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Parental Mental Illness and Labeling in the Classroom

It is undeniable that children come from various backgrounds that directly influence their identity and behavior. This influence can be positive, as in a stable home environment, or else negative, which is unfortunately the case for many individuals. The emotional turmoil and general instability that are typical of homes influenced by parental mental illness affect the social development and behavior of children therein. Additionally, the response to the child's behavior in a classroom setting have subsequent effects on him that can be even more damaging. Labeling, in this context, concerns children of persons with mental illness being seen by their teachers as no more than someone to be pitied and handled with care. The motivation behind such treatment is often well-meaning. In fact, such a response may even be a subconscious act of compassion: the child clearly has many other issues to deal with at home, so their educators try to make school easier for him.

Whether the attempt is intentional on the teacher's part or not, the reality is that children perceive such treatment as meaning that they are not thought to be capable of the same level of work that their peers are, leading to feelings of ineptness and insecurity. For this reason, teachers should pay careful attention to their actions towards such students. Although compassion and understanding are necessary when working with children affected by parental mental illness, excessive sympathy and lenience on the part of a teacher indicates labeling, which can alienate their student even further, increasing feelings of anxiety and isolation and lowering self-esteem.

The term parental mental illness (PMI) refers to any psychological disorder that affects an individual who has custody of one or more children. PMI can be a major issue because it often limits people's ability to effectively and safely care for a child. For example, a person in the midst of a depressive episode will likely not be as able to comfort or provide for a young child as one who is healthy and emotionally stable. In addition to issues of emotional and psychological impairment, a study reported by American Academy of Child & Adolescent Psychiatry shows that individuals with PMI are more likely to be single parents, face greater statistical chances of unemployment, and have an increased likelihood of engaging in substance abuse (Ranning, et al 954). These are not characteristics of a stable home environment.

The effects of mental illness often reach further than is immediately perceived. PMI can cause much tension and uncertainty in a household and can hinder a child's socioemotional and cognitive development. Studies show that parental mental illness can result in an increased risk of many adverse conditions and behaviors, including eating disorders (Bould, et al 384), low self-esteem (Thomson 159), substance abuse, depression, and poor academic performance, as well as diminished empathy and other negative behaviors (Costea 5). Although children affected by PMI are not the only demographic warranting specific attention, it should be noted that they are exceptionally vulnerable to many dangers.

Increased risk does not immediately indicate an actual repercussion. Resilience, as defined by Associate Professor of Yale University Dr. Jacob Tebes, is the ability to adapt to difficult circumstances. Tebes notes that "children often confound expectations and exhibit a remarkable capacity to adapt to the most adverse and challenging circumstances" (116). However, this ability is restricted in the presence of PMI, and other conditions that limit effective parenting (117). It may be that a parent is mentally ill, but that their illness does not act as an obstacle to their

parenting. However, this is unlikely, and its opposite is more frequently the case. The presence of PMI alone does not guarantee a child will have additional problems; the increased risk is a result of instability at home, which is often caused by the foundational issue of PMI.

All things considered, in the majority of cases concerning untreated, severe PMI, parenting ability, and, consequently, home stability and the child's behavior, are affected. This is not surprising, as young children learn by mimicking that which they experience. Social learning theory, as explained in an article published in the article "Children's Behavioral Problems and Their Relationship with Maternal Mental Health", emphasizes copying roles. That is, a child develops his understanding of human interactions by paying attention to people around him (Riahi, et al 46). While this can lead to children adjusting to social norms, it may result in learning negative habits from mentally ill parents, which then develop into being a part of their regular behavior.

Conspicuous negative behavioral trends often cause children to be labeled by their teachers, that is, viewed as and treated differently than other students, even if unintentionally, which, according to the article "Labelling and Self-Esteem: Does Labelling Exceptional Students Impact Their Self-Esteem?", can result in alienation and lowered self-esteem (Thomson 158). Of course, no teacher intends to have that effect on their student, but well-meant attention can often be misinterpreted by the child himself or by his classmates. Children are highly perceptive, often more so than they are given credit for, and the slightest differentiation in treatment can alter their perceptions of their environment and those within it.

Reception of special treatment is often viewed as an indicator of some notable quality. If the case is one of evident preferential treatment, it is assumed that the recipient is somehow considered superior. This belief can lead to peer reactions founded in jealousy and defensiveness.

