



The Association  
for Child and Adolescent  
Mental Health

# THE BRIDGE

November 2019

## Parental Mental Illness Special Issue

Paternal depression affects  
adolescent mental health

### Also inside

Research digests from  
JCPP and CAMH.  
Plus guest editorial  
from Our Time CEO  
Dympna Cunnane.



## Editorial

*The Bridge Editor,  
Dr Juliette Kennedy*

Welcome to The Bridge. In this edition we focus on parental mental illness and its effect on children. This is published in support of two conferences - ACAMH's conference titled "Parental mental illness – Supporting children and young people who live with a parent with a mental illness" to be held in London on 11th November 2019 (<https://www.acamh.org/event/pmi-nov/>), and a conference co-hosted by ACAMH, Our Time and RSM, titled "Parental mental illness and its impacts", on 13th December 2019: <https://www.rsm.ac.uk/events/psychiatry/2019-20/pyno4/>.

Both conferences are held in collaboration with Our Time, a charitable organisation which seeks to support families with a parent who has a mental illness. It aims to "create supportive environments for young people affected by parental mental illness where they can receive explanations about their parent's condition, build resilience, have fun and be heard" (see Our Time Mission Statement on the website: <https://ourtime.org.uk/about-us/who-we-are/>).

Our Time is keen to lobby for proper and timely recognition of children affected by parental mental illness and to work with groups and networks to identify their needs. They also work to inform and train professionals who work with young people to help them identify and support those affected by parental mental illness.

Dympna Cunnane, Chief Executive Officer of Our Time has written a powerful guest editorial to introduce this issue and will also be speaking at the conference. It is hoped that this day will 'Challenge the Silence' that children and young people face, who live with and sometimes care for, a with a parent with mental illness.



Research highlights in this edition are prepared by Dr Jessica K Edwards. Jessica is a freelance editor and science writer, and started writing for 'The Bridge' in December 2017.





## Guest Editorial

By Dympna Cunnane

**This edition of *The Bridge* is dedicated to the plight of children of parents with mental illness (COPMIs).**

Currently, these vulnerable young people are not considered in any policy or mental health provision in the UK.

Most developed countries recognise the children of parents with a mental illness as an at-risk group, who benefit from early intervention to prevent them continuing the intergenerational cycle of mental illness. In the UK, young people cannot get help until they themselves become ill. This is both financially stupid and ethically questionable.

As many as 3.7 million children<sup>1</sup> in the UK live with and sometimes care for a parent with a mental illness. It is estimated that without intervention, 70% risk developing a mental illness themselves by the time they reach adulthood<sup>2</sup>.

COPMI are not protected by the Care Act because they typically do not want to be identified and rarely reveal their home situation to professionals. They have specific needs which are different from carers who look after a parent with a physical illness.

Young people who have caring responsibilities may be targeted for support and offered counselling. However, this is often not welcome or helpful to those who care for a parent with a mental illness because they resent the implication that they are the problem. They fear that being offered counselling indicates the beginning of their own treatment journey, the slippery slope which they have witnessed in their parents.

Many also fear that confiding in a professional will bring interventions that endanger the family. Often, they do not trust the services because they have had experiences which have damaged that trust.

The conference *Parental Mental Illness and its impacts* is designed to bring together clinicians who treat adult patients and professionals who provide services for children and young people.

Up to now, it seems that mental health professionals who treat adults with mental illness have paid scant attention to their patients' children. We want to change this way of thinking and move towards an approach which recognises and supports the whole family. This would mean clinicians routinely recording the existence of COPMI and making provision for their welfare through a care pathway.

Routine identification of COPMI in adult mental health services will provide necessary information about the children, their family situation and needs, and hence form the basis for provision of family support and professional collaboration across services.

Having a parent with a mental health problem is one of the biggest risk factors for a first episode of major depressive disorder in children and adolescents<sup>3</sup>. Yet, this is not inevitable. Research suggests intervention can enhance parenting skills in households affected by parental depression and change the way children cope. In turn, this can reduce the risk of children internalising problems that might threaten their life chances<sup>4</sup>.

