

Family matters: infants, toddlers and preschoolers of parents affected by mental illness

Early interventions targeting adverse influences on young children and their parents can improve children's outcomes

One in five young people in Australia, including infants, toddlers and preschoolers, lives in a family with a parent with a mental illness.¹ Families affected by mental illness are more likely than other families to experience poverty and social isolation,² and are more likely to have children taken into care.³

A combination of factors influences the child's risk of psychopathology. These include psychosocial adversity, the child's developmental status and age, genetics, family relationships, the severity and chronicity of parental psychiatric disorder, comorbidity, and the involvement of other carers in the child's life. Not all children whose parents have mental health problems will experience difficulties themselves.⁴

Parental diagnosis itself does not confer risk, and many parents with severe depression, schizophrenia and other disorders are adequate caregivers.⁵ Rather, it is the severity and chronicity of psychopathology and the variation in parental personality, genetic characteristics, coping style and social circumstances that confer risk. Children's characteristics, such as temperament and sex, can also influence the parent-child relationship and parenting behaviour.⁶

This article outlines the impact of three key mental health disorders on parenting and young offspring, and describes implications for practice.

Parenting with depression (including perinatal depression)

Perinatal depression and anxiety (often co-occurring) are common mental health disorders affecting about 10%–15% of women. They may begin antenatally, often relapse, and can have detrimental effects on infant and child development.⁷ The prevalence of these disorders in fathers is about half that of mothers.⁸ There is a moderate increase in the risk of paternal depression when the mother is depressed.⁹

Parenting issues

Parents with depression have more difficulties in interaction with their infants, compared with parents without depression. Depressed mothers interact differently with their infants — they tend to express fewer emotions and show more sad affect than non-depressed mothers. In addition, they are more intrusive, less involved, less responsive to infant signals, and show more covert as well as overt hostility such as anger, criticism and irritability toward their children.¹⁰

Parents' negative attributions mediate the positive relationship between their depressive symptoms and

Nicholas M Kowalenko
BM BS, FRANZCP,
CertAdvTngChild
AdolescPsychiatry,
Clinical Senior
Lecturer,¹ and Chair²

Sarah P Mares
BM BS, FRANZCP,
CertChildPsychol,
Consultant Infant,
Child and Family
Psychiatrist³

Louise K Newman
MB BS(Hons), PhD,
FRANZCP,
Director⁴

Anne E Sved Williams
MB BS, FRANZCP,
DipPsychother,
Director⁵

Rosalind M Powrie
BM BS, FRANZCP,
AccredChildAdolesc
Psychiatrist,
Psychiatrist⁵

Karin T M van Doesum
PhD,
Researcher and
Prevention
Psychologist⁶

¹ Department of
Psychological Medicine,
University of Sydney
and NSW Institute of
Psychiatry, Sydney, NSW.

² Faculty of Child and
Adolescent Psychiatry,
Royal Australian and
New Zealand College
of Psychiatrists,
Melbourne, VIC.

³ Alternate Care Clinic,
Redbank House,
Sydney, NSW.

⁴ Centre for
Developmental
Psychiatry and
Psychology,
Monash University,
Melbourne, VIC.

⁵ Perinatal and Infant
Mental Health Services,
Women's and Children's
Hospital Child, Youth and
Women's Health Network,
Adelaide, SA.

⁶ Radboud
University Nijmegen,
Nijmegen, Netherlands.

nkowa@nsccahs.health.nsw.gov.au

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frequency of physical punishment of their child. More frequent physical punishment, in turn, predicts increased child externalising behaviour.¹¹ Punitive and harsh parenting practices greatly exacerbate the risk for problem behaviour in children who are assessed to be at genetic risk.¹²

A parental history of childhood abuse increases the risk of parental depression, and these two factors are important determinants of parenting and infant temperament.¹³