On the opposite end of the spectrum, if the teacher tends to be more sympathetic and lenient towards a certain child, some level of disadvantage or inadequacy is inferred. Not only do these situations create stigma and division between the student in question and his peers, but they can also alter his own self-perceptions. Individuals who recognize themselves as having been isolated and identified as needing special attention can easily default to questioning their own abilities. This reaction can only be amplified in a situation where the student's home life has already diminished his self-confidence. This is the case when PMI is concerned: a child's struggle with his parent's problems can cause pre-existing doubts concerning his competence and role in various environments.

When parents are mentally ill, they are often unable to fulfill their responsibilities in their household. This inability forces the child into a position where he feels compelled to compensate for his parent. In their article, "Navigating in an unpredictable daily life: a metasynthesis on children's experiences living with a parent with severe mental illness", Kristianna Dam and Elisabeth O. C. Hall explain that some children affected by PMI are "incapable of distinguishing between appropriate and inappropriate caring responsibilities" (442). This may mean they do an abnormal amount of household chores, whether cleaning or food preparation, or they may serve as a parent to their own younger sibling. Many will even attempt to become caregivers for their parents, reversing the traditional relationship.

Regardless of the tasks they take on, the child is prevented from fully enjoying his youth, and is held back from meaningful relationships and experiences. In the classroom, this forced independence can manifest as the student compulsively trying to maintain control, as he is unaccustomed to releasing it. This turns into a power struggle between student and teacher, and the teacher is often forced to rebuke the child for his dominating behavior, increasing both his

confusion concerning his role and his distrust of authority. Additionally, the exact opposite could occur: the child may feel so overwhelmed with his family situation that he completely avoids any additional responsibilities, refusing to do even what is required of him. To an unaware teacher, this would simply come across as laziness, and would not be tolerated. Should the educator be aware of the presence of PMI, however, they would be more inclined to accept the student's behavior out of compassion. This, though a natural human response, will not benefit the child, as he must be motivated to learn what is appropriate for him to do.

This is often very difficult, as such children often receive little to no instruction at home and infrequently understand why. Many have difficulty understanding the basic nature of their parent's illness, much less the resultant behavioral trends. The article "Depressive Symptoms among Children Whose Parents Have Serious Mental Illness: Association with Children's Threat-Related Beliefs about Mental Illness" discusses the prevalent trend of young children believing that their mentally ill parents are untreatable and even contagious (Ani, et al 76). False perceptions such as these intensify feelings of being unable to escape their situation, and lead to increased levels of psychological and emotional stress that could develop into the onset of mental health issues. Such a development could only serve to affirm the child's false beliefs about the infectious nature of their parent's illness. In reality, the child's "contraction" of the disorder is due entirely to environmental stressors and genetic predisposition. Knowing this could work towards reducing his stress levels, and could reduce the risk of future mental health problems.

With these children already at greater risk than most demographics, it seems unreasonable for schools not to offer the educational resources that could lessen their anxiety. Additionally, when schools *do* offer students what they need, they are more likely to seek out additional help when necessary. Janiece DeSocio, RN and assistant professor at Oregon Health Sciences

University, studied the effects of introducing mental health education to middle school students. "Students voiced increased comfort in seeking help from the school nurse, teachers, and counselors regarding mental health issues" (86). Providing children with the desired means of understanding their situation leads to increased long-term trust. This contrasts greatly with the resultant effects of labeling. Rather than feeling isolated as incompetent, the child comes to see adults as compassionate, helpful, and reliable individuals who recognize his humanity. This can only benefit students, especially those who so desperately need an adult figure they can depend on.

Mental health education, though extremely beneficial, is not an easily implemented, one-size-fits-all curriculum. Mental illnesses, and therefore parental mental illnesses, exist in tremendous variety. Although all forms of PMI can negatively affect children, the most severe cases are often affective disorders, including bipolar disorder, major depressive disorder, and schizoaffective disorder. This is due to the increased stigma around such illnesses. According to Dr. William R. Beardslee of Harvard Medical School, families impacted by affective disorders face extreme societal pressure to keep the illness hidden. This leaves children of depressed and manic parents with little means of interpreting their parents' behaviors (418). As established, these children likely do not fully understand their parents' illnesses. Add to this the believed necessity of secrecy, it is no surprise to find children of families with PMI are struggling.

As much as they want to help and understand their parent, such children often feel that if they expressed their concerns and complaints, they would be betraying their family's secret. This is something many children could not dream of doing, especially not without further damaging their relationship with their parent. Family relations may seem like a strange thing for a child to try and preserve in the face of PMI, but the reality is that in the absence of parental support, children desire it even more. A chapter of *Parental Psychiatric Disorder: Distressed Parents and their*

Families written by Sandra Bilsborough, et al, explains that children impacted by PMI want more than anything else to be recognized as important by the parent they live with (3). Unfortunately, when said parent is preoccupied with depression, mania, delusion, or the like, this recognition is not likely to occur, leaving children striving for affection and attention they will likely not receive.

