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REAL WORLD RESEARCH FOR FAMILY ADVOCACY PROGRAMS

The Impact of Depression on Children and Families An Interview with William R. Beardslee, MD

James E. McCarroll, Ph.D. (JM)

In This Issue

This issue of *Joining Forces Joining Families* features an interview with William R. Beardslee, MD, an expert in the fields of childhood depression and depression's impact on families and parenting. Dr. Beardslee of Harvard Medical School and Children's Hospital Boston has developed an evidence-based intervention, referred to as 'breaking the silence', to facilitate communication and function in families affected by depression. We believe this method will be of interest to and can be implemented by family advocacy personnel.

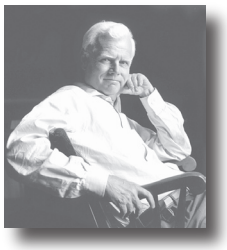
A guest contribution by Alesia Hawkins from the Center of Family Violence and Sexual Assault, Northern Illinois University, discusses the co-occurrence of intimate partner violence and child physical abuse, two types of maltreatment that are often interrelated in families, but treated independently by different jurisdictions and service providers.

Building Bridges to Research explains the differences between mediator and moderator variables, important research terms that are often misused or used interchangeably.

Please continue to provide your feedback on this newsletter. On behalf of our editorial staff, I want to wish you a very productive and enjoyable summer.

— James. E. McCarroll, Ph.D., Editor-in-Chief

Table of Contents



William R. Beardslee: Academic Chairman, Department of Psychiatry, Children's Hospital Boston and Gardner Monks Professor of Child Psychiatry, Harvard Medical School, Boston, Massachusetts

Dr. Beardslee has studied the mental health and resilience of children living in families affected by parental depression, poverty or violence. In this interview, Dr. Beardslee shares his knowledge about depression in children, as well as an evidence-based prevention and treatment intervention to help families understand, cope with and overcome depression.

JM: Dr. Beardslee, we are pleased to introduce you and your work to the readers of Joining Forces Joining Families. We believe these professionals who are committed to the well-being of our Army troops and families will find this topic to be timely.

JM:Could you tell us about the background of your work and how long you have been studying depression?

Dr. Beardslee: I started studying depression in 1979 with a small grant to look at the children of depressed parents. A larger study of preventive interventions for families facing depression began in 1984 and has continued to the present time.

Continued on page 2

What we mean by clinical depression is a more long-term and persistent change in functioning characterized by feeling down and blue and not being able to shake it.

JM: We use many different words, such as blue, down-in-the-dumps, and gloomy to describe a less than happy mood. What is clinical depression and how would you describe it?

Dr. Beardslee: Any of us — parents, teachers and children— can have a bad day. We may even say, "I'm depressed." But, what we mean by clinical depression is a more long-term and persistent change in functioning characterized by feeling down and blue and not being able to shake it. In the diagnostic manual it is two weeks or more of one major symptom and five associated symptoms. In practice, in the real world, it is the difference between having a couple of bad days because of some event in one's life and bouncing back versus having a host of different adversities at the same time, getting down because of them, and then just not simply being able to get back on one's feet.

JM: How then does the individual know when treatment is needed?

Dr. Beardslee: Studies have shown that depression is common. One in five Americans will experience a depression in their lifetime. Those with a high number of risk factors will experience even more, but only about a third of the time is depression recognized and professionally treated.

For the individual, I think it would be an awareness that something isn't right. If I am depressed, I don't feel the way I used to. I am not accomplishing things the way I used to. Often, one might be gripped by a persistent sadness, a sense of foreboding about the future. Some people have a sense that life is not worth living; some feel suicidal. Very often depression comes after a major loss, after bereavement, after moving abruptly to a new community, not being able to establish social bonds, or after the loss of a job. The key is to say "It's not normal to feel hopeless and depressed." There is help available in the recognition and treatment of depression. We often tell families the first place to turn is the pediatrician or the family practitioner who will be able to recognize depression and make an appropriate referral if need be.

JM: Would you say that depression affects men and women differently?

Dr. Beardslee: Depression in a parent has profound effects on the other spouse and on the kids, but probably in different ways. So often, men and women in families are in different roles. Often, women are the primary caretakers and run the household. If they get depressed, those routines get disrupted. With men, often out in the workplace, the work gets disrupted. So, although the depressions are diagnosed in similar terms, the effects on families depend on the role of the person.

