

# CHILDREN OF PARENTS WITH MENTAL ILLNESS (COPMI)

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Two Chatting Women  
with Two Children (*Zwei  
schwatzende Frauen  
mit zwei Kindern*) Käthe  
Kollwitz (1930). Käthe  
Kollwitz Museum Köln

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Children of parents with mental illness (COPMI) face multiple psychological, biological and social stressors that increase their personal risk for the development of mental disorders. Accordingly, lifetime prevalence of mental disorders in COPMI is significantly elevated. Furthermore, these children are at risk of general and specific developmental disadvantages. Despite the fact that COPMI can be described as the future generation of people with mental illness, research and intervention on the topic has been neglected for a long time. Still, health systems in many countries do not allow for preventive measures needed for COPMI and their families. Moreover, data exist mostly for high-income countries, whereas we have almost no information about the situation of COPMI in low- and middle-income countries, where the majority of children live.

The consistency theory (Grawe, 2007) assumes four basic needs that human beings aspire to satisfy and protect from harm: attachment, orientation and control, pleasure, and self-enhancement. When we imagine a child of a mother who suffers from depression or a father affected by schizophrenia, it becomes clear that these basic needs are commonly not met. A wide variety of difficulties are associated with a mental disorder among parents, for example, the mental disorder might prevent these parents from responding consistently, reliably, and warm-heartedly to their child's needs. They might behave and react in an unpredictable way and it might be difficult for them to spend quality time and contribute to their children's self-esteem. In many families, the mental disorder of a parent is not discussed openly or explained in a way that children can understand, often with the aim of protecting them or because of insecurities about how to best explain the disorder. However, this can lead to misattributions in the child, leaving them with feelings of guilt and the assumption that they might be responsible for their parent's suffering. At the same time, parents might experience feelings of guilt and low self-esteem about their role as a parent. Due to loyalty, children may try to compensate by performing tasks that parents are no longer able to do, like cleaning the house or caring for younger siblings. They might avoid inviting friends home or talking to other adults about their difficult situation. Caregivers with a mental disorder may be reluctant to seek help because of stigma or fear over losing custody.

It is clear that both children and parents face difficult situations that contribute to psychosocial distress and compound the biological mechanisms of the development of mental disorders. In this chapter we discuss the epidemiology, risk and protective factors for the transgenerational transmission of mental disorders, and strategies of prevention and intervention in relation to these children.

## EPIDEMIOLOGY

### Parents with Mental Illness Who Have Children

Globally, there are no reliable data on the number of mentally ill adults with children, or of children living with at least one parent suffering from a mental illness. Most of the few studies come from high income countries. For example, a representative study from Australia found an overall lifetime prevalence of self-reported mental disorders in parents of 37 %. In single-parent households the rate was significantly higher (50 %) (Johnson, 2018). The prevalence of all disorders was significantly higher in these children than among those whose primary caregiver reported no diagnosis, and highest among those whose primary caregiver

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**Table J.13.1 Prevalence of mental disorders among adults who are parents, according to study**

Study (Country)	Representative samples: Mental disorders in parents	Clinical samples: Adult patients who are parents	Comments
Johnson et al, 2018 (Australia)	• 37 %		<ul style="list-style-type: none"> <li>• 50 % in single-parent households</li> <li>• Overall, 8 % parents reported psychological distress</li> </ul>
Stambaugh et al, 2017 (US)	• 18 %		<ul style="list-style-type: none"> <li>• 4 % suffered severe impairment</li> </ul>
Maybery et al, 2009 (Australia)		• 20 %-28 %	
Luciano et al, 2014 (US)	• 7 % mothers • 3 % fathers	• 38 % women • 23 % men	• Severe mental illness
Royal College of Psychiatrists, 2015 (UK)		• 68 % women • 57 % men	

had more severe and comorbid disorders. Recent data from the US indicate that 18 % of parents suffered from a mental illness and 4 % showed severe impairment (Stambaugh et al, 2017). Another representative study found that 38 % of mothers had a serious mental illness, compared with 23 % of fathers (Luciano et al, 2014). Finally, a representative study from the UK found that 68 % of women and 57 % of men with mental illness had children (Royal College of Psychiatrists).