In the case of bipolar disorder, which is an illness involving mood dysregulation characterized by alternating periods of mania, depression, and relative normalcy, children experience numerous effects. In addition to increased likelihood of sleep disturbance (Sebela, et al 5), premature and risky sexual behavior (Nijjar, et al 1,354), eating disorders (Bould, et al 384), and the development of cyclothymia, a disorder similar too, but milder than bipolar disorder (Klein, et al 122), these children are more prone to various behaviors that can directly and negatively influence their learning experiences. According to an article published by the *Archives of Psychiatry and Psychotherapy*, children of bipolar parents are eight times more likely to be diagnosed with ADHD than the general population, and are also prone to mood swings, anxiety, and depression (Moghaddam, et al 39). These findings are altogether unsurprising, as children learn by example, and their parents often exhibit similar behaviors.

Attention Deficit Hyperactivity Disorder is characterized by an inability to remain focused on a specific task, as well as a level of impulsiveness that is uncharacteristic of most individuals at that developmental stage. A student with ADHD can be very distracting and disruptive in the classroom, and can demand a disproportionate amount of the teacher's time and energy. These students also do not respond to traditional means of instruction and correction; lengthy explanations and occasional reminders of rules prove ineffective. What has been proven effective in these situations is the teacher demonstrating respect for and understanding of the student. Gretchen Geng of Charles Darwin University reports that "Respectful and consistent positive

relationships between students and teachers… assist teachers [in understanding] ADHD students' behaviours" (26). Developing this relationship allows students to realize they are being viewed as human beings, not just problems to be dealt with.

It also leads to a greater ability on the student's behalf to recognize his teacher's motives. The child is aware that his teacher is conscientious of the situation, not just acting blindly in an attempt to regain control. This conscientiousness can actually counter the effects of labeling; as the child is aware of how the teacher views him, he will not be negatively influenced by differential treatment. As with mood swings and other affective symptoms, teachers must be extra conscientious. Especially, as Court Appointed Special Advocate Thomas C. Lovitt said, with children "who may be prone to taking regrettable action" (319). Children who show signs of developing mental health issues are far more likely to act out of aggression. This is when a teacher's actions are most critical. Students already prone to episodes of anxiety, depression, and the like who are further provoked by additional feelings of alienation may resort to violent acts that endanger themselves or others.

Major depressive disorder, commonly referred to as depression, is a prevalent affective illness in America that hinders parenting and limits nurturing abilities. In a report written by faculty of the University of Nebraska–Lincoln, parents with depression are described as "less responsive, less verbally engaging, more critical and reprimanding, less active, and generally less competent" (Sheridan, et al, 747). The same report indicates that such attributes in a parent result in children being underprepared for and unaccustomed to social interactions in school, as they cause said children to miss out on different aspects of growth and development that result in social and behavioral competence (748). For example, a child accustomed to getting minimal feedback, especially when that which he does get is entirely negative and critical, will be less likely to believe

in his own abilities, more likely to accept failure, and far less inclined to trust those who extend affirmation.

A child who is raised by people who fail to engage in activities and conversations with him will not feel compelled to engage with others, and will be more likely to internalize problems and concerns. As a student, he would then have very low expectations for himself and his work and would slip into a state of complacency, responding cynically others' attempts to offer positive reinforcement, behavior that can only result in isolation. Such a situation may sound hopeless, but for a teacher to accept that would only be a self-fulfilling prophecy. Were the student to even think that the teacher had given up on him, it would only serve as confirmation of his pre-existing feelings of incompetence. This puts a lot of pressure on teachers; however, supporting such students is not impossible.

There are many tried and true techniques that can be used to begin engaging even the most apathetic, uninterested students. The best approach, according to Douglas Llewellyn, professor at St. John Fisher College, is to demonstrate flexibility and offer choices, rather than demand adherence to specific rules. "The main thing about meaningful choice is that it engages willingness. It encourages people to fully endorse what they are doing; it pulls them into the activity and allows them to feel a greater sense of volition; it decreases alienation. When you provide people with choice, it leaves them feeling as if you are responsive to them as individuals" (94). Although helping students affected by PMI is admittedly not always as simple this, even the smallest attempt on behalf of the teacher to affirm the student's identity, open pathways of communication, or establish an appropriate, respectful relationship can be greatly beneficial.

