

Vol. 4, No. 4 2010

## Addressing Parental Depression



### Overview

When depression hinders parenting



### Review

Helping children by helping parents



### Next Issue

#### Building strengths with the Nurse-Family Partnership

*Nurse-Family Partnership* is an American program aimed at helping vulnerable new parents and their children. In our Winter 2011 issue, we review the 30 years of research on this landmark prevention program and the implications for bringing it to BC and Canada.



### Feature

Treating the parents of young children



### Letters

Public policy for curbing cannabis use

### About the Children's Health Policy Centre

As an interdisciplinary research group in the *Faculty of Health Sciences* at *Simon Fraser University*, we aim to connect research and policy to improve children's social and emotional well-being, or *children's mental health*. We advocate the following public health strategy for children's mental health: addressing the determinants of health; preventing disorders in children at risk; promoting effective treatments for children with disorders; and monitoring outcomes for all children. To learn more about our work, please see [www.childhealthpolicy.sfu.ca](http://www.childhealthpolicy.sfu.ca)



**Children's  
Health Policy  
Centre**  
VOL. 4, NO. 4 2010

### About the Quarterly

In the *Quarterly*, we present summaries of the best available research evidence on children's mental health interventions, using systematic review methods adapted from the *Cochrane Collaboration*. However, because the quality of evidence varies by topic, we retain flexibility in setting our acceptance criteria to ensure we are able to provide helpful information for policy-makers and practitioners. As well, we always provide details on the strengths and weaknesses of the research evidence.

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**SIMON FRASER UNIVERSITY**  
THINKING OF THE WORLD

# Quarterly

## This Issue

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#### When depression hinders parenting

When parents suffer from depression, their children are often affected. But these children do not inevitably experience poorer outcomes than their peers. We explore what can be done to promote the well-being of depressed parents and their children.

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Researchers have evaluated a wide variety of interventions aimed at helping the children of depressed parents. We examine the results of six randomized controlled trials to discover which ones were the most effective in assisting both children and parents.

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We encourage you to share the *Quarterly* with others and we welcome its use as a reference (for example, in preparing educational materials for parents or community groups). Please cite this issue as follows:

Schwartz, C., Waddell, C., Barican, J., Gray-Grant, D., Garland, O., & Nightingale, L. (2010). Addressing parental depression. *Children's Mental Health Research Quarterly*, 4(4), 1–16. Vancouver, BC: Children's Health Policy Centre, Faculty of Health Sciences, Simon Fraser University.

## Overview

### When depression hinders parenting

*I could take care of the basics to keep him alive until my husband came home, but I didn't have the interaction with him.... There was no sense of I love this baby.*

— A depressed parent<sup>1</sup>

*I just could tell that she was sick or something.... 'Cause ... she usually would get mad at me ... or sometimes she'd cry or something. That was hard for me to understand 'cause I didn't know what she was crying about.*

— Child with a depressed parent<sup>2</sup>



■ Children can experience profound consequences when a parent is depressed.

Depression causes enormous distress and suffering. And this suffering affects many people. Data from one population-based epidemiological survey suggest that approximately 1 in 5 women and 1 in 10 men will experience significant depression at least once during their lifetimes.<sup>3</sup> New mothers can be particularly vulnerable, with 8% to 15% meeting experiencing depression by their child's first birthday.<sup>4</sup>

### The effects on children

Children can experience profound consequences when a parent is depressed. Risks vary by developmental stage, with some being detectable as early as birth<sup>5</sup> (see Table 1).

**Table 1: Risks to children when parents are depressed**

Stage	Risks
Perinatal <sup>5</sup>	Premature birth & low birth weight
Infancy <sup>6</sup>	Cognitive delays, lower frustration tolerance, attachment issues & eating & sleeping problems
Childhood <sup>7</sup>	Social problems, cognitive delays, mental disorders & physical health difficulties

Parental depression has been clearly identified as a risk factor for children developing certain mental disorders. One study that tracked young people for 20 years found those with a depressed parent had significantly higher rates of depression, anxiety and conduct disorder.<sup>8</sup> Strikingly, when parents had their first depressive episode before age 30, their child's risk for

depression increased thirteenfold.<sup>8</sup>

## Reducing risk, increasing resilience

Researchers have tried to uncover the reasons for these poorer outcomes by observing depressed parents with their children. Despite their best intentions, mothers with postpartum depression can have difficulties responding consistently to their infants.<sup>5</sup> When children are older, depressed parents often experience difficulty providing appropriate and consistent discipline and supervision.<sup>3</sup> As well, they frequently express more hostility,<sup>6</sup> more withdrawal<sup>9</sup> and less nurturance<sup>3</sup> than parents who are not depressed.

