



Review Article

Screening for and Managing Parental Depression within the Primary Care Setting to Prevent Adverse Child Health Outcomes

Jessica Jeffrey¹, Devery Mitchell², William Beardslee³, Tony Kuo² and Patricia Lester¹

¹Division of Population Behavioral Health, UCLA Semel Institute for Neuroscience and Human Behavior, Los Angeles, USA

²Department of Family Medicine, David Geffen School of Medicine, Los Angeles, USA

³Department of Psychiatry, Harvard Medical School, Boston, USA

Abstract

Parental depression may result in negative health consequences, not just for parents, but for their children as well. Children of depressed parents are more likely to utilize costly health services, develop internalizing and externalizing disorders and exhibit poor academic performance. Treatment options based on family-centered therapy have been shown to be effective at preventing negative outcomes for children of depressed parents and have also been proven beneficial to the parents themselves. Parental depression should be viewed by the primary care physician as an intergenerational problem that deserves a multi-pronged treatment approach. This paper describes the impact of parental depression on children's health outcomes, outlines the provisions of the Affordable Care Act (ACA) that benefit parents with depression, reviews guidelines for screening adults for depression within primary care settings, and offers practical suggestions for preventing negative outcomes in children of depressed parents.

***Corresponding author:** Jessica Jeffrey, Division of Population Behavioral Health, UCLA Semel Institute for Neuroscience and Human Behavior, Los Angeles, USA; Tel: +1 3108255263; E-mail: jjeffrey@mednet.ucla.edu

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Introduction

Parental mental distress, often first encountered within the primary care setting, is most accurately conceptualized as an intergenerational problem. Children of mentally distressed parents (mother and/or father) are at risk for emotional problems and functional impairment, yet rarely receive prevention and early intervention services. Parental depression serves as a paradigm for parental mental distress and its impact on children. Within the United States, 17% of parents have experienced major depression in their lifetime and approximately 7% of parents have had major depression within the past one-year [1]. The majority of individuals with mental illness receive mental health care from primary care physicians, making primary care the “de facto mental health services system”. In fact, depression is one of the most common mental health conditions treated in the primary care setting and accounts for approximately 10% of all primary care office visits [2,3]. Given the high prevalence of parental mental distress present in the primary care setting, this is an optimal location in which children of these parents can be identified. This paper describes the impact of parental depression on children's health outcomes, outlines the provisions of the Affordable Care Act (ACA) that benefit parents with depression, reviews guidelines for screening adults for depression within primary care and offers practical suggestions for preventing negative outcomes in children of depressed parents.

Discussion

Impacts of parental depression

Depressed parents have difficulty functioning in the parental role. Although depressed parents desire to provide responsive parenting and a nurturing environment, they are more likely to exhibit disengaged and negative parenting styles [4]. Specifically, Radle-Yarrow et al. [5], revealed that parents with depression are less able to assist their children with developing emotional regulation, and they provide less consistency in the parent-child relationship. They are also more likely to exhibit anger and irritability towards their children. A further contributor to stress in these parents is the experience of family discord. Families of parents with depressive symptoms are often characterized by higher levels of poor marital adjustment, parent-child discord and parental divorce, and lower family cohesion than families of non-depressed parents [3,6], all of which can interfere with depressed parents' ability to function as a parent. Parental depression and the subsequent family discord significantly increase children's risk of adverse psychosocial, cognitive, and physical outcomes [7]. Additionally, suboptimal patterns of health care utilization and use of more emergent health care resources have also been recognized in children of parents with symptoms of depression [8].

Children's psychosocial health and cognitive outcomes

Children with depressed parents are more likely to exhibit internalizing disorders, such as anxiety or depression [9]. These children are themselves at a two to four-fold risk for developing a depressive disorder, and are at a fivefold risk of attempting suicide [9,10]. In fact, the strongest risk factor for development of depression in a child is having a parent with a depressive illness [9]. Beardslee et al.

