PH.D. THESIS

The family and the patient

An investigation of mental health problems, risk factors, and support for members of the families of psychiatric patients

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DEPARTMENT OF PSYCHOLOGY

UNIVERSITY OF GOTHENBURG

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Doctoral Dissertation in Psychology
Department of Psychology
University of Gothenburg
May 29, 2023

Cover layout: Andreas Nordh
Cover illustration: Ahmad Safarudin/Dreamstime
Printing: Stema Specialtryck AB, Borås, Sweden, 2023
ISBN: 978-91-8069-275-5 (PDF)
ISBN: 978-91-8069-276-2 (Print)
ISSN: 1101-718X Avhandling/Göteborgs universitet, Psykologiska inst.
Electronic version: http://hdl.handle.net/2077/75948

To families struggling with mental health problems.

Abstract

Nordh, E.-L. W. (2023). The family and the patient: An investigation of mental health problems, risk factors, and support for members of the families of psychiatric patients. Department of Psychology, University of Gothenburg, PO Box 500, SE-405 30 Gothenburg, Sweden.

The aim of this thesis was to improve knowledge of the members of the families of patients in contact with psychiatry by investigating mental health problems, risk factors, and support received. The thesis is based on three studies from two clinical research projects, one in adult psychiatry and one in child and adolescent mental health services (CAMHS). Parent-rated questionnaire data were used in all three studies. **Study I** was cross-sectional and investigated mental health problems and risk factors experienced by 8–17-year-old children ($N = 87$) of parents in treatment for depression, anxiety, or bipolar disorder in adult psychiatry. Findings indicate more mental health problems in these children than children in the general population, and that one third had symptoms at clinical levels. Risk factors associated with more children's symptoms were younger child age and exposure to multiple risk factors, as well as parents reporting low perceived parental control relating to how they can handle their child's behaviour. In **Study II**, data from three waves of measurement (baseline, 6, and 12 months) were used to evaluate the effectiveness of preventive interventions used in routine care in adult psychiatry to support 8–17-year-old children of parents in treatment for depression, anxiety, or bipolar disorder. Families ($N = 62$), including 89 children, received the intervention available at the patient's psychiatry unit: Family Talk Intervention (FTI), $n = 35$; Let's Talk about Children (LTC), $n = 16$; or intervention as usual (IAU), $n = 38$. Findings indicate that the development of child mental health problems over time differed significantly between groups. Mental health problems did not increase in children receiving the FTI and LTC interventions but did increase in children in the IAU group. Furthermore, parents receiving the FTI and LTC reported strengthened perceived parental control in relation to handling rearing situations with their children, compared with the IAU group. **Study III** investigated mental health problems in parents ($N = 111$) of 5–17-year-old children ($N = 98$) referred to CAMHS. Findings indicate that many parents (41%) experienced elevated levels of mental health problems at the time of the child's first appointment and that, in these families, children were reported to have more symptoms and the proportion of families experiencing problematic family functioning was higher. Parents with elevated mental health problems reported having received group-based parent training/education to a greater extent during the first year of contact with CAMHS, and they rated

participation in treatment planning significantly lower, than did parents below the cut-off for their own mental health problems. Taken together, the studies show that mental health problems in the members of the families of psychiatric patients are common, which underscore the importance of identifying the needs of the whole family when a patient is seen in psychiatry, to ensure that appropriate support is initiated. In adult psychiatry, investigating multiple relevant risk factors relating to the child, parent, and family can provide information about the child's and family's needs. Findings support the continued use of two preventive interventions to support the children of patients with depression, anxiety, or bipolar disorder. In child psychiatry, findings underscore the importance of addressing co-occurring parental mental health problems and that families experiencing co-occurring problems could need more extensive support, as the children were reported to have higher levels of mental health problems and more families were reported to have problematic family functioning. To meet the varying needs of families of psychiatric patients, findings indicate that interventions are needed at different levels of prevention and treatment.

Keywords: children, parents, family members, psychiatry, child and adolescent mental health services, mental health problems, risk factors, preventive interventions, support

Sammanfattning (Swedish summary)

Många familjer delar erfarenheten av att antingen en förälder eller ett barn eller ungdom (härifrån endast benämnda som barn) i familjen har psykisk ohälsa. Depression och ångesttillstånd drabbar en stor andel av befolkningen någon gång under livet och av de som drabbas av någon form av psykiatriskt tillstånd så är det mer än hälften som gör det innan 18 års ålder. När antingen en förälder eller ett barn drabbats av psykisk ohälsa påverkar det oundvikligen hela familjen, även om påverkan kan skilja sig avsevärt mellan olika familjer och familjemedlemmar.

Kunskapen om hur familjemedlemmar påverkas när någon i familjen har psykisk ohälsa har ökat under de senaste decennierna. Vad gäller barn till föräldrar med psykiatriska tillstånd vet man idag att de har en ökad risk att själva utveckla psykisk ohälsa. Kunskap finns också om viktiga risk- och skyddsfaktorer som kan öka eller minska risken att barns utveckling påverkas negativt. Utifrån denna kunskap har olika typer av förebyggande interventioner utvecklats. Effekten av sådana interventioner har undersökts i metaanalyser, vilka har visat att förebyggande interventioner kan minska risken att barn till föräldrar med psykiatriska tillstånd utvecklar egna svårigheter. Flera viktiga frågor kvarstår dock att undersöka, såsom effekten av olika typer av interventioner, vilka interventioner som passar vilka barn, föräldrar och familjer bäst, samt effekt på lång sikt. Interventionerna behöver också undersökas när de används i klinisk verksamhet och i olika kulturella kontexter.

Vad gäller föräldrar till barn med psykiatriska tillstånd så visar studier att det är många föräldrar som upplever en hög grad av föräldrastress och belastning utifrån de ökade behov som barn med psykiatriska tillstånd har. Högre nivåer av föräldrastress har i sin tur kopplats till högre nivåer av psykisk ohälsa hos föräldrar. Forskning har visat att en grupp med föräldrar till barn som har kontakt med barn- och ungdomspsykiatri (BUP) har samtidig psykisk ohälsa, även om prevalensen för hur stor andelen är skiljer sig åt mellan olika studier.

Utifrån att barn som är anhöriga till en förälder med psykiatriskt tillstånd är en identifierad riskgrupp bör förebyggande insatser ges för att minska risken att de utvecklar egna svårigheter. I Sverige är det sedan år 2010 inskrivet i hälso- och sjukvårdslagen (SFS 2017:30) att personal inom sjukvården särskilt ska beakta barns behov av information, råd och stöd när barnets förälder behandlas för ett psykiatriskt tillstånd. Inom vuxenpsykiatri i Sverige erbjuds både manualbaserade och icke-manualbaserade interventioner för att efterfölja lagen, även om uppföljningar visat att det endast är en liten andel av alla barn inom denna verksamhet som får förebyggande interventioner. Två manualbaserade interventioner som har fått spridning inom vuxenpsykiatri i Sverige är ”Beardslee familjeinterven-

tion" (eng. *Family Talk Intervention* (FTI)) och "Föra barnen på tal" (eng. *Let's Talk about Children* (LTC)). FTI är en intervention med sex till åtta träffar plus uppföljningsträffar som riktar sig till hela familjen, både föräldrar och barn. LTC omfattar en till två träffar endast med föräldrar, och har utvecklats inspirerad av bland annat FTI, men som en lägsta nivå för förebyggande stöd riktat till barn till föräldrar med psykiatriska tillstånd. Vissa delar är lika i interventionerna, de innehåller till exempel båda psykopedagogiska delar om förälderns diagnos och om risk- och skyddsfaktorer som kan påverka barns utveckling. I båda interventionerna betonas också vikten av kommunikation i familjen kring förälderns svårigheter och hur familjen kan påverkas, även om detta görs på olika sätt i de två interventionerna. Viktiga skillnader mellan interventionerna är längden och vilka familjemedlemmar som deltar under träffarna.

Inom verksamheter som möter barn med psykiatriska tillstånd rekommenderar många forskare att föräldrars mående bör beaktas vid beslut om vilka insatser ett barn och deras familj ska erbjudas. Inom BUP ställs frågor om ärftlighet och familjesituation tidigt i kontakten med nya familjer, men det finns inga tydliga riktlinjer om hur man ska stödja familjer med samtidig psykisk ohälsa i denna kliniska kontext. Studier har också visat att få journaler inom BUP innehåller information om föräldrars psykiska ohälsa.

Syftet med denna avhandling var att öka kunskapen om psykisk ohälsa hos barn till patienter inom vuxenpsykiatri och hos föräldrar till patienter inom BUP och att undersöka riskfaktorer för psykisk ohälsa i dessa familjer. Syftet var också att utvärdera effekten av förebyggande interventioner som erbjuds till barn som anhöriga inom vuxenpsykiatri i Sverige idag samt kartlägga insatser som ges till föräldrar med psykisk ohälsa inom BUP.

I avhandlingen ingår tre studier från två kliniska forskningsprojekt. Två av studierna är genomförda inom ramen för ett forskningsprojekt inom vuxenpsykiatri, som finansierats av Socialstyrelsen och som genomförts i samarbete mellan Göteborgs universitet och Lunds universitet, tillsammans med vuxenpsykiatriska kliniker i fem regioner i Sverige. Den tredje studien är genomförd inom BUP i samarbete mellan Göteborgs universitet och Sahlgrenska universitetssjukhuset. I samtliga studier är det föräldrar som är deltagare och kvantitativa data har samlats in med hjälp av frågeformulär.

Studie I syftade till att undersöka hur barn till föräldrar diagnosticerade med depression, ångest eller bipolär sjukdom mår psykiskt och till att undersöka riskfaktorer för psykisk ohälsa hos denna grupp med barn. Familjer rekryterades inom vuxenpsykiatri när patienter som är föräldrar erbjöds förbyggande interventioner med fokus på deras barn inom ramen för förälderns pågående kontakt. I studien ingick 87 barn mellan 8 och 17 år. Innan interventionerna genomfördes fyllde

föräldrarna i frågeformulär med skattningsskalor om egen psykisk ohälsa, barnets psykiska ohälsa, familjens fungerande och upplevda kontroll över sitt barns beteende, som reflekterar föräldrars tilltro att de kan påverka sitt barns beteende i olika vardagliga situationer. Frågeformuläret innehåll också bakgrundsfrågor om exempelvis kön, ålder och yrke. Resultatet visade att barnen rapporterades ha signifikant högre nivåer av psykisk ohälsa jämfört med barn i allmänhet och att 34% av barnen hade symptom över kliniskt gränsvärde som indikerar förhöjda nivåer av psykisk ohälsa. Ökande antal riskfaktorer i barnets liv ökade oddsen för att barnet rapporterades ha symptom över kliniskt gränsvärde. När olika riskfaktorer undersöktes framkom att högre nivåer av psykisk ohälsa hos barn kunde prediceras av yngre ålder hos barnet samt av om föräldrar rapporterade lägre nivåer av upplevd kontroll över sitt barns beteende. Sammanfattningsvis pekar resultaten på vikten av att uppmärksamma vuxenpsykiatriska patienters barn och att undersöka olika relevanta riskfaktorer för att identifiera deras behov av stöd. Vidare tyder studiens resultat på att det är viktigt att uppmärksamma yngre barn och föräldrar som upplever svårigheter relaterade till sitt föräldraskap.

Studie II syftade till att utvärdera förebyggande interventioner som idag används inom vuxenpsykiatri för att stödja barn till föräldrar med depression, ångest eller bipolär sjukdom. I denna studie jämfördes familjer som fått de manualbaserade interventionerna FTI och LTC med en jämförelsegrupp bestående av andra interventioner, både manualbaserade och icke manualbaserade, som familjer erbjuds inom reguljär verksamhet inom vuxenpsykiatri (eng. *intervention as usual* (IAU)). Familjerna fick den intervention som erbjöds på den psykiatriska enhet som patienten tillhörde. I studien ingick 62 familjer med 89 barn mellan 8 och 17 år. Föräldrarna fyllde i frågeformulär vid tre tillfällen; före intervention, efter 6 månader och efter 12 månader. Interventionerna utvärderades dels vad gäller effekt på förändring av psykisk ohälsa hos barnen, dels vad gäller förändring av föräldrarnas upplevda kontroll över barnets beteende. Data analyserades med hjälp av flernivåanalys som tog hänsyn till att det var upprepade mättillfällen för varje barn och att vissa barn ingick i samma familjer. Resultatet visade att förändringen över tid vad gäller barnens psykiska ohälsa skiljde sig signifikant mellan de olika interventionsgrupperna. I grupperna som fått FTI och LTC skedde ingen ökning av barnens psykiska ohälsa, vilket visade sig vara fallet i jämförelsegruppen. På det andra utfallsmåttet framkom också en signifikant skillnad i förändring över tid mellan grupper. Hos föräldrar som fått FTI och LTC ökade upplevd kontroll över barns beteende, medan den minskade i jämförelsegruppen. Det framkom inga signifikanta skillnader i förändring över tid på något av utfallsmåtten när FTI jämfördes med LTC. Sammanfattningsvis tyder resultaten på att FTI och LTC kan minska risken för att barn som har en

förälder med depression, ångest eller bipolär sjukdom på kort sikt utvecklar egna svårigheter, och stödjer fortsatt användning av dessa interventioner. Med tanke på att den grupp som ingår i studien är liten, behövs större studier för att bekräfta resultatet. Ytterligare forskning behövs också för att ta reda på vilken insats som passar vilka grupper av barn och föräldrar. Utifrån att LTC är en kort insats kan det övervägas om denna insats ska användas som en lägsta nivå för att nå så många som möjligt av barn till patienter inom vuxenpsykiatri, och att denna kan följas av längre insatser om ytterligare behov finns. För familjer med omfattande svårigheter kan dock andra insatser behövas direkt.

Studie III syftade till att kartlägga psykisk ohälsa hos föräldrar till barn som remitterats till BUP och även till att undersöka skillnader vad gäller barnens psykiska ohälsa, familjens fungerande och föräldrars involvering i barnens behandling mellan föräldrar med förhöjda självrapporterade nivåer av psykisk ohälsa jämfört med de som inte hade det. Totalt ingick 111 föräldrar till 98 barn mellan 5 och 17 år som mellan januari 2020 och februari 2021 kallats till ett första besök inom BUP. Den inkluderade gruppen barn motsvarade 5% av det totala antalet barn som kallades till ett första besök under denna period. Resultatet visade att 41% av deltagande föräldrar (föräldrar till 44% av barnen) rapporterade förhöjda nivåer av psykisk ohälsa vid tidpunkten för barnets första besök. Vidare rapporterade 42% av föräldrarna att de haft en tidigare behandlingskontakt för egen psykisk ohälsa under barnets liv, flest angav kontakt med primärvård eller med privat psykolog eller psykoterapeut. Det var en stor andel (41%) av de som skattade förhöjd psykisk ohälsa, som inte hade någon tidigare behandlingskontakt. I familjer där föräldrar rapporterade förhöjda nivåer av egen psykisk ohälsa, skattades signifikant högre nivåer av psykisk ohälsa hos barnen och fler föräldrar rapporterade problematiskt fungerande i familjen. När föräldrar ett år senare svarade på frågor om kontakten med BUP framkom då att föräldrar som vid tidpunkten för första besöket hade förhöjd psykisk ohälsa i högre utsträckning hade erbjudits gruppbaserat föräldrastöd/utbildning under året som gått och de skattade signifikant lägre på frågor om de upplevt att de varit inkluderade i behandlingsplaneringen, jämfört med föräldrar som inte hade förhöjda nivåer av psykisk ohälsa. Sammanfattningsvis visar denna studie att en stor andel av föräldrar till patienter inom BUP upplever förhöjda nivåer av psykisk ohälsa vid tidpunkten för deras barns första besök, och i dessa familjer skattas barnen ha mer psykiska besvär och en högre andel familjer rapporteras ha problematiskt fungerande. Resultaten pekar på vikten av att uppmärksamma samtidig psykisk ohälsa hos föräldrar, för att ha detta som utgångspunkt vid beslut om lämpliga behandlingsinsatser.

Sammantaget har studierna i denna avhandling bidragit med kunskap om

familjer till patienter med psykiatriska tillstånd. Studierna pekar på att psykisk ohälsa ofta förekommer samtidigt hos barn till föräldrar som har kontakt med vuxenpsykiatri och föräldrar till barn som remitteras till BUP. Resultaten pekar på vikten av att uppmärksamma familjemedlemmar till patienter inom psykiatrin för att säkerställa att lämpligt stöd till hela familjen initieras. De ingående studierna har också bidragit med kunskap om faktorer associerade med psykisk ohälsa hos familjemedlemmar till psykiatriska patienter. Inom vuxenpsykiatri kan frågor om olika riskfaktorer relaterade till barn, föräldrar och familjer användas för att avgöra vilka behov av stöd som finns. Frågor kring föräldraskap kan vara viktiga att undersöka, liksom att beakta de yngre barnens situation. Resultat från Studie II stödjer fortsatt användning av två manualbaserade interventioner som idag används inom vuxenpsykiatri för att stödja barn till föräldrar med depression, ångest eller bipolär sjukdom. Vidare hade en grupp med barn redan utvecklat symptom på psykisk ohälsa och detta tyder på behov av förebyggande insatser på indikerad nivå eller av egen behandling. Inom BUP visar resultaten på vikten av att fråga föräldrar om samtidig psykisk ohälsa, då det i dessa familjer rapporterades högre symptom hos barnen och oftare problematiskt familjefungerande. Det kan vara viktigt att hjälpa föräldrar till egen behandling, om de behöver det, men även att anpassa de insatser som ges inom BUP om föräldrar har samtidig psykisk ohälsa. Vidare behövs mer forskning kring hur behandlingar bör anpassas och hur föräldrar med samtidigt psykisk ohälsa kan involveras i beslut om deras barns behandling.

List of publications

This thesis consists of a summary and the following three papers, which are referred to by their Roman numerals:

I. Nordh, E.-L. W., Priebe, G., Grip, K., Afzelius, M., & Axberg, U. (2022). Mental health in children of parents being treated by specialised psychiatric services. *Scandinavian Journal of Public Health, 50*(8), 1113–1123. https://doi:10.1177/14034948221076208

II. Wirehag Nordh, E.-L., Grip, K., Thorvaldsson, V., Priebe, G., Afzelius, M., & Axberg, U. (2023). Preventive interventions for children of parents with depression, anxiety, or bipolar disorder: A quasi-experimental clinical trial. *ACTA Paediatrica, 112*(1), 132–142. https://doi.org/10.1111/apa.16555

III. Nordh, E.-L. W., Grip, K., & Axberg, U. The patient and the family: Investigating parental and child mental health problems, family functioning, and parent involvement in child and adolescent mental health services. *Unpublished manuscript.*

Studies I and II were financially supported by fundings from the Swedish National Board of Health and Welfare. Study III was financially supported by Sahlgrenska University Hospital, and fundings from the Foundation Queen Silvia's child and adolescent hospital research fund and the Local Research and Development Council of Gothenburg and Södra Bohuslän.