Even with these challenges, many children of depressed parents do well.<sup>10</sup> To better understand this apparent resilience in the face of adversity, researchers have investigated potential protective factors. One preliminary study found that young people with depressed mothers were significantly more likely to show resilience when they perceived their mothers as being warm yet not “over-involved,” and when they perceived both parents as not being “controlling.”<sup>10</sup> (Additional protective and risk factors for childhood depression, such as genetic susceptibility, are detailed in our Spring 2008 issue — *Preventing and Treating Childhood Depression*.)

## Treating parental depression

Canadians have yet to make substantial public investments in programs that can prevent depression. As a result, the need for detecting and treating depression early becomes even more critical for both parents and children. Anyone with concerns about depression should contact the family physician for information on effective treatment options. (Information on programs that can prevent depression in children can also be found in our [Spring 2008 issue](#).)

Effective treatment for parents can sometimes be enough to help children avoid negative outcomes. However, treatment for parents is not always enough. In our [Review article](#), we therefore provide a summary of the additional interventions that can help both children and parents. 🖐️

“Effective treatment for parents can sometimes be enough to help children avoid negative outcomes.”

## Helping children by helping parents

To identify interventions producing the best outcomes for children of depressed parents, we conducted a systematic review using methodology adapted from the *Cochrane Collaboration* (see the [Appendix](#)). In addition to our usual inclusion criteria, we selected only studies where at least one parent met diagnostic criteria for depression or dysthymia and where children were *not* depressed at study outset. Based on these criteria, we accepted six randomized controlled trials (RCTs) (described in eight different articles) from a total of 30 articles initially retrieved for assessment.

The interventions in the accepted RCTs were highly diverse, ranging from home visiting for mothers of infants to group cognitive therapy for adolescents (see Table 2). Nevertheless, cognitive techniques *were* used in most of the RCTs. Other interventions included non-directive counselling and psychodynamic therapy for mothers,<sup>11</sup> and psychoeducation for families.<sup>12</sup>



**■ Clinician home visiting improved many aspects of the mother-child relationship.**

**Table 2: Description of interventions**

Children's age range	Intervention
1–12 months	<b>Clinician home visiting:</b> <sup>6</sup> 43 Dutch mothers were taught parenting skills, positive ways of thinking about their infants & their parenting abilities & baby massage in 8–10 in-home sessions
2 months	<b>Cognitive-behavioural therapy (CBT):</b> <sup>11</sup> 43 British mothers were taught parenting skills, problem-solving & positive ways of thinking about their infants & themselves in 10 in-home sessions
	<b>Psychodynamic therapy:</b> <sup>11</sup> 50 British mothers explored their attachment history to increase understanding of their infants & promote a positive parent-child relationship in 10 in-home sessions
	<b>Non-directive counseling:</b> <sup>11</sup> 48 British mothers discussed any current concerns in 10 in-home sessions
2½–4 years	<b>Group CBT:</b> <sup>13</sup> 47 British mothers were taught parenting skills & depression reduction techniques (e.g., activity scheduling & problem-solving) in 16 community-based sessions
8–15 years	<b>Clinician-facilitated intervention:</b> <sup>12,14</sup> 59 American families were taught strategies to reduce children's feelings of guilt & increase their involvement in out-of-home activities in 2–9 community-based sessions*
9–15 years	<b>Group CBT family intervention:</b> <sup>9</sup> 56 American families were taught parenting skills, stress monitoring & coping skills in 12 community-based sessions
13–18 years	<b>Group cognitive therapy:</b> <sup>15</sup> 45 American youth were taught to identify & challenge unrealistic, negative thoughts, especially those related to having a depressed parent, in 15 community-based sessions**

\* Plus telephone contact or "refresher meetings" at 6- to 9-month intervals.