Our Time charity has developed interventions that aim to address the needs of the parents and their children and we have seen impressive changes in family functioning and the children's self-confidence and wellbeing.

We hope the findings in this edition of *The Bridge* encourage clinicians across the board to Think Family.

Helping young people affected by  
parental mental illness

As many as 3.7 million children<sup>1</sup> in the UK live with and sometimes care for a parent with a mental illness. It is estimated that without intervention, 70% risk developing a mental illness themselves by the time they reach adulthood<sup>2</sup>.

### References

<sup>1</sup> *Childhood Vulnerability in England: Children's Commissioner Report July 2018.*

<sup>2</sup> Rubovits PC. (1996). *Project CHILD: an intervention programme for psychotic mothers and their children. In Parental Psychiatric Disorder: Distressed Parents and their Families* (ed. M. Gopfert, J. Webster and M. V. Seeman), pp. 161–169. Cambridge University Press: Cambridge, England.

<sup>3</sup> Goodman SH, Rouse MH, Connell AM, Broth MR, Hall CM, and Heyward D. (2011) *Maternal depression and child psychopathology: a meta-analytic review. Clinical Child and Family Psychology Review* 14(1), 1-27. doi:10.1007/s10567-010-0080-1.

<sup>4</sup> Bresland NL, Parent J, Forehand R, Peisch V, and Compas, BE. (2017). *Children of parents with a history of depression: The impact of A preventative intervention on youth social problems through reductions in internalising problems. Development and Psychopathology.* doi: 10.1017/S0954579417001821.

### About the Author

Dympna has a BA (University College Dublin) in Psychology and Philosophy, an MA in Psychology (Tavistock Institute London) and a Postgraduate Diploma in Systems Thinking, as well as professional training in psychoanalysis (Jungian). She has worked as an organisation development specialist in large organisations, and has over twenty years' experience of working as a consultant to top level executives in international, public and private sector companies. Dympna is interested in mental wellbeing in its broadest sense, having trained and worked in therapeutic settings, as well as in applying her knowledge to the world of work and workplaces. She believes that the mind is our most powerful resource, and as such, determines much of our life experience.



# Improving outcomes for children exposed to parental mental illness: “it takes a village”

By Dr. Jessica Edwards

A multidisciplinary health and social care policy intervention known as “The Village”, was announced earlier this year in *Frontiers in Psychiatry*. This intervention aims to break down barriers to the care of vulnerable children of parents with a mental illness (COPMI) residing in Austria, and improve child development and well-being outcomes.

Using a collaborative “village” approach, Hanna Christiansen and colleagues will engage with key stakeholders and service providers in the Tyrol region of Austria to first scope and design, then implement and evaluate evidence-informed practice approaches that efficiently identify and provide collaborative care for COPMI. Over the 4-year study period, the researchers will also use open innovation science approaches that engage the general public residing in the Tyrol.

The researchers explain that each stage of the project — *underpinned by implementation science, realist evaluation and symbolic interactionism* — will focus on understanding the experiences and challenges of COPMI. In this way, they hope to capture the “child’s voice” in the COPMI health setting, which the researchers explain is still largely neglected in practice. The anticipated outcome of The Village project is that practitioners working with children and adults will know how to sensitively identify families with mental illnesses and COPMI. Practitioners will also be better positioned to ensure that the child’s voice is central to any proposed interventions.

## Referring to:

Christiansen, H., Bauer, A., Fatima, B., Goodyear, M., Lund, I.G., Zechmeister-Koss, I. & Paul, J.L. (2019), *Improving Identification and Child-Focused Collaborative Care for Children of Parents With a Mental Illness in Tyrol, Austria*. *Front. Psychiatry*. 10: 2333. doi:10.3389/fpsyt.2019.00233.

