Children of Depression: Stopping the Cycle

Applying a family-based approach to the prevention of depressive symptoms in children does work.

BY DIANA MAHONEY
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Childhood depression has grabbed a lot of headlines recently, with major news media devoting ample space to the question, "Why are so many kids depressed, and what are we doing about it?"

And few if any of these headlines have been bigger or louder than the recent ones addressing the possible association between suicide risk and antidepressant use in children and adolescents, and the Food and Drug Administration's directive that a black box label be placed on selective serotonin reuptake inhibitors warning of this possible association.

The news behind these headlines has forced child and adolescent health care providers to ask themselves not only what is being done about depression in kids, but also, in light of the potential dangers of drug therapy, what can be done differently? For many children, the answer may lie with their parents' depression.

Studies have shown that parents with untreated depression are likely to have depressed children. "The odds of a child suffering from depression are at 25% if one parent suffers from depression. If both parents suffer from depression, the child has a 75%," said David Fassler, M.D., of the University of Vermont, Burlington.

Children of depressed parents are also at higher risk for substance abuse, antisocial behavior, and a cascade of problems associated with attachment, anxiety, physical health, academic performance, self-esteem, aggression, behavior, and language (Psychol. Bull. 1990;108:50-76).

The problems can begin in infancy and grow along with the child. The younger a child is when the parent becomes depressed, the greater the impact will be, said Dr. Fassler, who is also coauthor of the book " 'Help Me, I'm Sad': Recognizing, Treating, and Preventing Childhood and Adolescent Depression" (New York: Little, Brown and Co., 2003).

Several studies have shown that depressed mothers have trouble bonding with their newborns, are less sensitive than nondepressed mothers to their babies' needs, and are less consistent in how they respond to their babies' behavior. The behavior of their babies—listless, unhappy, hard to comfort—reflects those deficits, as does defiant, out-of-control behavior in a toddler.

Pair the difficulty dealing with their children with depressed parents' irritability, fatigue, pessimism, and social/emotional withdrawal, and the cycle is perpetuated into adolescence, where it manifests as poor academic performance, lack of motivation, social withdrawal, a sense of hopelessness and, potentially, suicidal thinking.

Although parental depression is not the only risk factor for depression in children, it is a major—and changeable—one. "There are certain steps you can take to reduce the risks for a child with a family history of mental illness," Dr. Fassler said. These include monitoring the child for possible signs and symptoms of depression, as well as modifying the environmental contributors, which sometimes includes treating the parents' depression.

The first step toward effective intervention is to develop a treatment plan specific to the child and the family. Often, this might include individual and family therapy, school involvement, and, if necessary, adjunctive medication. Medication should only be used as part of a comprehensive, individualized treatment plan," Dr. Fassler said.

Applying a family-based approach to the prevention of depressive symptoms does work. In a 2003 study, William Beardslee, M.D., head of psychiatry at Children's Hospital Boston, and his colleagues at the affiliated Judge Baker Children's Center, tested the effectiveness of two cognitive, psychoeducational, preventive interventions in children of depressed parents (see related story).

Preliminary results from the first-of-its-kind longitudinal primary prevention study of healthy kids at risk for psychopathology showed that the interventions, which addressed parental depression, resulted in a significant reduction in risk factors and increase in protective factors in the participating families over more than 2 years.

The case for preventive intervention among depressed families is a strong one. Several studies on children who were depressed before puberty show that they had a higher rate of antisocial behavior, anxiety, and major depression as adults than adults who experienced their first depressive episode as teens. Often, these children have little understanding of depression and feel like outsiders in their own world.

On the other hand, children who receive support and reassurance that their depression has a name and is treatable—and that their parents' depression is not a reflection on them but an illness to be overcome—are less likely to get caught in the intractable cycle and become depressed parents themselves. ■

Models Build Resilience in Children of Parents With Depression

Helping children understand a parent's mood disorder through open, honest communication fosters resiliency in those who might otherwise succumb to mental illness, according to Dr. Beardslee.

For children living in homes with depressed parents, promoting resilience through communication is the central component of a family-based intervention developed by Dr. Beardslee and his colleagues at the Judge Baker Children's Center in Boston.

Based on studies they conducted in the 1980s, Dr. Beardslee has identified core characteristics of resilient youth: a desire to accomplish developmental tasks outside the home, such as doing well in school or in sports; a commitment to relationships with friends, siblings, and parents; and an understanding that they are not to blame for a parent's illness.

Giving depressed parents the tools to build resilience in their children is central to the Prevention Intervention Project. The manualized, stepwise therapeutic strategy teaches parents to encourage children to pursue interests, relationships, and activities outside the home and to talk about the illness in a productive way.

The intervention is designed for use by physicians, school counselors, nurses, and mental health professionals.

Two models—one lecture based, the other clinician led—have been tested with promising results. In the lecture-based model, parents attend two group meetings without their children. In the clinician-led version, parents and children attend a series of 6-11 meetings facilitated by a clinician, as well as a family meeting led by the parents during which the illness is discussed.

Participants in both interventions receive information about mood disorders, risk, and resilience, and both interventions focus on removing misunderstanding, guilt, and blame.

In the clinician-led intervention, cognitive information is linked specifically to the individual's life and family experiences, while the lecture intervention presents that information in a group format with opportunity for discussion. Unlike in the clinician model, children of families receiving the lecture intervention are not seen directly; parents are encouraged to talk with their children.

In an examination of the efficacy of the programs at 1 year and 2 ½ years post intervention among 100 families randomly assigned to one of the two intervention models, parents in both conditions reported significant change in child-related behaviors and attitudes, and the amount of change increased over time. Children in both conditions reported increased understanding of parental illness, and internalizing scores for all of the children decreased (Pediatrics 2003;112:e119-31).

Although more change was seen in the clinician-led group, the long-standing positive effects of both interventions suggest that interventions built around family involvement, even if brief, "translate into significant mental health gains for children and families," Dr. Beardslee said.

Perspective

We live in a society that believes in "better living through chemistry." Fortunately, there are those who rail against the trend of taking a pill for everything that ails us. But in the treatment of mental illness, hard work is critical to helping patients achieve health and well-being.

In my research, I have uncovered several key principles necessary to cultivate resilience and resistance in individuals so they won't need pills to manage clinical illness. We need to:

- ► Create a social fabric around individuals.
- ► Establish systems that promote interpersonal connectedness as a way to facilitate health behavior change.
- ► Develop infrastructures that promote social skills, personal value, and empowerment.
- ► Provide children with an adult protective shield to increase protective factors and decrease risk factors.
- ► Strive to minimize the experience and impact of trauma.
- ► Support quality psychosocial research at the level we have been supporting biomedical research.

Validated programs that incorporate these principles, such as the Preventive Intervention Project, need to be aggressively marketed. For example, people are more hyped about preventing maternal transmission of HIV than preventing parental transmission of depression because of the availability of clear-cut, proven, hard biologic interventions for HIV. To encourage a paradigm shift in mental illness, science needs to show equally strong evidence for psychosocial interventions, along with a strong advocacy campaign to convince people that psychosocial interventions are as valuable as biological ones.

Another obstacle is our couch-potato society's shortsighted preoccupation with how long something takes.

Some would argue that 6-11 manualized, evidence-based sessions aimed at helping a child keep from getting depressed is a significant time commitment, but consider the possible depression-related outcomes without such efforts: school failure, substance abuse, hopelessness, and suicide attempts. How can an individual or a society not make such a time investment?

It boils down to paying now or paying much, much more later, akin to the old Chinese proverb: "You are a fool if you wait until you are thirsty before you start digging your well."

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