\*\* Parents attended 3 meetings where they were informed about the general topics and skills taught to their children.

Although most interventions involved both parents and children, older children tended to participate more than younger ones. For example, in three RCTs involving mothers of infants<sup>6, 11</sup> and toddlers,<sup>13</sup> interventions understandably centred on the mothers, with children having relatively limited involvement. In contrast, in the one RCT focused on adolescents, parents had relatively limited involvement.<sup>15</sup>

## What works for the youngest children?

For depressed mothers of infants and toddlers, five interventions (described in three RCTs) produced very different results, as shown in Table 3. *Clinician home visiting* improved many aspects of the mother-child relationship, including maternal sensitivity and infant responsiveness.<sup>6</sup> In contrast, three interventions delivered individually to mothers without directly involving their infants (i.e., *CBT*, *psychodynamic therapy* and *non-directive counselling*) produced fewer benefits.<sup>11</sup> While *psychodynamic therapy* and *non-directive counselling* resulted in babies exhibiting significantly fewer behavioural challenges, such as temper tantrums and sleep and feeding problems, *cognitive-behavioural therapy (CBT)* did not.<sup>16</sup> As well, none of these therapies significantly improved infants' cognitive development or their attachment to their mothers. Similarly, *group CBT* for mothers of toddlers failed to produce any benefits.<sup>13</sup> The authors of this latter study suggested that this may have been due to many of the socially disadvantaged mothers having difficulties attending sessions.

**Table 3: Intervention outcomes for infants, toddlers and their mothers**

Program (follow-up)	Statistically significant outcomes	Non-significant outcomes
<b><i>Clinician home visiting</i></b> <sup>6</sup> (6 months)	<ul style="list-style-type: none"> <li>↑ Infant capacities</li> <li>↑ Infant initiation of interactions with mother</li> <li>↑ Infant responsiveness &amp; attachment to mother</li> <li>↑ Maternal sensitivity to child</li> <li>↑ Maternal structuring of interactions</li> </ul>	<ul style="list-style-type: none"> <li>Infant emotional &amp; behavioural symptoms</li> <li>Infant sleeping &amp; eating problems</li> <li>Maternal intrusiveness with child</li> <li>Maternal hostility to child</li> <li>Maternal depression symptoms</li> </ul>
<b><i>Psychodynamic therapy</i></b> <sup>16</sup> (18 months)*	<ul style="list-style-type: none"> <li>↓ Infant problem behaviours</li> </ul>	<ul style="list-style-type: none"> <li>Infant cognitive development</li> <li>Infant attachment to mother</li> </ul>
<b><i>Non-directive counselling</i></b> <sup>16</sup> (18 months)*	<ul style="list-style-type: none"> <li>↓ Infant problem behaviours</li> </ul>	<ul style="list-style-type: none"> <li>Infant cognitive development</li> <li>Infant attachment to mother</li> </ul>
<b><i>Cognitive-behavioural therapy (CBT)</i></b> <sup>16</sup> (18 months)*	None	<ul style="list-style-type: none"> <li>Infant problem behaviours</li> <li>Infant cognitive development</li> <li>Infant attachment to mother</li> </ul>
<b><i>Group CBT</i></b> <sup>13</sup> (12 months)	None	<ul style="list-style-type: none"> <li>Toddler emotional &amp; behavioural symptoms</li> <li>Maternal depression symptoms</li> </ul>

\* Five-year outcomes (which were all non-significant) are not reported as the attrition level exceeded our criterion.

## Outcomes that improve with age

The three interventions delivered to school-age children and youth (all of which included parent participation) produced at least some positive outcomes, as shown in Table 4. The *clinician-facilitated intervention* resulted in children better understanding their parents' mood disorder but had no effect on children's emotional symptoms or on family well-being.<sup>12</sup> The two interventions that included cognitive techniques, however, showed stronger