Contents

Tables

Acknowledgements

I took the first step towards this doctoral thesis nine years ago, and I now find myself having spent almost a quarter of my life on this journey. The work has been both demanding and time consuming and I have on many occasions doubted myself and the road I've taken. Looking back, however, it has been nine very meaningful years, and I have been fortunate to have been surrounded by many persons who have supported, guided, and encouraged me along the way. I am tremendously grateful to all of you.

First, I would like to offer my deepest gratitude to my main supervisor Professor Ulf Axberg. Thank you for your never-ending support and encouragement, your patience and generosity, and for sharing your broad knowledge in research and practice. I have learned so much from you! Thank you also Senior Lecturer Karin Grip, my co-supervisor, for invaluable insights and reflections, meticulous reading and re-reading of my texts and for always finding time to discuss work, life, and family. Furthermore, I would like to thank Professor Emeritus Anders Broberg, who introduced me to doing research, first as a research assistant and then as one of my original supervisors when I was accepted as a doctoral student. Your continuing dedication to research is an inspiration.

In the research projects I have been involved in, I have been privileged to work with several dedicated and competent colleagues. Thank you, Professor Gisela Priebe and Senior Lecturer Maria Afzelius, for sharing your knowledge about children of parents with mental health problems, and for much appreciated discussions about practice-based research and research findings. Thank you also, Professor Valgeir Thorvaldsson, for introducing me to analysis of longitudinal data, and for invaluable guidance in using advanced statistical methods. I am equally grateful for your encouraging words at the exact right time.

The research that this thesis is based on would not have been possible without all the participants, who have generously given of their time and contributed with their experiences. My appreciation also goes to Pia Svensson, who professionally coordinated the data collection during so many years. And Bimbi Dahne Widerberg, thank you for your helpful advice when planning and conducting the research project in adult psychiatry. The recruitment of participants was furthermore made possible by committed assistance from mental health professionals in adult psychiatry and the administrative assistants in child and adolescent mental health services.

I also want to express my sincere gratitude to Marie Carlsson, the department manager of the child and adolescent mental health services in Gothenburg, as well as Monica Johansson Lundgren and Susanna Pfeil Jacobsson, the former

and current manager of the child and adolescent mental health service unit in Frölunda, for encouraging me and giving me the possibility to do research.

During my time as a doctoral student at the Department of Psychology, I am very glad to have been part of the research group devoted to Clinical Psychology, Prevention, and Intervention from a lifespan perspective (CPPI). Thank you all for interesting, wise, and elaborate discussions concerning research. I hope our discussions and our work will continue in the future to improve care for children, parents, and families. I have also enjoyed the company of many wonderful and inspiring colleagues, thank you for making the department such a nice workplace. And to all my fellow doctoral students (past and present), thank you for invigorating conversations and for being such an important supportive force. Elin Alfredsson, thank you for luring me into research many years ago, when you asked me if I wanted to be a research assistant in your PhD project. I am also very glad to have you as a friend. Fanny Gyberg and Marja Onsjö, whom I started the doctoral programme with, thank you for sharing this journey with me. I also want to express my gratitude to Andrea Valik, for your encouragement and for carefully reviewing and giving feedback on my half-time report. And many thanks to Ann Backlund, who have patiently listened to all my questions and who always have had an answer to my administrative troubles.

I would furthermore like to acknowledge the importance of several influential persons from my years of training to become a psychologist and from my years working as a clinical psychologist. Unni Bonnedal, who inspired me to work with children and adolescents. Bodil Ahlman, who have meant so much to me as a supervisor and colleague. Maria Olinder, who have been an important role model as a psychologist. I have also been fortunate to work as a co-therapist with many experienced and competent social workers and family therapists, who taught me the importance of seeing the whole family when working with children and adolescents: Lisa Sandström, Eva Runeman, Gunilla Faxér, Monica Sabel, Annika Landén and Maria Andersson. And thank you also to all other colleagues and friends in child and adolescent mental health services in Gothenburg, and especially at the Frölunda unit.

Dear friends from my years of studies to become a psychologist and elsewhere, I am so happy to have you all! And Karolina, Anna, and Therese, friends whom I have known all my life. We have shared so much together, growing up and becoming who we are today. Thank you for being such an important part of my life.

To my family, I am so fortunate to have you. Thank you to my mother Lisa, for being the kindest, most encouraging person that I know and to my father Seppo, who inspired me to become a psychologist, and for always believing in

me. Thank you also to my brother Matti, whom I have come to share a dedication for research with. I am so glad to have you as my brother and to know that we are always there for each other.

During these nine years, what I cherish most is becoming the mother of two wonderful children – Henry and Valter – and sharing my life with my favourite person in the world, Andreas. You are the love of my life and my best friend. I am so grateful for our family and the life we have together!

Emme-Lina Wirehag Nordh
Gothenburg, April 2023

Introduction

The presence of mental health problems in a family member is an experience many individuals and families share. The life-time prevalence of the most common mental disorders, anxiety and depressive disorders, is 28.8% and 20.8%, respectively (Kessler et al., 2005), and it has been estimated that over 300 million people worldwide are diagnosed with depressive disorders, and that almost as many suffer from anxiety disorders, with high comorbidity between these disorders (World Health Organization, 2017). Almost half of all life-time onsets of mental disorders have been estimated to have occurred before the age of 18 years, and at age 14.5 years, the number of onsets of mental disorders peaks (Solmi et al., 2022). Experiencing mental health problems during childhood increases the risk of also being diagnosed with a mental disorder in adulthood (Mulraney et al., 2021). As many as two out of five children aged 0–16 years in the general population have been estimated to experience parental mental health problems (Christesen et al., 2022). Many families also have a child experiencing mental health problems, as about one in eight of all children are estimated to experience severe mental health problems at any given time during childhood (Barican et al., 2022).

In the 21st century, there has been an increased focus, both globally and nationally, on mental health and mental health problems in the population (Dalman et al., 2021; World Health Organization, 2021). Mental health problems are major contributors to the global burden of diseases (Whiteford et al., 2013). Depression has been estimated to be the leading nonfatal cause of disability (World Health Organization, 2017) and was one of the ten conditions contributing to the largest increase in the global burden of diseases between 1990 and 2019 (Vos et al., 2020). There are indications that mental health problems among children and adolescents are increasing. Internationally, this has been documented, especially concerning self-reported emotional problems in adolescent girls (Bor et al., 2014), and in Sweden self-reported mental health problems among 11–15-year-old children have increased considerably, especially over the past 10 years (Dalman et al., 2021). Reports also indicate that the number of children and adolescents seeking help from mental health services is increasing (Collishaw, 2015; Dalman et al., 2021).

Mental health problems can take many forms, including mild to severe tran-

sient distress in reaction to different life circumstances, as well as mental disorders of different degrees of severity that usually require treatment from mental health services (Dalman et al., 2021). Actions promoting mental well-being in the population, preventing mental health problems in at-risk sub-groups, and providing treatment for mental disorders are all needed (National Board of Health and Welfare et al., 2020; Offord et al., 1998; World Health Organization, 2021). Research has an important task in investigating the number of individuals who are affected by mental health problems of various types and degrees of severity, which can provide information about the actions needed at different levels in the community and healthcare (Dalman et al., 2021) as well as about the timing of interventions and treatment (Mulraney et al., 2021).

There is a widely recognized tendency for mental health problems to run in families, and this is sometimes referred to as the intergenerational transmission of mental disorders (S. H. Goodman, 2020). Growing up with a parent with a mental disorder has been found to increase the child's risk of developing her/his own mental health problems (Leijdesdorff et al., 2017; Rasic et al., 2014; Weissman et al., 2016). The development of mental health problems can, however, not be explained or predicted by a single factor or life circumstance (Fried & Robinaugh, 2020), and it is generally accepted that multiple genetic, biological, and environmental factors (Kendler, 2012, 2019) from multiple contexts relating to the individual, family, community, and society interact in the development of mental health problems (Rutter & Sroufe, 2000).

The role of the family has been emphasized in many influential developmental theories as well as in theories of the development of mental health problems (Masten & Shaffer, 2006). Different aspects of the family can promote development or protect from negative influences, while other aspects can increase the risk of negative child development (Masten & Shaffer, 2006). The family has been described as a system or unit, in which family members are inevitably intertwined, and individuals cannot be fully understood without considering their family context (Cox & Paley, 1997). Interactions between family members are considered to be bidirectional, so influences can run both ways between children and parents (Cicchetti & Toth, 2007), and interactions between family members have the potential to influence both child development and adult adaptation (Cox & Paley, 1997).

Families experiencing mental health problems in a family member have been investigated with different starting points, either the child or the parent, although these two perspectives are of course interconnected and cannot always be separated. Research into the children of parents with mental health problems has focused on different questions in past decades, and the earliest studies in-

vestigated whether this group of children was at risk (Rutter, 1966). Research is currently examining how the now well-documented risk can be understood and counteracted (S. H. Goodman, 2020; Hosman et al., 2009; Lannes et al., 2021). Parents of children with mental health problems being treated in child-oriented clinical settings have received less attention in research, although knowledge about parents' mental health problems in such clinical settings is increasing (Campbell et al., 2021).

This thesis aims to improve our knowledge of the families of patients in contact with psychiatry. In this thesis, "psychiatry" will be used interchangeably with specialized mental health services or specialized psychiatric services, as they all refer to secondary healthcare, which is the focus here. Two groups of family members will be in focus: 8–17-year-old children of patients in contact with specialized adult psychiatric services, and parents of children aged 5–17 years referred to specialized child and adolescent mental health services (CAMHS).

In this thesis, "family" refers to the caretaking family, which can, but need not, be the biological family of the child (Weissman, 2016), and the focus is on both children and parents. "Parent(s)" refers to the caregiver(s) responsible for meeting the developmental needs of the child, acknowledging the many forms a family can have (Cowan & Cowan, 2006). "Child(ren)" refers to children and adolescents under 18 years of age (SFS 2018:1197).

In this introduction, I first describe commonly used concepts and terms relating to mental health problems, and the definitions used in this thesis. Next, I review what is known about the number of families that experience parent or child mental health problems, followed by research into associated difficulties experienced by family members. The theoretical perspective guiding this thesis is described next, leading to a review of important risk and protective factors that can influence how family members are affected. This is followed by a section on preventive interventions developed specifically for the children of parents with mental disorders. The introduction continues with a section on the role of healthcare in identifying, supporting, and involving family members. Finally, conclusions and the clinical implications of previous research are summarized, followed by a section addressing the Swedish context in terms of legislation and clinical practice.

Concepts and terms related to mental health problems

Many concepts and terms are used in research, clinical practice, and everyday language to refer to mental health and mental suffering. In research, conceptual

clarity and definitions of the terms used are essential to be able to draw correct conclusions and effectively communicate about research findings to other researchers and the community (National Board of Health and Welfare et al., 2020).

The term "mental health" is used in different ways internationally versus in Sweden. Internationally, the World Health Organization (WHO) has defined mental health as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well, and contribute to their community" (World Health Organization, 2022, Concepts in mental health section, para. 1). This definition clarifies that mental health is a concept or dimension that is linked to, but different from, mental health conditions, which is the term used for "mental disorders, psychosocial disabilities and (other) mental states associated with significant distress, impairment in functioning, or risk of self-harm" (World Health Organization, 2022, Concepts in mental health section, para. 3). The European Commission uses the same definition of mental health as the WHO, but uses the term "mental ill health" instead of "mental health conditions" (European Commission, 2005, p. 4). In Sweden, several governmental authorities have reviewed the terms used internationally and their translations into Swedish, and have decided to use "mental health" as an umbrella term including two dimensions: (1) mental wellbeing, defined according to the WHO definition of mental health; and (2) mental illness, including both mental distress and mental disorders (National Board of Health and Welfare et al., 2020). Mental illness is thus defined in the same way as are mental health conditions and mental ill health, as described above. "Mental distress" in the Swedish conceptual model includes mild to severe mental health problems, something that many people experience in reaction to stresses in everyday life, which are usually transient (National Board of Health and Welfare et al., 2020). "Mental disorders" refers to disorders diagnosable according to diagnostic manuals, such as the *International Classification of Diseases* (ICD) (World Health Organization, 2016) or the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (American Psychiatric Association, 2013).

There are many other terms related to mental disorders, and in the vocabulary used for indexing articles in the PubMed search engine for example, terms such as psychiatric illness, psychiatric disorder, psychiatric diagnosis, mental illness, and psychological disorder are included (National Library of Medicine, n.d.). When using psychological formulations to refer to a patient's problem, the term "mental health problems" has been suggested as preferred, to distinguish them from psychiatric diagnoses based on diagnostic manuals (Johnstone, 2018). "Mental health problems" has also been suggested, instead of "mental illness", as the overarching term in the Swedish conceptual model, and instead use "mental

illness" for transient mental disorders such as depression and anxiety, in contrast to the term "neurodevelopmental disorders" (Granlund et al., 2021).

In the field of research into families experiencing mental health problems, "mental illness" is a commonly used term, and the terms "children of parents with mental illness (COPMI)" (see, e.g., Reedtz, Lauritzen, et al., 2019) and "families where a parent has a mental illness (FAPMI)" are sometimes used (see, e.g., Goodyear et al., 2015). In contrast to the Swedish model, mental illness in this context usually refers to parents with a mental disorder diagnosed according to diagnostic manuals (see, e.g., Leijdesdorff et al., 2017). However, the term "mental illness" is used in varying ways, and includes different diagnoses in different studies, sometimes referring to any mental disorder (see, e.g., Abel et al., 2019), a few specified mental disorders (see, e.g., Siegenthaler et al., 2012), or a dimensional approach in which self-assessed symptoms over clinical cut-off levels indicate mental illness (see, e.g., Middeldorp et al., 2016).

In this thesis, I have chosen to use the term "mental health problems" as the umbrella term covering both mental distress and mental disorders. In the rest of the text, however, other terms might sometimes appear, when citing authors who deliberately chose a specific word or when authors have not clearly specified how they defined or measured the terms used.

Number of families experiencing mental health problems in a family member

The number of families experiencing mental health problems in a family member has been investigated using various research designs, and discrepancies in the estimates can be related to different study settings, to different family members in focus, and to how mental health problems were assessed or operationalized (Reupert & Maybery, 2016). In this section, I start by focusing on what is known about the number of families that experience parental mental health problems, followed by families experiencing children's mental health problems, and co-occurring mental health problems in these families.

Parental mental health problems

In the general population, investigations have found that 18.2% of parents from a representative sample in the United States met criteria for having had a mental disorder during the previous year, based on a structured clinical interview, and that 3.8% met criteria for a severe mental disorder (Stambaugh et al., 2017). The prevalence of mental disorders was higher among mothers than fathers (Stambaugh et al., 2017). A population-based study from Germany using self-reports

found that 19% of parents reported mental health problems above clinical cut-offs during the previous week (Plass-Christl, Haller, et al., 2017).

Among patients attending adult psychiatry, a systematic review found that 12%–45% of the patients had children under 18 years of age, with higher rates found in outpatient settings (Maybery & Reupert, 2018). Excluding two studies with the most extreme estimates, the remaining seven studies showed prevalence rates of 20%–39% (Maybery & Reupert, 2018). In the Nordic countries of Finland, Sweden, and Norway it has been estimated that approximately one third of the patients in adult psychiatry are parents with children under 18 years of age (Korhonen et al., 2010; Östman & Eidevall, 2005; Ruud et al., 2019).

Studies of the number of children in the general population who experience parental mental health problems have used various operationalizations of parental mental health problems and types of data, and have differed as to whether both mothers and fathers are included. Based on a combination of medical records and questionnaires, it has been estimated that 21%–23% of all children under 18 years of age in Australia has a parent with a mental disorder (substance abuse excluded) (Maybery et al., 2009). A study based on parental reports found that over one-third of 4–17-year-olds had a parent who reported ever having been diagnosed with a mental disorder (Johnson et al., 2018).

Using medical records, it has been estimated that 23% of children aged 0–16 years have a mother diagnosed with a mental disorder (Abel et al., 2019). The definition used by Abel et al. (2019) was that a diagnostic code was registered in the mother's primary care medical records, after the mother had received a diagnosis or displayed symptoms of mental disorder during a clinical consultation, or had been referred to psychiatric care services or had been prescribed medication for a mental disorder (Abel et al., 2019). Another study using medical records from Denmark found that 39% of children aged 0–16 years had at least one parent with minor, moderate, or severe mental health problems treated in primary or secondary care (Christesen et al., 2022). Minor mental health problems were most common (23%), which in this study included receiving medication or services from a general practitioner or private psychologist, but no formal diagnosis of a mental disorder. Moderate parental mental health problems were found for 14% of the children, and severe parental mental health problems for 2% (Christesen et al., 2022).

Estimates from Sweden have found that about one in ten children in the general child population experience severe parental mental disorders during childhood, defined as having a parent diagnosed in specialized psychiatric services (Pierce, Abel, et al., 2020). Another Swedish study has shown that about 8% of the general child population experience a parent being admitted to inpatient psychiatric care

due to mental disorders during childhood (Hjern & Manhika, 2013). The authors concluded that a much larger group of children in the general population would have been included if the children of parents in contact with psychiatric outpatient care and primary care had also been included (Hjern & Manhika, 2013).

Co-occurring mental health problems

Many families also experience having a child with mental health problems, as research indicates that about one in eight of all children in high-income countries are diagnosed with a mental disorder at any given time during childhood (Barican et al., 2022), with anxiety disorders (6.5%) and disruptive disorders (5.7%) being the most commonly diagnosed childhood disorders (Polanczyk et al., 2015). If mental distress in children and adolescents were also included, the numbers would increase considerably (Collishaw, 2015).

One line of research has investigated the prevalence of parental mental health problems when a child is in contact with CAMHS. This gives indications of how common co-occurring mental health problems are in both children and parents in this clinical setting. Prevalence rates of 16%–79% have been found in such studies, depending on the operationalization used, the sampling method, and how mental health problems are measured (Campbell et al., 2021). A study of self-assessed parental mental health problems found that 36% of mothers and 33% of fathers scored for subclinical symptoms, indicating elevated levels of mental health problems when their child was referred to CAMHS (Wesseldijk, Dieleman, van Steensel, Bartels, et al., 2018). Another study using self-reports found that internalizing symptoms in a clinical range were experienced by 32% of mothers and 26% of fathers, and externalizing symptoms by 15% of mothers and 17% of fathers (Bellina et al., 2020). When information from mental health professionals has been used, concerning whether mental disorders are present in parents, it has been reported that as many as 79% of parents of children in CAMHS either have had or currently are diagnosed with a mental disorder, usually a mood disorder (Naughton et al., 2018). A project in child psychiatry in Sweden made two one-day inventories in which mental health professionals reported the number of patients for whom they knew of mental health problems in another family member. In the inventory from 2021, 59% of the families had at least one more family member with mental health problems, usually the parent (80%) (Linderborg et al., 2022). When medical records from specialized CAMHS in Norway were investigated, only about 9% of children were registered as having a parent with a mental disorder (Heradstveit et al., 2021). These numbers indicate a considerable under-detection of parental mental disorders in CAMHS (Heradstveit et al., 2021), although it is possible that more cases are known to the mental health professionals than are registered in medical records.

