



Caregiver ↔ Child: Mutual Influences on Mental Health

Lived experience and common sense both support the idea that caregiver and child mental health impact one another. It seems to go without saying that a thriving child is a source of joy and affirmation for a parent or other caregiver. Similarly, it seems obvious that children's thriving is promoted when their caregivers have robust mental health and the emotional reserves that are required to provide patient, positive, engaged parenting. On the other hand, it is equally clear that parents—and other caregivers who love a child—will experience distress when they see that child struggling or suffering, and that that distress will be greater if the caregiver feels ineffective in his or her efforts to reduce the child's struggles. It also seems evident that children will become distressed when their caregivers are struggling, and that that distress may be increased if the caregiver lacks the support, energy or capacity to provide reassuring, consistent parenting. Finally, it is not hard to see that these mutual impacts can build upon each other. Thus, regardless of whether distress “starts” with the caregiver or the child, both are affected, and because of the ongoing mutual

impacts, both caregiver and child distress can become amplified over time.

Yet the field of children's mental health has been slow to fully explore and acknowledge the ways that caregiver and child mental health mutually influence one another. Similarly, mental health service systems have been slow to develop and implement programs and interventions that take this mutual influence into account. There is, however, a growing body of research that offers a clearer view of the mechanisms through which caregiver and child mental health impact one another, and there is growing awareness of the implications that this research has for providing mental health care. This issue of *Focal Point* seeks to summarize some of this accumulating wisdom—from personal, lived experience as well as from practice and research—about the mutual impact of caregiver and child mental health, and about practical strategies to promote positive outcomes for children and caregivers who experience mental health difficulties.

Below, we describe some of the major pathways or mechanisms by which caregiver and child mental health/distress influence each other.*

Unfortunately, a great majority of the studies that examine these pathways are focused on evidence of risk and negative outcomes, so a discussion of the studies has an inherent focus on deficits. This does not mean, however, that the information from these studies has not been used to create service and support strategies that focus on building positive caregiver and child interactions and capacities. A number of such strategies are mentioned here, as well as in other articles contained in this issue of *Focal Point*.

Evidence of Mutual Influence

A great deal of the research that examines influences between caregiver and child mental health focuses on outcomes among children of mothers with serious mental illness. These studies generally show increased risk of adverse outcomes—including difficulties in social, emotional, and behavioral functioning—among children whose mothers have depression^{12,1}, bipolar illness^{1,6}, or schizophrenia.¹² Recent studies suggest that these risks can be set in motion even before a child is born. For ex-

* Much of this information comes from research reviews prepared by other authors. For the most part, the citations here refer to these reviews, rather than to the original studies that are included in the reviews. Information about the original sources can be found in the cited reviews.

ample, it appears that high levels of anxiety or stress during pregnancy (characteristic of mothers with mental illnesses^{4,12}) have an impact on fetal development, particularly the development of the stress response. As a result, when the baby is born, he or she may have a more sensitive temperament and may be more vulnerable to stress throughout his or her life. This emerging information is important for making decisions about mental health care during pregnancy. The article by Diane Solomon (page 26) takes on this issue, examining the benefits and risks associated with using medication to treat depression during pregnancy.

A much smaller body of research has examined the impact of a child's emotional or behavioral difficulties on maternal mental health. The majority of these studies document the impact on maternal mental health of having a child with a disruptive behavior disorder, including attention-deficit hyperactivity disorder (ADHD). Typically, such studies show higher rates of depressive symptoms among these mothers.^{4,9} Other studies show elevated rates of depression among mothers whose children are referred to mental health services for any reason.⁴ More positively, several programs that have been shown effective in reducing children's behavior difficulties have also been shown to have beneficial impacts on caregiver mental health.^{4,8}

Knowing that maternal mental illness is associated with certain child outcomes (and vice versa) is certainly important, but these kinds of findings represent only a small part of what is clearly a far more complicated picture. Until quite recently, there were few efforts to describe the influences from child to caregiver and from caregiver to child at the same time. Furthermore, there had been little exploration of the possible factors—within individuals, within the family, and within the larger social and economic environment—that might affect the interrelationship between caregiver and child mental health. For example, will the presence of another caregiver—like a father or a grand-

parent—buffer a mother from the impact of having a child with challenging behavior? Exactly why does a lack of economic resources exacerbate the risk of negative mutual impacts between child and caregiver mental health? Are there certain abilities or characteristics that make a child resilient, so that the impact of having a caregiver with mental health difficulties is less than might otherwise be expected?

