

An End to the Cycle:
Supporting Resilience in Children of Adults with Mood Disorders

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The Construct of Resilience

Since its emergence in research, the construct of resilience has become vastly popular in developmental and intervention sciences. Masten (2015), one of the pre-eminent figures in resilience, defines resilience generally as positive outcomes and adaptation despite adverse circumstances. Resilience literature focuses on the factors that allow for children to develop normally despite an environmental context of high risk. It raises the question of, What sets apart children who deal with extended behavioral and emotional problems from children who “bounce back” and develop typically, when both groups have been exposed to similar risk?

It is important to note the discrepancies in definitions of resilience as the terms have developed with the literature. Past definitions described resilient children as immune, invulnerable, or invincible (Anthony & Cohler, 1987). This outdated perspective gives the inaccurate sense that resilience is unchanging and fixed. Instead, there are many factors at work in the lives of resilient children that affect their ability to adapt to stressors. Resilience refers to processes, not necessarily traits (Luthar, Cicchetti, & Becker, 2003). Protective factors interact with risk factors to produce resilient outcomes. Different protective factors may have a different impact depending on the type and severity of risk as well as their timing. (Brennen, Le Brocque, & Hammen, 2003). Due to its complex nature, therefore, resilience must be studied contextually and, often, specifically to the vulnerable population under consideration.

Two conditions are implicit when describing children as resilient: (1) the children were exposed to significant stressors, and (2) there is evidence of adjustment following that exposure

(Masten, 2014). Consider the child who grows up with a parent who has a mood disorder. This child will likely be exposed to significant stress over the course of their development, and they are at a higher risk for psychopathology and other emotional and behavioral adjustment problems (Hammen, 2002). Yet, with the perspective of resilience in mind, there is hope for positive outcomes for those from this population.

Mood disorders are characterized by disturbances in affective states and reflect a vast range of symptoms and experiences (American Psychiatric Association, 2013). Growing up with a parent diagnosed with a mood disorder introduces chronic and episodic stress on an individual child and their family as a whole. (Hammen, 2002) The most common mood disorder diagnoses include Major Depressive Disorder (MDD) and bipolar disorders (BD), which includes Bipolar I, Bipolar II, and cyclothymic disorder. Mood disorders may result in altered parental functioning, due to altered mood, motivation, and interpersonal patterns (Anke et al., 2019; Brennen, Le Brocque, & Hammen, 2003; Goodman, 2002). Evidence indicates that children of adults with bipolar disorder experience impairments when compared to children with healthy parents in a variety of domains including life satisfaction, recreation, work, school, interpersonal relationships, and overall functioning (Bella et al., 2011). The goal of applied research is to improve outcomes for vulnerable populations. Understanding how parental mood disorders impacts outcomes for offspring, will help professionals in the field understand how best to support these children.

Walsh (2016) pointed out the importance of an ecological approach when studying resilience. Individual vulnerability and resilience are affected by interaction of factors at the individual, family, community, and larger systemic levels. A better understanding of how factors from interconnected systems shape the lives of vulnerable children can help professionals in the

field better learn to support them. A systemic approach is particularly relevant to children of adults with mood disorders because of the importance of the caregiver relationship, within the family system, in developing competencies throughout life (Arnold et al., 2023). Additionally, larger systemic factors (i.e., economic systems, social systems, education systems, etc.) play a role in the development and perpetuation of mental health conditions.

Environmental context is vastly important when looking at mood disorders. Because the nature of this conflict is systemic, a collaborative approach is necessary; the conversation is relevant to policy makers, clinicians, health care workers, case managers, educators, and other community members involved in the lives of families dealing with the stressor of a mood disorder diagnosis. Because mental illness is contextual and impacts functioning in many areas of life, understanding the complexities of human social relationships at all levels of ecological systems is necessary to support individuals from vulnerable populations.

In this paper I will propose how parental mood disorders expose children to cumulative risk over the course of their development and I will speculate how different disorders may affect a children's risk for psychological and behavioral problems differently. Specifically, I will review literature on how mood disorders may affect familial functioning, and this increases risk for negative outcomes for this population of children. Then, I will discuss the literature regarding protective factors for this specific vulnerable population. Finally, I will describe implications for practice and identify gaps in the research.

