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Clinical Considerations When Treating Adults Who Are Parents

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Abstract

When providing mental health services to adults, we are often treating individuals who, among their other roles, are also parents. The goal of this article was to provide practitioners with the state of the science about both the impact of parental psychopathology on children and the role that children's well-being has in parental psychopathology. We discuss the benefits of integrated care for adult clients who are parents, as well as the barriers to providing integrated care for both parents and children in psychotherapy, and provide recommendations for practice. With this information, practitioners will gain greater awareness of their opportunities to treat adults in their parenting roles as well as to contribute to prevention of mental disorders in children.

Keywords

adult psychopathology; adult psychotherapy; offspring mental health; parenting

The 12-month prevalence estimates indicate that anywhere from 17 to 30% of adults have a mental disorder (Bijl et al., 2003; Kessler et al., 2005). Across various countries, only one-third to two-thirds of these individuals receive some form of mental health treatment (Bijl et al., 2003; Wang et al., 2007). A majority of adults with a mental disorder are parents (67.2% of females, 75.5% of males; Nicholson, Biebel, Williams, & Katz-Leavy, (2004). Together, these estimates suggest that a striking number of adults seeking psychotherapy are parents. As these statistics do not include individuals whose problems do not meet formal psychiatric diagnostic criteria, an even larger proportion of parents likely exist among adults receiving psychotherapy.

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The challenge for both practitioner and parent, however, is that evidence-based treatments for adults focus largely on clients' patterns of thoughts, feelings, and behavior or their interpersonal difficulties in their adult relationships. Generally, conceptualizations and intervention methods addressing their roles as parents have not been a target of evidence-based interventions for adult psychopathology. Indeed, a recent review of the literature from economically diverse countries revealed substantial variability in whether and how interventions address adults' roles as parents and, by extension, the well-being of their children (Stein et al., 2014). Furthermore, most interventions aimed specifically at parenting practices are not designed to accommodate adult psychopathology (Maliken & Katz, 2013).

The shortage of integrated models and treatment options that attend to child and adult psychopathology is undoubtedly rooted in the historical and continuing compartmentalization of adult and child mental health services. As noted by others (National Research Council [U.S.] and Institute of Medicine Committee, 2009; Reiss, 2011), despite high rates of co-occurring psychopathology, parents and children rarely receive linked clinical care (major exceptions being family therapy and therapy for children that directly addresses psychopathology in parents).

Evidence-based therapies that focus on the psychological processes of the individual client are the predominant mode of mental health treatment delivery to adults, and there are only a few models of integrated services that attend to both parents' and children's mental health (Ammerman et al., 2013; Goodman & Garber, 2017). Yet, there is a need for integrative theoretical models and treatment options that specifically target adult clients who are parents. In addition, parent training programs that target child psychopathology have only recently recognized the need to address psychopathology in parents. Although integrated interventions that target psychopathology simultaneously in both parents and children are likely to be particularly effective for many families, such treatments are rare. Nonetheless, practitioners who treat parents with psychopathology have a clear and justified entry point for identification, prevention, and treatment of parenting problems and child mental health problems. However, there are no established standards of care for practitioners providing individual adult psychotherapy services to adults who are parents. Specifically, there are no guidelines or requirements for addressing adult clients' roles as parents, for evaluating the quality of their caregiving, or for screening and referring their children to services. As a result, potentially strong and cost-effective opportunities for helping parents and preventing child mental disorders are missed.

There are a variety of reasons that approaches to adult psychotherapy largely overlook their role as a potential avenue into prevention of parenting and child mental health-related problems. We highlight two reasons. First, training of practitioners and researchers is often specialized, such that adult and child training tracks are separate. For example, two of the larger clinical internship placement sites in the United States are Veterans Affairs hospitals and university counseling centers (APPIC Directory, 2011–2012 data), in which interns predominately or exclusively treat clients aged 18 and older. Trainees completing these internships receive little or no training in assessment or treatment of parenting or child psychopathology. Although specialization has its benefits, a cost is that few such trainees are exposed to treatment models that focus specifically on parents and their children, which is

essential for delivering integrated services to them. Finally, such trainees who become researchers often perpetuate this gap when developing new interventions.

Beyond the training, a second reason for the relative absence of evidence-based adult interventions that incorporate both parenting and child mental health concerns may be the relative lack of research on the extent to which the role of parenthood and child psychopathology influence adult mental health. In contrast, evidence-based treatments for child mental health concerns typically involve parents (Lock, 2015; Michelson, Davenport, Dretzke, Barlow, & Day, 2013; Miller, Rathus, & Linehan, 2007), based on the significant body of research on the relationship between parenting and child psychopathology. Later we discuss the growing evidence base that child psychopathology is linked to adult (parents') psychopathology (Qin & Mortensen, 2003; Sellers et al., 2016). As this evidence base grows, so too will the rationale and need for more treatments that target psychopathology in adults who are parents.

When treating psychopathology in adults who are parents, practitioners need to be knowledgeable about the nature and extent to which their children are at risk for mental health problems. There is a delicate balance to strike between two equally problematic stances. Historically, in both the mental health field and society more broadly, one stance has been to blame parents, particularly mothers, for causing their children's mental health problems (Chamak & Cohen, 2003). Even presently, well-intentioned mental health professionals can be a source of blame and stigmatization, as pointing to faulty parenting for explaining children's difficulties remains common (Hinshaw, 2005). This viewpoint is inconsistent with evidence that child psychopathology is multiply determined (Cicchetti & Rogosch, 1996) and that relationships inherently involve bidirectional influences (Sameroff & Mackenzie, 2003). However, recognition that it is inappropriate to blame parents for their children's problems may lead therapists to overlook the role of parental psychopathology as a risk factor for their children. This results in missed opportunities for clinicians treating psychopathology in adults to address a key risk factor in children's development of psychopathology and a key mechanism in that risk—parenting qualities—by applying empirically supported approaches to screening children's well-being and adult parenting quality. To help practitioners strike a clinically sensitive balance, we offer a summary of the literature that can enable practitioners to conceptualize and screen parenting and child functioning and make evidence-based decisions to refer children and their parents to services.

