Educational & Developmental Intervention Services (EDIS) Personnel Development

KIT

Keeping In Touch

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Inside this edition UNDERSTANDING DEPRESSION

Resource Article

As we continue with and expand our understanding of depression, the work of Weissman, and colleagues is particularly interesting as it examines how parental depression impacts children over a twenty year period. The authors conducted a longitudinal study. The data points for data collection were initially, at year one, at year ten, and again at year twenty. Included in the study was an experimental and a control group. A total of 125 children of parents with moderate to severe major depressive disorder constituted the high risk experimental group and 95 children of nondepressed parents constituted the low risk control group. Data were collected via interviews of the parents, their spouses, and the children and administration of psychological assessments. These data were then reviewed for reliability by raters who were blind to the previous and current clinical status of the subjects.

Some of the results supported a hypothesis that children exposed to depression are more likely to experience depression themselves or develop other mental health conditions. The subjects in the high risk group were three times as likely as the low risk group to develop mood and anxiety disorders. The mean age of onset of major depression was lower for the high risk group (i.e., 16 versus 19 years). The peak age of onset of depressive disorder in both groups was between 15 and 20 years, with an overall higher rate of depressive disorder in the high risk group. The overall rate of anxiety disorder was higher in the high risk group. Peak incidence of anxiety disorder was much earlier than that of depressive disorder (before puberty). Although anxiety rates declined for both groups after age 12 years, for the high risk group they began to increase again at approximately age 28 years, and this was attributed to an increase in panic disorders reported by women.

The authors also looked at substance use and abuse in the two groups. Substance abuse was relatively common amongst both groups. However, substance dependence was concentrated in the high risk group. Subjects in the high risk group were twice as likely to have alcohol dependence and six times as likely to have drug dependence.

Resource Article (continued)

Results regarding treatment for depression and anxiety were somewhat expected given the higher rates of these disorders in the high risk group compared to the low risk group. Subjects in the high risk group used more outpatient mental health treatment options (e.g., for brief periods of time, at least six months of treatment, several years of treatment) as well as inpatient hospitalization compared to subjects in the low risk group. But given the rates of these disorders in the high risk group, the overall rate of treatment was relatively low as 60% of the high risk group did not receive any psychiatric treatment.

Overall health and mortality was also examined. At age 35, subjects in the high risk group were five times more likely to report cardiovascular problems and two times more likely to experience neuromuscular disorders. Similarly, subjects in the high risk group had a higher mortality rate, though this finding was not considered statistically significant. There were four deaths in the high risk group compared with zero in the low risk group. Deaths were caused by suicide, lupus, lymphoma, and one cause of death was unknown (subject was estranged from family).

As early interventionists we cannot treat depression, but understanding how a parent's depressive symptoms can affect their child in the long run, well into adulthood, underscores its significance. We can, however, be mindful of the signs and symptoms of depression and be prepared to offer families information about mental health resources in our communities. Additionally, the support early interventionists provide through ongoing relationship-based family-centered intervention is also dramatically helpful.

Weissman, M. W., Wickramaratne, P., Nomura, Y., Warner, V., Pilowsky, D., & Verdeli, H. (2006). Offspring of Depressed Parents: 20 years later. *The American Journal of Psychiatry, 163* (6), 1001-1008.

On the WWW

The Mayo Clinic offers a free online Depression self-assessment tool. This short questionnaire is quick to complete and provides a score based on a depression scale (from none to severe). While it does not offer a diagnosis of depression, it may bring to light some of the signs and symptoms of the disease. You can then explore some therapeutic options as well as self care practices. There are additional links to related topics such as Seasonal Affective Disorder, Dysthymia, and Post Partum Depression to name just a few.

http://www.mayoclinic.com/health/depression/MH00103_D

What do the data say?

Can infants and toddlers be depressed?

While hard to imagine and perhaps even harder to accept, the answer is yes. Babies can experience depression. According to Dr. Shatkin, director of education and training at New York University's Child Study Center, the frequency is estimated at one in forty.

So how do babies get depressed? The mental health of babies is influenced by both nature and nurture. Genetics and brain chemistry are factors, but so too is the parent child relationship. And, the risk of the baby being depressed is three times higher if the baby has a parent or caregiver with depression. If a parent or primary caregiver is emotionally not there for the baby the critical reciprocal exchange, instrumental in supporting healthy attachment and emotional well being, is not present and the results can adversely affect the baby.

According to Goodman and Gotlib (1999) maternal depression may be passed on to a baby through four pathways. One way is that the depression or predisposition for depression may be inherited; in fact a baby may be born depressed. Another pathway for depression in a baby may be a result of the dysfunctional regulation, possibly due to a neurological deficiency or mother's stress-related hormones. Third, a baby's exposure to mother's negative thoughts, behaviors, and affect might also contribute to a baby's depression. The fourth avenue described by Goodman and Gotlib is a parent's stressful life and the resulting stressful context in which the child is exposed.