Method

I used Psych Info and reference sections of relevant articles to conduct a comprehensive literature review of peer-reviewed sources. For the section on implications for practice, I included quotations from a literature-guided interview with licensed Marriage and Family

Therapist, Chelsea Kline, who is one of the senior clinicians at Colorado State University's Trauma Resilience Assessment Center (CTRAC).

Parental Mood Disorders (MDD and BD) Contribute to Intergenerational Risk

There is strong evidence for a genetic component involved in the inheritance of mood disorders (Goodman, 2002). For example, Vandeleur et. al. (2012) found risk rates for offspring of adults with mood disorders of 50% for any mental health condition, including substance use and anxiety disorders, and 20% specific to a mood disorder. There is a strong correlation between parental diagnosis and behavioral and emotional problems in children at various developmental stages (Bella et al., 2011). Likely, genetic predisposition interacts with environmental stressors related to impaired functioning of the affected parent with both factors contributing to the generational nature of risk.

In Goodman's, (2002) integrative model of the transmission of risk to children of depressed mothers, she discusses the various theoretical processes proposed to explain how psychopathology is passed down between generations. She summarized the mechanisms through which the risk factor (maternal depression) interacts with moderators to affect vulnerabilities and eventually influence outcomes (psychopathology in the offspring). Mechanisms include: (1) the heritability of depression, (2) innate dysfunction of neuroregulatory mechanisms, (3) exposure to mother's negative maladaptive cognitions, behaviors, and affect, and (4) exposure to a stressful environment. Goodman's (2002) research supports the proposal that children of mothers with depression experience an interaction between biological factors and environmental factors, which affects their vulnerability.

The features of mood disorders specifically contribute in unique ways to the relational functioning of impacted individuals. As the standardized diagnostic manual used in clinical and

counseling psychology, the DSM-5 (American Psychiatric Association, 2013) is important to include in conversations about risk for this specific population. Specific behaviors related to each categorization of mood disorders will likely have different effects on parental functioning.

Major Depressive Disorder

Major Depressive Disorder is characterized by (1) decreased interest and enjoyment in activities previously enjoyable or (2) depressed mood. Individuals with depression may also experience decreased energy, agitation, insomnia/hypersomnia, distractibility, feelings of worthlessness, and suicidal ideation (American Psychiatric Association, 2013). These symptoms likely impact multiple domains of functioning including child rearing. To meet the DSM-5 criteria for MDD, the symptoms must persist for at least 2 weeks, but some individuals may experience extended mental health concerns related to depression. Particularly relevant to my conversation, is the DSM's inclusion of the peripartum onset specifier to MDD. The birth of an infant can trigger mood episodes, impacting parental functioning with a new infant (American Psychiatric Association, 2013).

Bipolar Disorder

In contrast, bipolar disorders (including BP I, BP II, and cyclothymic disorder) are characterized by manic or hypomanic episodes (American Psychiatric Association, 2013). During these periods of time, individuals with BD may experience increased risk-taking behaviors, inflated self-esteem, increased goal-directed behavior, irritability, and racing thoughts, etc. Subcategorizations of BD are distinguished based on the duration and severity of manic symptoms and the experience of a major depressive episode. (American Psychiatric Association, 2013). It is important to include representation for the full spectrum of MDD and BD in research, so that results are generalizable to the complete population of individuals with this disorder. It is

equally important for researchers to note how grouping together research participants with symptoms that differ in severity may impact their results. Similarly to MDD, for women with BD, the post-partum stage is a time of especially high risk for a mood episode (Sharma, Burt, & Ritchie, 2009). Following the delivery of an infant, maniac, hypomanic, or depressive symptoms may significantly impair parental functioning.

Included in the DSM-5 criteria for both MDD and BD is clinically significant distress and impairment in social, occupational, or other significant areas of functioning. (American Psychiatric Association, 2013). When a parent or caregiver is dealing with their own mental health challenges, whether they have received a formal professional diagnosis, their emotional disturbances are likely to impact their parenting and their ability to provide for the physical, mental, and emotional needs of their child.