[11], demonstrated that by the age of 20 a youth with an affectively ill parent has a 40% chance of experiencing an episode of major depression. By age 25 this rate increases to 60% [12]. In addition to increased risk for depression, the STAR-D child study reported an increased risk for anxiety among children with depressed parents, noting a rate of 19% among this population [13]. Other internalizing symptoms more common in these children include increased guilt, interpersonal difficulties and problems with attachment [11]. Such symptoms may contribute to the results seen in other studies which demonstrate that these children exhibit low social competence and low adaptive functioning within their educational environments [14]. It is no surprise then that cognitive delays and poorer academic performance are also more common in children of depressed parents [9].

Children with depressed parents are also at increased risk for externalizing disorders, including conduct disorder, attention deficit hyperactivity disorder [9,15] and substance abuse [16]. As reported by the Institute of Medicine and National Research Council [16], “even 5-year-old children of depressed mothers demonstrated more dysregulated aggression and heightened emotionality and had more externalizing problems”.

Children’s physical health

Parental depression may also negatively impact a child’s physical health. O’Brien et al. [17], revealed children with suboptimal growth in their first two years of life were significantly more likely to have mothers who were depressed than children who were gaining weight appropriately. Depression has also been associated with less back positioning for sleep and missed vaccinations [17-19]. These missed preventive health opportunities place children at risk for poor health outcomes.

Children’s health care utilization

Suboptimal utilization of health care resources is evident for children of depressed parents. These children are more likely to utilize acute mental health services and emergent care, while being less likely to utilize preventive health services. Depression may impact a parent’s ability to participate in preventive services for their children. Sills et al. [8], compared the health care utilization rates of 24,391 children with a depressed parent to 45,274 age-matched children without a depressed parent. This study demonstrated decreased use of preventive services and increased use of more costly medical resources. Specifically, it was determined that having at least one depressed parent was associated with greater use of emergency department and sick visits across all age groups and a lower rate of well-child visits among children 13-17 years old. Data from the 1997 United States Medical Expenditure Panel Survey revealed children of parents with depression are 2.8 times more likely to use mental health services themselves, which aligns with the increased mental health symptoms reported in this population. Higher utilization rates translate into increased health expenditures of general services (\$282 in children of depressed parents vs. \$214 in controls) and mental health services (\$513 yearly in children of depressed parents vs. \$338 in controls) in particular [20].

Expansion of mental health provisions under the ACA

The affordable care act equalizes mental health care coverage with medical and surgical care coverage by building on the 2008 Mental Health Parity and Addiction Equity Act and expanding parity protections to approximately 62 million people [21]. Essential health benefits included in the ACA expansion require that health plans

provide comparable coverage for mental health services, which fills a prior coverage gap for nearly 3.9 million people [21]. Requiring equity between medical, surgical and mental coverage plans means that individuals who previously had inadequate mental health coverage no longer have to ration their utilization of care. Now, parents who once worried about paying out of pocket to seek help for mental distress no longer have to do so. For families, the increased access to coverage for adults is amplified by the 2010 dependent coverage expansion, which allows for dependents to remain on their parent’s health insurance plan until age 26. Thus, the ACA has effectively expanded mental health coverage for families, but evidence has shown that administration of mental health services to the newly insured is lagging [22]. This empowers primary care providers with an even larger opportunity to screen parents for depression and engage their patients in a multi-pronged approach to prevent adverse health outcomes for both parents and their children.

Recommendations

Screening for parental depression within the primary care setting

The United States Preventive Services Task Force (USPSTF) recommends screening adults for depression when office supports are in place to ensure accurate diagnosis, as well as proper treatment and follow-up (Grade B recommendation) [23]. Utilizing screening tools such as the Patient Health Questionnaire (PHQ)-2 (97% sensitive and 67% specific in adults) and PHQ-9 (61% sensitive, 94% specific in adults) during patients’ primary care appointments are proven and effective methods for a primary care physician to identify a depressed parent (Table 1) [24]. The sensitivity of a test refers to how well a test can detect a specific condition in people who have the condition. In contrast, the specificity of a test measures the proportion of people without a condition who are correctly identified as not having the condition. USPSTF Guidelines do not recommend one screening method over another, and clinicians are encouraged to use whichever method best fits their practice setting and patient population [23]. Of note, if proper support staff or treatment modalities are not in place, screening is not recommended [23]. A positive screening, however, should prompt a diagnostic interview using standard diagnostic criteria, such as Diagnostic and Statistical Manual (DSM)-5 guidelines. If depression is diagnosed, follow-up visits should be scheduled during which the physician should inquire about any children at home. See table 2 for a conversational scaffold that may be utilized with parents following a positive screening.