The information in this review is aimed at practitioners serving adults with psychopathology who are also parents and has three broad goals: (a) to provide practitioners with the state of the science addressing the extent to which and pathways by which psychopathology in parents impacts children, as well as the role that parenthood has on psychopathology in parents; (b) to consider barriers that may interfere with practitioners' ability to incorporate parenthood and the well-being of clients' children into practice; and (c) to provide a starting point of practice recommendations for working with adult clients who are parents. Within the context of these goals, we argue that parents with psychopathology face unique challenges that can and should be addressed in adult psychotherapy. This arises both because having a parent with psychopathology is a major risk factor for child psychopathology, and

because the inherent challenges that accompany parenthood can directly influence the presence and severity of parental psychopathology, especially when parenting children who have emotional or behavioral problems. Despite the strong links between parent and child psychopathology, a number of barriers have prevented the integration of psychotherapy for both parents and children in current practice models. We provide concrete recommendations for practitioners to begin to address the lack of integrated treatment models. In particular, a first step involves greater screening and referral for children of parents receiving psychotherapy. This greater attention to the mental health needs of children of adult clients provides an unparalleled opportunity for adult practitioners to prevent psychopathology in children.

We begin with a few clarifications about terminology. First, when summarizing evidence, we use the term *parent* unless referring to a study in which only mothers participated; much of the literature on psychopathology in parents focuses on mothers. To address this shortcoming, we include a review on the role that fathers have in the transmission of psychopathology. Second, we use the general term *psychopathology*, except when citing studies that permit reference to a formal disorder or diagnosis. Finally, the literature on effects of parental psychopathology on child outcomes is focused largely on child psychopathology and not a broader set of outcomes (e.g., academics, physical health) that have also been studied (Benton, Skouteris, & Hayden, 2015; Pearson et al., 2016).

PSYCHOPATHOLOGY IN PARENTS AND CHILDREN ARE INEXTRICABLY LINKED

Parent Psychopathology and Child Outcomes

One in five children lives with a parent with psychopathology (Maybery, Reupert, Patrick, Goodyear, & Crase, 2009). For example, annually, approximately one in 10 children lives with a parent who abuses alcohol or drugs (Neger & Prinz, 2015; United States Department of Health and Human Services, 2012) or is exposed to maternal depression (Ertel, Rich-Edwards, & Koenen, 2011). Thus, a substantial number of offspring have parents with psychopathology. An even larger proportion of parents would likely benefit from psychotherapy but do not meet criteria for formal psychiatric diagnosis.

The large numbers of children living with parents with psychopathology raise two critical issues involving the intergenerational transmission of psychopathology: (a) the extent of risk for the development of psychopathology in offspring of parents with psychopathology, and (b) the extent to which those risks are specific to parental psychopathology or to related risks (e.g., marital conflict). Historically, the risks for offspring of adults with psychiatric diagnoses were conceptualized in terms of the probability that offspring would develop the same disorder (Cardno, Rijdsdijk, Sham, Murray, & McGuffin, 2002). Evidence from a worldwide sample of over 50,000 people assessing many different psychological disorders simultaneously in parents and offspring found that parent psychopathology was a robust, yet *nonspecific* predictor of their offspring's psychopathology (McLaughlin et al., 2012). Specifically, having a parent with a mental health diagnosis explained 12.4% of the onset of offspring cases (McLaughlin et al., 2012). In other words, although having a parent with

psychopathology is associated with offspring risk of psychopathology, there is limited evidence that parent and child will have the same disorder. For example, depression in parents is associated with elevated odds not only of offspring mood disorder but also of anxiety, substance, and behavior disorders in offspring, and with little variation in the strength of association across offspring disorder types. Moreover, the risk ratio of offspring diagnoses generally increases with an increasing number of parental diagnoses.

Adult psychopathology often co-occurs with other conditions that also constitute risk factors for children's development, such as unemployment, poverty, marital problems, and family instability (Freed et al., 2015; Gassman-Pines, Ananat, & Gibson-Davis, 2014). Moreover, when both parents have psychopathology, which is common, the risk of poor child outcomes increases (Kahn, Brandt, & Whitaker, 2004; Wesseldijk et al., 2016). In sum, children who have parents with psychopathology are at elevated risk for developing psychopathology, the nature of that psychopathology is not specific to the disorder in the parent, and comorbid psychopathology and co-occurring conditions enhance the risk.

Children's age when exposed to parental psychopathology matters. Although there is natural concern for infants of parents with psychopathology, the evidence shows that psychopathology in parents is associated with higher rates of psychopathology throughout offspring's lifespan. That is, psychopathology in offspring may emerge early or late in development. An important implication of this finding is that even if the offspring of adult clients do not exhibit symptoms at the time of the parent's treatment, they remain at increased risk for developing psychopathology at later points in their development, including in adulthood (McLaughlin et al., 2012). Moreover, factors such as the child's age at onset of parental psychopathology and the duration of the children's exposure are also important in the specific ways that risk is conferred.

Psychopathology in Fathers—Much of the evidence about parental psychopathology and child outcomes is derived from studies of mothers, although some studies include both parents. Regrettably, the rates of father inclusion in research have not increased despite calls for doing so (Parent, Forehand, Pomerantz, Peisch, & Seehuus, 2017); between 2005 and 2015, <1% of studies in top child psychopathology journals explicitly focused on fathers. Despite this limited empirical evidence, a few key studies provide some direction.