Children of parents with depression

Although there are adverse effects of maternal depression on child attachment,⁹ mitigating factors have also been identified.¹⁴ Children of mothers who have been depressed shortly after birth show more behaviour problems in early childhood (particularly if the depression persists), lower IQ scores in late childhood,¹⁵ and elevated rates of affective disorders in adolescence when maternal depression recurs.¹⁶ Paternal depression during the postnatal period is independently associated with an increased risk of behaviour and socioemotional problems in Australian preschoolers.⁸ Psychopathology in fathers is a risk factor for toddlers' externalising behaviour problems when mothers have been previously depressed, and for toddlers' internalising problems when mothers have either a history of, or current, depressive symptoms.¹⁷

Implications for practice

It is generally assumed that the successful treatment of parental depression is associated with reduced psychopathology in offspring. This is evident for children aged 7–17 years.¹⁸ However, recent systematic reviews have found that the treatment of maternal postnatal depression may not be sufficient to improve cognitive development, attachment, temperament and other developmental markers in infants and toddlers^{19,20} without an explicit treatment focus on the mother-infant relationship.²¹ There is evidence for effectively treating mild to moderate maternal postnatal depression with non-directive counselling, cognitive behaviour therapy, interpersonal therapy and psychodynamic therapy, and more severe postnatal depression with psychotropics.²² However, these interventions, on their own, have not demonstrated sufficient benefit to infants and young children. Two treatments for maternal depression that may improve infant outcomes are described in Box 1. Identifying paternal mental health problems is an important first step towards appropriate interventions.²³

1 Implications for practice: treatments for maternal depression to improve infant outcomes

A home-visiting intervention for depressed mothers and their infants

As part of a nationwide prevention program in the Netherlands for children of parents with mental illness, mothers and infants received 8–10 home visits from a prevention specialist. The intervention aimed to enhance the quality of the mother–child interaction by means of video feedback focusing on maternal sensitivity to the child's signals and needs. Cognitive restructuring of the mother's negative thinking, practical support, developmental education, baby massage and behaviour modelling were also included.

Improved mother–child interaction, attachment security and socioemotional functioning were found at 6-month follow-up.²³ At the age of 5 years, there were positive effects in children in the intervention group who experienced stressful life events. The data suggest that the early intervention might have served as a buffer against the development of externalising behaviour in reaction to stressful life events.²⁴

With broad dissemination since the initial study, this intervention is offered in 70% of adult mental health centres in the Netherlands. One mother who participated in the study said: "I have learned to read my son Lukas and to enjoy to communicate with him. Before I thought he did not like me and I felt insecure about my parenting."

Preventing perinatal depression relapse — a mindfulness-based intervention

Mindfulness-based cognitive therapy (MBCT) is one of a number of mental health interventions incorporating mindfulness skills to specifically reduce relapse rates in recurrent major depression.²⁵ A pilot study using MBCT modified for pregnant women²⁶ showed favourable outcomes in reducing perinatal mood and anxiety symptoms with high acceptability. In addition, the practice of mindfulness, which is a way of intentionally directing attention to the present moment with acceptance and non-judgement, develops skills which may assist a parent to be more receptive, open and attuned to their infant and themselves. Mindfulness is closely related to an important capacity in early parenting and the capacity of a mother to reflect on her own and her child's internal mental experience. Impairment in this capacity is a risk factor for psychopathological conditions in offspring. Extending parents' mindfulness skills may promote improved relationships via increased emotional regulation and awareness, reduced parental stress, and greater acceptance and compassion for the parent and infant.²⁷ ◆

Borderline personality disorder and parenting

Borderline personality disorder (BPD) is a complex mental disorder characterised by difficulties in interpersonal functioning, mood instability and poor impulse control. Rapid shifts between idealisation and devaluation are common, reflecting a poor sense of identity. Relationships can be unstable and complicated. Individuals with BPD may also be anxious, depressed and unable to manage difficult feelings. Self-harm and substance misuse are common.²⁹

The core features of BPD affect parenting capacity. The parent with BPD may have difficulties being emotionally available for their child and in managing feelings of

frustration. Early parenting can be disrupted by the parent's difficulties in understanding their infant's emotional communication.³⁰ Many individuals with BPD have histories of relationship disruption, trauma, abuse and neglect, and parenting can cause anxiety and bring back memories of the parent's own early trauma.