JM: Do boys and girls manifest depression differently?

Dr. Beardslee: There is a sex difference and it is very interesting. Before puberty, boys are three times more likely to be depressed than girls. After puberty, girls are about twice as likely to get depressed as boys. In adulthood, women are two times more likely to get depressed than men. I don't think we know why that occurs. We know that women are more likely to seek help and women are more likely to talk about their feelings, on average. The concern one has with boys is that they tend to shut off what is bothering them and either fight or get into trouble because of aggression or turn to substance abuse or develop other problems in adolescence.

The key for all of us who are concerned about youth is to recognize that depression

Continued on p. 8

JOINING FORCES
Joining Families

Editor-in-chief
James E. McCarroll, Ph.D.
Email: jmccarroll@usuhs.mil

Editor
John H. Newby, DSW
Email: jnewby@usuhs.mil

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Phone: 301-295-2470.

Editorial Advisor
LTC Mary Dooley-Bernard, MSW
Family Advocacy Program Manager
Headquarters, Department of the Army
E-mail: Mary.Dooley-Bernard@cfsc.army.mil

Editorial Consultants
David M. Benedek, M.D., LTC, MC, USA
Associate Professor and Scientist
Center for the Study of Traumatic Stress
Uniformed Services University of the Health Sciences
dbenedek@usuhs.mil

Nancy T. Vineburgh, M.A.
Director, Office of Public Education and Preparedness
Center for the Study of Traumatic Stress
Email: nvineburgh@usuhs.mil

Depression in Children: An Emphasis on Prevention

A Brief Review of the Research of William R. Beardslee, MD

Children of affectively ill parents are more likely to have increased rates of psychiatric disorder and other negative psychosocial outcomes than children from homes with parents without affective illness.

James E. McCarroll, Ph.D.

The study of childhood depression and the impact of parental depression on children is a relatively recent scientific endeavor. This article summarizes the research of Dr. William Beardslee whose work is on the cutting edge of this field. In a nutshell, Dr. Beardslee's approach is to educate a family about depression, facilitate their ability to talk about it and its effects in order to resume and strengthen healthy and meaningful communication and functioning.

An important part of Dr. Beardslee's work is building resilience in children of depressed and non-depressed parents. The interventions he employs are practical and can be applied by all levels of family advocacy personnel. Although not necessarily easy to implement, they have undergone rigorous scientific tests through a series of studies of randomized trials.

Children of affectively ill parents are more likely to have increased rates of psychiatric disorder and other negative psychosocial outcomes than children from homes with parents without affective illness.[1] Beardslee sees the processes that underlie the emergence of health or illness as dynamic and influenced by developmental changes. In his view, it is these developmental influences as well as societal adversity (e.g., living in poverty, exposure to violence, job loss, and other social ills) that are critical to understanding the risk for and the prevention of depression.

Risk factors are events, characteristics, or conditions that make a negative outcome more likely.[2] Such risk factors (often referred to as multiple adversities by Beardslee) act concurrently to predict the onset of serious affective disorder in adolescents more than single risk factors. In families with multiple risk factors (e.g., number of child diagnoses, duration of depression in a family member, and number of parental non-affective diagnoses), 50% of the children became ill with serious affective disorders compared with 7% of children who became ill in families with none of these three risk factors.[3]

Beardslee and colleagues in Finland investigated children's responses to low parental mood and found that their responses are sensitive to family dynamics.[4,5] Four patterns were found among the children: active empathy with the parent, emotional over-involvement, indifference, and avoidance. Discrepancies in the children's perceptions of parenting and the parents' perceptions of child distress can be meaningful in understanding family interactions, child well-being, and child development. These differences in perception can be the basis of a discussion of family dynamics and lead to increased understanding of the effects of depression on children.