Two meta-analyses report modest effect sizes for the association between depression in fathers and children's symptoms, with the relation slightly stronger for children's internalizing versus externalizing symptoms (Connell & Goodman, 2002; Kane & Garber, 2004). One of these meta-analyses also compares effect sizes for fathers' depression with mothers' depression, reporting that depression in mothers has a slightly stronger association with child mental health than depression in fathers (Connell & Goodman, 2002). A review of psychiatric disorders in fathers (Ramchandani & Psychogiou, 2009) notes that paternal substance abuse and children's outcomes have received the most empirical study, due to the increased prevalence of substance use disorders in men versus women. Fathers' alcohol consumption is prospectively associated with increased rates of externalizing symptoms and substance use in adolescent offspring (Malone, Iacono, & McGue, 2002). Thus, psychopathology in fathers is also important for child outcomes.

Pathways of Risk—It is important to understand *how* psychopathology is transmitted from parents to children. Of particular importance for intervention is the consideration that some risk mechanisms may be modified via treatment. That is, to the extent that practitioners treating adults with psychopathology help to reduce or eliminate risk factors associated with child psychopathology, the incidence of child psychopathology may decrease. Knowing which risk mechanisms are directly or indirectly modifiable, as well as those that do not reasonably change through therapy, can inform practitioners' case formulation about the priority of treatment targets.

There are typically four main risk pathways that have received empirical support (Goodman & Gotlib, 1999). The first and second mechanisms are biologically mediated. The first biological risk involves parental psychopathology during the prenatal period and its implications for a broad range of health and developmental outcomes in children. Maternal mental health during pregnancy is thought to be associated with poorer indicators of fetal growth such as birth weight, placenta weight, and glucocorticoid levels. However, despite the potential significance, much more evidence is needed to uncover the mechanistic pathway by which maternal mental health “programs” fetal development and may predispose children to later mental health disorders (O'Donnell & Meaney, 2016). The second biological mechanism is genetic risk, with varying degrees of heritability for different disorders. Notably, these two risk mechanisms interact. It is now well understood that genetic risk for the development of psychopathology may be expressed or exacerbated in the presence of other adverse environmental conditions that are associated with parental psychopathology (Caspi, Taylor, Moffitt, & Plomin, 2000; Knafo & Jaffee, 2013).

The third mechanism of risk transmission is through exposure to other types of stressors, such as increased family conflict, which is associated with development of psychopathology in children (Freed et al., 2015; Goodman & Gotlib, 1999). The fourth and final mechanism, and the one that is best understood, is parenting quality. Generally, there are several parenting qualities and practices that are consistently associated with children's healthy development: warmth, developmental sensitivity (i.e., attuning parenting practices to the child's abilities), firm but flexible discipline, and autonomy promotion (e.g., Maccoby, 2000). There is ample evidence demonstrating that parents with psychopathology can have deficiencies in these essential parenting qualities or struggle to engage in optimal parenting.

Several reviews address how specific disorders or experiences influence parenting. For example, one review concludes that mothers with a diagnosis or elevated symptoms of borderline personality disorder are more likely to engage in overprotective, insensitive, and hostile behaviors compared to mothers without borderline personality disorder or even mothers with other disorders (Eyden, Winsper, Wolke, Broome, & MacCallum, 2016). Mothers with histories of traumatic experiences, specifically childhood sexual abuse, are found to be more permissive and have more difficulty setting boundaries with their children than those without that history (DiLillo & Damashek, 2003). Parents with posttraumatic stress disorder (PTSD) or symptoms are, on average, more hostile and disengaged than those without those problems (Leen-Feldner et al., 2013). Maternal depression has a small but significant association with parental negativity, coercion, and hostility, particularly when dealing with young children, during active phases of depression, or in women who are

otherwise disadvantaged or both (Lovejoy, Graczyk, O'Hare, & Neuman, 2000). Finally, parental anxiety is associated with greater use of parental control, but this association is only observed for studies in which children are school-aged and for studies that use certain types of laboratory situations (van der Bruggen, Stams, & Bögels, 2008). Together, these reviews highlight the fact that parental psychopathology can be associated with poorer parenting quality, but that effect sizes are small to moderate. This suggests that many parents with psychopathology manage to maintain good-quality parenting. Furthermore, parental psychopathology is only one of several established predictors of parenting quality (Belsky, 1984; Lomanowska, Boivin, Hertzman, & Fleming, 2015).

Resilience Factors—Despite evidence of multiple pathways that indicate that parental psychopathology confers risk to children's mental health, not all at-risk children develop psychopathology. Different developmental models provide frameworks for conceptualizing the complex, multiple, interacting influences on children's development, with attention to child, family, community, and societal factors (Bronfenbrenner, 1977; Cicchetti & Rogosch, 1996; Sameroff, 1986). These models provide a useful direction to practitioners when evaluating at-risk parenting and children's risk for psychopathology in the presence of parent psychopathology, including identifying protective or resilience factors.

Resilience is the term used to describe children who do not evidence problems despite growing up in the presence of a known risk factor, such as parental psychopathology (Masten & Obradovic, 2006; for a review on resilience in the context of maternal depression, see Reuben & Shaw, 2015). Resilience may be attributed to child characteristics that serve to protect their well-being, such as a repertoire of strong coping skills for dealing with adversity (Langrock, Compas, Keller, Merchant, & Copeland, 2002; Pilowsky et al., 2006). Resilience may also be due to relationship factors, notably the presence of other caregivers (e.g., the other parent, a grandparent), economic factors, such as affording opportunities for children to have positive experiences outside the home, and societal factors, such as the absence of stresses such as racism and discrimination (Goodman et al., 2011; Luthar & Sexton, 2007).