**Table 4: Intervention outcomes for school-age children and their parents**

Program (follow-up)	Statistically significant outcomes	Non-significant outcomes
<b>Clinician-facilitated intervention</b> <sup>12</sup> (3–4 years)*	<ul style="list-style-type: none"> <li>↑ Child's understanding of parent's disorder</li> <li>↑ Parent's positive attitudes &amp; behaviours</li> </ul>	<ul style="list-style-type: none"> <li>Child emotional symptoms</li> <li>Family functioning</li> </ul>
<b>Group CBT family intervention</b> <sup>9</sup> (6 months)	<ul style="list-style-type: none"> <li>↓ Child depression symptoms**</li> <li>↓ Child anxiety symptoms**</li> <li>↓ Child emotional symptoms**</li> <li>↓ Parental depression symptoms</li> </ul>	<ul style="list-style-type: none"> <li>Any child psychiatric diagnoses</li> <li>Child depression symptoms<sup>†</sup></li> <li>Child anxiety symptoms<sup>†</sup></li> <li>Child emotional<sup>†</sup> &amp; behavioural symptoms**<sup>†</sup></li> <li>Parental depression episodes</li> </ul>
<b>Group cognitive therapy</b> <sup>15</sup> (2 years)	<ul style="list-style-type: none"> <li>↓ Days youth experiencing depression‡</li> <li>↓ Youth depression symptoms**<sup>±</sup></li> <li>↓ Youth suicidality</li> <li>↑ Youth functioning</li> </ul>	<ul style="list-style-type: none"> <li>Youth depression symptoms<sup>†</sup></li> <li>Youth non-mood diagnoses</li> <li>Youth emotional &amp; behavioural symptoms<sup>†</sup></li> </ul>

\* Calculated from the final regular session (rather than the final booster session).

\*\* Based on child self-report.

† Based on parent ratings.

‡ Among youth who developed depression, intervention youth had a later onset and fewer depressed days than controls.

± Based on clinician ratings.

results. The *group CBT family intervention* significantly reduced self-reported depression and anxiety symptoms among children and youth,<sup>9</sup> while *group cognitive therapy* resulted in fewer depression symptoms, reduced suicidality and increased general functioning among youth.<sup>15</sup>

Two studies also assessed whether children themselves were less likely to develop depression after completing interventions. Although children participating in *group CBT family intervention* were less than half as likely to develop depression compared to controls by 12-month follow-up (9% versus 21%), the difference was not statistically significant.<sup>9</sup> In contrast, adolescents participating in *group cognitive therapy* were significantly less likely to develop depression at 12-month follow-up compared to controls (9% versus 29%). However, differences in depression rates were no longer significant by 24-month follow-up.<sup>15</sup>

## Treating parents' depression

Two studies also examined how treating parents' depression affected children's outcomes. In *clinician home visiting*, mothers in both the intervention and control groups also received supplemental treatment services for their depression from providers who were independent of the study.<sup>6</sup> Depression levels declined significantly for both groups of mothers. Nevertheless, because *additional* gains were found only in the infants and

## Treating parents, benefiting children: A Canadian success story

What happens to children's behaviour when their parent's mood disorder is treated effectively? That's exactly what a group of Canadian researchers set out to determine. Byrne and her colleagues<sup>17</sup> examined data from a larger study where parents were randomly assigned to one of three treatment conditions: medication (Sertraline), interpersonal psychotherapy or both. Rather than analyzing children's outcomes based on treatment assignment (the criteria for our own systematic review), the researchers examined outcomes based on whether the parent's mood disorder successfully resolved (which it did for 66%).

Children (ranging from 4 to 16 years old) whose parents responded to treatment had significantly fewer emotional and behavioural problems than children whose parents did not improve, including a 58% lower rate of behavioural disorders. These findings suggest that effective treatments for parental mood disorders — *even without supplemental interventions for children* — can produce significant improvement for many young people.

mothers who participated in *clinician home visiting* (for example, increased maternal sensitivity), the study authors concluded that simply treating maternal depression was insufficient for improving the interactions between most depressed mothers and their children.

In *clinician-facilitated intervention*, all parents were encouraged to obtain independent treatment for their depression. Surprisingly, in families where parents did so, there was poorer cohesion and greater conflict, with children also experiencing greater emotional difficulty.<sup>12</sup> In explaining these counterintuitive findings, the authors suggested that the parents who sought treatment may have had more severe depression. As well, since the study did not assess the *quality* of the treatment that parents received, ineffective treatment may also explain the findings.