## Glossary:

**Open Innovation Science:** *the strategic use of public engagement to increase innovation and expedite translation.*

**Implementation Science:** *defined by Eccles and Mittman (2006) as the “scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services and care”.*

**Realist Evaluation:** *a theory-driven evaluation method first developed in 1997 by Pawson and Tilley. Realist evaluation helps explain how and why a complex intervention works or not, rather than simply whether an intervention is effective or not.*

**Symbolic Interactionism:** *a sociological theory based on the belief that meaning and knowledge are constructed and maintained through social interactions and that there can be many truths, depending on the way in which a question is asked, approached and analysed.*



# Family group cognitive behavioural therapy reduces youth internalising problems

*By Dr. Jessica Edwards*

Living with a parent with depression can have a marked impact on a child's overall psychological, behavioural and social welfare. Preventative programs that alter parenting and boost children's coping strategies in affected families seem to reduce youth internalizing problems,<sup>1</sup> but the broader effects of these programs are unclear. While children exposed to parental depression tend to have difficulties with peer relationships,<sup>2</sup> it is relatively unexplored how parental depression, youth internalizing problems and social problems interact. In 2017, Nicole Breslend and colleagues addressed these questions by investigating whether family group cognitive behavioural therapy (FGCB) delivered to families with parental depression, reduces youth internalizing problems and if so, if this reduction has a cascade effect on youth social problems.

The study, published in *Development and Psychopathology*, included 180 families with a parental history of major depressive disorder and children aged between 9 and 15 years. Half of the families were randomly allocated to receive FGCB and half were randomized to a written information comparison condition. FGCB included components intending to teach parenting skills (such as giving praise for appropriate behaviour, encouraging coping skills and ensuring structure) and youth coping skills (such as engaging in positive thinking, acceptance, distraction and new activities). Eight weekly group meetings and four monthly follow-up sessions were provided, and for most sessions, the parents and youths were separated. By comparison, those receiving the written information received three mailed packages containing psychoeducational material over an 8-week period. This material provided information on depression, signs of depression in youth and the effects of parental depression on families.

Breslend *et al.* found that compared to the written information group, those receiving FGCB showed significantly reduced youth internalizing problems at 12 and 18 months, which was associated with fewer social problems at 18 and 24 months, respectively. These findings were true for both boys and girls. Unexpectedly, and in contrast to previous research,<sup>2</sup> social problems were not related to changes in internalizing problems. The researchers propose that they might have been unable to detect a bidirectional relationship here because they only investigated social rejection, which might be a weaker predictor of internalizing problems than perhaps peer maltreatment (or victimization). Indeed, peer maltreatment or victimization has previously been put forward to explain the link between peer rejection and increased internalizing problems.<sup>3</sup>

Overall, while youth social problems are notoriously difficult to change,<sup>4</sup> this study shows that targeting internalizing problems in youth via FGCB delivered to families with a parent history of depression might be an effective way to reduce social problems.

Future work should now verify these findings in a more diverse sample, and determine whether changes in social problems, in terms of social rejection, are related to changes in peer victimization.

### Referring to:

Breslend, N.L., Parent, J., Forehand, R. Peisch, V. & Compas, B.E. (2017), *Children of parents with a history of depression: The impact of a preventive intervention on youth social problems through reductions in internalizing problems*. *Dev. Psychopathol.* 31:219-231. doi:10.1017/S0954579417001821

### References:

- <sup>1</sup> Compas, B. E. *et al.* (2010), *Coping and parenting: Mediators of 12-month outcomes of a family group cognitive-behavioral preventive intervention with families of depressed parents*. *J. Consult. Clin. Psychol.* 78, 623–634. doi:10.1037/a0020459
- <sup>2</sup> Hoglund, W. L. & Chisholm, C. A. (2014), *Reciprocating risks of peer problems and aggression for children's internalizing problems*. *Dev. Psychol.* 50, 586–599. doi:10.1037/a0033617
- <sup>3</sup> Buhs, E. S. & Ladd, G. W. (2001), *Peer rejection as antecedent of young children's school adjustment: An examination of mediating processes*. *Dev. Psychol.* 37, 550. doi:10.1037/0012-1649.37.4.550
- <sup>4</sup> Hoza, B. *et al.* (2005), *Peer-assessed outcomes in the multimodal treatment study of children with attention deficit hyperactivity disorder*. *J. Clin. Child Adolesc. Psychol.* 34, 74–86. doi:10.1207/s15374424jccp3401\_7