In a randomized trial of a group cognitive intervention for preventing depression in adolescent offspring of parents with a history of depression, adolescents were given 15 sessions of cognitive restructuring therapy while the control group was given the usual HMO treatment.[6] The cognitive restructuring was focused on identifying and challenging irrational, unrealistic, or overly negative thoughts, with a special focus on beliefs related to having a depressed parent. The usual treatment (control) group consisted of the randomly assigned study participants who initiated or continued any non-study mental health treatment or other non-health care services provided by the HMO or outside the HMO including medication. Those adolescents treated with cognitive restructuring techniques did better than adolescents treated with the usual treatment. Only 9% of the adolescents treated with cognitive therapy had a later depressive episode compared with 29% of those receiving the usual treatment during a median 15-month follow-up period. Thus, brief cognitive therapy can reduce the risk for depression in adolescent offspring of parents with a history of depression.

In a series of studies, Beardslee and colleagues developed a family-based selective intervention program for preventing depression. These studies of the prevention of depression tested two preventive approaches, both of which can be used by pediatricians, internists, school counselors, nurses, and mental health providers.[7] Their research method was an efficacy trial of two manualized approaches. [Editor's note: See JFJF, Volume 8, No. 1 for a discussion of efficacy trials.] They targeted non-symptomatic, relatively healthy children and adolescents, between the ages of 8–15, at risk for future depression due to the presence

Protective factors are conditions or processes that moderate the negative effects of risk factors and decrease the risk itself, the effects of the risk factor, enhance coping capacity. …Significant protective factors included family cohesion, positive self-appraisal, and good interpersonal relations.

of significant affective disorder in one or both parents.

Families were randomly assigned to either a lecture group or a clinician-facilitated condition. The goals of both interventions were to (1) decrease the impact of family and marital risk factors, (2) encourage resilience in children through enhanced parental and family functioning, and (3) prevent the onset of depression or a related mental illness. The lecture condition consisted of 2 separate group meetings in which psychoeducational material was presented to parents about mood disorders, risk, and resilience and efforts were made to decrease feelings of guilt and blame in children. The clinician-facilitated condition consisted of 6 to 11 sessions in which separate meetings were held with parents, with children, and as a family in which the parents led a discussion of the illness and of positive steps that can be taken to promote healthy functioning of the children.

Both groups reported significant changes in child-related attitudes and behaviors and the amount of change reported increased over time. Parents in the clinician-facilitated group reported significantly more change than those in the lecture condition. Parents who changed the most in response to the intervention had children who also changed the most. Their most important finding was that greater parental benefit (changes in illness-related behaviors and attitudes) was associated with significant global change among children. These changes included enhanced understanding of parental illness and improved communication with parents. They concluded that the connection between parental change and child change was mediated through family change. [Editor's note: See statistics article in this issue of JFJF for a discussion of mediating and moderating variables.] The positive interaction between parents and children and the understanding of the illness by everyone in the family (e.g., information about mood disorders) equip parents to communicate information to their children and to open a dialogue with their children about the effects of parental depression. Providing parents with factual information regarding risk and resilience in children, and linking this to family illness can result in behavioral change among parents that ultimately can translate into better functioning among children.

In a study of the relation between children's exposure to violence and mental health in a low income community, exposure to violence was correlated with internalizing symptoms (e.g., anxiety and depression), but more so for girls than for boys.[9] Beardslee and colleagues hypothesized that the effects of violence on self-esteem and chronic danger might mediate the link between violence exposure and mental health symptoms. The task was to find a way to improve children's mental health in this environment. The mother's mental health was a strong predictor of children's mental health and behavior problems. Although the two most important variables in this study, the mother's mental health and the children's exposure to violence, are amenable to interventions, much more information is needed to design the most effective community interventions. For example, the role of the fathers in this sample was unknown and more information is needed about the differences in exposures and reactions of boys and girls to violence.

Previous studies of depressed adults and children have identified many risk factors. While studies of resilience have been much more recent and more limited than studies on risk, several important protective factors have also emerged. Protective factors are conditions or processes that moderate the negative effects of risk factors and decrease the risk itself, the effects of the risk factor, or enhance coping capacity. Adolescent protective factors were identified in a longitudinal, community-based study that were associated with resilient outcomes in adulthood. Significant protective factors included family cohesion, positive self-appraisal, and good interpersonal relations.[2]

Positive factors identified in other research on adolescents included high levels of family cohesion at child age 15, higher self-concept and self-appreciation, and spending more time in the company of others.[10–12] In another study, resilient youth had greater self-regulatory skills, higher self-esteem, and more active parental monitoring.[13] Intimate personal relationships, the capacity to get work done outside of the home, and understanding of the parent's illness were protective for children facing severe parental depression.[14] These studies of risk and protective factors indicated that it was possible to identify children at high risk for depression.