### Helping children at every age and stage

Researchers have implemented and evaluated a host of interventions designed to help children of depressed parents. The eight we reviewed varied substantially regarding goals, core elements, outcome measures and efficacy, with children's ages being the basis for many of these differences.

For example, interventions for mothers of infants and toddlers focused on teaching mothers parenting skills and healthier ways of viewing themselves as parents. These interventions had limited child involvement and no participation by fathers. As well, outcome measures tended to focus on common behavioural challenges among infants, such as feeding and sleeping difficulties, along with infants' attachment to their mothers. Among these interventions, the *clinician home visiting* program was the most promising. Mothers learned more constructive ways of interacting with their infants, who, in turn, made a number of gains.

In contrast, interventions delivered to older children and their families had much greater child participation. Most included teaching children cognitive therapy techniques, and all included children's emotional functioning in the outcome measures. Among these interventions, *group CBT family intervention* and *group cognitive therapy* produced many positive benefits, including the particularly salient outcome of reducing children's depression symptoms. 🖐️

“ Group CBT family intervention and group cognitive therapy produced many positive benefits. ”



## Treating the parents of young children

“Life is not a mathematical equation,” wrote Pratibha Reebye, director of Infant Psychiatry at BC Children’s Hospital and clinical professor at the University of BC, in a collection of short stories published in 2006. “One plus one never really adds to two when we care or love someone.”

Reebye feels the same way as a practitioner, arguing that health professionals should never deal with a parent alone, but rather, in the context of the family. “I believe that we, as a society, don’t have enough insight into parents’ psyches.” As well, she believes that health professionals often don’t put enough emphasis on taking detailed parent histories — including how parents themselves were parented and how they themselves face the challenge of parenting now.

“Clinicians need to know that emotionally troubled parents may come in asking more questions about their *symptoms* rather than their parenting roles.” The answer, says Reebye, is to ask explicitly about parenting. “Questions about parenting should be *routine*,” she says. “If nobody even asks, it gives a subliminal message that says parenting is not important. But if you ask, ‘How are you or your children coping?’ it’s a chance for parents to talk about it.”

Reebye’s infant psychiatry clinic sees children from birth to 60 months but specializes in children age 36 months and younger. Infants are always seen with the caregivers. “I think the clinician needs to have a clear philosophical mandate,” Reebye says. “Some people believe depression is the cause of everything that is happening to the child. I prefer to tease these things apart. I think that just having a diagnosis of depression doesn’t make parents unfit.”

Reebye likes to start with what she describes as the “dyadic interaction” — that is, the relationship between the mother or father and child. “Some clinicians work exclusively with parents and don’t have an opportunity to address the infant,” she says. “But we know from the research that parental



“Questions about parenting should be routine.”

— Pratibha Reebye, psychiatrist

### Book gives a hand up to depressed parents

Parents looking for resources while they are depressed may find it helpful to consult an inexpensive handbook, according to Rob Lees. He is a registered psychologist with Child and Youth Mental Health, Ministry of Children and Family Development in Chilliwack. The book is *Parenting Well When You’re Depressed: A Complete Resource for Maintaining a Healthy Family*. According to Lees, it is part self-help and part workbook. “It’s a really powerful resource for families dealing with depression,” he says. *Parenting Well* offers a number of creative suggestions for initiating discussions about depression with children, including using videos, writing letters and drawing pictures. (The book was written by Henry, Clayfield, Phillips and Nicholson and published by New Harbinger Publications in 2001.)

sensitivity and warmth *can* be enhanced. In order to do this, we teach parents to read infants' cues — and most are able to do it,” Reebye says.

One way her team helps is by using video-feedback therapy. For example, if parents are having difficulty getting their child to eat, they might be asked to bring in some snacks and then be videotaped as they try to feed the child. “The parent would watch these tapes with me and I would ask them what they think. I'm amazed how parents can read themselves.” Reebye noted that usually she does not keep the videotapes but instead gives them to any parent who wants them. “It's for them to learn,” she says.

Another practice used by the clinic is called “Watch, Wait and Wonder.” Using this technique, parents watch their babies and wonder what they're doing and reflect on that with their therapist. The clinic also offers several forms of supportive therapies, including group exercises to enhance parental bonding experience with their child. “Medication is not the most important thing in my department,” according to Reebye.