Associations between mental health problems in family members as well as other related difficulties

Many associated difficulties have been investigated and reported for members of families in which a parent or child experiences mental health problems, and these are reviewed in the following sections. The parental diagnoses of depression, anxiety, and bipolar disorder will be paid special attention, as these parental diagnoses are in focus in two of the studies included in this thesis.

Children of parents with mental health problems

When listening to children's experiences of living with a parent with mental health problems, recurring themes in reviews of qualitative studies concern impact on everyday life, fear of stigma, worry for the parent, role-reversal in relation to the parent, and the child's own mental health problems (Beardslee et al., 2011; Dam & Hall, 2016; Reupert et al., 2021; Simpson-Adkins & Daiches, 2018; Yamamoto & Keogh, 2018). Themes of trying to make sense of what is happening to the parent and of lacking information about parental mental disorders have also emerged in children's own descriptions (Backer et al., 2017; Simpson-Adkins & Daiches, 2018; Tabak et al., 2016).

Mental disorders

In quantitative research, associations between parental mental disorders and mental disorders in the children are now well-documented from studies using different designs, child ages, and parental diagnoses (see, e.g., Ahmadzadeh et al., 2019; Beck, 1999; Davidsen et al., 2022; S. H. Goodman et al., 2011; Paananen et al., 2021; Wickersham et al., 2020). Associations are found between disorders in both mothers and fathers and in their children (Connell & Goodman, 2002; S. H. Goodman et al., 2011; Kane & Garber, 2004; Sweeney & MacBeth, 2016; Wickersham et al., 2020).

Much research has documented that children of parents with mental disorders have a higher risk of developing mental disorders than do children whose parents do not have a mental disorder (Paananen et al., 2021; Rasic et al., 2014). The incidence of major depression has been found to be three times higher in children of parents with depression (Weissman et al., 2016). Children who have at least one parent with a bipolar disorder have an increased risk of developing both affective and non-affective mental disorders, with estimates showing that they are nine times more likely to be diagnosed with bipolar disorder, two and a half times more likely to develop other mood disorders, and two times more likely to develop an anxiety disorder (Lau, Hawes, Hunt, Frankland, Roberts, &

Mitchell, 2018). Children of parents with anxiety disorders have a significantly increased risk of developing anxiety and depressive disorders (Lawrence et al., 2019). Children of parents with severe mental disorders, including schizophrenia, major depressive disorder, bipolar disorder and severe borderline personality disorder, have been found to have a 50% risk of developing any mental disorder by adulthood (>20 years) and 32% risk of developing a severe mental disorder (Rasic et al., 2014). A prospective cohort study of the incidence of mood and/or anxiety disorders in children of parents with depression and anxiety disorders found a cumulative incidence of 38% by the age of 20 years and 65% by the age of 35 (Havinga et al., 2017).

Findings of both high-risk family studies and population-based registry studies indicate that parental mental disorders increase the children's risk of developing any mental disorder, not only the same disorder as their parent. Severe parental mental disorders have been associated with all types of mental disorders in children (Dean et al., 2010; Paananen et al., 2021), and experiencing parental mental disorders during childhood has been associated with all types of mental disorders in adulthood (McLaughlin et al., 2012). A review of the specificity of depression, anxiety, and bipolar disorder, however, found that children of parents with anxiety disorders mainly showed an increased risk of developing anxiety disorders, while children of parents with depression and bipolar disorder had an increased risk of a broad range of diagnoses, as well as the same disorder as their parent (van Santvoort et al., 2015).

Experiencing parental mental disorders has also been associated with the course of mental disorders in children. Children of parents diagnosed with depression have ten times the risk of developing depression before puberty, compared with children whose parents did not experience depression, although the overall risk was low (Weissman et al., 2016). In high-risk children, the onset of depression is generally earlier, the duration of the disorder is longer, and the depression is associated with greater impairment (S. H. Goodman, 2007). Moreover, an increased risk of a chronic and recurrent course of depression has also been found in children who have a parent diagnosed with depression (Weissman et al., 2016).

Mental distress

Furthermore, well before a potential mental disorder has emerged, it is important to be aware of other difficulties these children might display during childhood. Higher levels of internalizing, externalizing, and general psychopathology have been found in children of parents with depression (Ahun et al., 2018; Ashman et al., 2008; S. H. Goodman et al., 2011). Children of parents with bipolar disorder

have been found to have significantly higher ratings for mental health problems compared with children from families without parental mental disorder (Diler et al., 2011; Lau, Hawes, Hunt, Frankland, Roberts, & Mitchell, 2018).

Increased levels of mental health problems have also been reported in children of parents in contact with health or welfare services because of mental disorders. Studies based on parental reports indicate that 39%– 50% of such children have clinical or subclinical levels of symptoms (Maybery et al., 2010; Sell, Barkmann, et al., 2021; Wiegand-Grefe et al., 2019). Children of patients who previously required or currently require inpatient care reportedly have increased levels of mental health problems compared with children in the same age groups in the general population, and 25%–50% reportedly have mental health problems in a clinical range (B. Larsson & Sundelin, 2000; Mathai et al., 2010). Longitudinal research has emphasized the importance of identifying and supporting children of parents with mental disorders, especially children who display sub-clinical symptoms, as such symptoms have been found to be strongly associated with the later onset of mental disorders (Mulraney et al., 2021).

Other associated difficulties

Several other difficulties have been documented in children with parents experiencing mental health problems, demonstrating the potentially vulnerable situation of these children. Children of parents with mental health problems have, for example, been found to use a wide range of healthcare (Plass-Christl, Klasen, et al., 2017; Waldmann et al., 2021), school-based and welfare services, without necessarily having been diagnosed with a mental disorder (Waldmann et al., 2021). About one in three children of parents in contact with outpatient psychiatry units have been found to be referred to other services, although estimates are uncertain because not all children are registered in their parents' medical records (Ruud et al., 2019). Of the referred children, 45% were referred to child protection agencies, 39% to CAMHS, and 35% to school-based services (Ruud et al., 2019). Children of parents in contact with healthcare because of mental or physical disorders have been found to take on domestic activities in the home to a greater extent than do samples from general populations, and emotional caring activities for the ill parent have been reported by 60% of these children (Kallander et al., 2018). Parental mental disorders have furthermore been found to increase the risk of child neglect (Mulder et al., 2018). Moreover, an increased risk of negative impact on physical health during childhood has been found, for example, increased risk of asthma and injuries (Pierce, Hope, et al., 2020) as well as increased later risk of cardiovascular and neuromuscular diseases (Weissman et al., 2006, 2016). Children's social (Ashman et al., 2008;

B. Larsson & Sundelin, 2000) and academic functioning has been found to be negatively affected (Bell et al., 2019; Bortes et al., 2020; Brophy et al., 2021; Shen et al., 2016), and in early adulthood, children of parents with mental disorders have increased risk of work disability due to their own mental health problems (Halonen et al., 2018).

Parents of children with mental health problems

Qualitative research has found that when parents of children with mental health problems describe their situations, feelings of guilt, helplessness and self-blame as well as personal distress are common (Crowe et al., 2011; McKeague et al., 2022; Shpigner et al., 2013). Furthermore, they describe a diminished sense of being good parents due to stigma and social isolation (Eaton et al., 2016) and parenting is described as challenged by increased demands because of the child's mental disorder (Rodríguez-Meirinhos et al., 2018; Shenaar et al., 2021).

Mental health problems

Associated problems and difficulties in the parents of children with mental health problems can be regarded as implying that children are responsible for or to blame for difficulties in their parents. Before reviewing associated problems in parents, I want to underscore that the parents are the ones responsible for the parent–child relationship. However, children and parents do influence each other through ongoing interactions, so investigating associated difficulties for parents when their child has mental health problems improves our knowledge of the situation and needs of these families.

Associations have been found between various mental disorders in children and parents' mental health problems (Gerkensmeyer et al., 2011), as well as between specific mental health problems in children, such as behavioural problems or disruptive behaviour (Civic & Holt, 2000; Gross et al., 2008; Harrison & Sofronoff, 2002), ADHD (Harrison & Sofronoff, 2002), developmental disorders (Karaivazoglou et al., 2019), bipolar disorder (Steele et al., 2010) and parental mental health problems, usually depressive symptoms. Associations between children's mental health problems and parents' mental health problems have been found for both mothers and fathers (Xerxa et al., 2021).

When associations between children's and parents' mental health problems have been studied longitudinally in general populations, it has been found that parents of children displaying increased initial mental health problems had an increased risk of developing mental health problems three years later. The risk of developing mental health problems in parents was greatest for parents whose children developed mental disorders during the same time period (K. Wilkinson

et al., 2021). Another longitudinal study has found that childhood mental health problems at 5 years of age, as well as child behaviour problems at 14 years of age, predicted mental health impairment in mothers 21 years after birth (Kingsbury et al., 2017). Early disruptive behaviours in children have also been found to predict more chronic and elevated levels of symptoms in mothers diagnosed with depression (Gross et al., 2009).

When the relative effects of either parent-to-child effects or child-to-parent effects have been compared, using a large population-based sample, the magnitudes of the associations were larger for parent-to-child associations (Xerxa et al., 2021).

In samples of clinically referred children, many parents have been found to have their own mental health problems (Campbell et al., 2021). Co-occurring parental mental health problems have been associated with more children's symptoms (Heradstveit et al., 2021; Rishel, Greeno, Marcus, & Anderson, 2006; Wesseldijk, Dieleman, van Steensel, Bleijenberg, et al., 2018), more child impairment (Rishel, Greeno, Marcus, Sales, et al., 2006), and a greater risk of child comorbid diagnoses (Heradstveit et al., 2021) than in children in CAMHS who have not experienced parental mental health problems.

Other associated difficulties

It has furthermore been documented that parents of children with mental disorders have higher levels of parenting stress, conceptualized as a negative psychological response relating to parenthood, than do parents in community settings (Barroso et al., 2018; Theule et al., 2013; van Steijn et al., 2014). Caregiver strain is a related concept, referring to additional demands on parents in certain circumstances, which has been found to be increased in parents caring for children with mental disorders (Brannan & Heflinger, 2006; Meltzer et al., 2011). Furthermore, children's mental health problems have been associated with decreased marital quality, social life, and parenting self-efficacy, reflecting how parents think about their ability to influence their children (Gross et al., 2008).

Mental health problems from a developmental psychopathological perspective

The theoretical perspective applied has consequences for choices concerning research methods and data analysis (Kazdin, 2022). The research methods chosen in the studies included in this thesis have been guided by a developmental psychopathological perspective, which describes developmental pathways and developmental processes involved in the onset of mental health problems from

a life-span perspective (Cicchetti & Toth, 2007; Cummings et al., 2000; M. Lewis, 2014). This perspective is commonly described as a macro-paradigm, integrating knowledge from multiple scientific disciplines and guided by a set of principles and assumptions about the nature of human development (Cummings et al., 2000). Much attention within this perspective has been paid to the first decades of life (Cummings et al., 2000), and the study of children at risk of developing mental health problems has been an important area of research, with developmental psychopathologists being equally interested in children at risk who develop difficulties and those who do not, and in why others under seemingly optimal conditions do develop difficulties (Cowan & Cowan, 2006).

A developmental psychopathological perspective is guided by systems theory, which emphasizes that development is the result of reciprocal interactions and coactions between multiple levels of a system (Masten et al., 2021). From a developmental psychopathological perspective, developmental pathways towards adaptation and maladaptation are described as emerging over time as a result of the "ongoing interplay between an active, changing organism in a dynamic, changing context" (Cummings et al., 2000, p. 24). This underscores that individuals are not passive recipients in these interactions, but instead have a role in shaping their own development, as their actions also influence the contexts surrounding them, which in turn influence the individuals (Cummings et al., 2000).

Child development is embedded within the family system, which in turn is embedded in the community and society (Masten & Shaffer, 2006). Each of these contexts includes several levels or sub-contexts, for example, the individual context includes levels relating to biology, affect, and cognition. The contexts surrounding an individual can be distal or proximal, with the family being the most proximal context, and also the most enduring in a child's life (Luthar et al., 2015). The family includes several levels or sub-systems relating to the parent–child relationship, the marital sub-system, and sibling relationships.

The family can usefully be considered a whole or unit in which all family members are interconnected and influence one another (Davies & Cicchetti, 2004; Masten & Monn, 2015). Family systems theory is guided by systems theory principles, as is the developmental psychopathological perspective, emphasizing a transactional interaction between individual and context (Davies & Cicchetti, 2004). It has been argued that family systems theory can contribute to developmental psychopathological models concerning the influences families have on individual development (Cummings et al., 2000; Davies & Cicchetti, 2004; Masten & Monn, 2015).

Risk and protective factors

Within the developmental psychopathological perspective, risk and protective factors are concepts used to describe circumstances that could influence development, directing it along different pathways (Cicchetti, 2006; Rutter & Sroufe, 2000). The term "risk factor" refers to "a characteristic, experience or event associated with an increase in the probability (risk) of a particular outcome over the base rate of the outcome in the general (unexposed) population" (Kazdin et al., 1997, p. 377). Risk factors exist in different contexts and at different levels within a context, and risk factors in the individual context could be, for example, genetic, biochemical, and cognitive (Kazdin et al., 1997; Kraemer et al., 1997). A risk factor says something about the probability for a group, but cannot identify which individual will develop difficulties (Reuben & Shaw, 2015). Furthermore, distal risk factors are believed to have a more indirect effect on outcomes and proximal factors a more direct effect (Bendersky & Lewis, 1994; Nolen-Hoeksema & Watkins, 2011). Families can influence children either directly, or indirectly, by influencing some other factor, which in turn influences the child (Masten & Shaffer, 2006). Even though a certain risk factor may have been shown to predict a certain outcome, this factor often can only explain a small part of the variance in child outcomes (Cummings & Valentino, 2015; S. H. Goodman, 2020).

Research into risk factors has pointed to the cumulative effects of experiencing multiple risk factors on child development (Appleyard et al., 2005). Experiencing multiple risk factors has been found to have a dose–response effect, as with more risk factors present, the likelihood of negative outcomes increases (G. W. Evans et al., 2013), and exposure to multiple risk factors has been associated with more difficulties for the child (Appleyard et al., 2005; Hosman et al., 2009; Wille et al., 2008). Cumulative risk models have been powerful in predicting outcomes, but do not specifically investigate the processes or effects of specific risk factors (G. W. Evans et al., 2013; Masten, 2018). Furthermore, findings indicate that there are no dominant factors that can predict, for example, depression or anxiety; instead, the cumulative effects of different factors are more influential (Hyland et al., 2016).

Protective factors are conditions that decrease the likelihood of undesirable outcomes (Kazdin et al., 1997), especially when adversity is high (Masten, 2018). Protective factors reduce the risk, although they may not have as strong an effect when many risk factors are present (Reuben & Shaw, 2015). Protective factors can also be protective for specific aspects of functioning, but not for other aspects, and the same also holds true for risk factors (Reuben & Shaw, 2015). Promotive factors, in contrast to protective factors, are resources that are more generally associated with positive outcomes regardless of the risk lev-

els (Masten, 2018), and they usually represent the positive end of a risk factor (Sameroff, 2020). Sometimes, however, the term "protective factor" is used to refer to all factors associated with positive outcomes (Reuben & Shaw, 2015). Factors promoting positive adaptation or that protect children exposed to risk improve our knowledge of factors that are important to strengthen to support child development (Masten, 2018; Masten et al., 2021). Some of these variables are malleable, which indicates that they can be targeted in interventions, and some are more static, which instead can guide an understanding of how to tailor interventions (Masten, 2018).

The concept of resilience captures the recognition that there is great variation in people's responses to the same experiences (Rutter, 2006), and that individuals exposed to risk can adapt successfully (Masten, 2018). The complex interaction between risk and protective factors over time influences child development, and multiple factors are likely to act in summative or interacting ways (S. H. Goodman, 2020). Thus, from a developmental psychopathological perspective, multiple levels within and from different contexts over time are worth investigating and analysing to be able to understand developmental processes and individual pathways (Cicchetti & Toth, 2007; Cummings & Valentino, 2015).

Factors influencing the association between mental health problems in family members

Multiple risk and protective factors could influence the association between parents' and children's mental health problems. Far from all children of parents with mental disorders develop their own difficulties, and knowledge of the factors moderating the association advances our understanding of when these children are at risk, whereas knowledge of mediating factors advances our understanding of how and why these children are at risk (S. H. Goodman, 2020; Luthar et al., 2015). This knowledge has implications for who to target with interventions and what the interventions should involve (Masten et al., 2021). I will now give an overview of important risk factors that have been found to increase the risk for children of parents with mental disorders, and for parents of children with mental disorders, with priority given to factors investigated in the constituent studies of this thesis.

Children of parents with mental health problems

Models inspired by a developmental psychopathological perspective have summarized important risk and protective factors and possible mechanisms or processes that could influence child development when a parent has a mental disorder

(S. H. Goodman & Gotlib, 1999; Hosman et al., 2009). The developmental model of the transgenerational transmission of psychopathology (Hosman et al., 2009) summarizes factors from different contexts relating to the child, parent, family, and community as well as five underlying processes involved in the transmission of psychopathology. These underlying processes are genetic vulnerability, prenatal influences, parent–child interactions, family processes and conditions, as well as social influences from outside the family. Inspired by this model, I will now review risk factors from these different contexts, as well as research into possible underlying processes that could explain the association between parents' mental disorders and children's mental health problems.

Factors related to the mental disorder or parent characteristics

Mental disorders vary considerably depending on the diagnosis, course of the disorder, and comorbidity, and the manifestations of a specific mental disorder can also vary between individuals (Cummings et al., 2000; S. H. Goodman, 2020). Certain characteristics of parental mental disorders have been found to increase the risk of children developing their own problems (Hosman et al., 2009). The severity of the parent's symptoms and the recurrent or chronic course of the disorder have been associated with an increased risk for the child (Ashman et al., 2008; Brophy et al., 2021; Gross et al., 2009; Hammen & Brennan, 2003; Mars et al., 2012), and some studies indicate that parent comorbidity also increases the risk of the child developing her/his own difficulties (Hosman et al., 2009; Johnson et al., 2018).

When the effect of current and past parental depression has been investigated, findings indicate that both influence the child's symptoms (Mars et al., 2012), although current parent depressive symptoms seem to influence the child's current functioning to a greater extent (O'Connor et al., 2017). More severe past depressive symptoms in mothers have been found to predict more current depressive symptoms in children, as well as more negative parent–child interactions (C. J. E. Foster et al., 2008). Treatment of parental mental disorders has been associated with improvements in children's symptoms and functioning (Cuijpers et al., 2015; Garber et al., 2011; Pilowsky et al., 2008), but studies also indicate continued behavioural problems in children even after parental recovery (S. H. Goodman & Gotlib, 1999).

Earlier onset of parental mental disorder has been found to increase the risk of their children developing mental health problems, which could be due to genetic factors or to social effects associated with earlier onset, for example, not being able to complete an education (Hosman et al., 2009). Furthermore, the likelihood of recurrent episodes of mental disorders increases with earlier disorder onset (Kessler et al., 2007).