Stressors Associated with Caregiving

Because individuals live within systems in which they actively contribute to, the impact of mental health disorders is not constrained simply to the individual. Systemic impact is bidirectional; the behaviors of individuals impact those they interact with, and the behaviors of others will shape the individual (Lerner, Johnson, & Buckingham, 2015). For the well-being of families, mental health of parents is particularly relevant considering the caregiving role and the responsibilities associated with it. In the spring of 2024, the Surgeon General of the US released a public health advisory, highlighting importance of parental mental health for the health of children and communities (Murthy, 2024). This document identifies stressors that affect caregivers disproportionately in comparison to nonparents. For example, financial burdens and poverty, time demands, sleep deprivation, child safety, isolation, and cultural pressure all uniquely contribute to stress placed on parents, and particularly impact single parent households

(Murthy, 2024). Although parenting is surely a rewarding endeavor, the demands placed on parents create significant challenges, even for healthy individuals. Given the pressure that parents are put under, and the lack of resources specifically targeted to this population, it is understandable that mental health is a prevalent concern (American Psychological Association, 2023). Immense pressure is put on caregivers forced to manage the stressors and responsibilities involved in parenting, while simultaneously dealing with their mood disorder symptoms. Intense demands on parents have direct and indirect impact on children and increases their risk for multiple challenges throughout their development.

For families from this population, risk is cumulative and parental mood disorders are one of many interrelated factors that impact outcomes in children (Walsh, 2016). Risk may be derived from factors indirectly related to a parent's mood disorder. Unlike a single bout of trauma, mental illness can be persistent and create ongoing relational challenges. Especially if left untreated, mood disorders exist in a long series of cascading stressors. When parents live with mental health challenges, they are impacted in multiple areas of life. In addition to the direct caregiving relationship, parental mental illness may socially impact functioning in other relationships, which indirectly affects a child's vulnerability. According to Hammen, (2002, p. 179) "Impaired functioning contributes to stressful circumstances that may in turn challenge the already symptomatic person's coping capacities and thereby perpetuate the disorder." For example, those experiencing mental illness may be at a higher risk for marital conflicts, which can have an impact on outcomes for children (Liu et. al, 2022). Similarly, those with MDD or BD may experience financial problems due to occupational dysfunction or problems managing finances. Hammen (1991) compared mean occupational and financial stress levels between mothers with unipolar depression, bipolar depression, and nonclinical populations. They found

significantly higher means for both occupational stress and the financial stress in women with unipolar and bipolar depression. Additionally, adults with mood disorders are more likely to have comorbidity and use substances, which may introduce more stress into the family environment (Gómez-Coronado et al., 2018). Particularly looking at BD, risk-taking behaviors are a key feature of the disorder (American Psychiatric Association, 2013). This may affect children if their parent's mania introduces them to unsafe physical or social environments. Every individual suffering from mental health problems will experience it differently; risk for children of adults with mood disorders may vary depending on a variety of contextual factors related to the disorder and to their social environment. Parental mental illness has an indirect impact on children when the consequences of untreated illness affect many domains of life. Therefore, interventions should aim to target multiple risk factors simultaneously, to provide holistic care for families.

Impaired Family Functioning as a Risk Factor

Marital Conflict

A common pattern experienced by families with parental mood disorders is interparental conflict. Liu et al., (2022) identified marital conflict as a barrier to developing family resilience particularly among families with a parent diagnosed with BD. One study found that interparental demonstration of threat, personal insult, verbal hostility, defensiveness, nonverbal hostility, withdrawal, and physical distress corresponded to children's experience of anger, fear, and sadness. They further linked this negative emotional reactivity to children's internalizing problems (e.g., worry, withdrawal) and externalizing problems (e.g., acting out) (Cummings, Goeke-morey, & Pappa, 2003). Marital conflicts may be specifically related to mood disorder symptoms in adults with mental health conditions.

