, spending more time with the IP |
| The concept of BFI | Increased openness in the family | Better communication between parents |
| | Professionals | Skilled, understanding, good alliance with the children |
| | Structure of the BFI | Every family member is listened to, focus on the children, enhances openness |

Children's experiences of BFI

Almost all the children said that it was good to have spoken out in the family, to be able to speak to their parents frankly, especially about feelings around the parent's abuse, which no one had talked about before. They mentioned sadness, anxiety, bellyache, and sleeping problems. Eight of the 10 children thought that the BFI had made a positive difference in their families, the remaining two children expressed neither positive, nor negative effects of the BFI. The children reported that their IPs had listened to them, also afterwards, and their relationship with the IP had become closer in several cases.

Our dad ... he can listen to us now ... he does not drink too much now ... and he wants to play with us, I got happy about that, and my sister became glad, too. (Family 3, boy, 9 years)

Most of the children felt better afterwards, their worries about the parent had decreased, even if the parent was not in remission. Some children could relate to their siblings experiences and felt relieved, others felt relief due to increased knowledge and better understanding of the parent's illness. They had received more information about the parent's treatment, diagnosis, about the heritability of alcohol abuse, but also details like what, where, with whom, and why the parent drank. Some children described how they could better stand up for their own desires, such as not wanting to be with the parent during a weekend if the parent drank alcohol.

It is like ... the whole family has started to talk and it makes one to feel much stronger. I guess I have become much more self-confident ... and we can talk openly about mother's problem, it's good. (Family 5, girl, 15 years)

The children reported that the set-up of the BFI was good, and the professionals were understanding. Most of the children did not perceive the BFI as frightening or demanding, but some children had been nervous prior to the sessions, which was related to how sensitive the issue of the parent's abuse was.

According to the parents, the children had been able to ask questions they could not ask otherwise, owing to their loyalty to their parents and their wish not to hurt the parent with painful questions. They described the children as

happier and in a better mood, crying less, sleeping better, feeling stronger, standing up for themselves more, relieved and less worried for the parent, more confident, and having fewer conduct problems. One parent also said that their children had become more 'normally loud and messy'.

It (the BFI) gave quite a lot ... the kids could ask questions they otherwise had avoided ... if we only had been sitting at home by ourselves, it had been too difficult, they would have thought that it would be too difficult for me ... , but now they asked how I thought when I drank, although I knew it made them sad ... (Family 1, IP-father)

Verbalizing the illness

Most of the parents talked about how they got help to find words and phrases to explain their illness on a suitable level to their children. It was a demanding task for the parents, often associated with feelings of shame and guilt. For all but one of the IPs, the family session was the first time ever talking about the abuse with their children. Some parents had needed concrete help, and thus the professionals had suggested keywords that the parents had noted so they could remember what to say in the family session. The professionals could remind them if needed. Afterwards, it was easier to talk about the topic. Feelings of shame decreased for several parents after they had broken the silence about the abuse. Honesty towards the children was necessary.

No, today I am not ashamed when I talk about it, those feelings decreased a lot after I had opened up with the children. You have to be totally honest with yourself, otherwise you cannot find the words, the good words that the children can understand ... not to complicate it ... it has helped me when I talk to other people too, to use so few words as possible. (Family 2, IP-mother)

Many parents described how it was hard but necessary to hear what the children had said, and difficult to view themselves from the children's perspective. The BFI had opened IPs' eyes as to how the abuse had affected the children. In several cases the parent's understanding of their children increased.

I asked them how they felt and if I drank too much beer. And I got the answers: we feel bad sometimes, we don't know what to do, we are afraid, and yes you do. It was hard to hear, but I needed it. (Family 4, IP-father)

Questions from the children could be difficult to answer, but explaining the abuse as an illness was helpful for parents and could relieve the feelings of guilt to some extent. When the parents had talked about the abuse, their treatment, and other things that they earlier had lied about or concealed from the children, they also felt relieved.

It feels much easier now when they know, instead of lying and finding out different stories, I can say that I have a meeting at the clinic and they only say, good, okay. (Family 8, IP-mother)

Closer relationships

Relationships were felt to be closer after the BFI in most of the families. In three families the children had begun to regularly be with the IP on the weekends. Some IPs described that they now played a more responsible role in the family. Parents discussed having listened to each other during the two first sessions, which enhanced their mutual understanding and communication, even if they were divorced. The positive changes were related to the increased openness about the illness and better communication in the families.

One couple divorced shortly after the BFI. That was not described as a direct consequence of the intervention. One NIP questioned her own role as a caretaker when the IP became more responsible for the children. Two parents described no change in the communication or relationships in the family. One of these two thought that the focus was too much on her abuse and she felt under pressure during the family session. However, she stated that the children had benefitted from the BFI.