Practicing parent-centered therapy

Studies have shown that establishing rapport with a depressed patient early on in the treatment process directly influences the effectiveness of treatment [25]. It is important to empathize with your patient and discuss the common nature of depression as well as the challenges that may be experienced when facing depression. Emphasize that parents themselves are not at fault for having depression. The discussion should include questions about how the patient feels their depression may be affecting his or her home environment. In particular, it is important to query what the parent knows about depression and whether he or she believes their depression is impacting his or her ability to parent. It may be helpful to begin this portion of the conversation by acknowledging the struggles of parenthood and introducing the idea that depression can make even the simplest of parenting tasks more daunting.

Tools	Application	Suggestions/Next steps
PHQ-9	Screen annually. Can also be used to track symptoms from baseline when given at each follow up visit.	Employ a full diagnostic interview to confirm the diagnosis. Think of your patient as a parent. Ask follow up questions about family and home dynamics. Inquire about the patient's children-their moods, their school performance, etc.
PHQ-2	Screen annually.	If positive, follow up with PHQ-9 and subsequent evaluation.
DSM-5 criteria	Parent complaining of depressed mood or high levels of stress.	Rule out physical disorder, medication side effects. Schedule a follow up visit to specifically talk about depressive symptoms and how they are affecting your patient's home life and family members.
Physician interview	Explore non-specific complaints like fatigue, body aches, headaches, insomnia, abdominal pain, etc.	Schedule a follow up appointment to discuss the possibility of depression as a diagnosis. Assess coping mechanisms and family support. Offer resources readily.

Table 1: Screening modalities for depression.

Empathize	Employ active listening. Promote an environment where the parent can feel safe to discuss their concerns. Acknowledge the difficulties of depression.
Normalize	Discuss the ubiquity of stress and family discord. Ask the patient what they know about depression or if they are close to anyone who has battled with depression.
Treat	Discuss depression treatment options. Work with your patient to discern the best mode of treatment for them.
Educate	Provide psychoeducation on depression and its effect on families and children. Give mental health and parenting handouts (see: http://www.samhsa.gov/ for options).
Refer	In addition to individual therapy, consider recommending a family-based preventive intervention, such as "family talk", to enhance family communication and problem solving and promotion of resilience in children (see: http://fampod.org for more information).

Table 2: Conversational scaffold for follow-up interview with a depressed parent.

"ENTER your patient's frame of mind"

Treatment options should be discussed with depressed parents. Specifically, individual treatment options include psychotropic medication (antidepressants), cognitive behavioral therapy, or a combination of medication and therapy. Although a detailed review of depression treatment is beyond the scope of this paper, several resources are available regarding depression treatment guidelines [26,27]. Treating a parent's depression is only one mode of what should ideally be multimodal approach to preventing poor outcomes for a depressed parent's children. If a depressed parent reports that their child is having behavioral health difficulties, including behavioral problems, mental distress, or school-related issues, the child should be evaluated by his or her primary care physician, or by a behavioral health clinician. Early discussion about family-centered preventive interventions can be an effective strategy for preventing negative outcomes in children of depressed parents [16]. Presenting such an option alongside the options for individualized treatment of depression will help a parent feel supported. This strategy will also help to address parental concerns about depression and its impact on parenting.

Recommending family-based therapy

Family-centered preventive interventions for depressed parents have been shown to improve family level outcomes [11,28-30]. Family talk, an evidence-based family-centered preventive intervention, utilizes a parent-led approach to planning and executing family meetings that involve psychoeducation about parental depression.