Parent-Child Interaction

Adults with mental health conditions show altered interactions with their children. One meta-analysis found a strong association between maternal depression and irritability and hostility toward her child, a moderately strong relationship between maternal depression and disengagement from her child, and a weak association between maternal depression and decreased prosocial parenting. They proposed that these disturbances in parenting practices may be related to parent's increased negative affect and decreased positive affect associated with depression (Lovejoy et al., 2000). Hammen (2002) suggests that mothers with MDD, may be affected by their increased episodic and chronic stress. Stress may impact a mother's availability to her child, yielding her inattentive, inconsistent, tense, and irritable. When interactions between the parent and child are characterized by negative words and actions, children may learn a negative attribution style which shapes their beliefs about the world and themselves (Goodman, 2002). Similarly, Bipolar mothers in the postpartum stage displayed significantly fewer behaviors attuned to their infants' signals (e.g. turn taking) when compared to nonclinical mothers (Anke et al., 2019).

Parental interaction, particularly when children are very young, has a profound impact on the formation of secure attachment. Children with parents who have depressive symptoms are at a higher risk for forming insecure attachment styles (Milan, Snow, & Belay, 2009). Young adults with parents diagnosed with BD or MDD similarly scored higher in anxious attachment and avoidant attachment designations (Ruggero, 2022). Attachment has been identified as a moderator variable between maternal depression and depressive symptoms in offspring. For children with a history of insecure attachment prior to preschool years, mothers' variability in depression trajectory predicted the children's experience of depressive symptoms years later. For

children with a history of secure attachment, mothers' improvement or degression did not predict the child's later symptoms of depression (Milan, Snow, & Belay, 2009). This research supports that insecure attachment may be the process through which parental mood disorders affect child outcomes.

Household Organization

In retrospective interviews with adult participants who grew up with a parent with a mental health condition, Power et al., (2015) identified chaos and unpredictability as a common theme among this population. Almost all participants in their study reported inconsistency with routines and unpredictability in their parent's moods. When their caregiver displays symptoms of mood disorders, children may be unable to predict their parent's reactions to a situation and they may learn that they are unable to depend on their parent for basic responsibilities.

Parentification

Parentification refers to the tendency for children to assume caretaking roles in relation to other siblings or parents. When a caregiver fails to meet the emotional, physical, or mental needs of all of their children, older children often fill that role (Hammen, 2002). For example, a teenage child may work multiple part-time jobs, take on housekeeping chores, or complete cooking to provide for younger siblings. Another example of parentification is when adolescents take on an emotional caretaking role to help their ill parent. Various studies show inconsistent findings on the long-term outcomes of parentification (Backer et al., 2016). Some studies report that children will unwell parents take pride when they assume additional responsibilities and that their ability to be helpful boosts their self-esteem (Backer et al., 2016). Other studies indicate that this responsibility may place additional burden on children and create extra stress on top of other

daily stressors (academic, relational, financial, etc.) (Hammen, 2002). Negative outcomes may be especially prevalent when expectations placed on children are age inappropriate.

Outcomes for Children of Adults with Mood Disorders

Modeling of Symptomatic Cognitions and Dysfunctional Coping

Parents with mood disorders may model to their children inappropriate emotional regulation, negative cognitions related to depression, and faulty interpersonal problem-solving skills (Hammen, 2002). Children learn through replication of patterns they observe in adults. Garber and Martin (2002) propose that children observe and adopt their parent's dysfunctional cognitions into their own functioning. For example, when a parent suffers from thoughts and feelings of worthlessness, they may expose these dysfunctional cognitions to their child. Their child may then be more likely to believe similar maladaptive cognitions, merely through exposure. Similarly, Hammen (2002) discusses how modeling may be a mechanism through which dysfunctional coping strategies is passed down from parent to child. Poor emotional regulation in parents, associated with a mood disorder, may teach children unhelpful methods of coping with life's stressors.

Stigma and Shame

Very young children are aware of their parent's mental health problems, even if they do not have a label for it (Backer et al., 2016). Yet families are often unable to have genuine conversations about the challenges they face with each other, close friends, or community members. For families with this experience, there is a consistent reluctance to discuss challenging events (Power et al., 2015). Youth who experience embarrassment due to their parent's inappropriate behaviors may attempt to hide their family life from their peers. Stigma and secrecy have a bidirectional reinforcing influence on each other, and they lead to shame and

guilt within a family (Haug Fjone, Ytterhus, & Almvik, 2009). Offspring of adults with MDD and BD may feel ostracized from their peers and may utilize multiple techniques to manage their impressions on others (Haug Fjone, Ytterhus, & Almvik, 2009).