Summary—There is ample evidence that offspring of parents with psychopathology are at increased risk for psychopathology and other psychosocial problems at every stage of their lives. The mechanism of risk from parent to child involves multiple pathways, of which any one risk factor is best understood in the context of other risk and resilience factors. Case formulation is enhanced by including an assessment of child, family, community, or societal protective and resilience factors in conjunction with identifying risk factors.

Children and Parent Psychopathology

We have emphasized the transmission of psychopathology risk from parents to their children. Here, we emphasize how parenthood can influence parent psychopathology. For example, having a child with emotional and behavioral problems is a stressor for parents, can contribute to the onset or maintenance of parent psychopathology, and can influence treatment attendance and success. Children with higher levels of inattention and defiance have parents who report greater stress, including time pressures, financial strain, and

negative emotions (Bussing et al., 2003). Daughters' depressive, conduct disorder, and oppositional defiant symptoms predict the recurrence of maternal depressive episodes (Sellers et al., 2016). Young children's difficult temperament and symptomatic behavior predict future increases in maternal mood symptoms (Allmann, Kopala-Sibley, & Klein, 2016). Taken together, these findings underscore the influences children's behavior can have on parents, an aspect of adult functioning that is easily overlooked in evidence-based adult psychotherapy modalities.

A key question is whether interventions aimed at children with psychological problems have any influence on parental psychopathology (Gonzalez & Jones, 2016). There is limited research to address this important issue, but available evidence is promising. For example, mothers' depressive symptoms decreased when a CBT-oriented intervention improved children's PTSD symptoms (Neill, Weems, & Scheeringa, 2016).

Parenthood as a Protective Factor—Despite the challenges of parenting, particularly with children who present emotional or behavioral difficulties, parenthood can serve a protective function for adult mental health. Concern for their children is commonly endorsed as a reason for living among mothers who have considered suicide (Linehan, Goodstein, Nielsen, & Chiles, 1983). Parents are less likely than nonparents to commit suicide, except in the case of losing a child, which increases parental suicide risk (Qin & Mortensen, 2003). Moreover, being a parent can enhance adult engagement in psychotherapy. For parents with severe mental illness, those with younger children report more hope, which improves psychotherapy outcomes, and furthermore, they are more trusting of their providers compared to adults with severe mental illness who are not parents (Bonfils, Adams, Firmin, White, & Salyers, 2014). This finding contradicts the belief that parents mistrust providers due to mandated reporting requirements.

Summary—For many adults, parenting is stressful and may be associated with the onset, maintenance, or recurrence of parent psychopathology, especially when children have psychopathology or other characteristics associated with parenting challenges. At the same time, the role of parenthood offers many protective benefits for those adults who struggle with psychopathology. Practitioners have an important opportunity to evaluate the roles that parenthood and children's well-being play in their conceptualization of the illness and treatment of the parent in their care.

TREATMENT APPROACHES

We have focused on how parental psychopathology influences children, and how child functioning influences parental mental health. We now turn to treatment approaches to working with parents who have psychopathology and that assess outcomes for both parents and children. There are three classes of intervention: adult psychotherapy, interventions that integrate parent and child treatment, and preventive interventions including parent management training.

Adult Psychotherapy and Children's Outcomes

Flight attendants always instruct passengers to secure their own oxygen masks before assisting others, using illustrations of parents putting on their masks before helping their children. This is a metaphor for best practices in parenthood. Adults must recognize and address their own mental health in order to effectively care for others. Thus, practitioners may assume that if their adult clients attain significant symptom reduction and enhanced adaptive functioning, then by extension their children's lives should improve. But what is the evidence for the "oxygen mask" assumption?

Several studies have evaluated the extent to which treating parents, without intervening with their children, improves children's well-being. Randomized controlled trials (RCTs), the gold standard for evaluating treatment effectiveness, have examined children's outcomes as a function of their parents' treatment. A recent meta-analytic review of psychotherapy for adult depression (Cuijpers, Weitz, Karyotaki, Garber, & Andersson, 2015) reports significant, albeit small, improvements in children's mental health following their mothers' treatment. Additional research shows that adolescents are more likely to seek treatment if their parents are in treatment, constituting a potentially indirect benefit (Sherman & Ali, 2017). Finally, in the few studies that contain additional outcome measures, among parents receiving psychotherapy for depression, there are improved parent-child interactions and decreased marital distress.

This and other reviews highlight the limitations of a body of knowledge based on small numbers of RCTs, but also point out the important implications for practice. First, most studies compare the outcomes of children whose parents are assigned to treatment and control conditions, and do not test changes in children's outcomes as a function of adult symptom reduction. This is an important limitation. Practitioners know well the variation in outcomes of adult treatment. An important next step in this line of research will be to test the question of the extent to which parents' changes in symptoms correspond with changes in children's outcomes.

A second related limitation is that few studies examine changes in parenting or in children's exposure to other stressors, both of which should account for differences in children's outcomes. For example, improvements in adult symptoms may not improve parenting quality. Children may benefit from reduced exposure to parental moodiness, anhedonia, and other symptoms but reap more benefit if parenting improves. Thus, there is a need for research that addresses mechanisms by which improvements tied to adult psychotherapy influence the functioning of clients' offspring.