# Summary of - Chapter: KidsTime Workshops: Strengthening resilience of children of parents with a mental illness

By Dympna Cunnane

**This is a summary of a chapter in the book Family Therapy - New Intervention Programs And Researches. The chapter introduces children of parents with mental illness (COPMI) as a group and explains the risk factors and the impact of parental mental illness on children. It offers examples of approaches that can help children in this situation, using the KidsTime Workshop model, and explains how a combination of family therapy and systemic therapy influences, together with drama, can create an effective multi-family therapy intervention.**

Children of parents with a mental illness face childhoods that can be full of challenging experiences, threatening their quality of life, development and long-term outcomes. However, these children are not an officially recognised group in the UK, and data and statistics are not gathered about them. Whilst UK policies recognise the needs of young carers, they do not address the specific challenges experienced by children whose parents have a mental illness. This is not the case in other countries; in Australia, these children are officially known as COPMI (Children of Parents with Mental Illness), and as 'Young Relatives' in most Nordic countries. Children of parents with a mental illness remain a hidden group in the UK, and many are reluctant to identify as a young carer, due to the shame and stigma often associated with mental illness, making them vulnerable and at risk of neglect.

The UK Children's Commissioner Vulnerability Report (2018) found that in an average classroom, eight children have a parent with mental health problems - this is the equivalent of 25% of the UK school population<sup>1</sup>. In 2018, Our Time, a UK charity which advocates for, and offers support to this group, did an analysis of existing data (supported by a team from Ernst & Young) which found that in excess of 3.4 million children and young people in the UK are currently living with a parent with a mental illness<sup>2</sup>. Further evidence indicates that, without support, 70% of these children are likely to go on to develop mental health problems themselves. With two ill parents, there is a 30-50% chance of the child developing a serious mental illness later in life<sup>3</sup>. A WHO review stated: "Children with a parent who has a mental illness or substance use disorder are placed at high risk of experiencing family discord and psychiatric problems. The intergenerational transfer of mental disorder is the result of interactions between genetic, biological and social risk factors occurring as early as pregnancy and infancy".

In Germany, where Our Time's partners, the "KidsTime Netzwerk", use the KidsTime Workshop model to support children and families; research has identified 3.8 million children affected by parental mental illness<sup>4</sup>.

## Summary of Key Facts and Statistics

- In excess of 3 million children in the UK live with a parent(s) with a mental health issue.
- On average 8 children in a typical classroom will be in this situation.
- This is 20-25% of the school population.
- Children in this situation are 70% more likely to develop a mental health condition.
- Parental mental illness is one of the 10 Adverse Childhood Experiences (ACEs) that has a life-time impact on both physical and mental health.
- Parental Mental Illness (PMI) is a root cause of many other ACEs.
- WHO identifies PMI as one of the most important public health issues of our generation.
- Intervention late after the onset of an ACE is less likely to be effective. Rising thresholds for acute support are exacerbated by significant reductions in early intervention spending by local authorities.
- By focusing on clinically diagnosable mental illness, Child and Adolescent Mental Health Service (CAMHS) interventions come too late to address ACEs.
- In 2018, the Children's Commissioner reported that despite the new provisions in law, 4 in 5 young carers were not being identified.





Research into adverse childhood experiences, known as ACEs<sup>5</sup> identifies parental mental illness as one of the ten most powerful sources of toxic stress in young people. The presence of mental illness in a parent is known to negatively impact on a child's cognitive and language development, educational achievement, and social, emotional and behavioural development<sup>1, 6, 7, 8</sup>. It can lead to anxiety and guilt arising from a sense of personal responsibility. Where there is severe mental illness in a parent, and no second parent who is well, it can lead to neglect or abuse. These children are also at greater risk of bullying, a lower standard of living, and financial hardship.

This article was a summary of: Chapter: KidsTime Workshops: Strengthening resilience of children of parents with a mental illness, by Klaus Henner Spierling, Kirsty Tahta-Wraith, Helena Kulikowska and Dympna Cunnane, in 'Family Therapy - New Intervention Programs And Researches' ISBN 978-1-78984-302-6.