Resilience among Children of Adults Suffering from Mood Disorders

Protective Factors at the Family Level

Because risk for this population involves many interconnected social processes, resilience involves relational processes as well. Resilience functions within the context of systems that include the family, community, and culture. Walsh (2016) developed a framework for family resilience with a theoretical grounding in a developmental system. She categorized family resilience into three domains: belief systems, organizational processes, and communication. Within these categories, Walsh (2016) identified nine key transactional family processes that facilitate better outcomes in response to adverse experiences. Resilient belief systems involve the tendency to make meaning out of adversity, to take a positive outlook, and to emphasize transcendence and spirituality. Resilient organizational processes include flexibility, connectedness, and mobilization of resources. Resilient communication involves collaboration, clarity, and emotional openness within the family. These are not fixed descriptors of families; instead, they function as “mutually dynamic interactive processes” (Walsh, 2016, p.320).

Similarly, hardiness has been identified as a characteristic influencing positive outcomes for families with a member with a psychological disorder. The construct of hardiness involves three domains: (1) mutual dependence and cooperation, (2) a shared sense of autonomy in relation to external challenges, and (3) openness to change (Greeff, Vansteenwegen, & Ide, 2007). Families who score high in hardiness experience a strong sense of unity (Greeff, Vansteenwegen, & Ide, 2007). Family cohesion, which entails mutual dependence, is an

important protective factor (Liu et al., 2022). To help families from this population, it is important to identify preexisting strengths that can be drawn upon and developed for increased mutual support.

Research supports that a healthy father may buffer the effect of the mother's mental health challenges on the outcomes for a child (Kahn, Brandt, & Whitaker, 2004). Conversely, children who tested for the most severe emotional and behavioral problems had two parents with poor mental health (Kahn, Brandt, & Whitaker, 2004). The presence of at least one consistent caregiver may provide opportunities for formation of a secure attachment, despite unpredictable behaviors from an affected caregiver. A healthy father (or mother in the case of paternal psychopathology) allows for children to experience supportive relationships with caregivers. In two-parent households, a healthy parent can compensate when the other adult is experiencing an episode impairing their parental functioning. Furthermore, a healthy father can help to enforce routines and roles, which provide a flexible structure to daily familial functioning (Liu et al., 2022). Reliable routine can reduce stress, and it is especially important for families when unpredictability is the norm.

Protective Factors External to the Family:

Connections beyond the immediate family reduces isolation and reduces the burdens placed on families. Connectedness is beneficial in a variety of contexts including extended family, friends, religious community, and school peers, etc. Commitment to relationships is related to good behavioral functioning in adolescents with parents with a mental health condition (Beardslee & Podorefsky, 1988). Support from teachers and friends has a significant negative relationship with depression symptoms and a significant positive relationship with self-esteem (Colarossi & Eccles, 2003). Quality friendships offer hope, inspiration, and a sense of belonging

(Hsing-Jung & Kovacs, 2018). It may be beneficial for children with a parent with a mood disorder to seek out opportunities for relationships with both peers and nonparental adults in academic, extracurricular, athletic, or religious communities.

Making community resources available may help buffer stress related to parenting with mood disorders. (Murthy, 2024). For example, access to mental health treatment, affordable childcare, transportation, and financial resources will help parents who are also suffering from mood disorders to manage responsibilities. Effective interventions should target the whole environment that perpetuates mental health problems. The goal of community programs and policies should be to slow the cumulative effect of stress on parents who have mental health conditions.

Another aspect of community resilience is interagency collaboration. (Foster, O'Brien, & Korhonen, 2011). This allows for a holistic approach to well-being in a variety of domains in a child's life. Professionals from various fields, including education, justice, behavioral healthcare, and social services, have a unique opportunity to partner together and with families to provide quality care.

