

Preventing Psychosocial Problems and Promoting Health-Related Quality of Life in Children and Adolescents Struggling with Parental Depression

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Abstract

Parental depression has a devastating impact on family life and children's social adjustment and mental health and little information exists as to how parental depression is associated with children's health-related quality of life. The present paper describes the research protocol of a Greek randomized clinical trial, examining the effectiveness of two preventive interventions (a family intervention and a psychoeducational discussion with parents) for families struggling with parental depression. An important question in this research is what factors can better predict the improvement of child outcomes in these families. Another issue of special interest is to explore the association of children's health-related quality of life with parental mental health symptoms and to examine to what extent each intervention can have a positive impact on this domain. Sixty-two patients diagnosed with depressive disorders and their offspring aged 8 - 16 years old are randomly assigned to the two intervention groups and they complete a series of questionnaires prior to interventions and 4, 10 and 18 months after intervention. This study will offer an evidence base for developing relevant initiatives in a national level and for integrating preventive actions for child mental health in routine clinical practice with adult depressed patients.

Keywords

Children, Family, Mental Health Promotion, Parental Depression, Prevention

1. Introduction

Parental depression has a devastating impact on family life and children's social adjustment and mental health during childhood and later in adulthood, with depression and anxiety being the major mental health problems among offspring of depressed parents (Beardslee, Gladstone, & O'Connor, 2012). The physical, social, emotional, and educational outcomes for adolescents are highly dependent on experiences within their family. However, health professionals pay little attention to children's experience of parental depression (Perrino et al., 2014). Although impairment on daily functioning at work or at home is one of the criteria for clinical depression, the adult studies of screening measures have not considered functioning as a parent in their assessment (National Research Council and Institute of Medicine, 2009). Moreover, the U.S. Preventive Services Task Force (USPSTF) in its evidence-based review in 2002 (U.S. Preventive Services Task Force, 2002) showed that none of the reviewed studies identified status as a parent during screening for adult depression. Additionally, the potential two-generation benefit to the parent and his/her offspring from identification and treatment of depressive symptoms has not been considered in the studies reviewed by the USPSTF. Children's feelings and emotional reactions to the physical and mental alterations that the illness may impose to a parent are often neglected.

Children, especially the younger ones, often find it difficult to understand the causes of the abrupt changes in family interrelationships due to parental depression and/or to cope with the considerable family discordance and the possible demands to undertake extended duties and new roles inside the family (Kaimal & Beardslee, 2010; Solantaus-Simula, Punamäki, & Beardslee, 2002). The transgenerational transmission of psychiatric disorders and the current increasingly high rates of depression in adults calls for integrating the promotion of child development and prevention of psychosocial symptoms or disorders of children in the services that are offered to families with parental depression (Beardslee, Gladstone, & O'Connor, 2011). Internationally, various preventive interventions have been developed for children from families struggling with parental mental disorders and they have been shown effective in randomized controlled trials (Beardslee, Solantaus, Morgan, Gladstone, & Kowalenko, 2013; Siegenthaler, Munder, & Egger, 2012).

For the abovementioned purposes, in 2011 the Department of Child Psychiatry of Athens University Medical School at Aghia Sophia Children's Hospital in collaboration with the Finnish National Institute for Health and Welfare introduced two preventive interventions, *i.e.* Family Talk Intervention (Beardslee, Gladstone, Wright, & Cooper, 2003; Beardslee et al., 1992) and Let's Talk about Children (LTC; Punamäki, Paavonen, Toikka, & Solantaus, 2013; Solantaus, Paavonen, Toikka, & Punamäki, 2010) in Greece, where there was a tremendous lack of research knowledge and systematic provision of evidence-based preventive services to children with parents suffering from depression or other psychiatric illness. The main objective of the present research project is to examine the effectiveness of FTI and LTC interventions in Greece. The safety and effectiveness of these two interventions have been demonstrated in previous clinical trials and meta-analyses (Beardslee et al., 2003; Beardslee et al., 1992; Punamäki et al., 2013; Siegenthaler et al., 2012; Solantaus et al., 2010), with parents reporting increase in families' understanding, enhancement of parenting skills and improvement of mental health symptoms both in parents and their offspring.