Depression itself may also serve as a risk factor for additional adverse outcomes. From the National Longitudinal Study of Adolescent Health, it was found that depression in boys

Continued on page 10

The Importance of a Multidisciplinary Approach to Identifying and Treating Maltreating Families

Alesia Hawkins, M.A., Northern Illinois University

Research on the co-occurrence of IPV and CPA has used a variety of research methods: large-scale random population samples, special population samples, and surveys of archival case studies. Estimates of the co-occurrence of IPV and CPA have ranged from 30% to 60% based on differences in samples and methodology.

In this article, Alesia Hawkins explains that the risk of child maltreatment appears to be greatly increased if there is spouse abuse in the household, regardless of whether the offender is male or female. Hawkins' article suggests good research possibilities for the Army Family Advocacy Program. She notes the limited amount of research that has examined characteristics of families with co-occurring spouse and child maltreatment.

Until recently, researchers have largely examined intimate partner violence (IPV) and child physical abuse (CPA) independently. In addition, different service systems respond to IPV and CPA. Due to these services operating separately, there are different types of information obtained from maltreating families by service providers and different treatments provided to these families that do not take into account the possible existence of both IPV and CPA existing.

Research on the co-occurrence of IPV and CPA has used a variety of research methods: large-scale random population samples, special population samples, and surveys of archival case studies. Estimates of the co-occurrence of IPV and CPA have ranged from 30% to 60% [1–2] based on differences in samples and methodology.

Random population samples

The National Family Violence Surveys (NFVS) found that 50% of the men who frequently assaulted their wives also frequently abused their children.[3] The rate of CPA by mothers who were abused by their husband was at least double that of mothers whose husbands did not assault them. In a re-analysis of the NFVS data, Ross found that the percentage of husbands who were physically violent toward their wives and engaged in at least one act of CPA was 22.8%, compared to 8.5% of husbands who engaged in CPA only.[4] The percentage of wives who were physically violent towards their husband and engaged in at least one act of CPA was 23.9%, compared to 9.8% of wives who engaged in CPA only. This study suggests that for husbands and wives, the greater amount of violence towards the spouse, the greater probability of physical abuse of a child by the abusive spouse.

Special population sample

Rumm et al. investigated the incidence of substantiated CPA in families with and without identified spouse abuse in U.S. Army families from 1989–95, using the Army's Central Registry of substantiated child and spouse maltreatment cases.[5] Families with identified IPV were twice as likely to have a substantiated report of CPA when compared with other military families.

Archival case studies

Co-occurrence of IPV and CPA has also been investigated by examining mothers' medical records. Of the medical records of 116 mothers of children identified for suspected child maltreatment in a single year at a metropolitan hospital, 45% indicated evidence of IPV.[6] Similarly, in a review of the medical records filed by emergency room staff based on child abuse reports of 32 mothers, 59.4% the mothers' medical records showed evidence of violence against them by their spouse.[7] In another study of child protection case records over a 7-month period, adult victimization was identified by social workers in 32.8% of the cases.[8]

Research on the co-occurrence of IPV and CPA has identified that overlap between child and spouse maltreatment exists in maltreating families. However, differences in study samples and the use of single sources of information (e.g., archival records, self-report, retrospective recall) to explore IPV and CPA may distort the degree of overlap. For example, information from child protection services may represent the most extreme cases of child abuse, as opposed to studies utilizing a general population sample.[2]

Little attention has been given to understanding what psychosocial characteristics are common in families experiencing both types of violence. The limited amount of research that has examined characteristics of families with multiple forms of violence, suggest that families with co-occurring IPV and CPA may present with problems (e.g., life stressors, neighbor-

***Multidisciplinary approach**, from page 5*

hood violence, and parental history of severe punishment) that are similar in nature but greater in severity compared to families with only one of these forms of violence. [9]

Most recently, Merrill et al. investigated the psychosocial characteristics of individuals at risk for perpetrating both IPV and CPA in a large sample of Navy recruits.[10] Approximately 40% of young adults identified as at risk for IPV were also at risk for CPA, whereas nearly 30% of individuals identified as at risk for CPA were at risk for IPV. Self-dysfunction symptoms, dysphoria, posttraumatic stress symptoms, and alcohol problems were prevalent among individuals at risk for both IPV and CPA. This suggests that multiple psychosocial symptoms may characterize individuals at risk for both IPV and CPA, and should be addressed in child abuse and domestic violence prevention programs.