### Mental Disorders in COPMI

Several studies report a significantly increased prevalence of mental illness in COPMI, who are about 2.5 times more likely to develop a mental disorder than children of parents without a mental illness.

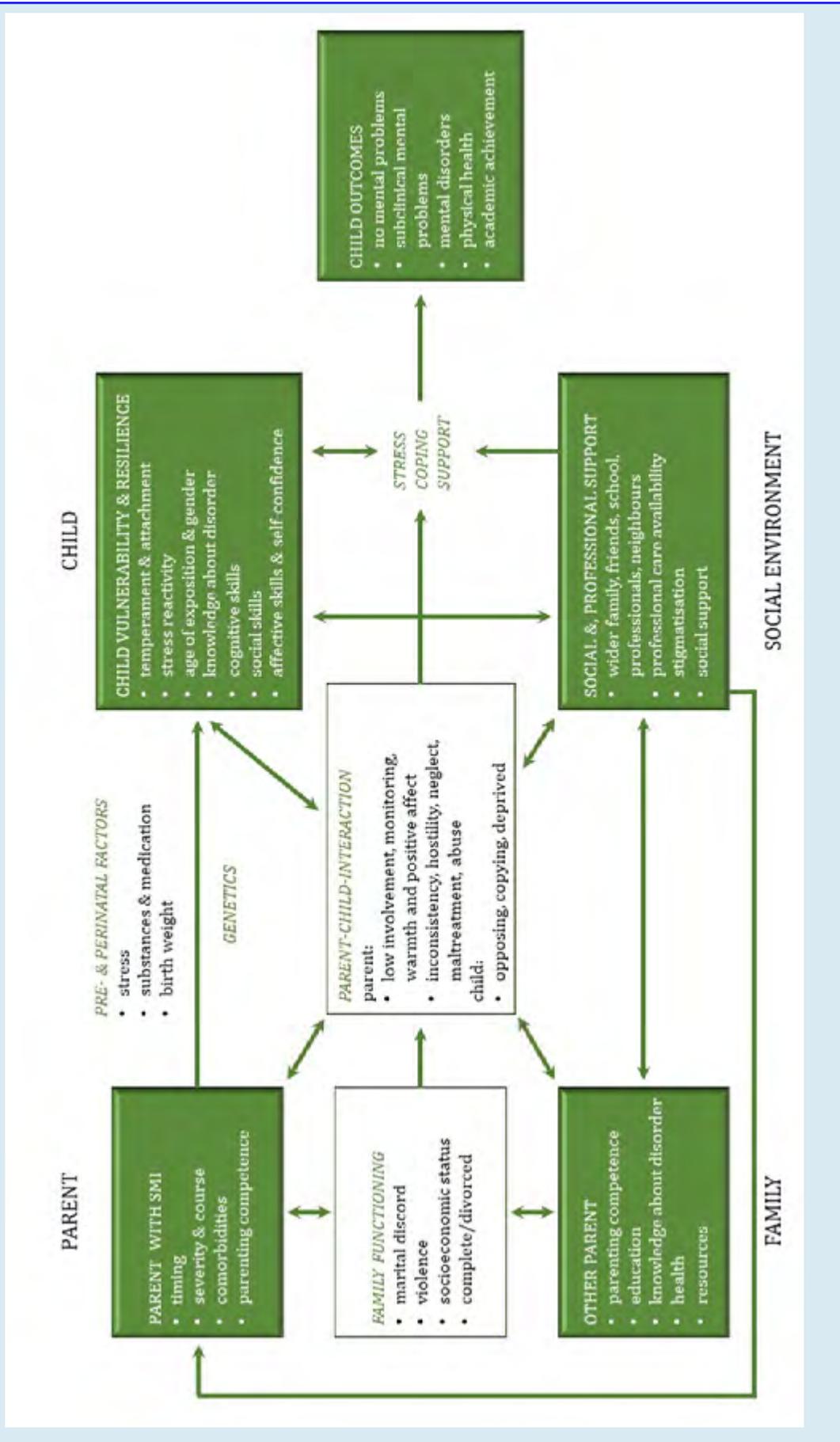
Taken together, these data indicate that one to two thirds of adult patients with mental disorders have children, and that about one fifth of children underage live with at least one caregiver with a mental disorder (see Table J.13.1)