The gender of the affected parent has been investigated as a possible factor influencing child outcomes. Meta-analyses have found some indications of small differences depending on parental gender, with children's internalizing problems being more strongly related to mental health problems in mothers than fathers, while no difference has been found for externalizing problems (Connell & Goodman, 2002). A more recent systematic review of adolescent depression and anxiety concluded, however, that maternal and paternal mental health problems were equally associated with such difficulties (Wickersham et al., 2020).

Factors related to child characteristics

Several factors relating to child characteristics have been investigated to understand which children are at increased risk of developing their own difficulties. Child age and gender have been investigated as possible moderators. It has been suggested that exposure to mental disorders during the child's earliest stages of life, including pregnancy, has the largest impact on child outcomes (S. H. Goodman et al., 2011; S. H. Goodman & Gotlib, 1999; Hosman et al., 2009). A stronger effect of maternal depression has been found at younger child ages, although the relative effect of the timing of exposure at different ages is not yet clear, as studies have reported varying results (S. H. Goodman, 2020).

Some studies indicate that child gender influences the association between parental depression and child outcomes (Reuben & Shaw, 2015), as, for example, stronger associations between maternal depression and internalizing problems have been found in girls than boys (S. H. Goodman et al., 2011). However, longitudinal studies have not found evidence of children being affected differently depending on their gender (Paananen et al., 2021). There is also a possibility that different parental diagnoses may affect children differently depending on child gender (Paananen et al., 2021).

Other child characteristics relating to temperament (e.g. high activity level or negative affectivity) and poor cognitive and social skills have been found to increase the risk for children (Hosman et al., 2009). Such characteristics may predispose children to be more or less affected and they could be a result of exposure to parental mental disorder or exist independently of such exposure (Reupert & Maybery, 2016). Characteristics such as higher self-efficacy beliefs (Collishaw et al., 2016) and self-understanding (Beardslee, 1989) have been associated with resilience in children.

Genetic and prenatal influences

Genetic factors are involved in the transmission of mental disorders between generations. The heritability of mental disorders has been documented in family

and twin studies (Leijdesdorff et al., 2017; Pettersson et al., 2019; Rasic et al., 2014) as well as genetic studies (Giangrande et al., 2022; Pettersson et al., 2019). Mental disorders have been found to have common genetic risk factors (Doherty & Owen, 2014; Giangrande et al., 2022); although no specific single genes have been found to contribute to the onset of particular disorders, multiple genes, each contributing a small amount of risk, are likely to be involved (Baselmans et al., 2021; Giangrande et al., 2022). The role of the environment in gene expression has been increasingly studied, and knowledge of the role of epigenetic processes is increasing (S. H. Goodman, 2020; Guintivano & Kaminsky, 2016).

Varying levels of genetic heritability have been found for different mental disorders. High levels of inherited risk have been found for ADHD, autism, schizophrenia, and bipolar disorder, while depression and anxiety disorders generally have low genetic heritability (Guintivano & Kaminsky, 2016; Pettersson et al., 2019; Sullivan et al., 2012). The heritability of schizophrenia and bipolar disorder has been estimated to be 60%–80% (Cardno & Owen, 2014) and of depression to be 31%–42%, which highlights the need also to understand other factors influencing the development of mental disorders (Sullivan et al., 2000).

Prenatal exposure to elevated levels of depression, anxiety, and stress has furthermore been linked to impaired foetal and infant development, which in turn has been associated with increased risk of later mental health problems in children (Glover et al., 2018; Koss & Gunnar, 2018; Monk et al., 2019).

Parent–child relationship

To understand how parental mental disorders might influence child development, much research has focused on the parent–child relationship and parenting, as these factors have a profound impact on child development (S. H. Goodman, 2020; Stewart-Brown & Schrader-McMillan, 2011) and as parental mental health problems can negatively affect parenting (S. H. Goodman & Gotlib, 1999; Hosman et al., 2009; Leinonen et al., 2003). Impaired parenting has been found to influence child functioning (Priel et al., 2020) and the development of children's mental health problems (McLeod et al., 2007; Natsuaki et al., 2014). Evidence suggest that different aspects of parenting are possible mediating factors between parents' and children's mental health problems (Elgar et al., 2007; Everett et al., 2021; Stein & Harold, 2015).

Parenting is believed to be influenced by multiple factors, including parent characteristics, child characteristics, and factors from the surrounding social environment (Bornstein et al., 2018), and different developmental phases of the child can pose specific challenges for parenting (Oyserman et al., 2000). Parenting can also have different influences on child development in different phases, with

younger children requiring more direct adult supervision, while other aspects of parenting might be more important in older children (Reuben & Shaw, 2015).

Characteristics relating to the type, severity, frequency, and duration of the mental disorder determine how parenting is affected (Hosman et al., 2009). Most is known about depression and parenting. Specific symptoms of depression, such as anhedonia, sleeplessness, and feelings of hopelessness and helplessness, may impair parenting (Cicchetti & Toth, 2007). It has furthermore been suggested that depressive symptoms can negatively influence parents' appraisals of both their children and their own competence as parents. Such appraisals may in turn influence parental behaviour (Dix & Meunier, 2009). With more symptoms of their own, the demands and difficult behaviours of children may arouse more distress in parents and affect interactions between parent and child (Dix & Meunier, 2009). Parental cognitions, for example, rumination or preoccupation, might also impair parental responsiveness and emotional availability, in turn influencing the parent–child interaction (Reupert & Maybery, 2016).

Parenting can be understood as encompassing parental cognitions and practices, and cognitions are generally believed to influence parenting practices (Bornstein et al., 2018). One type of cognition is parents' perceptions of how they manage different parenting situations, commonly referred to as parent self-efficacy beliefs (de Montigny & Lacharité, 2005). Depression has been found to be related to parents' more negative cognitions of themselves as parents and of their control over child development (S. H. Goodman et al., 2011) and also to low parental self-efficacy beliefs (Albanese et al., 2019; Fang et al., 2021). Low self-efficacy beliefs have in turn been liked to children's mental health problems (Albanese et al., 2019) and self-efficacy beliefs have the potential to influence parental behaviour (de Montigny & Lacharité, 2005). Parenting behaviours or practices can be conceptualized in many ways, but most can be encompassed in the two broad domains of positive and negative practices (Taraban & Shaw, 2018). Positive parenting practices include aspects of sensitivity, warmth, monitoring, and limit setting, and negative practices include aspects of inconsistent, controlling, over-reactive, and harsh parenting (Taraban & Shaw, 2018). Parenting practices that are low in positive and high in negative aspects are associated with worse child outcomes (Taraban & Shaw, 2018). Depressive symptoms have been associated with negative parenting behaviours in both mothers (Lovejoy et al., 2000; Oyserman et al., 2000) and fathers (Wilson & Durbin, 2010). Parental monitoring and support have been found to be predictors of positive child development, and parental monitoring can be negatively affected by parental mental disorders (van Loon et al., 2014, 2015). Great variability has, however, been observed among parents (Lovejoy et al., 2000), and many parents with

mental disorders can parent well, while others might need support in their parenting role (K. Foster et al., 2012). Parenting cognitions and practices have been found to be modifiable factors (Bornstein et al., 2018; S. H. Goodman & Garber, 2017), which underscores the possibility of addressing parenting and parenting cognitions in interventions aiming to support families experiencing parental mental disorders.

Family processes and conditions

It is not only the parent–child interaction that can be affected when a parent experiences mental health problems; rather, the relationship with the other parent and siblings and the functioning of the whole family can also be affected (van Loon et al., 2014). Furthermore, processes and conditions found in families with parental mental disorders could be both the consequences of mental health problems and their risk factors, which could influence both parental mental health problems and child development (S. H. Goodman, 2020; S. H. Goodman & Gotlib, 1999; Hosman et al., 2009). As described above, a greater number of risk factors experienced by the child is associated with a greater risk of mental health problems (Appleyard et al., 2005; Rutter & Quinton, 1984). The existence of additional stressors in the family context can increase the association between maternal depression and children's mental health problems (S. H. Goodman, 2020). Many factors relating to the family context have been investigated, and mixed results have been found concerning whether family context variables mediate the association between parents' mental health problems and children's mental health problems (Ashman et al., 2008; Lau, Hawes, Hunt, Frankland, Roberts, Wright, et al., 2018; van Loon et al., 2014).

Family functioning usually refers to the dynamics and collective functioning of the whole family and to the ability to satisfy the needs of the family members (Ryan et al., 2005; Sell, Radicke, et al., 2021). Reduced family functioning is reported in many families experiencing various parental mental disorders (Daches et al., 2018; Ryan et al., 2005; Sell, Barkmann, et al., 2021; van Loon et al., 2014). Higher levels of family dysfunction have in turn been associated with higher levels of mental health problems in children (Daches et al., 2018; Sell, Barkmann, et al., 2021; Wiegand-Grefe et al., 2019).

Marital interactions have been found to be related to parental mental health problems, and conflicts and negative interactions between parents are common in families experiencing parental mental health problems (S. H. Goodman & Gotlib, 1999). Interparental conflict and the general quality of the interparental relationship have been found to predict child adjustment problems, both current and over time (Harold & Sellers, 2018; van Eldik et al., 2020). Conflicts between

parents can influence children directly, but also indirectly by affecting the parent–child relationship and parenting (Harold & Sellers, 2018). Several studies have documented that marital conflict mediates the associations between parents' mental health problems and children's mental health problems, as marital discord was more strongly related to child outcomes than parent mental health problems was (S. H. Goodman & Gotlib, 1999; Hosman et al., 2009).

Increased caring activities have been reported in about one third of children of parents with mental disorders; these activities include supporting parents and family through practical chores such as cleaning, as well as providing emotional or personal support (Kallander et al., 2018). It has been suggested that taking over the parenting role, or parentification, is a risk factor found to be associated with both internalizing and externalizing problems in this group of children, and longitudinal analyses have shown that parentification predicts later internalizing problems (van Loon et al., 2017).

Communication in families is a narrow aspect of family functioning, and open communication in families, for example, children's self-disclosure, has been associated with fewer child mental health problems (van Loon et al., 2015). In families experiencing parental mental disorders, parental communications concerning mental health problems have been found to be mostly implicit, contradictory, and limited (Mueller et al., 2016), and children of parents with mental disorders have limited access to accurate information on mental disorders not influenced by stigma (Grove et al., 2017; Riebschleger et al., 2017). Qualitative studies have shown that children want information about their parents' mental disorders (B. M. Gladstone et al., 2011; Wahl et al., 2017), whereas adults have instead expressed wanting to protect children by not discussing mental health problems with them (Cudjoe & Chiu, 2020; B. M. Gladstone et al., 2011; Yamamoto & Keogh, 2018). Not having adequate understanding can, however, lead to confusion, mixed emotions and isolation (Cudjoe & Chiu, 2020).

The role of co-parents has been studied as a possible moderator of the association between parents' and children's mental health problems. A co-parent can support and increase resilience in children (Collishaw et al., 2016; S. H. Goodman & Gotlib, 1999) and, for example, make sure that children do not take on too much caring responsibility (van Loon et al., 2017). On the other hand, the risk for the child is increased considerably if both parents have a mental disorder (Brennan et al., 2002; Dean et al., 2010; Gottesman et al., 2010; Havinga et al., 2017; Kahn et al., 2004; G. Lewis et al., 2017; McLaughlin et al., 2012; Paananen et al., 2021).

The association between maternal depression and children's mental health problems has been shown to be stronger in samples of families in poverty (S. H.

Goodman et al., 2011). Socioeconomic circumstances have been found to moderate the association at two levels, either the direct association between parents' and children's mental health problems, or the association between parental mental health problems and parenting, as parenting has been found to be moderated by socioeconomic status (Stein et al., 2014). Socioeconomic disadvantage has, for example, been linked to harsh and withdrawn parenting (Vreeland et al., 2019). Socioeconomic disadvantage is common in families in which a parent has severe mental health problems (Pierce et al., 2020), and low socioeconomic status is a general risk factor for children's mental health problems (F. Reiss, 2013; Stein et al., 2014; Wille et al., 2008). Another family condition which has the potential to increase the risk of child mental health problems is growing up in a single-parent household (Stein et al., 2014; Wille et al., 2008), which has been associated with, for example, stronger associations between maternal depression and externalizing problems in children (S. H. Goodman et al., 2011).

Social influences from outside the family

The surrounding community can be a protective factor or a risk factor, depending on the opportunities for support from friends and extended family, as well as from school and mental healthcare (Hosman et al., 2009; Reupert & Maybery, 2016). It has been suggested that social support may reduce the impact of family dysfunction on children's mental health problems (Daches et al., 2018). Good quality social relationships have been found to be associated with sustained good mental health in children at risk of developing mental health problems (Collishaw et al., 2016).

Stigma associated with mental disorders is an issue found to affect both parents and children in families with parental mental disorder (Reupert et al., 2021). Stigma is considered to be a social process that evolves through interactions between individuals and between individuals and social structures (Reupert et al., 2021). A common response in families subjected to stigma is not to reveal difficulties to others, which can negatively influence help-seeking in these families (Reupert et al., 2021).

Parents of children with mental health problems

Knowledge of factors influencing the associations between child and parental mental health problems in families in which children have mental health problems advances our understanding of factors important to consider when supporting these families. More severe symptoms in the child have, for example, been associated with more parent mental health problems (Gross et al., 2008; Heradstveit et al., 2021). An aspect to take into consideration is that the level of a parent's

mental health problems may be influenced by when the parent is assessed, in relation to the course of the child's difficulties, i.e., in acute phases or in recovery (Steele et al., 2010). Biological and non-biological caregivers have different levels of shared genes, and biological caregivers have been found to have an increased risk of mental disorder compared with non-biological parents when their child is diagnosed with depression (Steele et al., 2010). Improvement of child depression through treatment has been found to be positively associated with improvement of parental mental health problems (P. O. Wilkinson et al., 2013), and improved child behaviour problems have been associated with decreased symptoms of depression in mothers (Gross et al., 2008).

Two related factors, parenting stress and caregiver strain, have attracted considerable attention in families experiencing child mental health problems. Characteristics of child mental disorders have been found to relate to the level of stress and burden in parents; for example, more severe child problems have been associated with more parental stress (Harrison & Sofronoff, 2002), which in turn has been associated with parental mental health problems (Shenaar et al., 2021). Co-occurring mental health problems in parents and children have also been associated with increased parenting stress (van Steijn et al., 2014). Stronger associations have been found between stress in the parents of children with externalizing rather than internalizing problems (Barroso et al., 2018). Differences in parenting stress between parents of children with different diagnoses have been investigated, and the results indicate higher levels of stress in the parents of children with autism and developmental delays, compared with other mental disorders (Barroso et al., 2018; S. A. Hayes & Watson, 2013). Stress in parents caring for a child with a mental disorder is strongly related to caregiver strain (Wingrove & Rickwood, 2019). More child problems have been found to be associated with more caregiver strain, as well as with more negative perceptions in caregivers (Green et al., 2020).

As in families experiencing parental mental health problems, several other adverse life circumstances have been reported in families experiencing child mental disorder, such as unemployment, financial difficulties, somatic illnesses, and poor or minimal support, factors that have the potential to negatively influence both parent and child (Campbell et al., 2021).

Preventive interventions

As children of parents with mental disorders are a subgroup of children identified as at increased risk of developing mental health problems, several preventive interventions have been developed for these children (Reupert et al., 2022; Than-

häuser et al., 2017), aiming to reduce the incidence, prevalence, and recurrence of mental disorders (Arango et al., 2018).

Preventive interventions are of three different types, depending on who the interventions target. Universal preventive interventions target the general population, whereas selective preventive interventions target a subgroup of individuals at higher risk of developing mental disorders, but who do not yet show symptoms (Haggerty & Mrazek, 1994; Muñoz et al., 1996). Indicated preventive interventions target individuals at increased risk who already show some signs or symptoms of mental disorder (Haggerty & Mrazek, 1994; Muñoz et al., 1996). The preventive interventions developed for children of parents with mental disorders are primarily selective preventive interventions, based on knowledge of factors influencing development and factors possible to address and modify through psychosocial interventions (S. H. Goodman, 2020; Masten & Cicchetti, 2010). The developed interventions vary in approach, components, settings they are used in, format, length, and who they target (Reupert et al., 2013; Siegenthaler et al., 2012; Tapias et al., 2021). Some interventions are used for children of parents with specific disorders, while others group children by age rather than by parental mental disorder (Reupert et al., 2013). Based on who the intervention targets, three main types of preventive interventions have been developed for this group of children (Reupert & Maybery, 2016). The first is peer-support programmes, targeting children with similar experiences in a group format. A second type target parents only, to indirectly support children by providing parents with information, skills, and support. There are also interventions targeting the whole family, either in a multifamily group format or individual family format (Reupert & Maybery, 2016).

Effect of preventive interventions

About 15 years ago the evidence base concerning the effects of preventive interventions for children of parents with mental disorders was limited (Fraser et al., 2006). The number of intervention trials has increased over the past decade, and today several meta-analyses contribute to our overall knowledge of the effects of preventive interventions (Havinga et al., 2021; Lannes et al., 2021; Loechner et al., 2018; Siegenthaler et al., 2012; Thanhäuser et al., 2017). The outcome measures in focus in all these analyses have been child mental health problems and/or incidences of mental disorders, although they differ concerning which parental diagnoses have been in focus and whether the analyses were conducted separately for children of different ages. All meta-analyses have included various types of preventive interventions.

In a recently published meta-analysis, Lannes et al. (2021) included 17

trials of preventive interventions for 0–18-years-old children of parents with different mental disorders, finding a significant effect of preventive intervention on the children's incidence of any mental disorder, with risk being reduced by almost 50%. A small significant effect was found on internalizing symptoms, and a decreasing slope was observed for externalizing symptoms, although it was non-significant (Lannes et al., 2021). This is in line with Siegenthaler et al. (2012), who found that preventive interventions reduced incidence in the same disorder as in the parent by 40%.

Two meta-analyses have focused specifically on families experiencing parental mood disorders. Loechner et al. (2018) reported that for children of parents with depression, intervention effects had a statistically significant small effect in terms of reducing internalizing symptoms directly after the intervention, as well as a small effect in terms of decreased incidence of depression, although the effect was not sustained at follow-up assessments (Loechner et al., 2018). Havinga et al. (2021) included trials of interventions for 6–25-year-old children of parents diagnosed with depression, bipolar, and anxiety disorders, finding a significant risk difference, with significantly reduced risk of developing depression or anxiety disorder at short-term and long-term follow-up, compared with any control condition, and symptom levels were also reduced.

Taken together, the meta-analysis results indicate that preventive interventions for children of parents with mental disorders have a significant but small effect in terms of reducing internalizing symptoms (Havinga et al., 2021; Lannes et al., 2021; Loechner et al., 2018; Siegenthaler et al., 2012; Thanhäuser et al., 2017), and the incidence of mental disorders (Havinga et al., 2021; Lannes et al., 2021; Loechner et al., 2018; Siegenthaler et al., 2012), while the effects on externalizing symptoms are mixed (Lannes et al., 2021; Siegenthaler et al., 2012; Thanhäuser et al., 2017).

