

Children whose parents have a mental illness: prevalence, need and treatment

Mental illness is common, with 45% of Australians experiencing it in their lifetime, and one in five in any given year.¹ The children of parents with mental illness can be affected in many ways. This review provides the basis for subsequent papers in this supplement by providing an overview of the prevalence, risks and outcomes for children who have a parent with a mental illness.

Prevalence: families and children

A United Kingdom national survey² of psychiatric conditions reported that about 10% of women and 6% of men with a mental illness (with a range of diagnoses) were parents. In separate (2008 and 2009) day audits conducted across the Central Coast Mental Health Service in New South Wales, about 28% of patients were identified as parents.³ Another study specifically examined child, as opposed to parent, prevalence in three ways.⁴ First, Australian Bureau of Statistics data showed that 23.3% of all Australian children lived in a family with a parental mental illness. Second, Mental Health Branch service-use data for the 2003–04 financial year indicated that across Victoria, 20.4% of patients had an estimated 14 403 children. Finally, a cross-sectional community study of 701 NSW families found that 14.4% of children had a parent with a mental illness. This suggests that up to one in five young people live in families in which a parent has a mental illness.⁴

Examining mechanisms of risk transmission

Risk exposure among children varies depending on a range of individual, parent, family and community factors. Numerous family, twin, adoption and high-risk cohort studies indicate a genetic contribution to the transmission of serious mental illness in offspring. However, several longitudinal studies have shown that offspring of mothers with schizophrenia had elevated risks of not only schizophrenia, but also of a range of psychotic, affective and personality disorders.⁵ One possible mechanism of this broad-spectrum effect is that the general vulnerability to the development of a mental disorder in offspring is mediated by both genetic and environmental factors.

Mental illness can compromise a parent's ability to care for children and the manner in which a parent interacts with his or her children. For example, fathers with depression spend less time with their infants than fathers without depression.⁶ There is also evidence that anxious parents are less likely to grant their children autonomy and more likely to demonstrate lower levels of sensitivity.⁷ Other research found a significant association between maternal mental illness (including schizophrenia, major affective disorder and bipolar disorder) and permissive

Summary

- Up to one in five young people live in families with a parent who has a mental illness.
- There are various genetic, individual, family and environmental risk factors for children living in these families.
- Outcomes for children vary according to factors related to a parent's mental illness as well as certain environmental protective and risk factors, related to the family, social support and community.
- Health care workers need to acknowledge their patients' parenting roles and responsibilities and the needs of other family members, especially children.

parenting (lack of parenting confidence, lack of follow through) as well as verbal hostility.⁸ Children of parents with psychosis might be directly involved in a parent's delusions.⁹ And while parental mental illness is a factor in 10%–42% of child-protection cases across Europe, the UK, Australia, Canada and the United States,¹⁰ it needs to be stressed that parental mental illness does not solely constitute a protective concern nor predispose a parent to abuse and/or neglect his or her children.

Accordingly, parenting competence and responsiveness are moderated by a parent's diagnosis, chronicity and severity, the presence of other disorders (in particular, substance use), and the timing of a parent's mental illness with respect to the age of the child.^{11,12} Additionally, children have characteristics that predispose them to be more or less affected, including temperament, sex, and cognitive and social skills. For example, a UK study¹³ found that children of depressed mothers did not meet the criteria for a psychiatric diagnosis when they had above-average intelligence and were socially engaging.

The family context, including the presence of marital discord, violence, the presence or absence of the other parent (and the presence of a disorder in the other parent) and the social support available to the family will also influence the level of risk that children are exposed to. In this way, a supportive father can successfully buffer the negative impact of maternal depression.¹⁴ Factors associated with successful parenting outcomes for mothers with schizophrenia were stability within the family and access to financial and social resources.¹⁵ Conversely, stability within the family might be threatened by the hospitalisation of the parent (for their illness), particularly if children need to relocate to another household.¹⁶ Stigma is often associated with mental illness, and children who live with a parent with a mental illness are perceived by some to be "contaminated" by their parent.¹⁷ One seminal study found that the direct effects of parental mental illness were less detrimental than the social adversity (such as unemployment, housing problems and isolation)

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associated with mental illness.⁹ Thus, given the multiple types of risk outlined here, not all children whose parent has a mental illness will be adversely affected, nor will all children in the same family be affected in the same way.

Outcomes for children

Maternal and paternal mental illness can potentially affect children in various ways. One general outcome for children, regardless of parental diagnosis, is the onerous caring responsibilities they might assume of their parent and/or siblings, which conflict with age-appropriate activities or attending school.¹⁶ Another study found lower levels of attainment — in terms of communication, academic competencies and social functioning — in children whose parents were experiencing higher levels of psychological distress.¹⁸ While parents' age, qualifications and socioeconomic status strongly mediated the effects of this distress, independent effects of mothers' mental health were maintained.¹⁸

In this section, we briefly summarise children's outcomes according to parent diagnosis. However, we note that some studies have found that diagnosis is not a strong predictor of the types of problems experienced by children; rather, they point more generally to mental illness severity, chronicity and current symptomatology as the determining factors in parenting competence.^{18,19}