## MECHANISMS OF TRANSGENERATIONAL TRANSMISSION

COPMI are exposed to several biological, psychological and social factors that increase the risk of developing a mental disorder. Four different pathways of transmission can be hypothesized (Santvoort et al, 2015):

1. *Multifinality*: A specific mental illness in the parent (for example schizophrenia) increases the risk of multiple mental disorders in the offspring (for example, for schizophrenia, depression, anxiety disorders etc.)

Figure J.13.1 A developmental model of transgenerational transmission of psychopathology (adapted from Hosman et al, 2014)



2. *Concordance*: A mental illness in the parent mainly increases the risk for the same disorder in the offspring (e.g., children of parents with agoraphobia are mostly likely to develop an anxiety disorder)
3. *Equifinality*: Different mental illnesses in parents increase the risk for similar problems in the offspring (e.g., children of parents with schizophrenia, bipolar disorder, or unipolar depression are more likely to develop unipolar depression)
4. *Specificity*: when the child's problems are specifically related to the parent's diagnosis (anxiety disorders in parents increase the risk for anxiety disorders in the child).

The extent to which the different pathways apply differs between disorders in parents and children. For severe mental illness, the risk ratio for the same disorder present in the child as in the parent was found to be higher (3.59; 95 % CI:2.57-5.02) than for a different disorder (RR=1.92; 95 % CI: 1.48-2.49) (Rasic et al, 2014).

Figure J.13.1 presents a model of the transgenerational transmission of mental disorder adapted from Hosman et al (2014).

## Mood Disorders

Unipolar depression and bipolar disorder in parents were found to be associated with an increased risk for several mental disorders in their children (multifinality). A 30-year longitudinal US study of children of parents with a depressive disorder found a twofold increased risk for a mood or anxiety disorder and a threefold elevated risk for the development of a depressive disorder (Weissman et al, 2016). Onset before puberty, recurrence, poor general outcome, and mortality were increased in these children. Other studies report similar findings (e.g., Potter et al, 2012; Goodman et al, 2011).

Children of parents with bipolar disorder have been reported to be 2.7 times more likely to develop any type of psychopathology—such as schizophrenia, substance use disorder, attention deficit/hyperactivity disorder (ADHD), and anxiety disorders – and four times more likely to develop an affective disorder (Lapalme et al, 1997; Leijdesdorff et al, 2017).

## Schizophrenia

Psychoses in parents also seem to be associated with a variety of psychopathology in the offspring. A review found that 15 % to 40 % of the children developed psychotic disorders themselves (Hameed & Lewis, 2016). Rates of other mental disorders such as ADHD, anxiety, bipolar, major depression, conduct/oppositional defiant disorder, and autism spectrum disorders were also elevated (Leijdesdorff et al, 2017; Reupert et al, 2013).

## Anxiety Disorders

Contrary to what happens with mood disorders and psychosis, anxiety disorders in parents are mainly associated with anxiety disorders in the offspring (transgenerational concordance) (Santvoort et al, 2015). The risk for developing

an anxiety disorder by offspring of parents with anxiety disorders is double that in offspring of parents without anxiety (Leijdesdorff et al, 2017). In a recent meta-analysis the risk ratio was estimated to be 1.76 (95 % CI=1.58-1.96) with a particularly high risk for children of parents with panic disorder and generalized anxiety disorder (Lawrence et al, 2019).