Several questions concerning the developed interventions remain to be clarified. Results are mixed concerning how long the effects of the interventions last (Loechner et al., 2018; Maciejewski et al., 2018), and questions concerning the effects of intervention intensity (i.e., duration and frequency) (Marston et al., 2016), who the interventions should target and preferred interventions for different child age groups need further investigation (Lannes et al., 2021). Furthermore, replication trials of the existing interventions are needed as well as trials in different treatment settings and cultures to investigate how these interventions work under naturalistic conditions (Bee et al., 2014; Lannes et al., 2021; Siegenthaler et al., 2012; Thanhäuser et al., 2017).

Components included in preventive interventions

The components and techniques included in preventive interventions for children of parents with mental disorders have been reviewed in three systematic reviews (Havinga et al., 2021; Marston et al., 2016; Tapias et al., 2021), with one of them focusing specifically on interventions for children of parents with depression, bipolar disorder, and anxiety disorders (Havinga et al., 2021).

The most common component found in any type of support for these children was psychoeducation (Marston et al., 2016; Tapias et al., 2021), which was included in all programmes for children of parents with mood/anxiety disorders (Havinga et al., 2021). This component includes, for example, information concerning the parental mental disorder, how the parental mental disorder can affect children, the developmental needs of children, as well as risk and protective factors (Havinga et al., 2021; Marston et al., 2016). Knowledge of parental mental disorders is thought to empower children and reduce their risk of future problems (Marston et al., 2016), as improved understanding can reduce feelings of frustration or fear (Havinga et al., 2021).

The second most common component was various sorts of skills training (Marston et al., 2016; Tapias et al., 2021). When targeting parents, skills training aimed to support parents in building positive parenting skills, such as how to help children develop adaptive coping strategies (Havinga et al., 2021) or enjoying positive time together, and when targeting children, the focus was, for example, on problem solving skills and help-seeking (Marston et al., 2016). Cognitive restructuring techniques were used in several programmes directly targeting children; however, as these interventions are preventive, such techniques may not contribute to change if cognitive distortions are not present in the children (Havinga et al., 2021). Parenting cognitions were addressed in a few interventions, aiming to empower parents in that the changes they make can positively affect their children (Marston et al., 2016). Family communication was also addressed in a few interventions in which family conversations were encouraged and techniques such as active listening were taught (Havinga et al., 2021). This component was included exclusively in interventions targeting parents and families (Havinga et al., 2021; Marston et al., 2016).

Apart from the techniques described above, less common components include exposure techniques, behavioural activation, relaxation, strengthening social support (Havinga et al., 2021), emotional regulation training, and playful activities (Tapias et al., 2021).

Research into the effects of the components of these interventions are needed to establish both why interventions work and which interventions are best suited for whom (Havinga et al., 2021), and furthermore to be able to improve

interventions (Marston et al., 2016; Tapias et al., 2021). To establish which components are effective, there is a need to investigate mediators or mechanisms that are involved in change, and for this, many studies are needed (Kazdin, 2007).

Preventive interventions used in adult psychiatry in Sweden

Since 2010, Swedish legislation has required that children of parents with mental disorders be given information, advice, and support if needed (SFS 2017:30). Adult psychiatry has been identified as an important setting in which to identify and support this group of children (National Board of Health and Welfare, 2013). In routine care in this clinical setting, various preventive interventions are in use, including preventive interventions developed specifically for this group, as well as focusing on the child during the parent's ongoing treatment, without using a specific method (Axberg et al., 2019). Two of the more widespread manual-based preventive interventions in adult psychiatry in Sweden are the Family Talk Intervention (FTI) (Beardslee et al., 1997, 2003) and Let's Talk about Children (LTC) (Solantaus & Toikka, 2006). As these are in focus in one of the studies of this thesis, they will now be thoroughly presented below.

Family Talk Intervention

FTI is a family-based clinician-facilitated preventive intervention developed for children of parents with affective disorders by William Beardslee and colleagues in the late 1980s in the United States (Beardslee et al., 1997). The focus of the intervention is on prevention, to reduce the risk of children developing their own difficulties (Beardslee et al., 2012). The intervention was developed based on a developmental psychopathological perspective, research on risk, and known protective factors for children in families experiencing affective disorders, and a guiding principle was that to provide support to children, their parents need to be strengthened (Beardslee et al., 1997). The theoretical foundation of the intervention is described as based on narrative and cognitive behavioural therapies (Beardslee et al., 2012).

The intervention targets and aims to decrease risk factors common in families experiencing parental depression as well as to increase protective factors (Beardslee et al., 2007). The intervention includes psychoeducation, which provide families with information about mental disorders and about risk and protective factors (Beardslee et al., 1998). Discussing with the whole family how the parental mental disorder affects the family helps create a family narrative concerning the mental disorder and aids in breaking the silence concerning the disorder (Beardslee et al., 2012). Engaging in dialogue concerning the parental mental disorder is seen as one of the most important components of this intervention

in terms of achieving change (Focht-Birkerts & Beardslee, 2000). Furthermore, the focus is on providing parents with information about children's needs and ways to support child development, achieving positive changes in parental behaviours and thereby improving resilience in children (Beardslee et al., 1997).

The intervention consists of six to eight face-to-face sessions led by a trained professional in different family constellations, including both parents and children (see Table 1, p. 30). Follow-up sessions after one and six months are recommended (Pihkala et al., n.d.). A manual and logbook are used to document the content covered, and families receive a self-help booklet. The method requires training, although no specific professional background is required. It was designed to be used by practitioners in a range of settings and from different theoretical backgrounds (Beardslee et al., 2007).

FTI has been found effective in increasing communication about and understanding of mental disorder in the family, and in increasing the parental focus on children (Beardslee et al., 1997, 2003). Furthermore, reduced child internalizing symptoms have also been documented (Beardslee et al., 2003; Giannakopoulos et al., 2021; Solantaus et al., 2010) as well as reduced general mental health problems in children (Giannakopoulos et al., 2021). The effect on mental health problems has not been significantly larger for FTI, than for briefer control interventions (Beardslee et al., 2003; Giannakopoulos et al., 2021; Solantaus et al., 2010). Results of one study, however, indicate that the effect of FTI occurred immediately after the intervention, while the effect of a briefer control condition was evident first at follow-up (Solantaus et al., 2010).

FTI has been implemented in several countries worldwide (T. R. G. Gladstone et al., 2015). In a Nordic clinical context, FTI was first introduced in Finland, where it was found to be safe and feasible (Solantaus et al., 2009) and was implemented as part of a national programme to support the children of parents with mental disorders (Solantaus & Toikka, 2006). FTI was implemented in Sweden at national level starting in 2006 and has been found to be safe and feasible in general psychiatric populations (Pihkala et al., 2010). It has also been used in families with a parent diagnosed with substance use disorder (Pihkala et al., 2017) and psychosis (Strand & Rudolfsson, 2017), and has been adapted for use in families in other care settings, for example, in families in which the parent is in palliative care (Eklund et al., 2022).

Let's Talk about Children

The LTC intervention, a brief preventive intervention for children of parents with mental disorders (Allchin & Solantaus, 2022), was developed in Finland to suit a healthcare system with limited resources for family treatment (Solantaus

& Toikka, 2006; Toikka & Solantaus, 2006). Its development was informed by FTI and a Dutch brief intervention for children of parents with mental disorders (Solantaus & Toikka, 2006; Toikka & Solantaus, 2006). The intervention was designed to be used by all healthcare professionals, even those with limited knowledge of child development and assessment (Solantaus & Toikka, 2006), as the manual includes important questions depending on the age of the children (Solantaus, 2006/2010).

The aim of this intervention is to support parents in recognizing their children's strengths and vulnerabilities and to promote child wellbeing through informing parents of how they can support their children (Solantaus & Toikka, 2006). Families are seen as key resources for child wellbeing, and emphasis is put on the child's every day interactions (Solantaus et al., 2010). Furthermore, in meetings, an action plan is developed in which strengths and vulnerabilities are summarized, and an important aim of the intervention is to assess the need for other interventions and to assist the family in accessing such support (Solantaus, 2006/2010; Solantaus & Toikka, 2006).

LTC consists of one or two discussions with parents only in which a logbook is followed and the content covered is documented; the parents receive the same self-help booklet as in FTI (Solantaus & Toikka, 2006). The LTC discussions have been found to be safe and feasible by parents and professionals and the intervention has been spread to several countries worldwide (Allchin & Solantaus, 2022).

The effects of the intervention have been documented concerning improved parent–child relationships, parenting skills, and parent confidence (Allchin & Solantaus, 2022). A qualitative study from the parental perspective indicates that one mechanism of change in LTC relates to how the intervention builds parental agency, as parents develop new perspectives on themselves and their parenting (Goodyear et al., 2022). Concerning child outcomes, studies have reported a decrease in mental health problems (Giannakopoulos et al., 2021; Solantaus et al., 2010). Child outcomes have been found to be associated with family functioning (Giannakopoulos et al., 2021) and also with cognitive shifts in the children's understanding of problems in the family (Punamäki et al., 2013). In Finland, this intervention is intended to be used for all new psychiatric patients, in a stepped-care model, in which LTC is the minimum-level intervention, to be followed by, for example, FTI if needed (Solantaus & Toikka, 2006).

Table 1 | Overview of Let's Talk about Children and the Family Talk Intervention

Intervention	Family member	Focus of meeting
Let's Talk about Children (LTC) (Solantaus, 2006/2010)	Parent(s)	**Meeting 1:** Assessing child development and strengths and vulnerabilities in the child's everyday life
	Parent(s)	**Meeting 1:** How parental mental health problems influence the family, and how the parent(s) can promote child well-being through strengthening protective factors
Family Talk Intervention (FTI) (Beardslee et al., 2012; Pihkala et al., n.d.)	Parent(s)	**Meeting 1:** Depression and the family; parental and family history is discussed
	Parent(s)	**Meeting 2:** Psychoeducation and discussing the family story
	Child(ren)	**Meeting 3:** Child's perspective on parental depression; listening to each child's questions and assessing the child's situation
	Parent(s)	**Meeting 4:** Preparation for a family meeting: the child's questions are discussed with the parent(s)
	Child(ren) and parent(s)	**Meeting 5:** The family meeting aims to open communication about parental mental disorder in the family
	Parent(s)	**Meeting 6:** Review of past meetings and planning for the future
	Parent(s)	Follow-up after 1 and 6 months

Similarities and differences between LTC and FTI

As LTC was developed based partly on FTI, and also uses the same self-help booklet (Solantaus & Toikka, 2006), these interventions have much content in common. Both FTI and LTC aim to support parents and children, include psychoeducation concerning parental mental disorder, and address risk and protective

factors in the child's life (Beardslee et al., 1997; Solantaus & Toikka, 2006). The delivery formats and emphases of the interventions differ, however. FTI includes the whole family, but LTC includes only parents. Furthermore, the length of the interventions differs, as FTI includes six to eight meetings whereas LTC is shorter, including only one or two meetings. In FTI, a dialogue about mental illness in the family is emphasized, and the subject is also addressed in the family meeting with the clinician present, although the goal is that the parent should lead the conversation (Beardslee et al., 2012). In LTC, parents receive information about the importance of discussing parental mental health problems with children and about how these conversations should be structured based on child age (Solantaus, 2006/2010). In both interventions, children's strengths and vulnerabilities are addressed, and in LTC this results in an action plan, formulated in collaboration between the professional and parents, for how the parents can support healthy development in the child's daily life (Giannakopoulos et al., 2021).

So far, these two interventions have been compared with each other in two randomized controlled trials (Giannakopoulos et al., 2021; Solantaus et al., 2010). The results indicate that children's mental health problems were significantly reduced in both interventions, although in one trial FTI showed a greater effect on children's symptoms at post-assessment, while no difference was found between the interventions at follow-up, when the effect of LTC also was evident (Solantaus et al., 2010). These trials were conducted in clinical settings, under controlled conditions, and studies under more naturalistic conditions have been called for to investigate the interventions' effectiveness when used in clinical practice (Giannakopoulos et al., 2021). Furthermore, comparison with a control group would permit establishment of whether the interventions have treatment or prevention effects (Giannakopoulos et al., 2021). This gap is something that one of the included studies in this thesis addresses.

The role of healthcare in identifying, supporting, and involving family members

Healthcare settings worldwide are dominated by individualistic traditions (Reupert et al., 2022), and many opportunities are missed to address issues relating to families, parenting, and the parent–child relationship because of a fragmented healthcare system (Acri & Hoagwood, 2015; Rishel, 2012). Children of parents with mental disorders have been referred to as an invisible or hidden group, as they have not been adequately identified or supported in healthcare, despite available knowledge of their increased risk of developing their own difficulties (Cudjoe & Chiu, 2020; Laletas et al., 2017). In the research reviewed throughout

this introduction, researchers have put forward several conclusions and implications for clinical practice; I now will give an overview of these, followed by a description of the Swedish context concerning legislation and clinical practice.

In adult-oriented clinical settings, researchers have consistently concluded that research findings underline the importance of identifying whether patients have children and of assessing and responding to their needs (see, e.g., Havinga et al., 2021; Reupert et al., 2022; Zalewski et al., 2017). Furthermore, preventive interventions have been found to have the potential to reduce the incidence of mental disorders and to reduce children's mental health problems (see, e.g., Havinga et al., 2021; Lannes et al., 2021), although more research is warranted into the effectiveness of the different interventions and their effective components, and into which interventions should be recommended for which children, parents, and families (Havinga et al., 2021; Thanhäuser et al., 2017). The importance of addressing the parenting role in adult-oriented settings has been stressed, as a way of supporting both parents and children (K. Foster et al., 2016; Maybery et al., 2015; Public Health Agency of Sweden, 2016; Reupert et al., 2017, 2022; Stein et al., 2014). Furthermore, the need to develop collaboration between agencies to help families in which both parent and child have mental health problems has been underscored (Afzelius et al., 2018; Campbell et al., 2021). In adult-oriented settings, organizational support from policy, guidelines, and management, is important for children to be identified and supported (Maybery & Reupert, 2009). Few countries in the world directly address the children of adult patients in laws (Reupert & Maybery, 2016); however, the Nordic countries are exceptions to this, with amendments specifically concerning this group of children having been implemented in healthcare laws (SFS 2017:30; Skogøy et al., 2018; Solantaus & Toikka, 2006).

In child-oriented clinical settings many researchers argue for the importance of identifying parental mental health status, to initiate adequate support and tailor actions within and between organizations according to family needs (Achenbach, 2017; Campbell et al., 2021; D. Reiss, 2011; Reupert et al., 2022; Weisz et al., 2015). Parents are important for the treatment of children's mental disorders, as they facilitate attendance, contribute their perspective, and participate in therapeutic activities to varying degrees (Haine-Schlagel & Walsh, 2015; Liverpool, Pereira, et al., 2021). It has been found that parental mental health problems may influence the outcome of treatment for both externalizing and internalizing child mental health problems (Beauchaine et al., 2005; Eckshtain et al., 2018; Rishel, Greeno, Marcus, Sales, et al., 2006). In some studies, the same improvement over time has been found in both children of parents with mental health problems and those without, although higher symptom levels at the

start of treatment in children of parents with mental health problems were still evident after treatment (Rishel, Greeno, Marcus, Sales, et al., 2006; Wesseldijk, Dieleman, van Steensel, Bleijenberg, et al., 2018). Parents could need their own treatment, and it has been suggested that collaboration between child and adult mental health services could be needed (Campbell et al., 2021). Other researchers advocate integrated care for the whole family at family clinics when both child and parent have co-occurring mental health problems (Wesseldijk, Dieleman, van Steensel, Bartels, et al., 2018). There have been initiatives to develop treatments targeting both parents' and children's symptoms as well as parenting, and more research is needed into such interventions (Everett et al., 2021).

Taken together, these conclusions and implications encourage healthcare professionals to identify and respond to family members' needs when they meet patients, and broadening the unit of care to encompass the whole family (Bell et al., 2019; K. Foster et al., 2012, 2016; Lagdon et al., 2021). The term "family-focused practice" (FFP) is today used to refer to how mental health professionals and healthcare respond to the needs of family members when either a parent or child has mental health problems (K. Foster et al., 2016). FFP corresponds well to the increased healthcare emphasis on taking into account the whole person within her/his context respecting her/his preferences and needs, and providing care that meets those preferences and needs, i.e., person-centred care (PCC) (Smith & Williams, 2016). In this model of care, the patient is involved and plays an active role in setting goals for care, and family members are also seen as important in making care decisions, if the patient wants them to be involved (Olsson et al., 2013). In child-oriented clinical settings, parents, as legal guardians, are involved in many decisions concerning care (Liverpool, Pereira, et al., 2021) and parental involvement in such decisions is wished for by both children and parents, although the parent's role in decision-making is sometimes complicated as they are not the patient (Liverpool, Hayes, et al., 2021b). Parents' active role in many interventions in CAMHS argues for their inclusion in treatment planning (Edbrooke-Childs et al., 2016; Liverpool, Pereira, et al., 2021). Patient participation in care decisions has been found to improve satisfaction, care quality, and treatment outcomes (Halabi et al., 2020). In CAMHS, including parents in shared decision-making has been associated with increased parental understanding of children's difficulties, more improvement of psychosocial difficulties (Edbrooke-Childs et al., 2016), and more engagement in the interventions provided (Cheng et al., 2017). As the participation of patients in decisions concerning healthcare is strongly advocated (Halabi et al., 2020), much research has focused on barriers to shared decision-making, and from this literature, and it has been suggested that individual, professional, and organizational barriers

exist (Boland et al., 2019; Gondek et al., 2017; D. Hayes et al., 2019). In paediatric clinical settings it has been found that parents' and children's negative emotional states can hinder the process and reduce the inclusion of parents and children in decisions (Boland et al., 2019), which has also been reported in CAMHS settings (Liverpool, Hayes, et al., 2021a).

Swedish legislation

In the Swedish context, several laws address the rights of family members in healthcare. Since 2010, the Swedish Health and Medical Act (SFS 2017:30) has clarified the responsibility of healthcare professionals to take into consideration the needs of the patients' children and to give information, advice, and support if needed. The law gives the healthcare system responsibilities for children who are members of the families of adult patients, and the law applies to all of healthcare. Although not discussed in detail here, healthcare professionals are also obliged by law to report to social services if they suspect that children are being maltreated (SFS 2001:453). Furthermore, the United Nations Convention on the Rights of the Child has been guiding law, policy, and clinical practice in Sweden since it was ratified in 1990; moreover, since 2020 it has had the status of Swedish law (SFS 2018:1197). Articles of the Convention state that the best interests of the child should be in focus in all actions concerning the child (article 3) and that the care and protection necessary for the child's wellbeing should be provided by parents or those legally responsible for the child (article 3). Furthermore, states should give appropriate support to parents so they can fulfil their responsibility for the child's development, by providing services to ensure this (article 18). The child should have the right to express her/his views in all matters affecting her or him in accordance with age and maturity (article 12). This law clearly specifies the rights of children, and that parents should be given support if needed, which is relevant in both adult and child-oriented clinical settings. Members of the families of patients in healthcare are also addressed more generally when it comes to participation in the planning of treatment in healthcare. The Swedish Patient Law (SFS 2014:821) mandates that health and medical care as far as possible should be designed and implemented in consultation with the patient and that the patient's relatives should be given the opportunity to participate, if it is appropriate with regard to the law on confidentiality (SFS 2009:400).