Schizoaffective disorder is a severe mental illness that lies almost in a grey area between several other disorders. Its symptoms can include the hallucinations and delusions common to

schizophrenia, but also mood disorder symptoms, such as depression, mania, and anxiety. This complex disorder is very difficult to deal with, especially in the case of PMI. While those with major depressive disorder are relatively uninvolved parents that often default to negative emotions, those suffering from schizoaffective disorder, according to Brown University's Dr. G. Costea, "show decreased verbal and emotional responsiveness, including less anger" (5). This mental illness presents a whole new level of emotional detachment that is anything but beneficial to a developing child.

Rather than being a less than ideal role model for their children, schizoaffective individuals are often entirely consumed by their illness, meaning they provide their offspring with little to no social stimulation. In short, schizoaffective disorder results in an extreme form of child neglect, albeit not necessarily intentional on the part of the parent. "These parenting attributes are risk factors that may be associated with disrupted attachment and developmental delays in language, attention, and social competence" (5). While language and other learning delays can be addressed through traditional schooling, social competence lies beyond the reach educational curricula.

Socioemotional attachment is a very important characteristic in developing children, and one that cannot be simply taught in a classroom. The *Bulletin of the Menninger Clinic* reports that "A child with an insecure attachment may alternatively have an internal working model that depicts his caregiver as unresponsive, his environment as dangerous or threatening, and himself as fundamentally undeserving of love and a secure attachment (Anderson & Gedo 251). In simpler terms, children who have not successfully developed healthy emotional attachment will instinctively respond negatively towards others' attempts at forming relationships. They effectively have learned that people in general are uncaring and uninterested, that they inhabit a dangerous place and must fend for themselves, and that they are by nature undeserving of affection.

In addition to feeling like they are in an unsafe environment, detached children will often behave negatively and even aggressively to demonstrate their independent ability to protect themselves. "Inconsistent and inadequate attachment relationships… are closely associated with subsequent conduct problems" (252). It is not surprising that children who feel unwanted and unprotected will respond by acting out against those around them. It is a natural human response to fight that which appears threatening. Disrupted or insecure attachment itself is beyond the realm of what a teacher can fix on their own; children affected by such things are in great need of therapeutic treatment. However, there are steps that can be taken in a classroom to reinforce such a student's security and emotional well-being.

The understanding that these beliefs are ingrained in a child's head immediately invokes sympathy and compassion in most individuals. Such feelings naturally lead to labeling and greater tolerance of misbehavior; however, tolerance is not what such a child needs. By accepting aggressive and violent actions without any form of reprimand, the teacher indicates to the student that such behavior is acceptable. Additionally, he reinforces the child's belief that authority figures and caregivers are passive individuals who cannot be relied on for responsiveness. This only serves to cement the existing cynicism, and does nothing to improve the child's behavior or the overall learning environment. What the teacher can do instead is direct sympathy into renewing patience, and handle misbehavior as they would any other student. This not only asserts that such actions are not to be tolerated in the classroom, but also that not all adults are uninvolved and uninterested. Additionally, in the absence of any differential treatment, the creation of division and altered peer and self-perceptions is avoided.

This is what educators must strive to do: help struggling children to see themselves as comparable to all other children. Although it cannot be denied that all children have their own

difficulties in life, treating them differently is not beneficial. In the case of PMI, the student has likely never been treated like the child that he is. For an educator to continue this trend only reinforces his belief that he is unworthy of such treatment. This is why it is so critical that teachers are mindful of their actions towards their students. Well-meaning acts of compassion can be detrimental if not executed with caution and mindfulness. In order to promote the mental and emotional health of students, educators should work towards developing appropriate, healthy relationships with them. This not only will serve to improve the overall environment of trust in the classroom, but will provide an example to the student of how people are supposed to interact. This will begin to counter the effects of the unhealthy relationships and emotional detachment the child experiences at home, and will strengthen his socioemotional skills. To put it succinctly, the best way an educator can support children affected by PMI is to ensure that they know their basic humanity is recognized and respected.

Works Cited

Anderson, Sarah M, and Paul M Gedo. "Relational Trauma: Using Play Therapy to Treat a Disrupted Attachment." *Bulletin of the Menninger Clinic*, vol. 77, no. 3, ser. 2013, 2013, pp. 250–268. *2013*.

Ani, C, et al. "Depressive Symptoms among Children Whose Parents Have Serious Mental Illness: Association with Children's Threat-Related Beliefs about Mental Illness ." *South African Journal of Psychiatry*, vol. 21, no. 3, Aug. 2015, pp. 74–78., doi:10.7196/SAJP.8253.