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- <sup>1</sup> *Children's Commissioner Vulnerability Report. 2018*
- <sup>2</sup> *Ernst and Young. Sizing the Problem—Analysis. Our Time*
- <sup>3</sup> *Rubovits PC. Project CHILd: An intervention programme for psychotic mothers and their children. 1996*
- <sup>4</sup> *Hetherington R, Baistow K, Katz I, Trowell J. The Welfare of Children with mentally ill parents: Learning from Inter-country comparisons WHO paper. 2001*
- <sup>5</sup> *Felitti Vincent J, Robert A, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) study. American Journal of Preventative Medicine. 1998; 14 (4): 245-258*
- <sup>6</sup> *Mattejat F, Remschmidt H. Kinder psychisch kranker Eltern. Deutsches Ärzteblatt. 2008;105 (23): 413-418*
- <sup>7</sup> *Cooklin A. Promoting children's resilience to parental mental illness: Engaging the child's thinking. Advances in Psychiatric Treatment. May 2013;19 (3): 229-240*
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## One in four children in the UK are exposed to maternal mental illness

*By Dr. Jessica Edwards*

New data published in *Lancet Public Health* show that nearly a quarter of children aged between 0 and 16 years are exposed to maternal mental illness. These data come from a national, retrospective cohort study conducted by Professor Kathryn Abel and colleagues in Manchester (UK) and Stockholm (Sweden). Their study included >500,000 children aged 0-16 years and >300,000 mothers who were included in the mother-baby link register of the UK Clinical Practice Research Datalink (CPRD).<sup>1</sup>

From this large cohort, the researchers found that the overall 2-year prevalence estimate of maternal mental illness (*defined as depression, anxiety, non-affective psychosis, affective psychosis, eating disorders, personality disorders, alcohol misuse disorder or substance misuse disorder*) in the UK was 23.2%. Importantly, they noted that the prevalence of diagnosed and treated maternal mental illness had risen, as the proportion of exposed children increased by almost 3% between 2005-2007 and 2015-2017. Whether this rise indicates that more mothers are developing a mental illness or that fewer mothers are missed by primary care is unclear. Regardless, Abel *et al.* show that by the age of 16 years, the cumulative risk of exposure to maternal mental illness is 53.1%.

The researchers also looked at how the prevalence of maternal mental illness varies across the UK. Here, the prevalence ranged from a high of 29.8% in Northern Ireland to a low of 16.8% in London. The identified geographic areas of highest prevalence seem to coincide with the most deprived regions. The researchers suggest, therefore, that more resources could be allocated to areas of higher deprivation, where the prevalence of maternal mental illness is highest.

These latest data add to previous studies conducted in Canada<sup>2</sup> and Australia<sup>3</sup> that estimated the prevalence of parental mental illness as 12% and 23%, respectively. These prior studies, however, relied on self-reported measures of mental illness rather than primary care data, and thus might be limited by responder bias. By comparison, Abel *et al.* explain that their UK-based study using the CPRD exemplifies how detailed health records and linkage to survey data can provide reliable information to guide policy and programmes to address the problems faced by children and adolescents and their families.

In an interview for Medical Xpress<sup>4</sup>, study author Matthias Pierce explained that affected children “are more likely to suffer from a range of negative life outcomes, including poorer physical and mental health, lower educational attainment and reduced quality of life”. Consequently, the researchers conclude that long-term planning of high-quality public health initiatives for children affected by maternal mental illness is urgently needed.

Additional studies that report on paternal mental illness are now needed to complete the picture on childhood exposure to parental mental illness.

### Referring to:

Abel, K.M., Hope, H., Swift, E., Parisi, R., Ashcroft, D.M., Kosidou, K., Su Osam, C., Dalman, C. & Pierce, M. (2019), Prevalence of maternal mental illness among children and adolescents in the UK between 2005 and 2017: a national retrospective cohort analysis. *Lancet Public Health* 4: e291-300. doi: 10.1016/S2468-2667(19)30059-3.