Swedish clinical practice

In Sweden, healthcare and social support are governed by two different jurisdictions: regions and municipalities (Fjellfeldt, 2023). Regions are responsible for organizing and dividing responsibilities between different levels of the health-

care system, which has two principle levels; primary care and specialized care (Swedish Association of Local Authorities and Regions, n.d.). In a large region in southwest of Sweden, the responsibilities for children and adults experiencing mental health problems are similar, with treatment of mild to moderate mental health problems are the responsibility of primary care, and of moderate to severe and complex problems usually needing treatment from specialized psychiatry (Västra Götalandsregionen, 2021a, 2022).

The Swedish National Board of Health and Welfare has been commissioned by the Swedish government to support the implementation of the law concerning the children of patients in healthcare, by providing mental health professionals with knowledge and methods to address the needs of these families (National Board of Health and Welfare, 2020). An evaluation of care for adult patients with depression and anxiety concluded that many specialized psychiatry units had written routines concerning how to support the children of parents with mental disorders, however, in primary care written routines were mostly lacking (National Board of Health and Welfare, 2019). An example of how the law has been implemented in specialized psychiatry is through a questionnaire containing items concerning the patient's child; this questionnaire is to be administered early in the contact with a new patient, and should be documented in the patient's medical records (Västra Götalandsregionen, 2021b).

There are indications from both Sweden and Norway that still not all children of patients in adult psychiatry are identified, although laws have been in place since 2010 (Afzelius et al., 2018; Reedtz et al., 2022). This has also been found in other countries that have implemented mandatory checks of whether parents with mental disorders have children (Dunn et al., 2021; Everts et al., 2022).

Children of parents with mental health problems can receive support from both healthcare and social services. In Sweden, peer-support groups are offered in many municipalities (Skerfving et al., 2014), and parent- and family-based preventive interventions are in use in adult psychiatry, although research indicates that far from all children of patients receive support in adult psychiatry or are referred to other services (Afzelius et al., 2018). The same phenomenon has also been demonstrated in Norway (Reedtz et al., 2022).

There seem to be several barriers that hinder the identification and support of children in clinical practice, even when appropriate laws are in place. Important factors that could influence whether children are identified and supported relate to the provision of time to fulfil the requirements of the law, lack of skills and knowledge in the workforce, lack of collaboration between agencies, and reluctance of patients to involve children and family members in their treatment (Lauritzen & Reedtz, 2015; Maybery & Reupert, 2009).

Concerning child-oriented settings, a recent review of Swedish policy documents concerning child and adolescent mental health services in a region in southern Sweden found that parental mental health problems was mentioned mainly as part of the assessment of children's mental disorders, via questions about heredity (Priebe et al., 2021). A study of medical records in child and adolescent mental health services in Norway showed that only a very small proportion of all records had information about parental mental health problems (9%), far less than was expected from other studies of this population (Heradstveit et al., 2021). According to the authors, there is a probable under-detection of parental mental disorders in CAMHS (Heradstveit et al., 2021). Reasons for this could be that the child is the patient in focus, there is insufficient time to assess the parents as well, and that the parents are not prepared to discuss their own mental health problems (Molitor & Dvorsky, 2019). Another reason could be that mental health providers working with children are not trained to work with adults or identify mental health problems in parents (Acri & Hoagwood, 2015). However, to provide the best possible care, responsible and ethical assessment of parental mental health problems would be beneficial to guide decisions concerning child treatment (Achenbach, 2017; Molitor & Dvorsky, 2019).

To summarize, several laws and guidelines in the Swedish context address members of the families of patients in healthcare, acknowledging the importance of identifying needs and providing support. These laws imply the need for a family-focused practice in Swedish healthcare. However, there seem to be hindrances to identifying and supporting these families in clinical practice. More knowledge is needed concerning the mental health of family members to get indications of the level of support they need, and of the types of actions that are appropriate in relation to needs.

General aim

This thesis aims to improve our knowledge of mental health problems, risk factors, and support for children and parents who are members of the families of psychiatric patients. The thesis includes three studies, and the specific aims of these were to: investigate mental health problems and risk factors in 8–17-year-old children of parents with depression, anxiety, or bipolar disorder in contact with adult psychiatry (Study I) and to investigate the effectiveness of preventive interventions used in routine psychiatric care to support these children (Study II). The aim of Study III was to investigate mental health problems in the parents of children referred to specialized child and adolescent mental health services, and to explore how these relate to children's mental health problems, family functioning, and parental involvement in treatment.

Summary of studies

The studies in this thesis are based on data from two clinical research projects designed to build knowledge of mental health problems, risk factors, and support for members of the families of psychiatric patients. In studies I and II, the parent is the patient and the children as family members are in focus, and in Study III the child is the patient, and the parents are the family members in focus.

Studies I and II are part of a longitudinal research project conducted in adult psychiatry. The project was financed by the National Board of Health and Welfare (Reg. no. 2.7-38380/2013) and approved by the Regional Ethics Review Board in Gothenburg (Reg. no. 1029-13). It was run in collaboration between Gothenburg University, Lund University, and specialized adult psychiatric units in five regions in Sweden. Recruitment started in 2014; the recruitment period was prolonged several times and ended in 2017.

The data for Study III come from a longitudinal research project conducted in CAMHS. The project was supported by funding from Sahlgrenska University Hospital, the Foundation Queen Silvia's child and adolescent hospital research fund and the Local Research and Development Council of Gothenburg and Södra Bohuslän and was approved by the Regional Ethics Review Board in Gothenburg (Reg nr. 806-17). The project was run in collaboration between the University of Gothenburg and Sahlgrenska University Hospital, and the study setting was an outpatient CAMHS unit. Recruitment started in January 2020 and was prolonged to 13 months from the initial six months.

In all three studies, quantitative data were collected using questionnaires and parents were the informants. Table 2 (p. 38) gives an overview of the instruments included in the three studies.

Table 2 | Instruments used in the included studies

Instrument	Abbreviation	Measures	Used in study
Strengths and Difficulties Questionnaire – Parent version (Björnsdotter et al., 2013; R. Goodman, 2001)	SDQ-P	Children's mental health problems	I, II, III
Clinical Outcomes in Routine Evaluation – Outcome Measure (Elfström et al., 2013; C. Evans et al., 2002)	CORE-OM	Parent psychological problems	I, II
Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983)	HADS	Parent symptoms of anxiety and depression	I
Symptoms Checklist – 90 (Derogatis & Cleary, 1977; Fridell et al., 2002)	SCL-90	Parent somatic and psychological symptoms	III
McMaster Family Assessment Device (Miller et al., 1985)	FAD	Family functioning	I, III
Dyadic Adjustment Scale, brief version (Sabourin et al., 2005)	DAS-4	Marital/relationship satisfaction	III
Parental Locus of Control questionnaire, Perceived Parental Control subscale (Campis et al., 1986; Hagekull et al., 2001)	PLOC-PPC	Perceived parental control concerning their ability to influence child behaviours	I, II
Hollingshead Four Factor Index of Social Status (Hollingshead, 2011)	SS	Parents' social status based on education and occupation	I, III
The Ohio Scales, Satisfaction subscale (Benjamin et al., 2001)	OHIO	Parents' perceived satisfaction and participation in treatment planning	III

Study I

Mental health in children of parents being treated by specialised psychiatric services.

Aims

The aim of this study was to investigate mental health problems in 8–17–year-old children of parents diagnosed with depression, anxiety, or bipolar disorder in contact with specialized adult psychiatry. Furthermore, the aim was to investigate risk factors for mental health problems in this group of children.

Method

Procedure and participants. Mental health professionals in adult psychiatry recruited participants from among patients and their partners, when they were offered a preventive intervention focusing on their children. Inclusion criteria were that the patient was diagnosed with depression, anxiety, or bipolar disorder and that participants could complete a questionnaire independently in Swedish. Exclusion criteria were: the family had received a preventive intervention during the previous 12 months; the patient had a main diagnosis of substance use or schizophrenia disorder; or the family was experiencing a severe crisis, such as divorce, violence, or family member death. Furthermore, children who were in treatment for depression or anxiety disorder or who were living in out-of-home care were excluded from the data collection. Participants completed a questionnaire before receiving the preventive intervention. During the recruitment period, 130 patients were asked to participate, and the final sample included parents from 63 families, and reports about 87 children from these families were included in this study. The mean age of the primary informants (whose child and family reports were used) was 41.0 years (SD = 7.2) and of the parent-rated children was 11.9 years (SD = 2.8).

Measures. The questionnaire included measures capturing child and parental mental health problems, family functioning, and perceived parental control as well as background questions concerning the parent and child. The mental health professionals also reported basic demographic information and the reason for contact with psychiatric care for all patients asked to participate.

Data analysis. In some families, reports were available from both patient and partner, but in the analysis, data from one primary informant (primarily the patient) for each child were used. Parent-rated child mental health problems were compared with a Swedish population-based sample and with clinical cut-off scores. A multiple linear regression analysis was carried out to investigate whether perceived parental control or general family functioning could significantly

predict the dependent variable, i.e., child mental health problems, controlling for child age and gender, parental social status, and parental mental health problems, here represented by the level of anxiety. Furthermore, a cumulative risk index was constructed to explore the effect of experiencing an increasing number of risk factors on children's mental health problems. The risk factors included were: young child age (8–10 years), low social status of parent, single parenthood, parent score above clinical cut-off on CORE-OM Symptoms subscale, long contact with specialized psychiatric services (top 25th percentile in our sample), and low perceived parental control (below the 25th percentile in our sample).

Main findings

Children in the included sample were reported to have significantly more mental health problems than the population-based sample according to the Total Difficulties scale of SDQ-P. Relative to Swedish clinical cut-off scores (Malmberg et al., 2003), 34% of the children exceeded the cut-off for the Total Difficulties score. When the Total Difficulties score was combined with the Impact score, 18 children (21%) had scores above the clinical cut-off for both, indicating clinical-level symptoms interfering with the daily life of the child.

The multiple linear regression indicated that the model explained 49% of the variance in outcome (i.e., $F[6,71] = 13.19$, $p < .001$, $R^2 = .53$, Adjusted $R^2 = .49$); child age ($b = -0.44$, $p = .020$) and perceived parental control ($b = -0.52$, $p < .001$) contributed significantly to the model, while the other variables did not. According to analyses using the cumulative risk index, children with four to six reported risk factors had increased odds of being categorized over the clinical cut-off on the combined Total Difficulties and Impact score, compared to children experiencing two to three or zero to one risk factor.

Conclusions

The findings of this study showed that many 8–17-year-old children of patients diagnosed with depression, anxiety, or bipolar disorder were reported to have increased levels of mental health problems. Furthermore, younger child age and less perceived parental control were found to be associated with more child difficulties, and more risk factors in the child's life were associated with increased odds of mental health problems at clinical levels. Taken together, the results underline the importance of identifying child needs when a parent is in contact with psychiatry to ensure that adequate support is initiated.

Study II

Preventive interventions for children of parents with depression, anxiety, or bipolar disorder: A quasi-experimental clinical trial

Aims

The aim of this study was to evaluate the effectiveness of preventive interventions used in routine care in adult psychiatry to support 8–17-year-old children of patients diagnosed with depression, anxiety, or bipolar disorder. Based on previous research we hypothesized that receiving either FTI or LTC would be associated with more favourable trajectories in (a) parent-rated child mental health problems and (b) perceived parental control, relative to the comparison group (intervention as usual, IAU). Differences in the outcome measures between FTI and LTC were also explored.

Method

Procedure and participants. Mental health professionals from adult psychiatry units recruited participants from patients and their partners, when they were offered a preventive intervention focusing on their children during routine care. For inclusion and exclusion criteria, see Study I above. During the recruitment period, 130 patients were informed about the study and 63 families, with 91 children, agreed to participate in the study. Participating families were non-randomly assigned to FTI (n = 35 children), LTC (n = 16 children), or intervention as usual (IAU; n = 38 children), consisting of any other preventive intervention given in routine psychiatric care. Three waves of parent-rated questionnaires were collected: at baseline, and after six and 12 months.

Measures. The questionnaire included measures of child and parental mental health problems and of perceived parental control of child behaviours, as well as background questions concerning the parent and child. The mental health professionals reported demographic information and reason for contact with psychiatric care for all patients informed of the study; as well, they completed a questionnaire about each included intervention and about themselves covering age, gender, training, and professional background.

Data analysis. Information on type of intervention given was missing for one family, so 62 families with 89 children (38 girls, 51 boys) were included in the analyses. Reports from one parent, referred to as the primary informant, were used in the analyses for each child. Child and patient characteristics and baseline results were compared, and no significant differences were found between the three study groups. The analytical approach for the evaluation of the interven-

tions was multilevel growth curve modelling, which accounted for multiple measurements per child and for siblings nested in families (i.e., a three-level nested data structure with time nested within children nested within families). The primary outcome measure was child mental health problems (SDQ-P), and the secondary outcome measure was perceived parental control (PLOC-PPC). The effect was evaluated by investigating the interaction between study group and time (Model 1). The effects of child age and patient symptoms at baseline and of change during the study were controlled for in a second model (Model 2). IAU was used as the reference group, but models were also refitted to have LTC as the reference category for comparison between FTI and LTC. Differences between groups in wave 3 were also investigated, although the main findings were based on the interaction effect. Effect sizes for the interaction effect were calculated, accounting for baseline mean differences across groups.

Main findings

A significant group × time interaction effect was found on the primary outcome measure, and expected average changes in children's mental health problems showed a decrease in the FTI and LTC groups and an increase in the IAU group, resulting in expected standardized differences, according to Cohen's *d*, of –0.86 and –0.88, respectively, at the end of the study (Model 1). When including covariates (Model 2), the interpretation of the fixed effects remained similar, and the group × time interaction effect was significant for both FTI and LTC, compared with IAU.

For the secondary outcome measure, we found a significant group × time interaction for the FTI and LTC groups, respectively, versus the IAU group, with expected standardized differences, according to Cohen's *d*, of 1.08 and 0.71 by study end (Model 1). There was an increase in the FTI and LTC groups according to this measure, while there was a decreasing trajectory in the IAU group. In Model 2, the interaction remained significant for the FTI × IAU comparison, but not for the LTC × IAU comparison; however, the changes in estimates were minor, with the lower boundary of the 95% confidence interval just below zero, which is why it is argued that the significant interaction in Model 1 indicates that LTC has a more favourable impact on this outcome measure than does IAU.

When the models were refitted to compare the FTI and LTC groups, no significant differences were found in either outcome measure in Model 1 or Model 2.

Conclusions

The findings indicate that FTI and LTC had favourable trajectories in child mental health problems compared with IAU, when measured up to 12 months after

the interventions started. Child mental health problems did not increase in the FTI and LTC groups, but they did increase in the IAU group. The findings also indicate that parents receiving FTI and LTC reported a strengthened belief in their ability to handle their children, compared with parents receiving IAU. These results encourage the continued use of FTI and LTC in adult psychiatry to support the children of parents diagnosed with depression, anxiety, or bipolar disorder.

Study III

The patient and the family: Investigating parental and child mental health problems, family functioning, and parent involvement in child and adolescent mental health services

Aims

The first aim of this study was to investigate mental health problems in the parents of children referred to a specialized outpatient CAMHS unit. The second aim was to compare children's mental health problems, family functioning, relationship satisfaction, and parental involvement in treatment between parents above and below the cut-off for elevated levels of mental health problems at the time of the first appointment at CAMHS.

Method

Procedure and participants. Participants were recruited from the parents of children referred to CAMHS for mental health problems. All parents whose child was scheduled for a first appointment during the recruitment period were invited in writing to participate. Participating parents completed a questionnaire at the time of the first appointment and one year later. The only exclusion criterion applied was if the parents could not complete the questionnaire independently in Swedish. Parents (N = 111) of 98 children (49 girls, 46 boys, 3 other) chose to participate. Both legal guardians participated for 13 children. The included sample corresponds to 5% of all children scheduled for an intake appointment during the recruitment period (N = 1824). The mean age of the participating parents was 45 years (SD = 6.3, range 30–68) and the mean age of the children was 12.5 years (SD = 3.1, range 5–17). Child age and gender did not differ from between the included sample and all children whose parents had been invited to participate. The social status of the parents in the included sample was significantly higher than that of parents in a population-based reference population. One year later, the parents of n = 71 children completed the follow-up questionnaire.

Measures. The first questionnaire included measures of parent and child

mental health problems, family functioning, and relationship satisfaction as well as background questions. At follow-up one year later, questions concerning contact with CAMHS and satisfaction with and participation in treatment planning were completed.

Data analysis. For children both of whose legal guardians participated in the study, information from one primary informant was used for reports about the child and family. When available, the mother's ratings were chosen, making the mother the primary informant, as more mothers chose to participate in the study. Descriptive statistics concerning mental health problems in parents were reported in two ways, first in relation to a cut-off score (T-score ≥63) on SCL-90 equivalent to the 90th percentile indicating elevated mental health problems; second, as described from questions concerning previous treatment for mental health problems during the child's life. Differences between parents above and below the SCL-90 cut-off were compared concerning measured variables using the independent-sample *t*-test and Pearson's chi-square test.

Main findings

The findings indicated that 41% of the parents reported elevated mental health problems at the time of the child's first appointment at CAMHS, which corresponds to parents of 44% of the included children. Furthermore, 42% of the participating parents had a previous treatment contact with health services due to mental health problems during their child's life, and 50% of the children were estimated to have experienced one or both parents having a previous contact with mental health services. Parents in our study had usually been in contact with primary care or private options. There was a large group (41%) of parents with elevated mental health problems who had no previous contact with mental health services. Children of parents with elevated mental health problems, compared to those below the cut-off, were reported to have significantly higher levels of mental health problems. The proportion of families with problematic family functioning was also significantly higher among these families. There was no difference in relationship satisfaction between families in which parents reported above or below the cut-off. Parents with elevated levels of mental health problems reported having received group-based parent training/education to a greater extent than did parents at levels below the cut-off. Satisfaction with and participation in treatment planning were significantly lower in parents above versus below the cut-off for mental health problems. Half of the parents reported having discussed their own mental health problems during the contact with CAMHS, and half of them would have wanted to discuss them more.

Conclusions

In a clinical sample of children referred to CAMHS, findings indicate that many families experienced co-occurring parent and child mental health problems. Furthermore, in families in which parents reported elevated levels of their own mental health problems, children were reported to have higher levels of symptoms and more families experienced problematic family functioning. This indicates complex needs in these families and emphasizes the need to take these factors into account during assessment to ensure that appropriate support for the family is initiated.