This method utilizes guided discussion and creation of a family narrative in order to help all individuals within the family to express their own experience of depression, which in turn encourages the development of valuable coping skills. Specifically, families focus on developing skills in communication and problem solving. The focus of such a model is preventive for the children, and the benefits extend to the parents of the family as well. Beardslee and colleagues [11] demonstrated that this type of family-centered therapy can decrease risk factors, such as family conflict and lack of parental focus on their children, and simultaneously increase factors demonstrated to be protective, such as supportive family relationships and increased family understanding [11]. These findings have been adapted and replicated, with continued evidence for long-term health benefits for the children involved [29,30].

Practice implications and benefits to the family unit

Treating a patient with depression is similar, but not identical to, treating a parent with depression. The recognition of depression in a parent should lead the family physician to think about outcomes not only for his or her patient, but for the family unit as a whole. The family physician is in an ideal position to screen for depression, initiate depression treatment and, through psychoeducation and referral to family-based preventive interventions, promote enhancement of family functioning and prevention of negative outcomes for both parents and their children (Table 3).

Clinical Recommendation	Strength of Recommendation
Screen all adult patients for depression if clinical care and support measures are in place [23,25].	B
Simple screening questions perform as well as screening questionnaires such as PHQ-2, PHQ-9 [23,30,31].	B
Providing early intervention for the depressed parent can prevent negative outcomes for the parent and the child [11,28-30].	B
For at-risk women who recently gave birth, screen for postpartum depression [32].	B

Table 3: Key recommendations for practice.

Note: A=Recommendation based on consistent and good-quality patient-oriented evidence; B=Recommendation based on inconsistent or limited-quality patient-oriented evidence; C=Recommendation based on consensus, usual practice, opinion, disease-oriented evidence,* or case series for studies of diagnosis, treatment, prevention, or screening

Conflict of Interests

William Beardslee has received support from the NIMH, various foundations, and other governmental agencies. He provides consultation to other research projects, agencies and non-profit organizations. He has nothing to disclose. All other authors have no conflict of interest and no financial disclosures.