## Personality Disorders and Substance Use Disorder

High rates of mental disorders have been found in children of parents with personality disorders and substance use disorder though the majority of studies have been conducted with respect to antisocial/dissocial and borderline personality disorder (BPD). Children of parents with BPD show an increased risk for multiple psychopathologies, including internalizing and externalizing disorders, emotional dysregulation and insecure attachment patterns (Eyden et al, 2016). Compared to children of mothers with other mental disorders, children of mothers with BPD suffer from a greater number of mental disorders in general, specifically ADHD, disruptive behavior disorders and BPD (Barnow et al, 2013; Weiss et al, 2016). The combination of major depressive disorder and BPD in parents significantly increases the risk for major depression in the offspring. In a study comparing children of parents with major depressive disorder only, and depression with comorbid BPD showed a prevalence of 10 % of major depressive disorder in children in the first group and 45 % in the second (Abela et al, 2005).

Studies on personality disorders other than BPD are sparse but a significant link between conduct/oppositional defiant disorder in children and antisocial/dissocial personality disorder in parents is established (Frick et al, 1992) [See Chapter D.3](#). A high-risk study conducted in Switzerland with children of parents with alcohol or heroin dependence yielded a lifetime prevalence of mental disorders in offspring of 63 % and 61 %, respectively (Vidal et al, 2012). Parental substance dependence was associated with multiple psychopathological outcomes in children, such as mood and anxiety disorders, ADHD, and substance dependence. These findings were replicated in Iran with children of parents dependent on opioids or methamphetamine (Paravesh et al, 2015).

## OTHER OUTCOMES IN COPMI

### Physical Health

Physical health issues in COPMI have not been studied to the same extent as mental health ones. Nevertheless, there are data indicating that parental mental illness not only affects the psychological but also the physical health of the offspring (Santvoort et al, 2015). For example, a representative cohort study from Australia supported a relationship between maternal depressive symptoms in early childhood and childhood asthma (Giallo et al, 2015). A 20-year follow up study found that having depressed parents doubled the likelihood of physical health problems in their children (Weissman et al, 2006b). An association between maternal mental illness and atopic dermatitis has been consistently found (Letourneau et al, 2017). The Avon Longitudinal Study of Parents and Children found that offspring of mothers with postpartum depression exhibited increased sleep problems in late adolescence (Taylor et al, 2017).



## Academic Performance

A variety of studies in several countries have consistently shown that children of parents with mental health problems perform worse academically than their counterparts (Mechling, 2011; Berg et al, 2016; Ranning et al, 2018). Poor academic achievement and other school related problems such as absenteeism and not completing homework seem to be positively correlated with the time children have to perform age-inappropriate responsibilities due to their parent's illness (Cree, 2003). Beyond scholastic performance, an elevated rate of unemployment was found in adult COPMI (Christoffersen & Soothill, 2003).

## Parentification

Children and adolescents who have a parent with a mental disorder often care and support their parents, both physically and emotionally. In some cases, this may result in role-reversal, boundary distortion, and an inverted hierarchy. This phenomenon has been described as "parentification" (Minuchin et al, 1967). A number of studies have shown that children who experience parentification are at an increased risk of showing psychopathology in adulthood. The effect of parentification on mental health problems seems indirect via perceived stress (Van Loon et al, 2015).

## Other Adverse Consequences

Several other adverse consequences have been reported to be associated with parental mental illness (e.g., Christoffersen & Soothill, 2003; Gellatly et al, 2018; Tabak et al, 2016), which further compound the problems such as:

- Child maltreatment
- Neglect
- Family separation and foster care
- Lack of parent's attention
- Stigma
- Teenage pregnancy.

In summary, children of parents with a mental disorder have about twice the risk for any mental disorder compared with children of parents without a mental disorder. Further, risk for the development of the same disorder as that present in the parent is higher than for other disorders. Particularly high rates of mental disorders are found in offspring of parents with personality disorders and substance misuse. Mental illness in parents does not only affect mental health in their children but is associated also to other adverse outcomes such as poor physical health and poorer academic outcomes.

## RISK AND PROTECTIVE FACTORS

Several risk and protective factors have the potential to either increase or decrease the likelihood of the transgenerational transmission of mental illness, which are important moderators or mediators. According to the developmental model of transgenerational transmission (Hosman et al, 2014), child factors, parent factors, and environmental factors can be distinguished. These factors may interact with each other multiplying the effect (Collishaw et al, 2016). Surprisingly, regardless of a number of publications on this topic, only a few studies report empirical data on risk and protective factors for the transgenerational transmission (Goodman & Gotlib, 1999; Hosman et al, 2014).