General discussion

Building on previous research, this thesis aimed to improve our knowledge of members of the families of patients in contact with psychiatry regarding mental health problems, risk factors, and support given in routine psychiatric care. The findings of the included studies will now be discussed, followed by presentations of the methodological and ethical considerations, conclusion, clinical implications of the findings, and recommendations for future research.

Mental health problems in members of the families of patients in contact with psychiatry

Findings indicate that mental health problems are common in the members of psychiatric patients' families. A third of children (34%) of parents in adult psychiatric care were reported to have elevated levels of mental health problems (Study I) and nearly half of the children (44%) referred to CAMHS had a parent who reported elevated mental health problems (Study III). The included studies indicate that there is a large group of families with co-occurring mental health problems in both adults and children in these clinical settings.

The children of parents in adult psychiatric care were also reported to have more mental health problems than did children in a population-based reference group, which is in line with much previous research demonstrating that the children of parents with mental disorders are at risk of developing their own mental health problems during childhood (S. H. Goodman et al., 2011). The findings concerning the number of children over the clinical cut-off for mental health problems, are furthermore consistent with the numbers found in other studies of the children of parents in contact with health or welfare services because of mental health problems (Maybery et al., 2010; Sell, Barkmann, et al., 2021; Wiegand-Grefe et al., 2019), although the rates found in our study were somewhat lower. There are several possible explanations for this. First, the parental diagnoses in focus were depression, anxiety, and bipolar disorder, so the findings are restricted to families with these parental diagnoses in adult psychiatry. Second, the included families were recruited when a preventive intervention was offered as part of the patient's regular treatment. From previous research we know that not all children in adult psychiatric settings are identi-

fied (Afzelius et al., 2018; Ruud et al., 2019) or offered preventive interventions (Afzelius et al., 2018). There is the possibility that the included families were identified because of more pronounced child difficulties or needs of the children and families; however, several exclusion criteria were applied, for example, excluding children already in treatment for depression or anxiety disorder from the data collection, and excluding families experiencing a current family crisis. In sum, this points in the direction that the families in the included sample might not represent the families most burdened by child mental health problems or difficult family situations. It is therefore likely that the level of mental health problems found in children in Study I is an underestimation of the extent of mental health problems in the children of parents with depression, anxiety, or bipolar disorder.

Regarding mental health problems in the parents of children in contact with child and adolescent mental health services, the number of parents found in this research to have elevated self-reported levels of mental health problems (41%) is in line with the numbers in other studies using self-reports, which have reported rates of 31%–39% (Campbell et al., 2021). Studies using other ways of investigating parental mental health problems, for example, through reports from professionals, have shown that up to 79% of parents of children in CAMHS have experienced past or current mental health problems (Campbell et al., 2021). In our study, we used parents' own reports concerning previous treatment for mental health problems and found that 42% reported having received treatment for mental health problems during their child's life. A recent Swedish study, although based on reports from professionals, found that 59% of patients in contact with CAMHS had at least one more family member in need of mental health services, which was the parent in 80% of the cases. In Study III, we found that not all parents with elevated self-reported mental health problems had a previous treatment contact with healthcare, which indicates that the rate of previous or current experience of parental mental health problems is even higher in this sample.

In families with CAMHS-treated children whose parents have elevated mental health problems, the children were reported to have statistically significantly higher child mental health problems than do the children of parents below the cut-off for mental health problems, corroborating the findings of other studies (Wesseldijk, Dieleman, van Steensel, Bartels, et al., 2018). It has also been reported that the children of parents with mental disorders receive interventions from CAMHS for longer periods, have higher levels of mental health problems and more psychiatric comorbidities (Heradstveit et al., 2021). The results of previous research and our findings underline that families in CAMHS with co-occurring

mental health problems have complex care needs, as both child and parent have mental health problems.

The prevalence of mental health problems in family members informs us of possible needs for action at different levels of healthcare or by other services (Dalman et al., 2021); and taken together, the findings underline that the members of the families of patients in contact with psychiatry need a broad range of support. The children of parents with mental health problems should receive selective preventive interventions, as they are identified to be at risk of developing mental health problems (Arango et al., 2018). In a Swedish clinical context, such interventions are available in adult psychiatry, although research indicate that they do not reach all children of parents in this clinical setting (Afzelius et al., 2018). The findings of Study III have implications for settings other than adult psychiatry where selective preventive interventions could be needed, as parents in this study with previous treatment contacts had usually been in contact with primary care or private options. This suggests that selective preventive interventions for the children of parents with mental health problems in such clinical settings needs to be implemented, especially as it has been found that there is a lack of routines concerning how to support the children of adult patients in primary care settings (National Board of Health and Welfare, 2019). There is also the possibility to support these children through selective preventive interventions in other settings outside healthcare. In community-based settings, peer-support groups are commonly offered this group of children, sometimes combined with parallel groups for parents. There is however a lack of studies of the effect of such interventions in a Swedish context (Skerfving et al., 2014).

Findings of Study I also suggest that some children could need preventive interventions on an indicated level as well as treatment, as we found that a group of children in adult psychiatry already showed signs of mental health problems. Subclinical levels of mental health problems in the children of parents with mental disorders must be identified and addressed, as they have been strongly associated with later mental disorders in the same children (Mulraney et al., 2021). In Study I, we do not have information about the number of children who were excluded because of being treated for depression or anxiety disorder. However, concerning children already identified as having mental disorders, establishing inter-agency collaboration between adult psychiatry and CAMHS or social services has been recommended to improve care for these families (Afzelius et al., 2018; Campbell et al., 2021).

Families from Study I in adult psychiatry with co-occurring mental health problems likely overlap with a group of families identified in Study III, in which parents reported having received treatment from adult psychiatry during the

child's life. Concerning families in contact with CAMHS in which children and parents experience co-occurring mental health problems, the implementation of coordinated treatment targeting both parent and child mental health problems has been suggested (Everett et al., 2021; Wesseldijk, Dieleman, van Steensel, Bartels, et al., 2018), as well as adapting treatment within CAMHS (Achenbach, 2017; Campbell et al., 2021) and supporting parents in their parenting role (Campbell et al., 2021). Furthermore, findings indicate that not all parents with elevated mental health problems had a previous treatment contact, treatment for the parents themselves could need to be considered. The findings underscore the importance of discussing current mental health problems, both to ensure that parents have the support they need concerning their own treatment, and to identify children and families in contact with CAMHS for whom interventions need to be tailored according to more complex family needs.

Support for family members in clinical practice

The findings of the included studies also contribute knowledge of current clinical practice and interventions that family members receive in routine care. In adult psychiatry, various preventive interventions are used to fulfil the requirements of Swedish law to give information, advice, and support if needed to the children of parents with mental disorders (SFS 2017:30). In the included effectiveness study (Study II), findings support the continued use of two manual-based preventive interventions, i.e., FTI and LTC, to support the children of parents with depression, anxiety, or bipolar disorder in contact with adult psychiatry. The results of Study II showed that children's mental health problems did not increase in these two groups, as did occur in the comparison group receiving any other preventive intervention (IAU). The aims of FTI and LTC are to promote child wellbeing and prevent development of children's mental health problems (Beardslee et al., 2012; Solantaus, 2006/2010), and our results are in line with the aims of these interventions. In previous trials comparing FTI with LTC, both interventions have been found to have a statistically significant effect in terms of decreasing child internalizing symptoms, which indicates a possible treatment effect of these interventions (Giannakopoulos et al., 2021; Solantaus et al., 2010). However, in our study, when these interventions were studied under naturalistic conditions and compared with a comparison group, the results suggest a preventive effect, as symptoms did not increase in the FTI or LTC groups. In our study, the focus was on change in mental health problems over time compared between groups, and statistically significant differences in change over time were found for FTI and LTC compared with IAU, supporting the continued use of both FTI and LTC.

When FTI was compared with LTC, no statistically significant differences were found in expected trajectories in child mental health problems, which is in line with the results of previous studies (Giannakopoulos et al., 2021; Solantaus et al., 2010). As reviewed in the introduction, FTI and LTC share many components, although there are also several differences in format and emphasis between them. The results indicate that both these interventions seem to support children in ways that reduce the risk of developing mental health problems. However, we still do not have enough knowledge of who the different interventions work best for (Giannakopoulos et al., 2021; Lannes et al., 2021), and more research is needed to clarify which interventions are effective for which subgroups, for example, different age groups or families in which parents perceive more difficulties in their parenting role. Furthermore, more research is needed concerning which components of the preventive interventions are effective. From the results of our research, it is impossible to be certain that differences do not exist between these interventions due to the small sample sizes in the included groups, and larger studies are needed to verify our findings.

As the preventive interventions under investigation are not primarily directed at reducing children's symptoms, other outcome measures are recommended to complement the evaluation of them (Beardslee et al., 1997; Reedtz, van Doesum, et al., 2019), which also could shed light on how these interventions work. In Study II, a secondary outcome measure of perceived parental control was used, which captured parents' beliefs in their ability to handle and influence their children's behaviour. Study findings indicate that parents receiving FTI and LTC reported strengthened such beliefs. There was a significant interaction effect for FTI compared with IAU, even when controlling for covariates. For LTC compared with IAU, the interaction was significant in Model 1 but not in Model 2 when controlling for covariates, although change in estimates was minor (from 0.23 to 0.22), with the lower boundary of the 95% confidence interval just below zero. It is therefore argued that the significant interaction found in Model 1 indicates that LTC also has a more favourable impact on this outcome measure than does IAU, although this needs to be verified in larger samples.

By including other outcome measures, it is possible to generate hypotheses concerning which components of the interventions contribute to change (Ialongo et al., 2006); possibly, the components of the interventions directed at supporting parents are important in order to achieve change. Both FTI and LTC include components directed at supporting parents in their parenting role (Beardslee et al., 2012; Solantaus, 2006/2010) and at strengthening parents' belief in themselves (Marston et al., 2016). A qualitative study of parents' experience of LTC found that the LTC discussions enabled parents to reflect on their parenting and

on their child's behaviour, and that this understanding positively affected the parents' self-efficacy and personal agency (Goodyear et al., 2022). From other studies, higher self-efficacy beliefs have been associated with both parent's and children's wellbeing (Albanese et al., 2019), and it is therefore encouraging that the results in Study II indicate that FTI and LTC seem to support parents and positively affect their belief in themselves as parents.

For preventive interventions to have a large effect at the population level, it is essential that interventions with small effects should reach the whole population at risk in order to have a preventive effect (Offord et al., 1998). As selective preventive interventions for children of parents with mental disorders have been found to have a small effect, according to meta-analyses (see, e.g., Havinga et al., 2021; Lannes et al., 2021; Loechner et al., 2018), it is important to reach as many as possible in this at-risk group. From the perspective of reaching as many as possible in the population under study, LTC has advantages, as it is a brief intervention that could be used in many families. Furthermore, the manual provides professionals with relevant questions to ask parents of children of different ages (Solantaus, 2006/2010), so it can be used by professionals who do not consider themselves to have sufficient knowledge of child development. In Finland, where LTC was developed, this intervention is recommended for all new patients in contact with psychiatry, and FTI is used for families in need of more extensive support (Solantaus & Toikka, 2006). This suggests that LTC may be suitable as a minimum level of support for the children of parents with depression, anxiety, or bipolar disorder in contact with adult psychiatry. However, it is advisable to have a selection of interventions to offer, to meet the different needs of patients, family members, and families in contact with adult psychiatry.

In Study III, differences in the types of treatment received during the first year of contact with CAMHS were explored between parents above or below the cut-off for elevated levels of mental health problems at the beginning of the contact. The findings indicate that parents above the cut-off to a greater extent reported having received group-based parent training/education. Possibly this group of families might need support that is more tailored to the parent and whole family's needs. There is however no clear recommendations concerning how to address co-occurring mental health problems in this clinical setting (Priebe et al., 2021), although parental mental health problems have been suggested to be one of several factors causing evidence-based treatments for children not to produce the same effect in clinical practice as in efficacy trials (Weisz et al., 2015). Many parents in our research wished that their own mental health problems had been discussed more within CAMHS, and more research into how best to support these parents and families is needed. Furthermore, parents' perceived involvement in

treatment planning was found to be lower among parents experiencing elevated mental health problems. Improving the involvement of this group of parents in shared decision-making concerning healthcare could be important in order to improve their engagement in and possibly the outcome of treatment (Cheng et al., 2017; Liverpool, Pereira, et al., 2021; Moberg et al., 2022).

Risk factors associated with mental health problems in family members

The studies included in this thesis have also built our knowledge of the factors associated with mental health problems in members of the families of patients in contact with psychiatry. This knowledge can inform us about factors that are important to assess and address in these families and to take into consideration during clinical decision-making. For the children of parents with depression, anxiety, or bipolar disorder, findings indicate that with an increased number of risk factors relating to the children (i.e., age), parents (i.e., severity of mental health problems, long contact with psychiatry and low perceived parental control), or family (i.e., low social status and single parenthood), the odds of children's mental health problems at clinical levels increased (Study I). This is in line with results of much previous research into cumulative risk models, which has demonstrated that it is the number of factors rather than which specific ones that affects the risk of developing mental health problems (Appleyard et al., 2005; G. W. Evans et al., 2013). This type of risk index cannot say anything about specific factors, patterns of factors, or underlying processes, although such indexes have been found to have important predictive value in identifying children at risk of developing mental health problems (G. W. Evans et al., 2013). From the results in Study I, it can be concluded that it is informative to investigate many factors in different contexts when assessing the needs of children, to identify children at increased risk.

Another important aspect of the findings concerns perceived parental control of child behaviour, which reflect parents' self-efficacy beliefs about their ability to handle their child in different rearing situations (Hagekull et al., 2001). Results suggest that lower perceived parental control predicted more mental health problems in the children of parents with depression, anxiety, or bipolar disorder (Study I). Previous research has shown that lower self-efficacy beliefs are associated with more children's mental health problems (Albanese et al., 2019), and hence parenting cognitions such as perceived parental control could be important to address when supporting parents in adult psychiatric care. As the second outcome measure in Study II, this measure was used in evaluating

the effect of the two interventions, and results indicated that such beliefs indeed were strengthened after participating in FTI and LTC (Study II).

Family functioning also seems to be something that many families in contact with psychiatry struggle with. General family functioning was reported to be problematic in 57% of the included families in adult psychiatry (Study I). Previous research has reported associations between parental mental disorders and dysfunction in the family context (van Loon et al., 2014), and more problematic family functioning has been related to more children's mental health problems (Wiegand-Grefe et al., 2019). In Study I, family functioning did not significantly predict children's mental health problems, which could be because our results were based solely on parental reports. Other studies have found that child-reported problematic family functioning was more strongly associated with child mental health problems, than problematic family functioning reported by parents (Daches et al., 2018). In Study III, problematic family functioning was more common in families experiencing elevated parental mental health problems, which has also been reported in other studies in the CAMHS setting, where family dysfunction and interparental difficulties have been reported in families experiencing co-occurring mental health problems (Campbell et al., 2021). The fact that many families reported problematic family functioning indicates that this is a factor that could be important to address to support the patient and the whole family.

In Study I younger children were reported to have more mental health problems, and age was also a significant predictor of children's mental health problems. Previous research has argued that younger children, primarily in the first years of life, are more sensitive to exposure to mental disorders in a parent (Hosman et al., 2009; Stein et al., 2014). The increased reported difficulties in these children could be because they were exposed to parental mental health problems earlier in life. As parents were informants in our research, there is a possibility that they are more aware of difficulties in younger children. However, in a British normative population studied using the same instrument as used here, no age differences were found between younger and older children (Meltzer et al., 2000). From this the conclusion was drawn that the difference found in the study sample was not due to a general age difference effect, pointing to the importance of paying attention to the younger children of patients with depression, anxiety, or bipolar disorder. There can be reasons however why parents are unaware of difficulties in their older children; for example, children have described avoiding discussing their own feelings and needs with parents, as a way of not upsetting them (Simpson-Adkins & Daiches, 2018). Identifying the needs of children of all ages is therefore warranted.

Social status was investigated in the included studies, and a significantly

lower social status on the Hollingshead Index was found in parents in contact with adult psychiatry (Study I) than in parents in general. However, this factor was not found to significantly predict children's mental health problems in this sample. In other studies, however, poverty has been found to be a general risk factor for mental health problems (Stein et al., 2014; Wille et al., 2008) and in families experiencing maternal depression, low socioeconomic status has been found to increase the risk of child mental health problems (S. H. Goodman et al., 2011). Furthermore, many families experiencing parental mental health problems also experience low socioeconomic status (Pierce, Abel, et al., 2020). Contrary to the sample in adult psychiatry, social status according to the Hollingshead Index was significantly higher in the sample in child psychiatry compared with parents in general (Study III). It is impossible to conclude from Study III whether or not the included parents are a representative sample of parents accessing care in CAMHS, and a larger sample is needed to get an indication of this pattern.

Methodological considerations

A naturalistic design was chosen to be able to answer the research questions and to increase the generalizability of the findings and the external validity of the study (Kazdin, 2022). Patients and families were recruited from routine care in representative clinical settings. The support families received had already been implemented and was not introduced or controlled by the researchers. Furthermore, the mental health professionals responsible for the interventions and treatments given were practitioners employed in these clinical settings. Several considerations concerning the methods chosen in the included studies, however, need to be discussed.

Measures selected

The choice of variables in our studies was guided by a developmental psychopathological perspective, with a focus on factors relating to the child, parent, and family context that are possible to identify and address in clinical practice. The included measures were chosen based on whether they would capture such variables or constructs. The measures were also chosen based on their psychometric characteristics, which increases their likelihood of assessing the construct of interest (Kazdin, 2022). Furthermore, measures that had been tested in populations similar to the included samples were preferred, as well as measures with available Swedish reference populations, both clinical and population based. However, for three of the measures (i.e., FAD, DAS-4, and HADS), we relied on clinical cut-off levels established in other countries (Kabacoff et al., 1990; Sabourin et

al., 2005; Zigmond & Snaith, 1983). As cultural differences between countries can be substantial, for example, concerning family functioning, this indicates a need to be cautious when drawing conclusions using these instruments. FAD and DAS-4 have, however, been used in other populations in a Swedish context with satisfactory results (Bylund et al., 2016; Salari et al., 2014).

One important aspect of assessment concerns whether or not a broad/global or narrow/specific definition of the variable or construct is measured. Concerning family functioning, many self-report measures are available (Hamilton & Carr, 2016). Our research used a subscale measuring general family functioning (Kabacoff et al., 1990), tapping into several aspects of ways that families can function. When comparing ours with other studies, this is important to bear this in mind, as measures of specific aspects of family functioning could produce other results.

Concerning children's mental health problems, the Total Difficulties score of the SDQ-P (Björnsdotter et al., 2013; R. Goodman, 2001) measure was used in all included studies, and this instrument includes questions concerning both internalizing and externalizing symptoms in children. The choice to use a global score including both these dimensions was guided by the psychometric properties of the scale (Stone et al., 2010), and by the notion that the children of parents with mental illness generally have an increased risk of a broad range of difficulties (Dean et al., 2018; van Santvoort et al., 2015). Other intervention trials of preventive interventions for the children of parents with mental disorders, have evaluated the effect on either internalizing or externalizing symptoms, which could influence the differences between studies. From meta-analyses, there is a general conclusion that preventive interventions have a small statistically significant effect on internalizing symptoms, but the results are more inconclusive concerning externalizing symptoms (Havinga et al., 2021; Lannes et al., 2021; Loechner et al., 2018). This could have consequences for the effect shown on a global score including both these dimensions, as was used in Study II.