Implications for Practice

Mental Health Screening of Parents

Evidence supports that women with mood disorders are particularly vulnerable to mood episodes (depressive, manic, hypomanic) after delivery of an infant (Sharma, Burt, & Ritchie, 2009). As previously discussed, when parents experience severe symptoms, their parental functioning may be impaired, and they may be unable to provide for the needs of their child. Due to this finding, it is important to identify generational risk early and mobilize resources before challenges become severe and have irreversible effects. A report from the American Academy of

Pediatrics recommends prenatal and postnatal screening of MDD and other mental health conditions during visits with primary health care providers (Earls, 2010).

Parent-Child Interactions

Interventions should be designed to improve parent-child interactions, because impaired family functioning increases risk for negative outcomes, as previously discussed. Focusing on changing dysfunctional patterns of interaction may have a significant impact in the long run, because of the importance of the caregiving relationship. I speculate that this is particularly relevant for younger children, who have less control over their environment. In my interview with Chelsea Kline, senior clinician at CTRAC, I asked her about how professionals can support resilience in vulnerable populations when much of the work occurs outside of the therapy office.

“You can have a client come to therapy 60 minutes a week but that will not have as much lasting impact. We need to be putting the work and the time into changing the environment and changing the interactions” (C. Kline, personal communication, October 14, 2024).

Kline also described how changing patterns of behavior creates an environment to support parental recovery and decreases the possibility of relapse, because the caregiving relationship has bidirectional influence. All individuals involved must be willing to change behaviors and improve their functioning, which likely presents significant challenges.

It is important for clinicians to work collaboratively with each family member to identify strengths in addition to dysfunctional patterns. One study looking at parenting with maternal depression found that perceived maternal warmth and acceptance were related to more resilient outcomes (Brennen, Le Brocque, & Hammen, 2003). The child’s perception of their parent’s behavior towards them has implications for their development. For this reason, it is important to

consider the child's perspective when focusing on parent-child interactions in interventions, at least when the child is old enough to reflect on the situation and generate possible solutions.

When appropriate, the parent and the child should be equally involved in determining goals for the intervention. During our conversation, Kline (personal communication, October 14, 2024) continued:

“Talk to the child. Recognize the impact that they have experienced. With our treatment, we are looking at top challenges, not just from the parent, but also from the child. It's really about understanding how [a disorder] is impacting [the] child and [the] family and how can we work collaboratively to build those skills.”

Therapeutic interventions targeted at parenting practices may have a positive effect on children by promoting healthy parenting skills and building the confidence to utilize those skills, which include increased warmth and emotional care (Ruggero et al., 2022). For fathers with depression, paternal self-efficacy, or positive appraisal of competence in parenting, was related to increased warmth in parenting (Trahan & Shafer, 2019). I suspect that developing parenting skills would benefit both child and parent by improving the caregiving relationship. These interventions will be most effective if they are sensitive to the child's specific developmental level and their capacity to learn and change. Improving overall family functioning is an important goal of counseling in addition to symptom reduction.

It is important to note that there are circumstances where it is unrealistic to expect to fully change the relationship with a mentally unwell parent. In such instances, it is still important for children to experience regulating relationships within a safe environment, even if they are unable to form secure attachment with their parent. For this reason, it is important for multiple adults to be in the lives of children (Colarossi & Eccles, 2003).

Psychoeducation for Families

Even very young children are not ignorant of the differences between their parent and nonclinical parents of their peers (Backer et al., 2016). Developmentally appropriate education can reduce shame by introducing language and a framework through which to understand the differences that children from this population may observe (Foster, O'Brien, & Korhonen, 2011). This can help children understand that their parent is not a “bad person,” with hurtful intentions. Instead, education can help children to understand that their parent is a person suffering from a mental health condition, with dysfunctional patterns of behavior. Education can help reduce shame when children understand that their parent’s symptomatic behaviors are not the child’s fault. Education can similarly reduce isolation if they learn that there are other families who face similar things. When I asked her about psychoeducation, Kline said (personal communication, October 14, 2024), “It can help to also say that they are not alone in this experience. A lot of kids who have gone through similar things feel the same way.”