The concept of BFI

Almost all of the informants described the professionals positively, both as people and in their professional roles. They were perceived as competent, skilled, and engaged, as well as sensitive and good listeners. They were also good at meeting the children, and the children liked them, according to the parents. They were not stressed, and they took time with the family. They were good at explaining and building an alliance with the family.

They were nice and they knew what they did. (Family 1, boy, 14 years)

The structure of the BFI was considered to be well thought out. When everyone was heard, insight and openness in the families increased. It was difficult to expose one's abuse and hear the other's reactions, but that was helpful at the end, too. Some parents and a few children desired a greater number of children's sessions. To have the sessions at home when the children were involved gave a sense of security for the children. The BFI's focus on relieving the family of feelings of guilt could help the parents to look ahead.

I saw that it (the BFI) was positive for my son and felt that I have to give up those thoughts that I make him sick ... I am not to blame that I was sick, so we must do the best, we have to go ahead. (Family 6, IP-mother)

Discussion

The focus of the present study was to explore how the BFI was experienced by families with parental substance use disorder. Increased openness about the substance use disorder in the families was a main thread throughout all categories and a central issue reported in the children's experiences. Parents could break the silence for the first time; children were able to ask sensitive questions about the illness. The issue of abuse seemed to be less taboo in the families after the BFI. Thus, as an important goal of the BFI is to open up a dialogue about parental illness, the BFI seems applicable in families with parental substance use disorder. The concept of the BFI, including positive experiences with the professionals, was regarded as a condition for the process of verbalizing illness and opening up a dialogue with the children.

The experiences of the BFI resemble those of our earlier interview studies of families with parental mental illness: decreased feelings of guilt for both parents and children, decreased feeling of shame for the parents, and feelings of relief for the children (21,22).

Children's wellbeing

Most the children felt that the BFI made a positive difference in their families and for themselves, according to the interviews. They related the improvement to increased openness about the parent's illness. Additionally, the parents reported that the children felt better. No negative effects for children were disclosed in the interviews. Results of the assessment using SDQ show decreased emotional and conduct problems.

It is worth noting that the children in this study had many psychological symptoms according to the SDQ at baseline, reported by the children themselves as well as the parents. The mean scores of all the problem scales and total score were high compared with the Swedish community sample, e.g. mean total score was six compared to 12.1 in our material, according to the parents' assessment (19). The scores were also high compared to a Finnish study of families with parental affective disorder (8).

Understanding children's perspectives—improving parents' mentalizing abilities

Almost all of the parents described how the intervention helped them to develop a better understanding of their children's feelings and behaviours. The professionals assisted the parents in adjusting their language to a level that was easy for children to understand.

The ability to understand how one's own and others' mental states, experiences, and emotions influence the behaviour in a given situation is defined as mentalizing (23). One important way to increase the ability to mentalize is practicing verbalizing personal experiences and asking questions about the private experiences and cognitions of others. It is obvious that the BFI process has many elements for improving parents' mentalizing. According to Kalland et al. (24), a parent's increased ability to mentalize can reduce future 'transmission of negative parenting models over

generations', and subsequently increase the wellbeing of both children and parents. The authors have, hence, developed a group intervention for increasing the mentalizing ability of first-time parents.

Solantaus et al. (25) found in their questionnaire study that a majority of the children perceived that they were better understood by their parents after a BFI, and a majority of the parents reported that their understanding of their children improved, and thus mutual understanding within the family increased. Mutual understanding seems to emerge when the parents are guided step-by-step to take on their children's perspective. The concept of mentalizing may be applicable to BFI, as one of the basic elements in the parent's process.

Limitations

The number of interviewed children is relatively small, owing to the attrition of the youngest children in the study. Additionally, the total number of participants reduces the value of SDQ results, which are meant to be seen as complementary to the qualitative results. The transferability of qualitative studies, i.e. the external validity, is limited. The description of the context helps the reader to conclude whether the findings are useful in other settings.

The trustworthiness of data from interviews with children has been discussed, but research shows that children from the ages of 3–6 years can recall autobiographical memories accurately and stably over time. When attention is paid to the child's developmental stage, it is possible to gain valid information from children (26,27). The children were informed about confidentiality in the beginning of the interviews, to diminish a possible bias due to children's loyalty to their parents.

Conclusions

Positive experienced effects for children and parents are reported in families with parental substance use disorder, with possible connection to use of Beardslee's family intervention. The concept of the intervention was also perceived as positive, enhancing open dialogue about the illness as well as the parents' mentalizing abilities. The present study suggests that Beardslee's family intervention is applicable as a preventive method for children in families with a parent suffering from substance use disorder.

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Disclosure statement

The first author has been engaged in implementation of Beardslee's family intervention in Sweden.

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