Measurement sensitivity refers to whether a measure can detect differences that are expected to be found in a sample (Kazdin, 2022). In Study II, the included interventions are preventive and do not specifically target children's mental health problems, which has consequences for the expected effects of such measures. In other groups of children, research indicates that the effects of preventive interventions tend to be stronger when children's symptoms are more pronounced, and that the effects of universal and selective preventive interventions are not as strong as those of indicated preventive interventions or treatments (Leijten et al., 2019). Treatment research has concluded that treatments designed to target specific symptoms generally have larger effect sizes on symptom outcome measures than do treatments that are more diffuse or non-specific (Yulish et al.,

2017). Using outcome measures of children's mental health problems, as is done in many evaluations of preventive interventions for the children of parents with mental disorders, is nevertheless important to be able to follow development over time, as these interventions aim to reduce the risk of developing such difficulties. Other measures are needed, however, to investigate how these interventions work (Reedtz, van Doesum, et al., 2019), and one such measure, of perceived parental control (PLOC-PPC), was also included in Study II.

Sampling and recruitment of participants

Challenges in recruiting participants can threaten the external validity and generalizability of results (Kazdin, 2022). For studies I and II, the number of interventions given by mental health professional in adult psychiatry had been estimated before planning the project. However, during the recruitment period, far fewer patients than expected were asked to participate. One possibility is that fewer interventions than estimated were conducted in clinical practice. Furthermore, the exclusion criteria were formulated so that families in crisis would not be included, and there is the possibility that the family situation in many families in contact with adult psychiatry was difficult and that they were not asked to participate. The mental health professionals were the ones who decided whether a patient was eligible to invite, based on the inclusion and exclusion criteria, and they were the ones who recruited. Other studies have found that one reason for not to inviting patients to participate in clinical research is not wanting to cause them distress (Jorm et al., 2007), and this could have been another reason for not inviting patients to participate in this project.

Furthermore, not all patients invited wanted to participate. This could affect the characteristics of the included sample, and be a threat to the external validity of the findings (Kazdin, 2022). In other clinical research, the reasons stated by patients for not participating are, for example: not having the energy to participate because of symptom severity; the time required for participation; and being uncomfortable at revealing information about their mental disorder (Bixo et al., 2021). In our project the patients did not have to state reason for not wanting to participate, based on ethical considerations.

In studies I and II, patients with bipolar disorder chose to participate to a greater extent than did patients with depression and anxiety disorders. This could be an effect of the units working with patients with bipolar disorder, which often are specialized on this group of patients. This could also have been an effect of the mental health professionals who recruited families to interventions and to the research, as well as were in the treatment process the patients were when invited to participate.

Studies I and II were designed to include multi-informants, whereby patients would be asked to participate first, and if they accepted, both their partners and their children over 10 years old would then be asked to participate. To support the mental health professionals in recruiting participants, the research team had close contact with the units during the recruitment period, which was prolonged several times. Despite these efforts, the intended sample size was not reached, and only a few partners and very few children were included. This meant that evaluation based on multi-informants was impossible, and that the groups included in the evaluation trial were smaller than planned. This has consequences for the possibility to detect differences between groups (Kazdin, 2022).

In Study III the intended number of participants was reached, although they represent only a very small group of all possible participants. Participants were informed of the study and invited to participate in writing to be able to reach all possible participants and not burden the mental health professionals with administration related to the research project. Although all parents received the written information, it is possible that some did not read it. In this study, it was possible to compare the included children with all children whose parents had been invited to participate concerning age and sex, which revealed no differences. However, it is uncertain whether the participating parents are representative of all parents of children accessing CAMHS. Parents in the included sample were found to have statistically significantly higher Social Status according to the Hollingshead index, compared with a population-based reference group. The number of parents with mental health problems estimated in our study must therefore be interpreted with caution, and a larger sample needs to be investigated to verify or get a more representative estimate.

Unfortunately, not all measures were available in a range of languages. Consequently the participants in all three studies were required to be able to complete the questionnaire independently in Swedish to participate, which meant that parents not yet fluent in Swedish were underrepresented in the included samples.

Self-reports completed by parents

Another important methodological consideration is that the participants included in both projects were parents, so results are based solely on parent-rated questionnaire data. Parental reports are commonly used to investigate children's mental health problems (De Los Reyes et al., 2015) and to evaluate preventive interventions for children of parents with mental disorders (see. e.g., Reedtz, van Doesum, et al., 2019; Solantaus et al., 2010). The use of parental reports also made it possible to include reports on children aged 8–9 years who would have been too young to complete the questionnaires themselves.

Modest agreement has generally been reported regarding reports from different informants about mental health problems in the same child, and discrepancies between informants reflect their different views, for example, depending on the context in which difficulties emerge and where the informants interact with the child (De Los Reyes et al., 2015). If both internalizing and externalizing problems are of interest, both parents' and children's reports should be included; however, for the measure of children's mental health problems included in this research use of parental reports has been recommended if only one informant is available (Kuhn et al., 2017).

Another methodological consideration is that reports from parents with mental health problems could be biased towards reporting more mental health problems in children (De Los Reyes & Kazdin, 2005; Maoz et al., 2014). However, evidence is not conclusive concerning this tendency, as not all studies have found support for this effect (De Los Reyes et al., 2015). Furthermore, in samples of parents with depression, both child and parental reports have been found to predict new onsets of depression in children to a similar degree, whereas for younger children, parental reports could better predict new onsets (K. J. S. Lewis et al., 2012).

Reports concerning family functioning can differ between family members (Daches et al., 2018), and parents with mental disorders have been found to report more family dysfunction than do their partners and children (Sell, Daubmann, et al., 2021). It has also been found that parents with mental disorders may not want to reveal difficulties in the parenting role for fear of losing custody, which could lead to biased reports concerning parenting difficulties (Sherman & Hooker, 2018). This makes multiple sources of information especially relevant when examining such variables in the context of parental mental disorders (Sell, Daubmann, et al., 2021). Lack of multi-informants is therefore a limitation of the included studies.

In the included samples, mothers chose to participate to a greater extent than fathers, as in much previous research into families experiencing mental health problems (Campbell et al., 2021; Ramchandani & Psychogiou, 2009). Concerning studies I and II, this could also reflect the fact that, for depression and anxiety, higher prevalence rates of these diagnoses are found among women than men (Stambaugh et al., 2017; Steel et al., 2014).

Quasi-experimental design

The evaluation of the preventive interventions (Study II) was designed as an effectiveness study, to investigate how the interventions work in naturalistic real-world settings for a clinically referred sample, delivered by practitioners

and in comparison with other interventions used in routine care (Weisz et al., 2015). In efficacy trials, experimental control is emphasized, as such studies are usually conducted in settings created for research, with participants recruited through, for example, ads, and delivered by individuals employed in specific projects (Weisz et al., 2015). However, to claim effectiveness for an intervention, the standards for both efficacy and effectiveness trials need to be met (Gottfredson et al., 2015), and it has been suggested that clinical decision-making should be guided by the results of both randomized controlled trials and more pragmatic trials conducted in clinical practice (Hasson et al., 2020)

The design of the effectiveness study was quasi-experimental (Shadish & Cook, 2009). Based on estimations prior to the study, it was not deemed possible to randomize the patients, due to the small number of professionals at each unit trained in the interventions under investigation and due to the small number of interventions given by these professionals. Participants therefore received the intervention available at their units, and non-random assignment was applied. By not randomizing the participants, several threats to internal validity were introduced, for example, selection bias, which refers to systematic differences between groups existing before the interventions were given (Kazdin, 2022; Shadish & Cook, 2009). In Study II, possible differences between groups at baseline were controlled for statistically, and no statistically significant differences were found. However, it is difficult to be certain that all unobserved variables were similar between groups, and issues relating to different psychiatry units or the professionals' reasons for choosing between the various interventions could have introduced bias.

An important design feature that can counteract this threat is inclusion of a comparison group (Shadish & Cook, 2009), and in this study patients from the same or similar psychiatry units were used for this purpose. The comparison group consisted of patients undergoing any other type of intervention apart from FTI and LTC given in routine care, ranging from very brief to long interventions in various formats. This approach has several implications for the results. Time could possibly change the content of the comparison interventions, as more knowledge accumulates and could change their content (Kazdin, 2022). There could also be variation in the effectiveness of the different approaches within IAU, in which comparison with a certain type of IAU could yield different results. Furthermore, the diffusion of interventions was possible in this study: the mental health professionals conducting the different interventions sometimes contributed interventions to multiple study groups, there was overlap between their training, and sometimes professionals trained in the manual-based interventions instead gave an IAU. Furthermore, the interventions were already

implemented in these settings and the researchers had no part in supervising those delivering the interventions. Since no fidelity assessment was conducted, there is a risk that the interventions were not given according to the manuals. However, all the professionals conducting the manual-based intervention had proper training in them, which should increase fidelity to the models.

Furthermore, the loss of participants who did not complete the follow-up questionnaires, referred to as attrition, can threaten the internal validity, as those who do not complete the questionnaires at follow-up could differ from those who do, which could influence results (Kazdin, 2022). In Study II, differences between those who stayed in the study and those who did not were controlled for, and no significant differences were found.

Data analysis

Difficulties with recruitment have consequences for the power to detect differences between groups in intervention trials, which can threaten the data-evaluation validity (Kazdin, 2022). The relatively small number of families in the study groups, particularly in the LTC group, contributed to uncertainty in estimating effect sizes and parameters. However, multilevel growth curve models (Singer & Willet, 2003) were used to analyse the data, and since the data came from longitudinal follow-ups, with up to three measurement occasions included in the growth curve analysis, uncertainty in parameter estimation was reduced, thereby increasing the statistical power to detect the true effect sizes.

To address the magnitude of change, additional information beyond statistical significance is needed, which can be provided by reporting effect sizes. In the studies included in this thesis, Cohen's *d* effect sizes have been used to standardize the difference between two means (Cohen, 1992) and to estimate the size of the interaction effects found in the effectiveness study (Feingold, 2015). The benchmarks proposed by Cohen are commonly used in research, and in the meta-analyses of preventive interventions for the children of parents with mental disorders, small effect sizes for continuous symptom measures according to Cohen's suggested levels have been found (see, e.g., Lannes et al., 2021; Loechner et al., 2018). However, information concerning whether the effect is meaningful, commonly referred to as clinical significance, is also valuable (Kazdin, 2022; Sundell, 2012). It has been argued that the reduced incidence of mental disorders would be a more relevant way of measuring the clinical significance of preventive interventions for the children of parents with mental disorders (Garber et al., 2009); however, in Study II, information about the incidence of mental disorders was not included and was impossible to report.

Ethical considerations

Ethical considerations are essential for the way research is conducted, to ensure that research is designed in such a way that the research questions can be answered and the participants are treated with respect (Bond, 2012; Swedish Research Council, 2017). In both projects, sensitive personal data were handled, so both research projects were reviewed and approved by an ethics committee (Reg. no. 1029-13 and 806-17). Informed consent was given by all participants, and the voluntary nature of participation was emphasized. In studies I and II, the mental health professionals involved in the patient cases were the ones who informed and recruited the participants. Since this could be considered a dependency relationship, the recruiting professionals were given thorough instructions about how to address the question of participation and to emphasize that participation is voluntary and that the participation decision would not influence the care received.

Study III addresses ethical considerations concerning asking parents to participate in the project, even though they were not patients in this clinical setting. However, in contacts with CAMHS, questions concerning heredity and the family situation are asked during assessment, so the risk of completing questionnaires including such questions was considered low. Furthermore, parents were in contact with mental health professionals who could help them seek help for themselves if needed.

In the effectiveness trial (Study II), all the children were given preventive interventions, as the children of parents with mental disorders should be given support according to Swedish law if this need has been identified (SFS 2017:30). The results for the comparison group need to be discussed from an ethical point of view. In IAU children's mental health problems increased, which was not found for the two manual-based interventions. The interventions included in the comparison group consisted of a broad range of shorter- to longer-term interventions delivered in different family constellations (Axberg et al., 2020), so possibly their outcome varied. As all families were in contact with psychiatry, and as the mental health professionals had identified these families, the children and/or parents were most likely to be referred to further support or other services if needed.

An important ethical consideration is that children were not included as informants in any of the studies, even though children's mental health problems were an important outcome measure. The participation of children in research into interventions and support in healthcare is important, as they can contribute their views in accordance with the United Nations Convention on the Rights of Children (SFS 2018:1197). Studies I and II were designed to include multi-

informants (i.e., patients, partners, and children), although the recruitment of participants, especially the partners and children, was not successful. The patients were the ones who gave consent to inform and include their children, and there is the possibility that the adults wanted to protect their children from participating. Including children's experiences in research into preventive interventions could, however, contribute insights into the effects of interventions from the children's perspective, which could be especially important as children themselves are directly included in some, but not all, interventions. The participation of children in research concerning preventive interventions varies greatly (I. Larsson et al., 2018), although children have been included as informants in other quantitative evaluations of such interventions (Giannakopoulos et al., 2021). In qualitative research children have been included as participants examining, for example, children's experiences of living with a parent with a mental disorder (Yamamoto & Keogh, 2018), children's experiences of participation in preventive interventions (Pihkala et al., 2012), and children's perceived support needs (Grove et al., 2016).

Conclusion

This thesis builds our knowledge of the families of patients in contact with psychiatry. One of the most significant findings to emerge is that many families in contact with both adult and child psychiatry experience co-occurring child and parental mental health problems. The findings highlight the importance of assessing the needs of members of the families of psychiatric patients, to be able to initiate appropriate and timely support for both patients and their families.

The children of parents with mental health problems constitute an identified risk group for whom selective preventive interventions are recommended. The findings encourage the continued use of two preventive interventions that are currently used in routine care in adult psychiatry to support the children of parents with depression, anxiety, or bipolar disorder. There is, however, a need for more research into which interventions should be administered under which circumstances in adult psychiatry. The findings from adult psychiatry also show that some children were reported to already have developed symptoms, suggesting the need for indicated preventive interventions or treatment.

Findings from child psychiatry underscore the importance of assessing current mental health problems in parents to identify parents and families with co-occurring mental health problems. Parents could need their own treatment as well as support within child psychiatry to be able to support their child's recovery.

In child psychiatry, more research is needed into how to adapt treatment when the parent also has mental health problems.

The included studies have furthermore contributed knowledge of factors associated with mental health problems in members of the families of psychiatric patients. In line with past research, it was found that for the children of parents with mental health problems, a greater number of risk factors in the child's life was associated with increased odds of child mental health problems. Furthermore, low parental belief in themselves as parents was found to be a factor that predicted higher levels of children's mental health problems, which indicates that parenting is an important factor to address in patients who are parents, as a possible way of supporting their children. Family functioning was reported as problematic in many families in contact with psychiatry, and this could need to be addressed to support these families. In sum, this thesis has shown that mental health problems in family members are inevitably intertwined, and a developmental psychopathological perspective that addresses multiple relevant risk and protective factors can help identify the support needs of families in contact with psychiatry to be able to initiate appropriate support.

Clinical implications

The findings have several implications for clinical practice:

- Mental health professionals in adult-oriented clinical settings should routinely identify whether their patients have children and, if so, assess these children's needs for support.
- Assessing multiple risk factors relating to the child, parent, and family context can help in identifying children who are at increased risk of experiencing mental health problems and in identifying factors to address when supporting these families.
- Continued use of the two manual-based preventive interventions, i.e., Family Talk Intervention and Let's Talk about Children, to support the 8–17-year-old children of parents with depression, anxiety, or bipolar disorder in contact with adult psychiatry is supported.
- Let's Talk about Children may be suitable as a minimum-level intervention in adult psychiatry, as it is brief and hence possible to deliver to many families.
- Mental health professionals working in child-oriented clinical settings should address current parental mental health problems as well as family functioning when assessing the support needs of families accessing care.
- To meet the varying needs of families in contact with psychiatry, various interventions are needed, and mental health professionals should be provided

with knowledge and training concerning how to identify, assess, and support member of the families of both adult and child patients.

Future directions

As findings have shown that the younger children of parents in contact with adult psychiatry were reported to have more mental health problems, there is a need to further investigate the situation of children of different ages, and to also include children under 8 years of age of patients in contact with psychiatry. When it comes to estimations of mental health problems in family members, more large-scale studies including representative samples from both adult and child psychiatry could improve our knowledge of the prevalence rates of mental health problems in family members in these clinical settings.

Further investigations of Family Talk Intervention and Let's Talk about Children using larger samples and multi-informants are needed, as well as investigations of factors that moderate or mediate the effects of these interventions. Analysis of the effects of interventions for children of different ages and for parents of different symptom levels or perceived parenting difficulties could shed light on which interventions should be recommended for whom. Studies of mediators of change would also address the question of what causes change in these interventions. There is furthermore a need to investigate the effect of preventive interventions in more long-term follow-ups.

An important area of future research concerns how to support families with co-occurring mental health problems, which this thesis found is relevant to both child and adult psychiatry. Research into adaptations of interventions and treatment is needed, as well as into forms of interagency collaboration, to be able to make recommendations about how to tailor actions according to the needs of the whole family when both parent and child experiences mental health problems.

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Appendix

I. Nordh, E.-L. W., Priebe, G., Grip, K., Afzelius, M., & Axberg, U. (2022). Mental health in children of parents being treated by specialised psychiatric services. *Scandinavian Journal of Public Health, 50*(8), 1113–1123. https://doi:10.1177/14034948221076208

II. Wirehag Nordh, E.-L., Grip, K., Thorvaldsson, V., Priebe, G., Afzelius, M., & Axberg, U. (2023). Preventive interventions for children of parents with depression, anxiety, or bipolar disorder: A quasi-experimental clinical trial. *ACTA Paediatrica, 112*(1), 132–142. https://doi.org/10.1111/apa.16555

III. Nordh, E.-L. W., Grip, K., & Axberg, U. The patient and the family: Investigating parental and child mental health problems, family functioning, and parent involvement in child and adolescent mental health services. *Unpublished manuscript.*

The aim of this thesis was to improve knowledge of the members of the families of psychiatric patients by investigating mental health problems, risk factors, and support received from psychiatry. The thesis is based on three studies from two clinical research projects. In studies I and II, children of parents diagnosed with depression, anxiety, or bipolar disorder in contact with adult psychiatry are in focus, and in Study III, parents of children referred to child and adolescent mental health services (CAMHS) are in focus.

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is a licensed clinical psychologist with a focus on children, parents, and families.

ISBN: 978-91-8069-275-5 (PDF)
ISBN: 978-91-8069-276-2 (Print)
ISSN: 1101-718X Avhandling/Göteborgs universitet, Psykologiska inst.
Electronic version: http://hdl.handle.net/2077/75948