A multidisciplinary approach can foster prevention and treatment efforts in identifying and targeting unique characteristics that exist among families with co-occurring IPV and CPA that is differentiated from families involved with IPV and CPA only.

Implications for service providers

Child welfare and domestic violence programs historically have responded separately to victims of abuse. Service providers can play an integral part in facilitating a better understanding of the co-occurrence of IPV and CPA. Incorporating a multidisciplinary approach in the assessment of IPV and CPA in maltreating families across agencies may help determine the type of services needed to reduce violence within the families. Moreover, awareness of how both forms of violence co-occur may foster service providers' efforts in conceptualizing and providing treatment for maltreating families.

Collaborative efforts between prevention programs to reduce IPV and CPA have received increased attention.[2, 11–12] Beeman, Hagemeister, and Edleson suggested using a multidisciplinary approach for IPV and CPA.[13] They recommended that (1) service providers identify and provide distinct services for families with co-occurring IPV and CPA, (2) systematic and repeated training across disciplines to expand and enhance the capacity of programs to serve families experiencing multiple forms of violence, and (3) service providers establish on-going structures for communication and collaboration at the policy, management, and direct service levels. They believe that communication across agencies that intervene in both IPV and CPA develops the best practice protocols and inter-agency agreements for responding to these families.

Overall, family violence research indicates a substantial degree of overlap between IPV and CPA. These findings provide support for integrating service providers' expertise, resources, and services that intervene in IPV and CPA cases in order to establish a multidisciplinary approach to the co-existence of IPV and CPA. Further, a multidisciplinary approach can foster prevention and treatment efforts in identifying and targeting unique characteristics that exist among families with co-occurring IPV and CPA that is differentiated from families involved with IPV and CPA only.

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Continued on page 12

Building Bridges to Research: Mediators and Moderators

James E. McCarroll, Ph.D., and Laurie T. Martin, Sc.D.

(Dr. Martin is a research associate in the Department of Society, Human Development, and Health, Harvard School of Public Health, Boston, MA.)

Overall, moderators and mediators help us understand relationships, and have important implications for the development of prevention and treatment interventions.

Many research articles in behavioral science refer to an outcome as mediated or moderated by a third variable. These important terms, often misused or used interchangeably, are very different concepts with important implications for the understanding of research procedures and results. This article explains the differences.

A mediator is a factor that explains *how* or why the relationship exists. In order for a factor to be a mediator, it must lie on the pathway between the independent variable (the factor you are interested in studying) and the dependent variable (the outcome). In order to be a mediator, a variable must demonstrate a significant degree of relationship between the independent and the dependent variable. If no relationship exists, then the hypothesized mediator does not lie on the causal path and hence cannot be a mediator.

To illustrate, we use an example from Buckner, Bassuk, & Beardslee who examined the association between exposure to violence and mental health in poor children.[1] They found that children exposed to violence experienced more mental health symptoms than those who had not been exposed (the direct relationship). To help explain this relationship, they investigated four factors as possible mediators of violence and mental health symptoms: perceptions of environmental danger, locus of control, self-esteem, and emotional regulation. The authors found that exposure to violence led to lower self-esteem and a higher perception of danger, both of which, in turn, led to internalizing symptoms and poor mental health. Therefore, self-esteem and perceptions of danger are mediators in the relationship between exposure to violence and mental health; they help explain why exposure to violence is related to poor mental health.

In contrast, moderators explain *what* or in what subgroups certain relationships exist. In other words, moderators help us understand if there are certain characteristics of people or environments that make the relationship between the independent variable and the outcome stronger or weaker. A moderator may affect the direction or the strength of the relationship of interest. A moderating variable should have little or no statistical relationship to either the independent or the dependent variable.