References

- Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE (2005) Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 62: 617-627.
- Unützer J, Park M (2012) Strategies to improve the management of depression in primary care. *Prim Care* 39: 415-431.
- Stafford RS, Ausiello JC, Misra B, Saglam D (2000) National patterns of depression treatment in primary care. *Prim Care Companion J Clin Psychiatry* 2: 211-216.
- Lovejoy MC, Graczyk PA, O'Hare E, Neuman G (2000) Maternal depression and parenting behavior: A meta-analytic review. *Clin Psychol Rev* 20: 561-592.
- Radle-Yarrow M, Nottlemann E, Belmont B, Welsh JD (1993) Affective interactions of depressed and nondepressed mothers and their children. *Journal of Abnormal Child Psychology* 21: 683-695.
- Fendrich M, Warner V, Weissman MM (1990) Family risk factors, parental depression, and psychopathology in offspring. *Dev Psychol* 26: 40-50.
- Nomura Y, Wickramaratne PJ, Warner V, Mufson L, Weissman MM (2002) Family discord, parental depression, and psychopathology in offspring: Ten-year follow-up. *J Am Acad Child Adolesc Psychiatry* 41: 402-409.
- Sills MR, Shetterly S, Xu S, Magid D, Kempe A (2007) Association between parental depression and children's health care use. *Pediatrics* 119: 829-836.
- Gladstone TR, Beardslee WR, O'Connor EE (2011) The prevention of adolescent depression. *Psychiatr Clin North Am* 34: 35-52.
- Weissman MM, Wolk S, Goldstein RB, Moreau D, Adams P, et al. (1999) Depressed adolescents grown up. *JAMA* 281: 1707-1713.
- Bearslee WR, Wright EJ, Gladstone TR, Forbes P (2008) Long-term effects from a randomized trial of two public health preventive interventions for parental depression. *J Fam Psychol* 21: 703-713.
- Beardslee WR, Salt P, Porterfield K, Rothberg PC, van de Velde P, et al. (1993) Comparison of preventive interventions for families with parental affective disorder. *J Am Acad Child Adolesc Psychiatry* 32: 254-263.
- Batten LA, Hernandez M, Pilowsky DJ, Stewart JW, Blier P, et al. (2012) Children of treatment-seeking depressed mothers: A comparison with the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) child study. *J Am Acad Child Adolesc Psychiatry* 51: 1185-1196.
- Luoma I, Tamminen T, Kaukonen P, Laippala P, Puura K, et al. (2001) Longitudinal study of maternal depressive symptoms and child well-being. *J Am Acad Child Adolesc Psychiatry* 40: 1367-1374.
- Bould H, Koupil I, Dalman C, DeStavola B, Lewis G, et al. (2015) Parental mental illness and eating disorders in offspring. *Int J Eat Disord* 48: 383-391.
- National Research Council and Institute of Medicine (2009) Depression in parents, parenting, and children: Opportunities to improve identification, treatment, and prevention. The National Academies Press, Washington, D.C., USA.
- O'Brien LM, Heycock EG, Hanna M, Jones PW, Cox JL (2004) Postnatal depression and faltering growth: A community study. *Pediatrics* 113: 1242-1247.
- Chung EK, McCollum KF, Elo IT, Lee HJ, Culhane JF (2004) Maternal depressive symptoms and infant health practices among low-income women. *Pediatrics* 113: 523-529.
- Mandl KD, Tronick EZ, Brennan TA, Alpert HR, Homer CJ (1999) Infant health care use and maternal depression. *Arch Pediatr Adolesc Med* 153: 808-813.
- Olfson M, Marcus SC, Druss B, Alan Pincus H, Weissman MM (2003) Parental depression, child mental health problems, and health care utilization. *Med Care* 41: 716-721.
- Beronio K (2015) Affordable care act expands mental health and substance use disorder benefits and federal parity protections for over 62 million Americans. ASPE, US Department of Health and Human Services, Washington, D.C., USA.
- Saloner B, Bandara S, Bachhuber M, Barry CL (2017) Insurance coverage and treatment use under the affordable care act among adults with mental and substance use disorders. *Psychiatr Serv* 68: 542-548.
- U.S. Preventative Services Task Force (2002) Screening for depression: Recommendations and rationale. *Ann Intern Med* 136: 760-764.
- Maurer DM, Darnall CR (2012) Screening for depression. *Am Fam Physician* 85: 139-144.
- Lee King PA, Cederbaum JA, Kurzban S, Norton T, Palmer SC, et al. (2015) Role of patient treatment beliefs and provider characteristics in establishing patient-provider relationships. *Fam Pract* 32: 224-231.
- ACP Clinical Guidelines (2008) Current Guidelines. American College of Physicians, USA.
- Adams SM, Miller KE, Zylstra RG (2008) Pharmacologic management of adult depression. *Am Fam Physician* 77: 785-792.
- Compas BE, Forehand R, Thigpen JC, Keller G, Hardcastle EJ, et al. (2011) Family group cognitive-behavioral preventive intervention for families of depressed parents: 18- and 24-month outcomes. *J Consult Clinical Psychol* 79: 488-499.

29. Podorefsky DL, McDonald-Dowdell M, Beardslee WR (2001) Adaptation of preventive interventions for a low-income, culturally diverse community. *J Am Acad Child Adolesc Psychiatry* 40: 879-886.
30. D'Angelo EJ, Llerena-Quinn R, Shapiro R, Colon F, Gallagher K, et al. (2009) Adaptation of the preventive intervention program for depression for use with low-income Latino families. *Fam Process* 48: 269-291.
31. Arroll B, Khin N, Kerse N (2003) Screening for depression in primary care with two verbally asked questions: Cross sectional study. *BMJ* 327: 1144-1146.
32. Yawn BP, Dietrich AJ, Wollan P, Bertram S, Graham D, et al. (2012) TRIP-PD: A practice-based network effectiveness study of postpartum depression screening and management. *Ann Fam Med* 10: 320-329.



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