For clinicians dealing with parents facing depression, Reebye says: “Don't be worried about the diagnosis itself. Concentrate on the human potential. And, most of all, don't convey hopelessness to the parent.”

Parents who would like more information about Reebye's clinic or who require assistance with depression should contact their family doctor or their local [Child and Youth Mental Health team](#) (funded by the Ministry of Children and Family Development) for assistance. 🖐️

“ Parental sensitivity and warmth can be enhanced. ”

### Public policy for curbing cannabis use

To the Editors:

Your issue on treating substance abuse identified specific policies that may reduce harmful alcohol use among adolescents. What role can public policy-making play in addressing cannabis use in Canadian youth?

David Brown  
Kelowna, BC

Canada's recent policies on cannabis have promoted abstinence primarily through law enforcement.<sup>18</sup> However, the fact that Canadian youth have some of the highest rates of cannabis use in industrialized countries strongly suggests that this approach has failed.<sup>19</sup> Current rates of use also suggest that many Canadian youth may be vulnerable to the known health risks of early cannabis use, including attention and memory problems and motor vehicle accidents.<sup>19</sup>

Fischer and colleagues<sup>19</sup> document the merits of replacing the current emphasis on law enforcement with a public health approach. The multi-faceted public health approach stresses identifying and tackling risk factors that can lead to more serious substance problems in young people, including using cannabis before age 14 and using it daily or near daily.<sup>19</sup> The approach includes promoting health along with preventing and treating cannabis abuse and dependence. Harm reduction, which focuses on pragmatically minimizing the negative outcomes associated with use of a given substance, is also part of a public health approach. While abstinence may be the most reliable way to avoid harm, switching the emphasis from law enforcement to harm reduction may actually reduce detrimental outcomes more effectively in the end.<sup>19</sup> 🖐️



■ **The multi-faceted public health approach stresses identifying and tackling risk factors that can lead to more serious substance problems in young people.**

#### We welcome your questions

If you have a question relating to children's mental health, please email it to [chpc\\_quarterly@sfu.ca](mailto:chpc_quarterly@sfu.ca) or write to the Children's Health Policy Centre, Attn: Daphne Gray-Grant, Faculty of Health Sciences, Simon Fraser University, Room 2435, 515 West Hastings St., Vancouver, BC V6B 5K3.

## Research methods

For our review, we used systematic methods adapted from the *Cochrane Collaboration*.<sup>20</sup> We limited our search to randomized controlled trials published in peer-reviewed scientific journals over the past 10 years.

To identify high-quality intervention evaluations, we first applied the following search strategy:

<b>Sources</b>	<ul style="list-style-type: none"> <li>• Medline, PsycINFO, CINAHL, ERIC and the Campbell Collaboration Library</li> </ul>
<b>Search Terms</b>	<ul style="list-style-type: none"> <li>• Child of impaired parents, parental (maternal or paternal) depression, parent (mother or father) with depression or depressed parent (mother or father) and prevention, treatment or intervention</li> </ul>
<b>Limits</b>	<ul style="list-style-type: none"> <li>• English-language articles published from 2000 through January 2010</li> <li>• Child participants who were 18 years or younger</li> </ul>

Next, we applied the following criteria to ensure we included only the highest-quality pertinent studies:

- Clear descriptions of participant characteristics, settings and interventions
- At least one of the child's parents met *Diagnostic and Statistical Manual of Mental Disorders*<sup>21</sup> criteria for a diagnosis of major depression or dysthymia (in their child's lifetime)
- Children did not meet criteria for a diagnosis of major depression
- Random assignment of participants to intervention and control groups at study outset
- Follow-up of three months or more (from end of intervention, including booster sessions)
- Maximum attrition rates of 20% at post-test or use of intention-to-treat analysis
- Outcomes analyzed based on random assignment of participants
- Studies included at least one child mental health outcome measure
- Reliability and validity of all primary measures discussed or documented
- Levels of statistical significance reported for outcome measures

Two different team members then assessed each retrieved article to ensure accuracy of interpretations. Any differences were discussed until consensus was reached. Data were then extracted and summarized by the team. 🖐️

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BC government staff can access original articles from [BC's Health and Human Services Library](#).

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