Beardslee, William R., and Lynn Focht-Birkerts. "A Child's Experience of Parental Depression: Encouraging Relational Resilience in Families with Affective Illness." *Family Process*, vol. 39, no. 4, ser. 2000, 2000, pp. 417–434. *2000*.

Bilsborough, Sandra, et al. "What We Want from Adult Psychiatrists and Their Colleagues: 'Telling It like It Is'." *Parental Psychiatric Disorder: Distressed Parents and Their Families*, Second ed., Cambridge University Press, 2015, pp. 3–7.

Costea, G O. "Considering the Children of Parents with Mental Illness: Impact on Behavioral and Social Functioning." Brown University Child and Adolescent Behavior Letter, vol. 27, no. 4, ser. 2011, Apr. 2011, pp. 1,-5–6. *2011*, doi:10.1002/cbl.20137.

Dam, Kristiann, and Elisabeth O. C. Hall. "Navigating in an Unpredictable Daily Life: a Metasynthesis on Children's Experiences Living with a Parent with Severe Mental Illness." *Scandinavian Journal of Caring Sciences*, 2016, pp. 442–457. *2016*, doi:10.1111/scs.12285.

DeSocio, Janiece, et al. "Teaching Children About Mental Health and Illness: A School Nurse Health Education Program." *The Journal of School Nursing*, vol. 22, no. 2, ser. 2006, Apr. 2006, pp. 81–86. *2006*.

Geng, Gretchen. "Investigation of Teachers' Verbal and Non-Verbal Strategies for Managing Attention Deficit Hyperactivity Disorder (ADHD) Students' Behaviours within a Classroom Environment." *Australian Journal of Teacher Education*, vol. 36, no. 7, ser. 2011, July 2011, pp. 17–30. *2011*.

Klein, Daniel N, et al. "Cyclothymia in the Adolescent Offspring of Parents With Bipolar Affective Disorder." *Journal of Abnormal Psychology*, vol. 24, no. 2, ser. 1985, 1985, pp. 115–127. *1985*.

Llewellyn, Douglas. "Choice: The Dragon Slayer of Student Complacency." *Science Scope*, Mar. 2013, pp. 90–95.

Lovitt, Thomas C. "What Teachers Can Do for Children Living in Difficult Circumstances." *Intervention in School and Clinic*, vol. 45, no. 5, ser. 2010, May 2010, pp. 317–320. *2010*, doi:10.1177/1053451209359076.

Nijjar, Rami, et al. "Sexual Risk Behaviors in the Adolescent Offspring of Parents with Bipolar Disorder: Prospective Associations with Parents' Personality and Externalizing Behavior in Childhood." *Journal of Abnormal Psychology*, vol. 44, ser. 2016, 15 Jan. 2016, pp. 1347–1359. *2016*, doi:10.1007/s10802-015-0112-x.

Moghaddam, Mahboubeh F, et al. "The Comparison of Behavioral and Emotional Problems in Children with a Bipolar Parent and Children with Healthy Parents." *Archives of Psychiatry and Psychotherapy*, vol. 3, ser. 2014, pp. 37–42. *2014*.

Ranning, Anne, et al. "Children of Parents With Serious Mental Illness: With Whom Do They

Grow Up? A Prospective, Population-Based Study." *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 50, no. 11, ser. 2016, Nov. 2016, pp. 953–961. *2016*.

Riahi, F, et al. "Children's Behavioral Problems and Their Relationship with Maternal Mental Health." *Journal of Jahrom University of Medical Sciences*, vol. 10, no. 1, ser. 2012, 2012, pp. 41–46. *2012*.

Sebela, Antonin, et al. "Sleep Characteristics in Child and Adolescent Offspring of Parents with Bipolar Disorder: a Case Control Study." *BMC Psychiatry*, vol. 17, no. 199, ser. 2017, pp. 1–8. *2017*, doi:10.1186/s12888-017-1361-8.

Sheridan, Susan M, et al. "Efficacy of the Getting Ready Intervention and the Role of Parental Depression." *Early Education and Development*, vol. 25, pp. 746–769. doi:10.1080/10409289.2014.862146.

Tebes, Jacob Kraemer, et al. "Resilience and Family Psychosocial Processes Among Children of Parents with Serious Mental Disorders." *Journal of Child and Family Studies*, vol. 10, no. 1, 2001, pp. 115–136. *2001*, doi:1062-1024/01/0300-0115.

Thomson, Margareta Maria. "Labelling and Self-Esteem: Does Labelling Exceptional Students Impact Their Self-Esteem?" *Support for Learning: British Journal of Learning Support*, vol. 27, no. 4, 2012, pp. 158–165. *2012*.