Knowing more about exactly how caregiver and child mental health are connected is clearly important for the design of more creative, and more effective, interventions. Below, we describe some of the main strands of research that are contributing to this



knowledge and informing the development of new intervention and support strategies.

Interpersonal Relationships and Interpretations

Early Interactions. How a primary caregiver understands and responds to her infant's behavior has implications for the caregiver's own mental health and functioning as well as for the baby's development. Mothers with schizophrenia or depression are more likely than their peers to be withdrawn, and less sensitive and responsive to their infants.^{4,1,12} In turn, this is associated with infant unresponsiveness, as well as fussiness and disturbed sleep. And of course, a fussy, sleepless infant places a high level of demand on his or her mother, thus contributing to caregiver distress. A mother whose child is fussy or unresponsive may come to feel ineffective as a parent, blaming herself and

further increasing stress.⁴ This type of interactional pattern is stressful for the infant as well, and increases the risk that the baby will develop ongoing difficulties in regulating his or her emotions and interacting with others.^{4,12} A number of successful programs have responded to these kinds of findings by screening pregnant women and new mothers for depression, and offering support and treatment that helps prevent an escalating cycle of mother-child distress during this critical early childhood period.^{12,8} The article by Carrie Mills and Anne Riley describes some of these strategies in more detail. (See page 28.)

As is typical of the broader literature on caregiver-child influences on mental health, this research seems to tell a story in which the problem starts with a mother who has mental health difficulties. Yet it is also quite possible to envision a different scenario, in which the experience of mothering a very difficult baby actually initiates feelings of inadequacy or depression in a mother. Regardless, the reciprocal nature of caregiver-infant interaction provides a good illustration of how, in the absence of any sort of buffering or intervention, distress in caregivers and infants can become amplified in their interactions with each other.

Discipline. Caring for a child with behavioral difficulties—including caring for a child with ADHD—presents ongoing challenges for caregivers, and greater stress in the parenting role.^{4,5,10} If the child has difficulties in emotional regulation, he or she may be particularly challenging to parent effectively. If the caregiver has ADHD, this may create additional challenges in providing appropriate emotional response, as well as consistent discipline and follow through.¹³ Having schizophrenia or depression can also make it difficult for a caregiver to provide consistent, firm, involved discipline.^{4,12} If the caregiver has difficulty providing consistent discipline, the child's behavior may become yet more challenging.

Family Interactions. Maternal mental health difficulties and child emotional or behavioral difficulties each affect, and are affected by, other

stressors within the family. This can lead to patterns of interaction that exacerbate stress and conflict within the family and between parents, which in turn can decrease the quality of child discipline and increase child behavioral and emotional difficulties.⁴ Rates of divorce and separation are elevated among adults with mental illness and among those with ADHD,^{10,3} and it appears that rates are high among parents of children who have significant emotional or behavioral disorders as well, though this has not been formally studied.

There is a wide variety of treatments aimed at improving caregiver-child interactions. In general, it appears that providing treatment to a mother and (separate) treatment for her child at the same time enhances the effectiveness of both treatments.⁴ However, newer approaches more explicitly exploit the mutual influences between children and caregivers by treating both within the same intervention. Evidence is emerging for the effectiveness of several of these programs,^{4,12} and research on these programs is contributing to understanding not just how parent and child mental health influence each other, but also which specific factors in the family context work to amplify or reduce these mutual influences. As Elgar and his colleagues put it, "...each mechanism that mediates [these] mutual influences... is a fulcrum of better interventions"⁴ (p.452). An important recent study, which examines mutual influences as well as these "mediating" factors, is described in the article on Early Head Start by Catherine Ayoub and Rachel Chazan-Cohen (page 15).

Social and Economic Resources

Rates of mental health difficulties and diagnoses are higher among people with low incomes than among people with more economic resources. This is very much true for caregivers with depression. The rate of depression among mothers generally is estimated to be between 5 and 25 percent; however, for mothers with low incomes, the rates appear to be in

the 40 to 60 percent range.⁸ While not as well documented, it appears that depression rates are also high for fathers and grandparent caregivers with low incomes.⁸ The article by Sandra Bailey and Bethany Letiecq (page 22) focuses on depression among grandparent caregivers in rural Mon-

tana, many of whom have very low incomes. The article also focuses on Native American grandparent caregivers, who suffer from higher rates of depression than their majority culture counterparts.