### See also:

Weis, J.R. & Renshon, D. (2019), Steps towards a comprehensive approach to maternal and child mental health. *Lancet Public Health* 4: PE268-PE269. doi: 10.1016/S2468-2667(19)30087-8.

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<sup>1</sup> <https://cprd.com/home>

<sup>2</sup> Bassani, D.G., Padoin, C. V., Philipp, D. & Veldhuizen, S. (2009), Estimating the number of children exposed to parental psychiatric disorders through a national health survey. *Child Adolesc. Psychiatry Ment. Health* 3: 6. doi: 10.1186/1753-2000-3-6.

<sup>3</sup> Maybery, D.J., Reupert, A.E., Patrick, K., Goodyear, M. & Crase, L. (2009), Prevalence of parental mental illness in Australian families. *BJPsych. Bull.* 33: 22–26. doi: 10.1192/pb.bp.107.018861.

<sup>4</sup> Addelman, M. (2019) One in four U.K. children have a mother with mental illness. *Medical Xpress*: <https://medicalxpress.com/news/2019-06-uk-children-mother-mental-illness.html>.

# Paternal depression affects adolescent mental health

By Dr. Jessica Edwards

A large body of studies have shown that exposure to maternal depression is a key risk factor for adolescent depression;<sup>1</sup> comparatively fewer studies have investigated the influence of paternal depression on children and adolescents. A study published in 2017 in *Lancet Psychiatry*, however, has now assessed the association between paternal and adolescent depression symptoms, independent of maternal depression, in two large population-based cohorts.

Gemma Lewis and colleagues analysed >6,000 families included in the Growing Up in Ireland (GUI) child cohort study<sup>2</sup> and >7,000 families recruited to the UK Millennium Cohort Study (MCS).<sup>3</sup> Only two-parent families were included in the analysis, where fathers lived with the child. Because the two cohorts were representative, and made comparable measures at similar ages, the researchers could replicate their data in independent settings. Specifically, all adolescents completed the Short Mood and Feelings Questionnaire (SMFQ) to provide a self-report measure of DSM-IV depression symptom severity at age 13 or 14 years. Parents in the GUI cohort completed the short eight-item version of the Centre for Epidemiological Studies Depression Scale when children were aged 9 years, while parents in the MCS cohort completed the Kessler six-item psychological distress scale when children were aged 7 years. From these data, the researchers tested uni-variable associations between paternal and adolescent depressive symptoms, and then adjusted for maternal depressive symptoms to test for independent associations.



Lewis et al. found that after adjusting for child emotional symptoms, paternal depression symptoms were significantly associated with depression symptoms in adolescents: each three-point increase in paternal depression symptoms resulted in an increase in the SMFQ score by 0.24 points in children in the GUI cohort and 0.18 points in children in the MCS cohort. Clinically, although the findings were small, they were observed after 4 and 7 years of follow up for the GUI and MCS cohorts, respectively. Most strikingly, the effect size was similar in magnitude to the association between maternal and adolescent depression symptoms.

The findings of this study are inconsistent with the earlier theories put forward that mothers are primarily responsible for shaping children's mental health. Rather, these data support that depression symptoms should be recognised and treated in both mothers and fathers and that intervention should be family focused.

As depression in one parent is a risk factor for depression in the other parent, the researchers explain that clinicians should assess for paternal depression in families where maternal depression is diagnosed. This is especially important because men are less likely to seek treatment for depression than women.<sup>4</sup>

Going forward, the data suggest that treating paternal depression in clinical populations will lead to improvements in offspring outcomes that are comparable with those seen when treating maternal depression.<sup>5</sup>

### Referring to:

Lewis, G., Neary, M., Polek, E., Flouri, E. & Lewis, G. (2017), *The association between paternal and adolescent depressive symptoms: evidence from two population-based cohorts*. *Lancet Psychiatr.* 4: 920-926. doi: 10.1016/S2215-0366(17)30408-X.

### See also:

Underwood, L. & Waldie, K. (2017), *The effect of paternal depression on depressive symptoms in adolescent offspring*. *Lancet Psychiatry.* 4: 889-890. doi:10.1016/S2215-0366(17)30432-7.