Psychosis

Longitudinal studies of offspring of parents with schizophrenia have consistently found reduced attentional ability in infants and children.²⁰ Compared with controls, a higher frequency of externalising or disruptive behaviour disorders (including attention deficit hyperactivity disorder [ADHD], conduct disorder and oppositional defiance disorder), as well as mood and anxiety disorders, have been reported in this group of children.^{22,23} Other outcomes research is less clear, with one group of longitudinal studies finding that children's social and emotional competence was predicted by various environmental factors, such as minority group status and stressful life events, with maternal schizophrenia having the least impact.^{23,24}

Bipolar disorder

Compared with control groups, it has been found that the offspring of bipolar parents are at increased risk for mood and other disorders, including substance use, ADHD, conduct disorder and oppositional defiance disorder.^{25,26}

Anxiety

Anxiety disorders in parents, including generalised anxiety, post-traumatic stress disorder, panic disorder and social anxiety have all been found to affect offspring, with the consensus being that such children have an estimated twofold risk of developing an anxiety disorder themselves.⁷ Additionally, children might be at risk of acquiring attention problems; one Australian longitudinal study found that children of mothers experiencing anxiety during or after pregnancy are at greater risk of experiencing attention problems at 5 and 14 years of age.²⁷ However, the Avon Longitudinal Study of Parents and Children of 7000 children in England found at 4- and 6.5-year follow-ups that postnatal maternal anxiety was associated with alterations

in emotional and conduct problems but not with hyperactivity.²⁸ Another study found that social phobia and separation anxiety disorder in offspring were accounted for by the same disorders in the parent, whereas agoraphobia and obsessive compulsive disorder in offspring were accounted for by parental panic disorder.²⁹ Such data indicate that there are different risk factors for the expression of individual anxiety disorders in children at risk.

Depression

Small effects of postpartum depression on children's cognitive development, including language and IQ, can occur, especially among boys.³⁰ Grace and colleagues³¹ argue that chronic or recurrent maternal depression, rather than postpartum depression per se, is related to later adverse effects on children. In a large longitudinal study conducted over 20 years, Weissman and colleagues³² found a threefold increase in depression, anxiety and substance dependence in the offspring of people with a depressed parent, compared with those whose parent had no diagnosis. Ramchandani and Psychogiou¹² conclude that maternal depression carries a greater risk for children in developing emotional problems, compared with paternal depression. However, for behavioural problems, the effects of depression in either parent are equivalent. A high prevalence of attachment disturbances is described in the offspring of depressed mothers.³¹

Attention deficit hyperactivity disorder

Parental ADHD is associated with ADHD in children, even when the parent's condition had remitted and regardless of the sex of the parent.³³ Parental ADHD predicted higher levels of family conflict and lesser levels of family cohesion relative to families without parental ADHD than families where neither parent had ADHD.³³

Eating disorders

An early study found that infants whose mothers had anorexia nervosa and/or bulimia nervosa were lighter than control infants,³⁴ although the research is far from unequivocal on this issue. A longitudinal study of 10-year-old children of mothers with anorexia nervosa and/or bulimia nervosa found that index children scored significantly higher than control children on the restraint, shape-concern and weight-concern subscales on the Eating Disorder Examination, and demonstrated increased emotional problems, measured by the Strengths and Difficulties Questionnaire.³⁵

Borderline personality disorder

The few studies in this area indicate that children whose mother had borderline personality disorder displayed increased impulsivity, an inability to name and modulate affect, internalised negative self-attributions,³⁶ and a disorganised pattern of attachment.³⁷

Effective family and child practice

Although the studies reported above attribute child risk according to diagnosis, many factors, including those from the social environment, will contribute to children's outcomes. For example, a child with multiple family and social supports and a high functioning parent will be

exposed to less risk than a child whose parent has a severely disabling psychiatric disorder, with few social supports.

Hence, over and above the effect of genetic transmission, there is significant potential for parental mental illness to adversely affect children. This also provides an opportunity for the mental health workforce to be proactive. It is imperative that there are procedures to identify the parenting status of patients, to screen for competence in various domains (parenting, child wellbeing and family dynamics) and, at a minimum, to refer parents and/or children to appropriate services if required. The opportune time to assess or intervene is when a patient presents for treatment; for example, to his or her general practitioner, mental health clinician (including adult mental health), or maternal–child health sector worker. Children’s mental health services may also be an appropriate location to identify parental mental health status and intervene with families in a holistic manner. Parenting support, educating children about mental illness, and intensive family therapy should also be available to families, depending on their need and the context from which the service is provided.

There are clear treatment guidelines regarding the inclusion of families for mental health conditions. For example, in psychiatric practice, patients can expect that their role as a parent will be identified and that the wellbeing of their dependent children will be considered as part of routine care.³⁸ The Australian Infant, Child, Adolescent and Family Mental Health Association provides generic worker and organisational approaches to meet the needs of families and, in particular, children.³⁹ Overall, within a prevention approach where a range of determinants of mental health interact, services need to focus on increasing the positive determinants impacting on child and family wellbeing (eg, improved parent–child relationships, strengthening social supports, improved mental health literacy), while at the same time reducing risk factors for poor outcomes for the child and family (eg, poverty and social isolation).

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