Gender is often a moderator. In the Buckner et al. study[1] mentioned above, there was a relationship between exposure to violence and mental health symptoms (internalizing symptoms such as anxiety, depression, and somatic complaints) and it was stronger for girls than for boys. Thus, gender was a moderating variable in the relationship between exposure to violence and mental health symptoms. It affected one group (girls), but not the other (boys).

The differences between mediators and moderators are more complex than this presentation. We have only highlighted the differences. The reader is referred to Baron and Kenny [2] for detailed descriptions of these concepts and to Buckner, Bassuk, and Beardslee [1] for more detail on their analyses of moderating and mediating variables in the association between children's exposure to violence and mental health symptoms. Overall, moderators and mediators help us understand relationships, and have important implications for the development of prevention and treatment interventions.

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***Dr. Beardslee Interview**, from page 2*

is real and that it is treatable. There are very good treatments, among the best in medicine, among the best in psychiatry, for depression. Those of us who are professionals need to work very hard to make it easy for people with depression to get help.

If you compare families with depression and other adversities such as job loss or victimization by violence or bereavement to families with no depression then the rates of depression in the children of parents with depression are two to four times as high in adolescence to those with no depression.

JM: If a parent is depressed, how likely is it that the child will become depressed?

Dr. Beardslee: If you compare families with depression and other adversities such as job loss or victimization by violence or bereavement to families with no depression then the rates of depression in the children of parents with depression are two to four times as high in adolescence to those with no depression. Why do I say "With other adversities in addition to depression?" Because we have come to understand that depression in a parent often serves as an identifier of a constellation of adversities. We find that the families at greatest risk are those in which there are multiple adversities experienced at once. On the other hand, for depressed parents it means that if depression occurs without these associated adversities and if treatment can begin quickly then the prognosis for both them and the children is very good.

JM: If the parents are not depressed how likely is their child to become depressed?

Dr. Beardslee: Kids can still get depressed in the absence of parental depression. In addition to having parents and other relatives with depression, there are other experiences that put children at higher risk for depression: undergoing loss experiences such as bereavement, loss of community, being the victim of bullying, having real trouble in school, and learning disabilities or hyperactivity. In adolescence, kids often become depressed after relationships fail or they fail in grades or in sports or some endeavor that they didn't do as well in as they thought they would. Most of the time, appropriate treatment can turn this around. Many kids with these problems do not become depressed, but kids with these problems do become depressed at higher rates.

Just to summarize, childhood and adolescent depression are largely unrecognized and untreated so parents need to be alert to the signs of depression and seek help. The signs are a real change in the usual way a child is behaving: a child who has become more irritable, who shows less interest in friendships or pleasurable things, and who is withdrawing (see Table 1).

JM: What can be done to prevent the children of depressed parents from also becoming depressed?

Dr. Beardslee: That is what we have really focused on over the last 20 years. What we found is that we can help parents most by helping them get back on track with being good parents. Many parents with depression feel overwhelmed. They feel they have irrevocably harmed their children and think that nothing can be done. That sense of helplessness and hopelessness goes along with depression. In fact, many people who have depression can be excellent parents and any parent with depression can do things to help their children. So, the first communication has to be one of hope. You can be a good parent despite depression.

What does a parent with depression need to do? Number one, get treatment for the depression. Getting treatment will help the energy and the good parenting come back. Secondly, work to build resiliency in children. We think that all parents can do this.

Building resilience is a basic aim of education, health care, and parenting. Resilience training is really tied to very specific actions. In our own work in the three core areas (kids' activities, kids' relationships, and kids' understanding), we take specific steps. The first is telling our kids what we are doing and the second is taking concrete actions. We ask families, for example, "How have your child's friendships been disrupted because of this move or because of this depression?" And then "What very concrete steps in your own life can you take to move this along?" We found that depressed parents welcomed the idea of building resilience and were frankly relieved and overjoyed to find

Table 1: Signs of Depression in Adolescents and Younger Children

- ❑ Diminished interest in friends and friendships
- ❑ Decline in school performance
- ❑ Irritability
- ❑ Aches and pains, especially in young children, and resistance to attending school

If any or a cluster of these signs persist for several weeks, it may signal depression and professional help should be sought.