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<sup>2</sup> Murray, A. et al. (2011), *Growing up in Ireland national longitudinal study of children*. Technical report number 1. <https://www.dcy.gov.ie/documents/growingupinireland/technicalreportseries/DesignInstrumentationMainReport.pdf>.

<sup>3</sup> Joshi, H. & Fitzsimons, E. *The UK Millennium Cohort Study: the making of a multi-purpose resource for social science and policy*. *Longit Life Course Stud* 2016; 7: 409-430. doi: <http://dx.doi.org/10.14301/llcs.v7i4.410>.

<sup>4</sup> Matheson, F.I., Smith, K.L., Fazli, G.S., Moineddin, R., Dunn, J.R. & Glazier, R.H. (2014), *Physical health and gender as risk factors for usage of services for mental illness*. *J Epidemiol Community Health* 68: 971-978. doi: 10.1136/jech-2014-203844.

<sup>5</sup> Weissman, M.M., et al. (2006), *Remissions in maternal depression and child psychopathology: a STAR\*D-child report*. *JAMA* 295: 1389-1398. doi: 10.1001/jama.295.12.1389.





## Young COPMI must be better informed to ensure adequate support

By Dr. Jessica Edwards

Family-focused interventions can reduce the risk of acquiring a mental health problem by up to 40% in children of parents with a mental illness (COPMI).<sup>1</sup> Unfortunately, data suggest that COPMI have low mental health literacy<sup>2</sup> and typically do not seek help from health providers or from within their own network if they are old enough to do so.<sup>3</sup> Furthermore, COPMI typically do not receive dedicated attention from mainstream mental health services.<sup>2</sup> For this reason, legislation was introduced in Norway in 2010 to enforce systematic COPMI identification. Researchers in Norway simultaneously established the longitudinal Norwegian COPMI project to support the new legislation. Despite these actions, however, COPMI care and support in clinical practice in Norway is still considered unsatisfactory.

In 2018, a new study from COPMI project researchers published in *Frontiers in Psychiatry* characterized COPMI aged 0-17 years with the goal of improving COPMI identification and informing preventive intervention. Reedtz *et al.* detailed the core life

circumstances of a cohort of 581 young children (mean age 8.6 years) to parents who were receiving treatment for a psychiatric illness and/or substance abuse. The study involved 422 parents, the majority of whom had one diagnosis and between 1 and 7 children. Information was gathered for each child using the “Family Assessment” form,<sup>4</sup> which collected information such as whether the child had been given information about the parent’s treatment and condition, as well as the family unit and composition (including the number of siblings, residence and access to caregivers).

Reedtz *et al.* found that 46.0% of parents in their cohort had a serious mental illness: 76.2% of children were living with a mentally ill parent and 32.5% of children lived with a single parent with a mental health disorder, either full or part time. Reedtz *et al.* note in their study that those children living with a single parent with a mental health disorder, represent a highly vulnerable group that are likely to need the support of others to ensure their healthy development.

The researchers then used their cohort characteristics to investigate the relationship between a parent's diagnosis and disorder sensitivity and a child's living arrangements. They found that factors that led to an increased chance that the child did not live with the mentally ill parent were: (1) that the parent had a serious mental illness, (2) that the parent had an addictive disorder, and (3) that the ill parent was the father. Diagnosis severity was a strong predictor of the child's living arrangements, with the odds of a child not living with a parent being three times higher if a parent had a severe mental disorder than a mild mental disorder.

Perhaps most importantly, the researchers found that ~40% COPMI were uninformed about their parent's illness. Reedtz *et al.* explain that this deficit suggests that mental health services for adults should be better enabled to comply with current legislation in Norway. The factors that increased the likelihood of COPMI learning about their parent's illness included: (1) living with a single parent with a mental illness, (2) that the child was older (teenager), (3) that the affected parent was the mother, (4) that the primary diagnosis was a severe mental illness, and (5) that the disorder was a personality disorder, schizophrenia or another psychotic disorder.