Caregiver or child mental difficulties can both contribute to and be exacerbated by economic difficulties, which in turn can exacerbate caregiver and child distress. For example, it is well recognized that having mental health difficulties can make it hard for a person to obtain and maintain employment. It is much less well recognized that having a child with emotional or behavioral challenges can also make it hard for a caregiver to maintain employment. A caregiver's work can be constantly interrupted due to the high levels of parenting demands and the ongoing need to interact with service providers, including day care facilities and/or schools.²

Unfortunately, caregivers with low incomes often lack access to mental health care.⁸ What is more, treatments that are available often have low rates of engagement and retention among these caregivers. Kris Gowen (page 17) reviews some studies that examine reasons for this apparent mismatch between available services and the needs and preferences of depressed women with low incomes. Interventions that respond more appropriately to the needs and circumstances of caregivers with low incomes can be quite effective, however.⁸

In general, strong social support and interpersonal relationships act to buffer people from various risks and adversities. People with mental illnesses are likely to have fewer interpersonal relationships and less social

support than their peers. This is also true of caregivers of children with emotional or behavioral disorders,^{9,11} who are often shamed and shunned because of their children's behavior. There is some evidence that support groups and various forms of supportive therapy may be helpful in promot-

ing positive maternal-child interactions, particularly where parenting stress is high.¹²

Mobilizing Positive Influences

Knowing about risks—and about processes that contribute to risk—draws attention to negative outcomes. However, various studies have shown that many children of parents with mental illnesses are resilient. Like Felicia Brown, whose story begins on page 20, they are successful across life domains, including education and interpersonal relationships.^{1,12} Indeed, having a parent with a mental illness appears, at least for some children, to confer—or to promote the development of—possible benefits ranging from increased empathy^{1,12} to increased creativity.⁷ The assets and capacities that promote resilience can be found in children, in parents, and in the family system and its social environment. Thus, the risk of difficulties in children is likely to be much decreased if a mother with a mental illness has effective parenting skills, stable family relationships, and a high level of partner support and social/financial resources.¹² From studying resilience, researchers have developed interventions to help parents who have mental illness promote resilience in their children.¹ These interventions appear to have success not only in preventing emotional or behavioral difficulties in children, but also in reducing parent guilt and improving family communication.

Other, newer interventions have been developed in order to mobilize positive impacts through the various pathways of mutual influence. Thus

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we see promising newer interventions that treat caregivers and their children simultaneously, and/or that work to support enhanced interaction or bonding between caregivers and children (or between family members more generally).^{4,12,8} Other recent interventions have achieved initial success at least in part through a focus on increasing parents' social support and peer networks.⁸ In short, "Just as there is evidence that untreated problems in children or mothers can deleteriously influence the health of the other, there is also evidence that interventions that exploit these [mutual] influences can extend the benefits of individual treatments to other family members"⁴ (p. 453).

Perhaps most interesting, yet still relatively unstudied, are programs that offer comprehensive support and intervention. These programs are designed to respond holistically—and in an individualized manner—to the needs of families in which a parent has a mental illness, and thus mobilize a variety of positive influences and factors to impact caregiver and child mental health. Such programs include attention not just to family relationships, but also to promoting family members' successful participation in social and community settings, including school and employment. Chip Wilder and Betsy Hinden (page 7) provide a description of one such program, while "Mary" (page 10) gives a personal perspective on what it is like to be a program participant. Finally, Joanne Nicholson, Kathleen Biebel, Valerie Williams and Karen Albert (page 11) summarize findings from a research project designed to identify the essential characteristics and components of these kinds of comprehensive programs to support parents with mental illness and their families.

Despite the variety of emerging intervention and support approaches, there is an obvious need for much further work. In particular, there is only sparse research on caregivers other than mothers, or on interventions that include a focus on building resiliency or bolstering social support. The more comprehensive programs are also not yet well evaluated. And while some attention has been paid to developing treatment approaches that

engage low-income parents and parents from ethnic or racial minorities, this is another area where research is thin. Continuing efforts in research and program development will be needed to help build effective strategies for supporting positive mutual influences between caregiver and child mental health.

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