What we found is that we can help parents most by helping them get back on track with being good parents. Many parents with depression feel overwhelmed.

that there were positive things that they could do (see Table 2).

We often found that in families with depression, they were not talking to each other. We believe that the family can understand depression as a medical illness and can have a conversation about it that makes sense and helps remove the guilt, the blaming and the misunderstanding that so often occurs with depression. Our work has been very much to help families master depression by talking about it.

When the initial conversation about depression was successful it then often led to successful conversations about other things. Families learned that family meetings, strategically planned to talk about difficult issues, were very helpful. As families mastered depression they got back on track. They made peace with the illness and moved on the way one does with a medical illness. It is also important to note that explanations, however good, are never static when children are involved. As children grew older they drove the need for understanding depression anew, for new conversations and for understanding it differently.

Much to my surprise and to my real pride and pleasure, we did a long-term study comparing two forms of getting this prevention across: one, a lecture followed by a group discussion, and the second, a clinician-based intervention where a clinician works with the family over a few sessions to help the family hold a meeting. We found that these interventions led to long-term and sustained effects in the family's ability to understand the illness and in the family's ability to protect the children. So, we are confident that these approaches can help. The book I wrote (Beardslee, 2002) is for both clinicians and families to try to learn about these techniques. The basic point is that not only did we have these ideas, but we tested them in a randomized trial design and have been able to show sustained effects. [Editor's note: See Joining Forces Joining Families Volume 8, No. 1, Fall/Winter 2004 for a discussion of randomized trials in clinical research.]

Table 2: How Depressed Parents Can Build Resiliency in Children

- ❏ Support your child's involvement in normal activities and routines such as going to school, to sports, to a place of worship, and so on.
- ❏ Do not let your depression disrupt the usual patterns of your child's life.
- ❏ Build and support your child's relationships within the family and outside such as letting your children's friends continue to come to your home to visit and letting your children go over to other houses.
- ❏ Provide an age-appropriate explanation for the way you are feeling so that your family can understand depression is a medical illness, and that you are receiving treatment to get better.
- ❏ Break the silence that often surrounds depression by having a family conversation that can help remove feelings of guilt, blame and confusion for both parents and children.
- ❏ Continue to have more conversations to sustain family communication that often facilitates the recovery process for the depressed parent and builds resilience in children.

JM: What are your thoughts on how to deal with the combination of violence, depression, and alcohol?

Dr. Beardslee: That particular vicious cycle is toxic for the individual, toxic for the spouse, and toxic for families. People who have been injured by violence are likely to be depressed and likely to use alcohol to medicate themselves. I would say categorically as a psychiatrist, as a doctor, as a parent, and as someone who has worked with depression for years, alcohol inevitably makes depression worse. It is not a treatment; it doesn't help. So, recognizing that is a first step. Secondly, the key point about depression is that it is treatable and people feel dramatically different when they get treatment. When interpersonal violence occurs in a family, the first question to ask is "Are the individuals safe?" All of us in the caregiving professions first have to make sure that the environment is safe and then work on getting treatment for alcoholism or talking through what the difficulties are or getting treatment for depression..

JM: What do you see as future directions for depression research and, particularly, with regard to violence?

Dr. Beardslee: One thing that we have learned is that if a violent event occurs, we need to intervene very quickly to support those who have been victimized. Secondly, we need to spend more time thinking about effective prevention: recognizing when people are reaching the breaking point and trying to provide support for them. In psychiatry and in public health we are recognizing the value of preventive intervention. We are trying to put preventive intervention programs in place. There are certainly examples of this, such as home

Continued on page 10

***Dr. Beardslee Interview**, from page 9*

visitation and high quality day care that have reduced interpersonal violence and led to very positive outcomes. So, as we move forward, I believe we are going to see more effective treatments and more effective preventions that will help us.

JM: What else would you like to say to our readers?

Dr. Beardslee: One, hope is always available. Two, the dominant fact of our mental existence as parents, and I speak as a humble parent myself, is the care of our children. Thirdly, I think that one of the important things about our work with depression in families is that it didn't improve as a result of just one conversation. It is a process we refer to as "breaking the silence." Parents had one conversation with the kids followed by another and another. Whether as a practitioner or as a parent, if you are thinking about using some of the things that we learned, say, "We don't have to do this all at once." Our first conversation with kids should be a successful one and we should make ourselves open to continued conversations as the time evolves.