A third limitation involves comparison groups. Swartz et al. (2016) report encouraging results of two brief psychotherapies for depressed mothers with depressed children. Improvements in children's mood, assessed about 3–6 months after maternal depression remission, are found for both therapies. However, they note that the lack of a nontreatment control precludes knowing if children's mood problems would improve over time without treatment. Similarly, children whose parents' depression remitted had better psychological, physical, and behavioral functioning compared to children whose parents' depression did not remit, but the improved children still fared significantly more poorly than children of never-

depressed parents (e.g., Billings & Moos, 1985). Thus, improvements in child behavior must be considered relative to typically developing children and should be related to changes in parenting or other aspects of the environment known to correspond with depression in mothers and to interfere with children's healthy development. A fourth and final limitation is the predominance of studies involving treatment of depression in parents, to the neglect of understanding how treatment of other disorders in parents might benefit the children (for a few exceptions, see Niccols, Milligan, Sword, et al., 2012, regarding maternal substance use).

Summary—Despite these limitations, there are reasons to be encouraged by this emerging evidence and guidance for practitioners. When parent treatment leads to significant symptom reduction, their children's symptoms may improve, even months later. On the other hand, it is important to recognize that symptom reduction does not automatically lead to improved parenting quality.

Integrated Treatments Targeting Parents and Children

There are different types of integrated treatments, but they share the defining feature of addressing both mothers and children's mental health at the same time. Some target children's mental health via improved parenting (Goodman & Garber, 2017), others treat mothers and children separately but concurrently, and finally, some intervene directly with the dyad. Here, we focus on integrated treatments that directly target mental health in both the parent and the child within the same treatment. Please note these integrated treatments focus on mothers.

First, there is a growing body of intervention research on integrated programs for mothers with substance abuse disorders. These programs address the needs and barriers faced by these mothers, along with the needs of their children, with services in a single setting that comprehensively meet the needs of women and their children. Two reviews—one on child outcomes and the other on parenting—summarize the evidence for such programs (Niccols, Milligan, Smith, et al., 2012; Niccols, Milligan, Sword, et al., 2012). Overall, integrated treatments are associated with small improvements in children's emotional and behavioral functioning and in parenting quality relative to treatments focused solely on mothers' substance use. Important next steps in this line of research are to conduct high-quality studies that continue to identify how and to what extent integrated programs are associated with improvements in parenting processes relative to individual treatment of the mother's substance abuse, and how parents' treatment for substance use relates to children's outcomes. In particular, studies are needed that evaluate programs aimed at improving mother-child interaction among mothers with substance addiction who also have young children.

Another study took an integrative approach to address high levels of depression in mothers of children with ADHD. The Integrated Parenting Intervention for Attention Deficit Hyperactivity Disorder (ADHD) aims to improve maternal psychopathology and parenting by integrating cognitive-behavioral therapy (CBT) and behavioral parent training. Results show small to medium effect sizes for reductions in maternal depressive symptoms, negative

parenting, and child behavior problems compared to a group receiving behavioral parent training only (Chronis-Tuscano et al., 2013). A related approach, In-Home CBT (IH-CBT) for mothers with postpartum depression, many of whom also had PTSD symptoms, reports reductions in maternal depressive symptoms and improvements in parenting quality (Ammerman et al., 2013, 2015).

Several dyadic interventions also show promise in integrating parent and child treatment. Child–parent psychotherapy approaches emerged from attachment theory. One intervention focuses on mothers and children who have experienced trauma (Lieberman, Van Horn, & Ippen, 2005). In the traumatized sample, child–parent psychotherapy shows reductions across a broad range of symptoms in mothers and children compared to mothers receiving individual treatment plus case management, and notably, symptom reduction is sustained several months after treatment completion (Lieberman, Ghosh Ippen, & Van Horn, 2006). For toddlers, child–parent psychotherapy improves toddlers’ cognitive development (Cicchetti, Rogosch, & Toth, 2000). In toddler child–parent psychotherapy, although recurrence of depression between baseline and postintervention is similar between mothers in the intervention group versus control group, toddlers who are part of the child–parent psychotherapy show better cognitive performance, regardless of their mothers’ depression status. In contrast, toddlers who are part of the control group and whose mothers had a recurrence of depression show the worst cognitive performance.

Summary—In the past decade, different approaches have emerged for integrating parent and child interventions. Not surprisingly, the emerging evidence supports the view that integrated approaches are effective at improving the symptoms of both mothers and their children and at improving parenting quality. They begin to suggest that treatment of both members of the dyad may reduce parents’ symptoms even if they are not the direct therapy target. Although it is clear that more research is needed, accumulating evidence suggests the need to develop and deliver interventions for parents with psychopathology that incorporate a focus on children in addition to the parent as the target of treatment.

Preventive Interventions

The third category of intervention is preventive. There are several types of interventions aimed at preventing psychopathology in children by intervening with families of parents with psychopathology (predominantly affective disorders) and mostly involve mothers (Siegenthaler, Munder, & Egger, 2012). Although the duration, theoretical approach, and client target (parents, families, or children) vary, most of the preventive interventions have a specific structure, such as CBT or psychoeducation, including educating children about their parents’ conditions. A meta-analysis reports that, on average, preventive interventions decrease the risk of onset of new disorders in offspring by 40%, such that an estimated 17 families would need to be treated to offset the emergence of psychopathology in one child (Siegenthaler et al., 2012). More recently, an RCT comparing a family group CBT-oriented prevention for families with a no treatment control reports that children in the intervention group have a significant reduction in both depressive and anxiety symptoms through an 18-month follow-up (Bettis, Forehand, Sterba, Preacher, & Compas, 2016).

