Table 2 The Main Diagnoses (ICD-10, DSM-IV) of Identified Patients

Diagnosis	Girls		Boys		All	
	N	%	N	%	N	%
Affect disorders ICD-10 *F32-33, F41, F92-94* DSM-IV *296, 300, 313.23, 313.89*	25	15	41	25	66	40
Relationship disorders ICD-10 *Z00-Z63, T74* DSM-IV *V61.20, V61.21*	15	9	25	15	40	24
Traumatic and adjustment disorders ICD-10 *F43* DSM-IV *309*	4	2	15	9	19	12
Developmental and organic disorders ICD-10 *F80, F84, R62* DSM-IV *315, 299*	8	5	15	9	23	14
Hyperactive and oppositional disorders ICD-10 *F90, F91* DSM-IV *314, 312.8*	4	2	7	4	11	7
Functional disorders ICD-10 *F98* DSM-IV *307*	–	–	6	4	6	4
Total	56	33	109	66	165	100

problems of the referred children have varied from a symptomless situation (about one fifth of the referred children) to an adjustment disorder or further to psychotic or autistic symptoms, severe psychosocial deprivation, or sexual abuse. The main diagnoses given to the identified patients (referred children) are presented in Table 2, according to the diagnostic classifications ICD-10 and DSM-IV.

All families who have used our family ward have also had more or less severe problems in the whole family connected with problems of the referred child. So far, in our medical records only the main diagnosis is easily available, and the family problems are seen in records only if the referred child has no separate main diagnosis. In 24% of the treatment periods the main diagnoses have been the DSM-IV Axis IV diagnoses revealing family relationship disturbances or psychosocial problems of the family, severe problems in child rearing and parenting or family crises and negative life events.

Mentally ill parents

In 36% (41/113) of the families treated in our family ward one or both parents have had a psychiatric diagnoses and separate treatment before coming to the family ward. In addition to this in 13% (15/113) of the families one or both parents have been given a new referral to adult psychiatric treatment during the family ward treatment by a consulting adult psychiatrist. Since these mentally ill families have often been severely disturbed they have most often been given a new interval treatment period or several periods likewise in our family ward. So, altogether in 63% (104/165) of the total treatment periods one or both parents have had mental illness. Mentally ill parents have indeed been a specific challenge to our treatment model.

In our experiences there are two main issues that need to be seriously taken care of when working with the mentally ill families. First, one should have a special focus on the referred child (or children). During the family treatment period one of the main tasks is to raise and emphasize the viewpoint and developmental needs of the referred child and also other children in the family. Assisting, supporting and guiding deficient parenting in concrete everyday situations during functional sessions is important but not enough if it is not connected with a parent's deeper understanding and an improved motivation to see the child.

In mentally ill families children's problems are often almost "psychotically" denied because of unbearable anxiety and guilt, but when the whole family is in intensive care and in a holding environment parents are more able to face these painful questions. Also, clarifying structures and boundaries of the family, especially between adults and children, is helpful. Asymmetrical sharing of parental responsibilities during the symptom