Babies cannot tell us how they feel. Rather they show their signs of depression physically and emotionally. Signs of depression in babies and young children may come in the form of inconsolable crying, irritability, poor growth, sleep problems, flat affect, limited interest in and engagement with people and materials, and inability to show excitement or enthusiasm. These behaviors are not foreign to very young children, but they are concerning if there is any prolonged loss of interest and engagement and long lasting disturbances in sleep and eating which do not have a physical reason.

Consider the still face experiment, designed by Edward Tronick. In the experiment the parent and baby engage is a playful exchange. Then the parent stops, looks away, and shows a flat affect. The baby tries to engage the parent and when unsuccessful the baby begins screeching, turning away and showing obvious signs of discomfort. Briefly after that the parent reengages the baby in a playful interaction. The baby's reaction to the unresponsive parent provides a glimpse into the potential reaction of a baby if her mother or primary caregiver was regularly unresponsive. The illustration of the still face experiment is remarkable and enlightening. To learn more about this experiment and view the video clip go to the Zero To Three website (http://main.zerotothree.org/site/PageServer?pagename=ter_stillface).

Goodman, S.H. & Gotlib, I.H. (1999). Risk for psychopathology in the children of depressed parents: A developmental approach to the understanding of mechanisms. *Psychological Review, 106*, 458-490.

Consultation Corner

From May through September 2013, we are excited to have Erin Troup, LCC, NCC, CT as our consultation corner expert. Erin will address the topic *Understanding Depression*.

How do I, as an early interventionist, work with a Parent I may feel is depressed?

Depression is the most common mental illness affecting 1 in 10 people. Depression is also found to be more common in caregivers who have a child with a developmental delay or disability. Severity varies from person to person as well as duration of depression.

In early intervention, working with parents experiencing depression can be difficult at times. Some of the challenges may come in the form of numerous cancellations, children becoming more and more stressed, and challenging behaviors surfacing. Early interventionists may also notice that the intervention strategies the family wants to apply are not implemented or forgotten. Parents can also be distracted or appear very tired or frustrated during your visits.

As mentioned in the past KIT, talking with a family or noticing that things may be difficult is the first step in having the conversation. Education is also very important. Understanding how the symptoms of depression can affect a growing child is a difficult conversation to have but a necessary one. This is not entering into a therapeutic counseling session.

Rather, it is talking with the family about what they would like to see out of the intervention support you provide and remind them that you need their help for their child to continue developing optimally. Giving parents some control and encouragement is not only comforting to them it is motivating, particularly when things are not going well. Some days may be harder than others. Encourage the family to work with you but be aware that they may become frustrated easily and sometimes they may have to take a break during the session. Recognize the parent's stress and collaboratively focus on intervention strategies that are based on their priorities, truly easy to do, naturally fit in the context of their typical day to day happenings, and keep a focus on helping the parent receive some positive interaction with the child.

Another helpful strategy is trying to get outside. Often in colder winter months, individuals can develop a seasonal affective disorder. This is a form of depression that is thought to stem from lack of sunlight. If the weather is looking better and the temperatures are safe for little ones, help the parents to get outside. Sunshine is good for everyone!

Having resources available when that parent wants or needs them is very beneficial. Help parents think of things to do when they are stressed and encourage them to contact local support centers or keep hotlines on hand for when or if needed.

Consultation Corner (continued)

When working with families experiencing depression it is of utmost importance that you too seek out some support in the form of good supervision. Meet with a trusted co-worker to discuss the difficulties so that you do not feel isolated. Try not to overwhelm yourself with many difficult cases. We tell our families to take time for themselves so we must grant ourselves the same permission. Be aware of the things you may be hearing and recognize that these stories do have an impact on the way you process stress (even if you have seen it all). Self care is the biggest key in working well with families who may be experiencing depression.

KIT Newsletters are available online at www.edis.army.mil

Continuing Education for KIT Readers

The Comprehensive System of Personnel Development (CSPD) is offering a continuing education opportunity for KIT readers.

In line with the focus on *Understanding Depression*, readers are invited to receive continuing education contact hours for reading the monthly KIT publications (May through September 2013) and completing a multiple-choice exam about the content covered in these KITs.

KIT readers will receive the exam in October 2013. There is no need to register for the CEUs. Rather, if you are interested complete the exam online at www.edis.army.mil Upon successful completion of the exam, you will receive a certificate of non-discipline specific continuing education contact hours.

Thank you for your continued interest in the KIT.
Please share your KIT questions/ideas via email to
EDISCSPD@amedd.army.mil