### Child Factors

#### *Gender and age*

A metaanalysis of potential moderators for problem behavior in children of depressed mothers yielded significant gender differences (Goodman et al, 2011). Girls are more likely to show internalizing problems than boys, while there are no gender differences with respect to externalizing problems. In general, it is assumed that a parental mental illness has the highest influence on childhood mental health in the early years (Hosman et al, 2014).

#### *Temperament and attachment*

A difficult temperament among offspring has been found to be associated with a higher risk of transgenerational transmission. For example, children with one or more depressed parent were twice as likely to develop a depressive disorder 20 years later if they had shown a difficult temperament in the early years (Bruder-Costello et al, 2007). However, a clear causal link could not be drawn. The mediating role of attachment in this process has been deduced mainly from theoretical models and indirect empirical data. For example, it was found that maternal depression is associated with an increased rate of insecure attachment in offspring and with an elevated risk for behavior problems (Cicchetti et al, 1998). A mediating role has also been reported between attachment in fathers who abuse alcohol and internalizing, externalizing and substance abuse behaviors in their offspring (Włodarczyk et al, 2017).

#### *Cognition*

Active coping strategies such as problem-solving, seeking social support, and sharing problems with parents were associated with fewer internalizing problems in adolescents (Loon et al, 2015). No protective factors have been found for externalizing problem behavior. A study found that a cognitive style characterized by negative attributions or self-criticism seems to partially mediate the association between parental borderline personality disorder and child depressive symptoms (Abela et al, 2005).

General cognitive factors may play a moderating role in the transmission of mental disorders. As such, child risk-taking and poor working memory increase the relationship between maternal depression and internalizing problems in the child (Flouri et al, 2017). Poor working memory also had an effect on the relationship between maternal depression and childhood conduct problems.

#### Jane

Jane is an 8-year-old girl living with her mother who had been diagnosed with bipolar disorder with psychotic features

When Jane was five years old, her mother took her in a car and tried to kill herself and Jane by crashing the car. Jane knew what her mother was trying to do because her mother was screaming that she would do it. "Mom has a sick head and I'm afraid her head will kill her". The girl constantly observes her mother, monitors her expression, and worries about her mother all the time. In spite of her age, Jane checks if her mother takes the medications prescribed, if she attends her appointments with the psychiatrist, and attends to an inordinate proportion of household duties.



Municipal Shelter (Städtisches Obdach). Kathe Kollwitz, 1926

### ***Emotion regulation***

Emotion regulation seems to influence the transgenerational transmission of mental illness as well. Positive emotion regulation was reported to moderate the relationship between maternal depression and child internalizing symptoms (Silk et al, 2006). There is also some evidence of an indirect effect—emotion regulation might be a mediator between attachment, temperament and internalizing symptoms in the offspring.

### ***Emotion processing***

Emotion processing—the ability to process stress and other extreme events and move past them—has been found to be connected with transgenerational transmission. In a large study, children’s reactions to their parent’s sad feelings and their own depressive symptoms were assessed. Results indicated that children who displayed emotional over-involvement or avoidance had elevated depressive symptoms (Solantaus-Simula & Punamäki, 2002).

### ***Attribution***

A study from Nigeria assessed the influence of beliefs about mental disorders in COPMI on their own depressive symptoms (Ola et al, 2015). Children who believed that mental illness was contagious showed more depressive symptoms than those who did not share this belief. This was especially true for younger children. At the same time, the belief that people with mental disorders are dangerous did not contribute to their depressive symptoms.

In summary, young age and female gender, a difficult temperament, poor coping strategies, emotion regulation and beliefs about parental mental illness, as well as general cognitive skills such as working memory and emotion processing, have all been shown to moderate and mediate the transgenerational transmission of mental illness. However, empirical evidence is sparse and causation cannot always be established.