Overall, Reedtz *et al.* found that the most vulnerable and "invisible" group comprised COPMI aged 0-5 years: these children have limited access to mental health support services and receive the least information about their parent's illness and cannot seek help independently. These children represent an important target group for early intervention and thus more support is urgently needed to facilitate this. Going forward, the researchers hope that their findings demonstrate how identifying COPMI and their living arrangements can inform mental health workers about what type of support and intervention COPMI and parents need the most.

### Referring to:

Reedtz, C., Lauritzen, C., Stover, Y.V., Freili, J.L. & Rognmo, K. (2018), *Identification of Children of Parents With Mental Illness: A Necessity to Provide Relevant Support*. *Front. Psychiatry* 9: 728. doi:10.3389/fpsy.2018.00728.

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# Researchers COMPARE mental illness transmission routes from parent to child

By Dr. Jessica Edwards

An estimated 25% of children in Germany live with a parent who is affected by mental illness. These children are at a high risk of psychological and developmental disorders, including severe mental illness (SMI).<sup>1</sup> Indeed, the trans-generational transmission of mental disorders (TTMD) seems to be a major risk factor for SMI development in children.<sup>2</sup> Children of parents with a mental illness (COPMI) are thus likely to comprise the next generation of patients with a mental illness and represent a target high-risk group for prevention programs.

In 2009, Hosman *et al.*, proposed a model to explain TTMD.<sup>3</sup> By this model, TTMD comprises four major domains: the parent, family, child and social environment. These domains interact with their respective systems and are influenced by five transmission mechanisms: genetics, prenatal factors, parent-child interactions, family, and social factors. While much research has provided support for these individual domains and transmission mechanisms, research testing the TTMD model as a whole to explain SMI risk in affected children is lacking. Earlier this year, researchers in Germany announced the development of the randomized controlled multicenter study known as COMPARE — **C**hildren **O**f **M**entally **I**ll **P**arents **A**t **R**isk **E**valuation. The study aims to test the components of the TTMD model and establish the efficacy and cost-effectiveness of a high-quality randomized controlled trial (RCT) that aims to interrupt TTMD in COPMI.

As can be found in their *Clinical Study Protocol* published in *Frontiers in Psychiatry*, Hanna Christiansen and colleagues will address five key sub-topics in the model-testing part of COMPARE. The first, known as COMPARE-family, will test the TTMD from parents to children. This sub-topic comprises the central RCT to COMPARE, testing the effects of high quality parental cognitive behavioural therapy (CBT) versus parental CBT plus Positive Parenting Program (CBT+PPP) on children. COMPARE-emotion will use behavioural measures, peripheral physiological markers and neuro-imaging techniques to assess emotion processing and regulation in COPMI and the impact on TTMD. COMPARE-interaction will investigate parent–infant interactions, and how maternal co-morbid depression and anxiety in the peri-partum period affects infant development. COMPARE-work will assess the working conditions of mentally ill parents compared to healthy parents and the effects that working conditions have on the family. Finally, COMPARE-school will investigate the effects of parental mental illness on youth academic achievement, psychosocial adjustment and child well-being.

The researchers hope that COMPARE will establish specific transmission profiles for a range of parental disorders with or without co-morbidities and will identify the risk profiles for children at high versus low risk. Gaining this information is anticipated to improve the development of targeted TTMD interventions.





### Referring to:

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### See also:

Stracke, M., Gilbert, K., Kieser, M., Klose, C., Krisam, J., Ebert, D.D., et al. (2019), COMPARE Family (Children of Mentally Ill Parents at Risk Evaluation): a study protocol for a preventive intervention for children of mentally ill parents (triple P, evidence-based program that enhances parenting skills, in addition to gold-standard CBT with the mentally ill parent) in a multicenter RCT–part II. *Front. Psychiatry*. 10:54. doi: 10.3389/fpsy.2019.00054.

German Clinical Trials Register, Clinical Trial Registration: DRKS-ID: DRKS00013516. [https://www.drks.de/drks\\_web/navigate.do?navigationId=trial.HTML&TRIAL\\_ID=DRKS00013516](https://www.drks.de/drks_web/navigate.do?navigationId=trial.HTML&TRIAL_ID=DRKS00013516).

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