It will be useful for adult practitioners to be aware of the possibility of referring clients to preventive interventions that can offset future psychopathology in children. Brent et al. (2015) report a significant delay in the onset of major depressive episodes, and in their severity, for adolescents receiving a CBT preventive intervention that is followed over six years. Notably, the effect is only for adolescents whose parents are not acutely depressed at the start of the program. Similarly, evidence-based interventions for parenting are generally found to be less effective for parents with psychopathology relative to parents without psychopathology (Beauchaine, Webster-Stratton, & Reid, 2005; Maliken & Katz, 2013). Because of this, several prominent parenting interventions such as The Incredible Years, Triple P-Parenting Program, and Parent–Child Interaction Therapy now include modules addressing aspects of parent psychopathology that are conceptually relevant to parenting, such as training around anger management, emotion regulation, parental distress, and conflicts (Maliken & Katz, 2013). To date, the results are mixed (Maliken & Katz, 2013; Webster-Stratton & Reid, 2010). Improvements in parents' psychopathology are typically modest, and there is a need to better understand the best balance of focus on parenting skills and on parental symptom reduction for different types of parental problems. In a recent review of this literature, Goodman and Garber (2017) suggest additional steps that have strong potential to improve these outcomes, at least partly by enhancing feasibility of parents' participation in these programs.

In sum, there is adequate evidence for practitioners serving adults to consider making changes in their work by taking into consideration the mental health and developmental risks for the children of their clients. In addition to appreciating the role of parenting in their clients' functioning, practitioners may need to be on alert to the need for their clients' children to be evaluated or referred to services. Moreover, practitioners should not overlook children who do not yet manifest symptoms, those with subclinical symptom levels, those who are not meeting developmental milestones in a timely manner, and those who are stressed even in the absence of symptoms. Practitioners must consider whether there is a need for including (or referring to) one of the evidence-based intervention approaches.

Summary—Accumulating evidence demonstrates that preventive interventions specifically designed for children and families in which a parent has psychopathology are beneficial by preventing psychopathology in children. Enhanced parenting interventions that attend to processes such as emotion regulation in parents appear to yield modest benefits to parenting quality compared to traditional parenting interventions.

BARRIERS TO ADDRESSING THE UNIQUE CHALLENGES OF PARENTS IN TREATMENT OF ADULT CLIENTS

Legitimate barriers exist that make it difficult to address the needs of parents and their children in standard interventions with adults (Nicholson, Hinden, Biebel, Henry, & Katz-Leavy, 2007). We focus on the four most common barriers: (a) the clinician's theoretical orientation, (b) the client–practitioner relationship, (c) practitioner training and competency, and (d) the availability of evidence-based mental health services for children and parents in communities.

Practitioner's Theoretical Orientation

Some psychotherapy approaches hold that clients should set the direction of their therapy. In this framework, the practitioner's introduction of an issue the client did not generate would violate the theoretical model. Person-oriented and humanistic approaches posit that individuals know what is best for them, and the role of the therapist is to facilitate the client's self-discovery (Miller & Rollnick, 2002; Rogers, 1951). Thus, these practitioners would only discuss parenting-related issues if clients introduce them.

Perhaps more subtle is the cultural individualism that penetrates U.S. psychotherapy approaches (Nagayama, 2003). Individualistic values tend to direct the focus of intervention to the needs and desires of the individual. Even therapies that focus explicitly on relationships, such as interpersonal psychotherapy or dialectical behavior therapy, are premised on the importance of the client's individual functioning for interpersonal functioning. Although other individuals in a client's life may benefit from the client's improvements, this is often not a treatment priority. The individualistic perspective is not inherently problematic. However, it does represent a barrier to integrating the role of parenthood—a relationship—into many therapeutic approaches.

Addressing the Focus on the Individual—Therapeutic practices emphasizing the client's self-direction and inherent wisdom must qualify these principles under specific situations. For instance, when a client poses a danger to self or others, a practitioner must act, even if action goes against the client's goals and desires. A practitioner must also act in the best interest of others when there is reason to suspect harm to others. This includes mandated reporting of child maltreatment. Because there is ample evidence that the offspring of parents with psychopathology are at elevated risk for psychopathology themselves, it follows that there is justification for practitioners to consider when they must act (e.g., make referrals for children in need of services).

The Therapeutic Alliance

Practitioners may be concerned that their clients would be threatened in some way by their therapist's assessment of their parenting or of their offspring's well-being. The perception of the therapist as judgmental could evoke embarrassment, shame, or anger, or the risk of a report to child protective services (Nicholson, Biebel, Hinden, Henry, & Stier, 2001). In these instances, practitioners may be concerned about risk to the therapeutic alliance. Indeed, qualitative evidence indicates that many parents with psychopathology fear such judgments (Zalewski, Stepp, Whalen, & Scott, 2015).

Addressing the Alliance—Addressing the role of parenting with clients can be aided by explaining why the therapists ask about the well-being of other family members, including children, and about how clients function in their various roles, including parenting. This interest can be a standard part of clinical practice. To do so is supported by evidence of risks to children of parents with psychopathology and the related challenges and stresses parenting places on adults with mental health concerns. The rationale for this role-based approach to understanding clients is that therapists may have suggestions and solutions, not judgments, for clients. Including screening of children and parenting as a standard can be

done at the onset of therapy and not introduced unexpectedly midway as a concern arises. In regard to client shame or anger, many practitioners are skillful at handling those client reactions in therapy sessions, including when those emotions are directed at the therapist (Koerner, Tsai, & Simpson, 2011). Clients who are parents stand to benefit from clinicians' trusting that it is possible to work through alliance ruptures and arrive at a deeper understanding with the client.

Finally, practitioners are encouraged to review informed consent over the course of treatment. By ensuring that parents are well versed on the limits of confidentiality, parents may feel freer to discuss their parenting concerns and their children's well-being. They will be reminded and may understand the practitioner's professional obligations that mandate their role as advocates for children.