Simultaneously, I speculated that psychoeducation must be handled with caution and care. I asked Chelsea Kline (personal communication, October 14, 2024) if there can be any potential negative aspects to psychoeducation:

“Just because we can understand why someone is doing something doesn’t mean that it doesn’t have an impact. It doesn’t negate the negative impacts that they have had on the child. This is why I think you have to validate first. You must hear the child’s impact because you have not lived their life. You have to come in with the client as the expert.”

When working with children, it is important not to explain away or use education to justify their parent’s inappropriate behaviors. Psychoeducation may be beneficial, especially in families where mental health language is not a part of their daily vocabulary. When families are

aware of the common characteristics of the disorder, they can better prepare and know what to expect for future episodes. For some adolescents, understanding their parent's disorder can help them make sense of the effect that the disorder has had on their relationship with their parent.

Family Systems Approach

Ruggero et al. (2022) recommended comprehensive psychoeducation of symptomology of BD and MDD combined with a systemic approach, utilizing techniques from marriage and family therapy. They discussed the importance of understanding family of origin, including tools such as genograms and timelines to highlight alliances, conflicts, and other relevant attachment information. This helps everyone in the family to understand the parent's behavior and its impact within their own unique family environment. Understanding the family's past functioning can help the family to identify key processes important in adapting to stressful situations. Individual therapy and group therapy may both be equally beneficial, but practitioners should have a comprehensive understanding of the interpersonal nature of risk and resilience.

“I think when you are dealing with systemically [related] diagnoses, including intergenerational risks, the more based in the system that diagnosis is, the more systemic the approach must be. And that looks differently. [...] We need to put a lot more efforts into looking into the environment and shifting the environment to create healthier happier people. The context matters a lot, when looking at parent's mental health” (C. Kline, personal communication, October 14, 2024).

Autonomy

When adults with mood disorders receive individual treatment, the perspective of their children is often left out of the discussion (McConnell Gladstone, Boydell, & McKeever, 2006). Simultaneously, evidence supports that for adolescents, some independence from their parent

with a mood disorder is related to good behavioral functioning (Beardslee & Podorefsky, 1988). It may be beneficial for clinicians to help clients create developmentally appropriate boundaries with their parents who have a mood disorder. Chelsea Kline (personal communication, October 14, 2024) touched on the concept of autonomy in our conversation: “They get to decide the kind of relationship that they want. A lot of the work I do is helping them to grieve the parent they wish they had, accept the one they do, and give them some agency about what they want that relationship to look like.”

As they develop into adolescence, it is typical for children of adults with mood disorders to actively avoid exposure to their parent’s symptoms and seek solitude. (Haug Fjone, Ytterhus, & Almvik, 2009). Exposure to parental mania or depression may be significantly distressing for children (Hammen, 2002). Creating distance from parents may promote resilience, especially when their parents’ impaired functioning has not improved.

Personal Accomplishment and Expression

According to Hsing-Jung & Kovacs, (2018) group activities (e.g., sports, music, art, school) can provide meaning, promote self-efficacy, and develop a sense of connection with others. Extracurriculars can provide opportunities for children to develop skills and to discover strengths. Particularly, music and artistic expression have been identified as comforting for some children. When children relate to lyrics, they may experience a sense of identification and acceptance that reduces their loneliness and confusion (Haug Fjone, Ytterhus, & Almvik, 2009). Involvement in activities may allow youth to invest in activities outside their dysfunctional home and genuinely develop passion within their daily lives. I asked Chelsea Kline (personal communication, October 14, 2024) to describe a strengths-based approach to psychosocial assessment:

“We are trying to shift the paradigm from [asking] what is wrong with you? to [asking] what happened to you? And now we are also going a step further from [asking] what happened to you? to [asking] what is right with you? Your trauma and your risk are not the only parts of your story. [...] They are so used to people seeing the bad or seeing the challenges first and foremost. [...] Just having someone when they meet you ask about those strengths like that is usually one of the first things I do in my assessments.”

This quote illustrates the importance of mental health providers to approach interventions holistically. Asking clients about their interests and strengths outside of the home can build rapport between the therapist and client. Additionally, identifying these strengths and interests can help adults support the vast potential of vulnerable children.