## Parent Factors

### *Parenting*

Mental illness in parents has been found to be associated with poor parenting (Hosman et al, 2014). For example, parents with social anxiety disorder showed a less positive affect and warmth, as well as more criticism and doubts about their children's competence when compared to parents without an anxiety disorder (Crosby Budinger et al, 2012). Mothers with borderline personality disorder were found to have difficulty in correctly identifying their children's emotional state and be more overprotective than healthy mothers (Petfield et al, 2015). At the same time, parents with mental illness experience more parenting stress, decreased feelings of competence, and less satisfaction with respect to their role as a mother or father (Petfield et al, 2015). The majority of studies have found that negative parenting styles may contribute to the transmission of mental disorders, while the absence of positive parenting is less likely to do so (Wilson & Durbin, 2012).

Other negative parenting features that have been found to be associated with decreased child mental health were high expressed emotions, decreased parental monitoring, insensitivity, overprotection, hostility, and criticism (e.g., Beardslee et al, 2011; Loon et al, 2015).

### *Health status and availability of parents*

The health status and availability of parents are hypothesized to play a significant role in transgenerational transmission (Goodman & Gotlib, 1999; Wlodarczyk et al, 2017). Research results indicate that lifetime prevalence of mental illness in COPMI increases if both parents suffer from a mental disorder, compared to when only one parent is affected (e.g., Dean et al, 2010; Hosman et al, 2014; McLaughlin et al, 2018; Vidal et al, 2012). Parenting status contributes to transmission as well. For example, the risk for externalizing problems in children of depressed mothers was lower for children of two-parent families compared to those from single-parent families (Goodman et al, 2011).

### *Disorder-related factors*

A higher number of comorbid disorders, chronicity, and severity are positively correlated with the prevalence of mental health problems in offspring (Beardslee et al, 2011; Johnson, 2018). A WHO survey concluded that the likelihood of mental illness in COPMI increased from an odds ratio of 1.9 for children of mothers with one disorder to 3.2 for children of mothers with three concurrent disorders (McLaughlin et al, 2018). The same pattern was found for mentally ill fathers. With respect to the time course of parental mental illness, onset of a parental depressive disorder before the age of 30 was associated with a much higher relative risk (13.1) for depressive symptoms in COPMI than a later onset (relative risk = 4.1) (Hosman et al, 2014). Of course, age of onset is highly confounded by child age and sensitive periods of influence of a parental mental illness. For example, the duration of exposure to active parental bipolar disorder in childhood is an important risk factor for the subsequent development of mood and non-mood psychopathology in the offspring, particularly during the first two years of life (Goodday et al, 2018).



Click on the image to watch a family discuss how they coped with the mother's mental illness (6:42)

To conclude, parenting capacity is affected negatively by parental mental illness. Negative parenting styles in particular are associated with transgenerational transmission. Disorder-specific characteristics such as number of comorbid conditions, chronicity, and severity of the parent's disorder also increase risk.

# MY PARENT HAS A MENTAL ILLNESS



## Environmental Factors

Disentangling the effects of genetic inheritance, environmental factors and their interaction is a complex problem. Mental illness by itself is associated with higher levels of adverse environmental factors such as lower socioeconomic status, more family conflict, less family cohesion, lower levels of social support, and increased stress. Some of these contextual factors may have a moderating role in the transmission of mental disorders while others do not seem to explain mental illness in offspring independently from the parental mental illness (Cicchetti et al, 1998; Petfield et al, 2015).

Pre- and peri-natal factors may interact with genetics to influence the risk of mental disorders in offspring. A Finnish birth cohort study investigated the association between parental psychosis and potential risk factors for schizophrenia and their interaction (Keskinen et al, 2013). The presence of any biological risk factor (such as high birth weight, high maternal age) increased the risk of schizophrenia significantly only among children of parents with psychosis, whereas the presence of any psychosocial risk factor showed no interaction with parental psychosis.

### *Poverty*

Material deprivation is strongly associated with mental illness in general, and the same is true for their transgenerational transmission (Luciano et al, 2014). Children of depressed mothers had an increased risk for internalizing and externalizing problem behavior if they came from low income families compared to those with middle or high income (Beardslee et al, 2011; Goodman et al, 2011).