Parenting issues

Parenting presents several challenges for patients with BPD. Pregnancy may occur as a result of an impulsive sexual act or in an unstable abusive relationship. The desire to become a parent may be ambivalent, and the parent may have unrealistic expectations that a child will care for them.³¹ Parents with histories of abuse are at risk of repeating abuse and dysfunctional relationship patterns.³²

Parenting risk for BPD is largely related to the parent's difficulties in forming a stable intimate relationship (attachment) with their own child.

Children of parents with BPD

Many infants of mothers with BPD have attachment disorganisation, disruptive behaviour disorders and features of attention deficit disorder. Lack of emotional availability in early parent–child relationships has a negative impact on the child's emerging understanding of emotions, empathy and relationships.³³

Implications for practice

Assessment of parenting capacity in cases of severe BPD includes a review of the parent's feelings and ideas about the child and their ability to provide emotional care. The capacity of the parent to think about the child's emotional world (parental reflective capacity)³⁴ is a key indicator of risk.

Assessment of the child should identify developmental delay (particularly in socioemotional domains), signs of anxiety, traumatic exposure, and relationship disturbance. Observational assessment of the parent and the child provides key information about the quality of the relationship and the child's emotional responses to the parent.

Psychosis

Psychotic conditions include schizophrenia, schizoaffective disorder, bipolar mood disorder and drug-induced psychoses. Delusions, hallucinations and thought disorder may be chronic or intermittent, depending on the diagnosis. Symptoms of the illness and associated mood changes, lethargy, lack of motivation and compromised sleep may add to parenting disruption.

Parenting issues

For women with more severe psychotic illnesses (usually schizophrenia), pregnancy outcomes are compromised, with higher smoking rates, less antenatal care and higher rates of prematurity.³⁵ Symptoms of the illness, social adversity and medication side effects can compromise parenting. There may be child protection authority involvement, with an increased likelihood of children being taken into care.⁵

2 Managing psychosis: good practice points

- Assess and provide team support with general practitioner from pregnancy onwards
- Assess and manage maternal mental state and parent-infant interaction
- Provide ongoing postnatal community support from a team with GP and mental health support, as well as child-based services, including maternal-child services, parenting services, and childcare with advocacy for these services
- Offer sexual health and contraceptive advice

Children of parents with psychosis

Adverse impacts include compromised intellectual development with reduced IQ when risk factors such as mental illness, rigid attitudes to parenting, poverty, and low parental education are present.³⁶ Other problem outcomes include infanticide, sudden infant death, compromised neurodevelopment, and attachment difficulties.³⁷

Implications for practice

Most authors cite a combination of good clinical practice — including accurate diagnosis and a biopsychosocial approach to management of the parental mental illness — with attention to the infant, the parent–infant relationship, and the whole family (Box 2). Evidence for improving infant outcomes is scant. Appropriate care should begin in pregnancy, include consideration of the potential impact of psychotropic medications on parent and fetus, and is best supported by an expert team.³⁸ Following birth, long-term community follow-up from a team including a general practitioner and specialised mental health and family workers is likely to provide benefit.³⁹ Local networks may provide information on pathways to appropriate and specialised care such as specialist mother–baby units integrated with obstetric, perinatal and infant mental health care.⁴⁰ Advocacy for mother and infant is generally required.⁴¹

Conclusion

Much current evidence suggests that the greatest impact of parental mental disorders occurs during the early stages of a child's life.⁴² Interventions targeting adverse influences on young children and their parents in the early years can improve child outcomes,⁴³ and are cost-effective.⁴⁴ Good practice in early interventions that support parents with mental illness and their young children⁴⁵ offers opportunities to mitigate vulnerabilities and build strengths to optimise the development and wellbeing of the next generation, improve parental health, and enhance family functioning. Significant investment in intervention early in children's lives is required to achieve these aims in Australia.⁴⁶

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