JM: Thank you for sharing your thoughts with us. I believe that your eloquence and your optimism are very exciting and I thank you for your time.

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***Dr. Beardslee's Research**, from page 4*

The incidence and prevalence of depression in active duty military personnel and their families is not known. It is likely that many of the same risk factors identified in research on civilian communities are also present in the military.

(but not girls) predicted increased risk of acquiring sexually transmitted diseases (STD). The authors concluded that screening for depression among sexually active adolescents may identify many of those at risk for later STD.[15]

Dr. Beardslee advocates strongly for more mental health services, particularly for underserved populations such as those in poverty and who lack health insurance or lack coverage for mental health conditions. His view is buttressed by the powerful evidence amassed by his research and that of his colleagues on the prevention and treatment of childhood depression. Part of the approach to the problem of depression is to advance beyond psychiatric treatment and attempt to ameliorate adverse societal factors that predispose or directly contribute to depression. Among these conditions are poverty, exposure to violence, and social isolation. Successful prevention of depression would be of enormous benefit to society in terms of relief of the burden of suffering and associated negative outcomes thought to be associated with depression such as child and spouse maltreatment, substance abuse, and suicide.

The future of depression research may lie in better understanding of child and adolescent development and how much it can be modified by interventions. Current research on genetics and its interaction with the environment may someday lead to improved understanding of the genetic-environment interface and its relation to stages of development. It may be possible to identify critical periods in a child's development for intervention and tailor interventions based on the child's sensitivities and particular environmental risks. Also, advances in brain research and other organic mechanisms that can be treated pharmacologically may enhance the opportunities for intervention at many levels for children and adults.[2]

The incidence and prevalence of depression in active duty military personnel and their families is not known. It is likely that many of the same risk factors identified in research on civilian communities are also present in the military. Such risk factors (multiple adversities) may be more concentrated in the current military environment of frequent, rapid, and hazardous deployments. We encourage military family advocacy program personnel to consider the possible role of depression in the treatment of families in which maltreatment has occurred and in violence prevention efforts where it is likely that a broader audience can be reached and prevent new cases of depression. Examples of such arenas are education classes for military personnel, the various parenting programs

Continued on page 11

***Dr. Beardslee's Research**, from page 10*

sponsored by the military and public education events such as depression screening.

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Websites of Interest

Important Websites on Depression

There is a staggering number of websites on depression sponsored by academic and professional groups, advocacy organizations, drug companies, and news organizations that feature depression information. Here are several sites with general and research information.

- **The National Institute of Mental Health (NIMH)** offers comprehensive depression information at: **www.nimh.nih.gov/healthinformation/depressionmenu.cfm.** Research information on depression can be found at: **http://www.nimh.nih.gov/publicat/depresfact.cfm**

  In addition to general depression information and resources, the site features the nation's first and only campaign on male depression, *Real Men, Real Depression* at **http://menanddepression.nimh.nih.gov/.** The campaign's resources may be helpful for FAP and our Army community. There is information on depression throughout the lifecycle and public education material in Spanish.

- **Screening for Mental Health (www.mentalhealthscreening.org)** provides the premier public education event for depression, National Depression Screening Day, which is held each October. Registered sites receive a kit of educational materials and depression screening forms to conduct their own depression awareness campaign.

- **The Childrens' Hospital in Boston** offers an interactive website **(www.experiencejournal.com)** designed to promote the healthy coping of children and their families struggling with significant physical and emotional illnesses. The illnesses include depression, cardiac disease, inflammatory bowel disease, and the transplant experience. The website contains collections of pictures, stories, and personal experiences from families about what it has been like to live with their children's illness. It is the collective wisdom of children, parents, and their health care providers

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***Multidisciplinary approach**, from page 6*

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JOINING FORCES
Joining Families

Coming Next Issue

Our Fall issue will feature an interview with distinguished psychologist, **Sandra T. Azar, Ph.D.** of The Pennsylvania State University. Dr. Azar will address the assessment of parenting and its relationship to prevention and treatment of maltreating and non-maltreating parents.