Gaps in Research

Although our understanding of resilience has come a long way since its conceptualization, there are still areas where the literature is limited. When looking at parental mental illness, there are significant gaps in our understanding of the interaction between generational risk and protective factors.

A significant portion of the research focuses on maternal depression, but there is limited evidence for how fathers differ from mothers when parenting with a mood disorder (Abel et al., 2019). I suspect that one potential explanation for this lacuna is that the burdens related to caretaking and housework fall disproportionately onto women, especially when children are young (Lachance-Grzels, Bouchard, 2010). Research focused on parental mental health may focus on women because mothers have higher support needs. Another explanation for the invisibility of fathers in this field of research may simply be a result of base rates of gender and mental health diagnosis. Women have higher rates of diagnosis for both MDD and BD

(American Psychiatric Association, 2013). Mothers with depression may be a larger and more accessible population to include in research. Future studies should consider paternal mental health to fully understand how mood disorders impact an entire family.

I previously discussed how children's perspectives are often left out of conversations on treatments for families with a parent with a mood disorder. Additionally, academic research excludes children's perspectives when studying family systems (Hammen, 2002; McConnell Gladstone, Boydell, & McKeever, 2006). Due to complications with consent and confidentiality, children whose parent experiences a mood disorder are often left as an invisible population. Researchers often opt for self-report measurements from parents instead. One perpetuated perspective is that children are passive members in their environment, and that they inactively assimilate risk and resilience (McConnell Gladstone, Boydell, & McKeever, 2006). When the children of adults with mood disorders are involved as participants in research, it is often only in retrospect, after the children themselves have developed into adults. Though their perspectives as adults are important, this academic trend misses the impact of parental mood disorders at specific points in development. Furthermore, children's perspectives must be considered to develop interventions that support them in their specific developmental stage. Future research should consider methods to ethically include the perspective of children.

Because experience of mood disorders may vary significantly depending on context and individual, researchers must be mindful of how grouping together individuals from a wide range of functionality and severity will affect results. Research that focuses on the most severe cases but leaves out individuals who experience symptoms below the threshold for diagnosis, is likely to find different results than other studies depending on the population included.

Furthermore, research seems to exclude BP when looking at mood disorders; most literature focuses on maternal depression. When parents with BP or other mood disorders are included in studies, they are often grouped into the larger category of mood disorders. Expanding research to include parenting practices of individuals with BP will generalize the results to the full population of individuals with mood disorders. Understanding how the cyclical nature of mania and depression impacts parenting, will help practitioners better support emotional and behavioral health of children.

Some questions remain in the literature about the nature of protective factors. Resilience refers specifically to factors associated with positive outcomes despite significant adversity. Yet there is some confusion in the literature regarding whether such factors are beneficial to populations who are not significantly at risk. One future area of research may be to study the interaction between the degree of risk and impact of the protective factor(s). This will increase understanding about the specific processes (moderation and mediation) through which risk and resilience impact outcomes.

Conclusion

Inheritance of mental health conditions from parent to offspring is highly complicated and involves a variety of mutually influential biological, social, and psychological factors (Goodman, 2002). For parents, a mental health condition has significant implications for all members of the family. Children who have a parent with a mood disorder are at a higher risk for negative outcomes due to multiple mechanisms related to transmission of parental MDD and BD symptomology. Yet, an environmental context of high risk does not necessarily guarantee negative outcomes for children. Research in resilience suggests that preventative interventions with children from this population would be beneficial, especially when the intervention targets

multiple risk factors and simultaneously promotes protective factors (DiFonte & Gladstone, 2017). For example, improving communication between all family members may decrease interpersonal stress and help model healthier coping to children. Because risk and resilience are highly contextualized within relational processes, clinicians must be mindful of the family of origin when working with individual children or adults. Furthermore, collaboration between multiple fields at work in the lives of children will help professionals identify children's needs, develop individualized strategies, and mobilize community resources to support vulnerable families. Future research in intervention sciences should address the current limitations and develop more comprehensive models of risk and resilience. An extensive understanding of the role of parental mood disorders within the context of family functioning will help practitioners identify specific areas to target in practice. Learning how to change patterns of behavior between individuals will reduce the odds against vulnerable families for generations to come.

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