Clinical Competency

Training in adult psychotherapy rarely provides sufficient training in child development or parenting or methods of assessing or intervening in either. This is a considerable barrier because working outside of one's competencies is unethical. Several professional codes (American Psychological Association, Ethics Code, 2010; Code of Ethics of the National Association of Social Workers, 2008) explicitly state that practitioners should refrain from working outside their areas of competence. How does this influence treating adult clients as parents? Practitioners who inquire about children's well-being may learn that their client is concerned about their parenting or their children's well-being. When this information is shared, practitioners without child clinical or family training may feel they are not competent to provide a parenting-related service, such as assessing or treating the children or offering parent training.

Addressing Competence—Practitioners are bound to work within their areas of competence. However, practitioners often find themselves obligated to intervene beyond the scope of their standard practice. For example, the lack of evidence-based child or family services in many communities, long wait lists for these services, or the simple reality that additional services are burdensome and unrealistic for many families compels many practitioners to reconsider the boundaries of their practice. No standards exist for weighing these concerns. Ethical practitioners evaluate the potential gains and harms of broadening the range of intervention they provide. Often they seek continuing education for the concerns that require broadening their competencies and often avail themselves of peer supervision or consultation (see Table S1 for practitioner training tools).

We hope that the information and perspectives provided in this article increase clinician awareness of the risks that adult mental health problems pose for parenting and for children's well-being. Further, we hope we contribute to practitioners' decisions about the steps they can take to screen and potentially intervene in their clients' roles as parents. These can include coordinating care with another practitioner and referring clients for additional evaluations or services when they exist in the community. In sum, all practitioners who treat adults who are parents are encouraged to use this knowledge and the related references to better integrate the role of parenthood into their treatment.

Limited Availability of Services for Parents and Children

Appropriate local referral options may not be available. It may be impossible or highly impractical to refer clients to appropriate services for parenting- and child-related problems. Where such services exist, there are often long wait lists.

Addressing Limited Availability of Services—Although many practitioners are also activists for better or more community services, the limited availability of services for families is undoubtedly one of the most challenging barriers to comprehensive care. When services that address parenting-related issues cannot be provided by the practitioner and there are no community services available, one can seek consultation with colleagues in other communities. This includes locating digital health-care options, which includes, but is not limited to, digital health interventions, computer- or Internet-based interventions, or telehealth (for glossary of terms and examples of specific service delivery, see Hollis et al., 2017). Digital health-care options are viewed as beneficial because of their potential for increased access, their efficiency, and their ability to be personalized. In this meta-review of digital health interventions of children and young people, the evidence for effectiveness was strongest for computerized cognitive-behavioral therapy for depression and anxiety in adolescents. The meta-review also cautioned that for other childhood and adolescent disorders, the evidence base for effectiveness was less certain (Hollis et al., 2017). To give one recent example of its application with children, behavioral telemedicine was used to successfully decrease ADHD problems in children, with the additional benefit of reducing parental stress (Myers, Vander Stoep, Zhou, McCarty, & Katon, 2015; Vander Stoep et al., 2017). The rapid growth of these types of delivery platforms has prompted professional organizations to issue guidelines that are consistent with standards of care and ethical guidelines of their profession (e.g., psychologists see “Guidelines for the Practice of Telepsychology,” <http://www.apa.org/practice/guidelines/telepsychology.aspx>). Even if practitioners do not participate in providing digital health care, they can familiarize themselves with the guidelines prior to recommending that parents or parents’ children may benefit from such services. Although such options for all types of parenting-related concerns or child mental health options are not yet available, such services will increase in the near future. Finally, for practitioners in communities with limited or no family and child services, practitioners can consider expanding their competencies through continuing education.

PRACTICE RECOMMENDATIONS

Finally, we discuss ways that practitioners can modify their practice in relating to clients as parents, based on the evidence reviewed. We include references to resources, tools, and referral options that can aid the screening of parental and child functioning. The list is not exhaustive, but provides exemplars of tools that have good psychometric properties and have proven useful in practice and research with children and parents. We focus on screeners that can be used to determine whether a formal assessment or intervention referral is warranted. Notably, the screener examples referenced in Table S1 are all self-report tools. Although self-reports have their limitations in assessing parenting and child well-being, they can facilitate early conversations about parenting and children, helping practitioners identify situations that require more indepth assessment.

Screening Parenting Quality and Client's Role as a Parent

With small changes to intake procedures, practitioners can screen parenting stress, satisfaction, and quality at intake. For example, screening parenting stress can enhance practitioners' determining whether the role of parenting is contributing to ongoing psychopathology or interfering with the parent's implementation of therapist recommendations and, more broadly, with therapy progress. The questionnaire format may yield information that does not arise in the course of less structured discussions about sources of stress. Conversely, when screeners reveal that parents report high satisfaction with parenting or feeling efficacious, practitioners may better understand the degree to which parenthood may serve as a protective factor for a client, one that may enhance motivation for therapeutic change in adult symptoms. The quality of parenting can be screened through self-report measures that assess the use of parenting practices, which may provide the practitioners with information about links between parents' symptoms and their parenting. Case formulation can be enhanced by disentangling how certain roles and identities of the client contribute to or maintain symptoms.

Screening Children's Well-Being

Practitioners may find it useful to collect screening information about the adjustment of clients' children. When a description of a child's behavior indicates possible difficulties in emotional, relationship, or school functioning, a referral for evaluation, which may lead to treatment, is warranted. In addition to intake screening of children's adjustment, practitioners are encouraged to routinely monitor how children's functioning influences their clients' symptoms. When the offspring's functioning at intake does not indicate present risk, routine periodic monitoring during the treatment course for the parent may reveal previously unreported or emerging concerns and referral needs.