However, the effect varies globally with a higher impact in high- and upper-middle income countries (McLaughlin et al, 2018).

### ***Social support***

Support from people outside the core family seems to be a protective factor (Hosman et al, 2014; Włodarczyk et al, 2017). This support can be provided by any healthy adult such as grandparents, teachers, or neighbors, who assume the role of “significant other” by serving the child as a stable and healthy support person and giving attention when the ill parent is not available. Support for the ill parent has been shown in a longitudinal study to decrease transgenerational transmission (Lee et al, 2006). Conversely, the social environment can be a risk factor, as when COPMI experience stigmatization or social exclusion.

## **INTERVENTION**

To meet the specific needs of COPMI, various interventions have been developed and there is some empirical support for the effectiveness of prevention, even though studies have so far shown mixed results (e.g., Bee et al, 2014; Cuijpers et al, 2014; Kersten-Alvarez et al, 2010; Kersten-Alvarez et al, 2011). Overall, treatment of the ill parents have been associated with improved outcomes in their offspring, although there are few studies that target the same symptoms in both child and parent (Cuijpers et al, 2014; Schneider et al, 2013).

There are several meta-analyses of programs for COPMI evaluating heterogeneous interventions and showing limited efficacy (e.g., Cuijpers et al, 2014; Siegenthaler et al, 2012). A subsequent, more comprehensive meta-analysis included 96 randomized controlled trials with 50 independent samples of children of parents with a diagnosed mental disorder (current or previous), which reported either children’s psychopathology or that had observations of mother-infant interaction (Thanhäuser et al, 2017). For both mother-infant interaction interventions and for interventions for children and adolescents the benefits were generally small.

## **Treatment Approaches**

### ***Treatment of the ill parent***

Longitudinal studies on parental anxiety and depression show heterogeneous effects of parent treatment on children’s symptoms. For example, a six-year prospective study on the effects of treatment of parents with panic disorder showed a reduction in children’s anxiety symptoms. Other studies (e.g., STAR\*D; Wickramaratne et al, 2011) showed that children of mothers whose depression had remitted early had fewer externalizing problems.

### ***Family Talk Intervention***

One of the most widely used programs for COPMI is the Family Talk Intervention (FTI). This is a whole-family approach that seeks to enhance child resilience and communication within the family (Beardslee et al, 1997a; Beardslee et al, 1997b). One of its main goals is to enhance children’s knowledge about the parental disorder, which seems to improve children’s outcomes (Punamäki et al,

In summary, parental mental illness is associated with adverse environmental circumstances. While poverty adds to the risk for mental illness in COPMI, social support for the ill parent and the child decreases the risk. Family characteristics also seem to play a crucial role in the transgenerational transmission. Children of couples who are both affected by mental illness and those from single-parent families are at an increased risk.

2013; Solantaus et al, 2010). Apart from reducing parental disorder symptoms, this lessens children's feelings of guilt, anger, and shame. Core elements of FTI are:

- Assessment of all family members
- Psycho-education about the parent's disorder
- Connecting the family history to psycho-education
- Reduction of guilt and shame in children
- Enhancement of children's support.

FTI consists of eight sessions with potential follow-up sessions if needed. The FTI program has been adapted in a variety of countries, especially in Northern Europe (e.g., Beardslee & Röhrlé, 2009; Pihkala et al, 2011; Punamäki et al, 2013; Solantaus et al, 2010).

### ***Support groups***

Specific support groups for COPMI have been shown to be of little benefit so far.

## **CHALLENGES FOR PREVENTION AND INTERVENTION**

Low utilization of services to support COPMI and their families is a challenge. A study from the UK assessing children of parents with depression (Potter et al, 2012) found that only 37 % of the children already suffering from a mental illness were in contact with a service. Even one third of those children identified as suicidal or who showed self-harming behaviors were not receiving any service.