Resources for Practitioners and Parents

Practitioners can provide parents with online resources that offer tips for parenting children of different ages and for helping children with emotional and behavior problems. Several of the websites listed contain tabs for providers, parents, and some even for children. Several of these online resources give tips for talking with children about parents' psychopathology in age-appropriate ways. Furthermore, tips are provided for parents for how to manage a household when symptoms may be in an acute phase. In effect, these resources frame psychopathology as something a parent has rather than who the parent is. In this way, it provides parents with language and a framework for talking about their psychopathology in a manner that does not undermine their role as a parent.

Referral Options

Practitioners can use Table S1 and Figure 1 in conjunction with each other to assess and guide their clinical decision-making process. Specifically, Table S1 provides examples of child and parent assessments, resources for practitioners and parents, and training opportunities for practitioners. The assessments and online resources listed are examples that are clinically relevant and have established psychometric properties pertaining to the measurement of children's well-being, the role of parenting, or parenting quality. In

adults may be sitting across the room from one of the biggest prevention targets in the field of public health: adults with psychopathology who are parents.

As a practitioner, there are many areas of clients' lives that need attention, and often there are more topics and items than can reasonably be attended to in any given session or even throughout the entire course of treatment. Additionally, there are many worthy topics of continuing education that practitioners can choose to learn that also have immense societal value. So why devote therapy time or one's own training time to focus on clients' children? Practitioners will differ in their answer to this question. Our own answer is this: Children are the most vulnerable individuals in society and depend entirely on parents and other adults to provide the environments they need for healthy development. A practitioner who is treating a parent possesses a unique opportunity to intervene on behalf of a child. Treating adults who are parents may be the most underutilized and yet powerful tool to reduce the incidence of psychopathology in the next generation.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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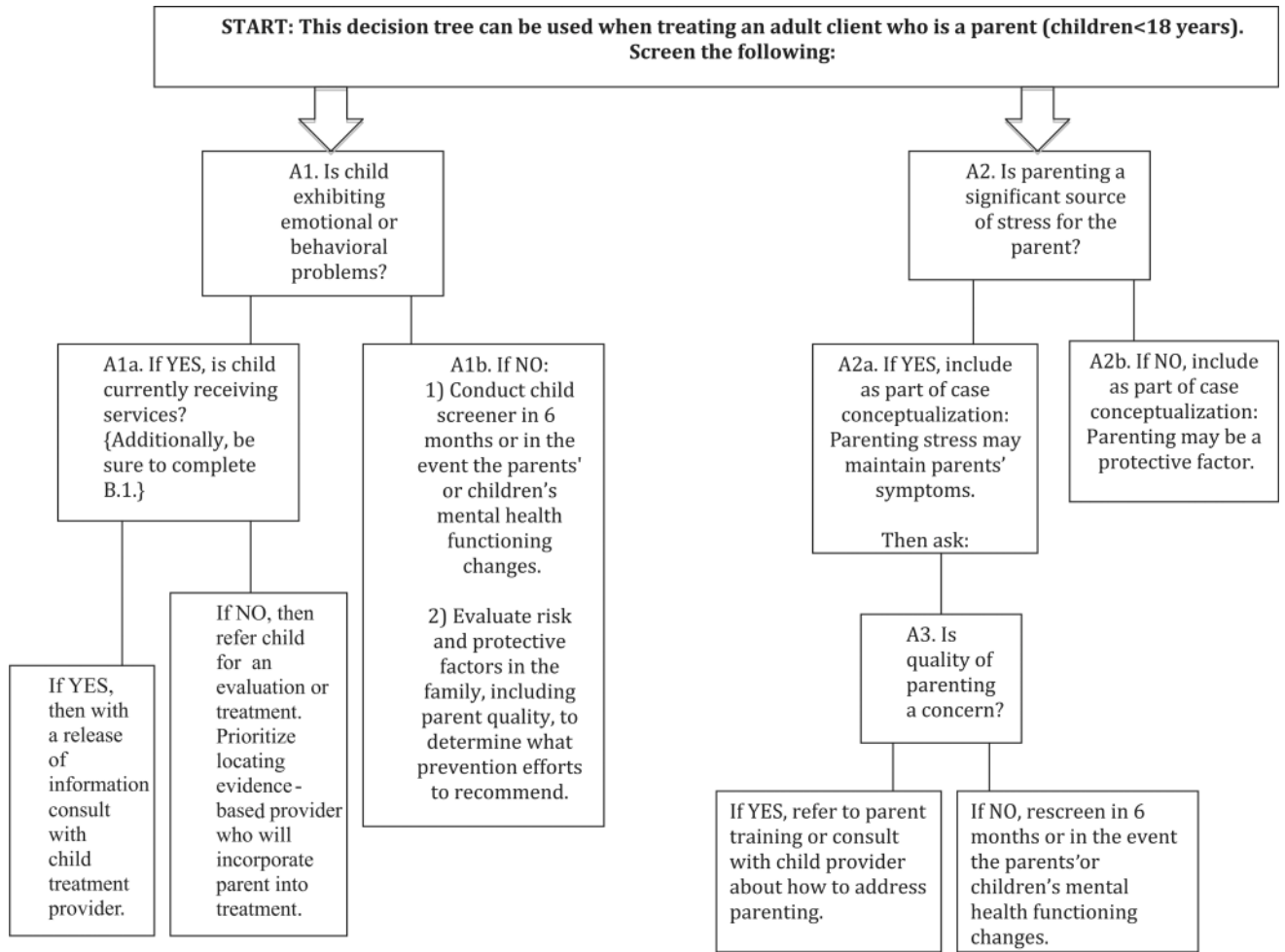


Figure 1. Clinical decision tree for practitioners with parents on their caseload.