Although parents' therapists could play a decisive role, several studies indicate that therapists mainly focus on the needs of their adult patients. For example, a medical record study in New Zealand of adult patients seeking help from a crisis assessment team reported that less than 50 % of these records included information about the situation of the children (Pfeiffenberger et al, 2014). A specific action plan to enhance the child's well-being was only present in 6 %. Comparable results were found in a Norwegian study (Lauritzen et al, 2014). These results show that enhancing psychotherapist's awareness and knowledge about these issues is needed in order to provide COPMI with the necessary information and with adequate support (Leijdesdorff et al, 2017).

## **ONGOING RANDOMIZED CONTROLLED TRIALS**

Regrettably, there is an overall lack of effective interventions for COPMI, though recently some higher quality studies are in progress. We list three of these. Interested readers may find the details in the references provided.

The first is the Danish High Risk and Resilience Study (VIA 7 & 11). This is a prospective study targeting children of parents with schizophrenia or bipolar disorder by identifying risk profiles through a comprehensive test battery, and comparing the results to those of children with healthy parents (Thorup et al, 2018a; Thorup et al, 2018b).



Click on the image to watch a brief clip highlighting that a parent mental disorder can have a positive impact in the long term (3:49).



Click on the image to access the COPMI Australian website. This site has a large number of resources, many of them translated into languages other than English

The second is the COMPARE study, which seeks to examine the effects on children of parental psychotherapy compared with parental psychotherapy in conjunction with a parenting program—targeting the fact that parenting skills have been shown to be reduced in parents with a mental illness. The assumption is that the addition of a parenting program will lead to incremental effects above and beyond treatment of parents alone (Christiansen et al, 2019b; Stracke et al, 2019).

The third study (“The Village”), an implementation and dissemination study, focuses on the identification of COPMI within the adult mental health system and the facilitation of collaborative care highlighting the “child’s voice” as a focus (Christiansen et al, 2019a).

Other ongoing studies worth mentioning include:

- A study in the Netherlands on the effects of an internet-based preventive group treatment (*Kopstoring*). An aspect of this study is that it also seeks to examine the cost-effectiveness of the intervention (Woolderink et al, 2010).
- In the UK, a group intervention (Young SMILES) for COPMI aged six to 16 years and their parents is being evaluated in a feasibility trial (Gellatly et al, 2018; 2019).
- An international group is examining a modified form of the Child Talk Intervention (Child Talk +) (Reedtz et al, 2019).

## ARE THERE PRACTICAL STEPS THAT CLINICIANS CAN TAKE TO HELP THESE CHILDREN?

While the data available is compelling, the issues are very complex and the evidence to guide clinical practice scarce. Thus, clinicians may become overwhelmed by the data, confused, and give up trying to do anything. Are there simple, practical measures that clinicians can take even in settings with limited resources?

A basic first step is to *identify* children of parents with a mental disorder. For example, asking about whether there are children living at home when diagnosing them in the clinic or when admitting a patient to hospital and, if so, providing appropriate support not only for the parent but also for the child and other family members. The Family Talk Intervention (FTI) is the most widely used standardised intervention, which has been adapted in several countries and languages. COPMI support groups, however, have shown limited benefit.

Secondly, open *communication* within and outside the family about the mental illness of a parent is crucial in order to demystify the problem and ensuring that children acquire adequate and realistic knowledge about the disorder. The involvement of a non-affected parent, other adults that may provide *social support* or institutional assistance may help to stabilize the family and serve the special needs of the child. Here, *education* about potential fears of negative consequences and stigma may encourage parents to utilize services to support their children.

Finally, *screening* of the child’s mental health status by a professional is advisable because the risk to develop a mental disorder is high and early intervention is associated with greater benefit.



Click on the image for a webinar by Holly Swartz MD from the University of Pittsburgh describing a research study about the impact on school age children of psychological interventions for maternal depression (59:23)

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There is currently a focus on new ways of establishing collaborative care (e.g., by involving other health professionals, education and welfare staff), essential when dealing with these complex, multi-system issues. In this line, detecting and treating anxious and depressed mothers in paediatric and primary care settings—and not just in specialist mental health services—is essential since these are eminently treatable conditions and their improvement is likely to reduce morbidity in the children in the short and long term.

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