According to previous literature, we hypothesized that both interventions would have positive impacts on children's and parents' psychosocial symptoms and that both interventions would promote children's prosocial behaviour, with the FTI showing a greater effectiveness in improving family functioning. An important question in our research is what factors can better predict the improvement of child outcomes in these families, *i.e.* parents' clinical improvement of depressive and/or anxiety symptoms per se or other factors relating to parent-child relationships, parenting skills, social support and family functioning. This question is of great significance given that effective interventions should target at important mediating factors that explain the transgenerational transmission of depression and adversity rather than just address the individual clinical needs of parents struggling with depression.

Another issue of special interest in the present study is to explore the association of children's health-related quality of life with parental mental health symptoms and to examine to what extent each intervention can have a positive impact on this domain. Health-related quality of life is a significant health outcome measure in clinical and epidemiologic studies nowadays (Fayed et al., 2012; Solans et al., 2008). This concept reflects a subjective, multidimensional and comprehensive model of health concerned with dimensions such as physical and psychological well-being, family life, school performance and peer relations (Ravens-Sieberer et al., 2005). Moreover, health-related quality of life can reflect an individual's perception of their position in life in the context of the cultural and values systems in which they live and in relation to the goals, expectation, standards and concerns.

The assessment of health-related quality of life is, thus, related to broad social and public health concerns and can offer potential applications for need assessment and social policy formulation.

2. Methods

2.1. Design and Participants

The present study is a randomized clinical trial conducted in the capital city of Athens, Greece. The participants are assessed prior to interventions and parents' and children's reports are collected 4, 10 and 18 months post-intervention. Patients with a single episode or recurrent major depressive disorder clinician-based diagnoses according to ICD-10 (World Health Organization, 1992) and their partners are invited to participate. Participants should receive psychiatric treatment and have at least one child aged 8 - 16 years that he/she does not receive treatment for any mental disorder. Patients receiving psychotherapy and patients with co-morbid psychiatric or physical illness can be included in the study. However, schizophrenia spectrum disorders, a life threatening physical illness in parents or children, ongoing family therapy, dispute over child custody and an urgent need for child protection services are all exclusion criteria. Thirty-two families (80.0 % mothers as the identified patient; 53.3% girls as the assessed offspring) are included in the FTI group and 30 families (81.3% mothers as the identified patient; 40.6% girls as the assessed offspring) are included in the LTC group. Parents' mean age is 41.4 and 41.1 years in the FTI and the LTC group respectively, while children's age is 11.7 and 12.3 years, respectively. Concerning parents' education level, in the FTI group, 16.7% have a low educational level, 46.7% have a middle level and 36.7% have a high level of education. Respectively, the rates of parental education level in the LTC group are 12.5%, 65.6%, and 21.9%. Regarding family socioeconomic status, 20% come from a low level, 73.3% from a middle level, and 6.7% from a high level in the FTI group. The respective rates in the LTC group are 34.4%, 50%, and 15.6%. Inclusion criteria for children and adolescent were to be between 8 and 16 years old, to be able to read Greek and complete the questionnaires themselves.

Clinicians provide verbal and written information regarding the study. The right to refuse or later withdraw from the study is emphasized to all family members. Informed consent is given by parents and children over 15 years. Instructions are also given to parents to inform younger children about their right to refuse to participate in or to withdraw from the study at any point. Families that give their consent are randomly assigned to the intervention groups. The clinicians that offer the interventions are mental health professionals that have been extensively trained in these interventions and they receive supervision and keep a fidelity logbook for each case they undertake.

2.2. Interventions

The FTI is an evidence-based program designed for mental health professionals treating parents with depression and/or anxiety to foster resilience in their children and the family unit (Beardslee et al., 1992). It can be implemented by experienced mental health professionals and appropriately trained psychologists, social workers, mental health nurses, occupational therapists, and general practitioners. It begins with two parent sessions that include individual and family history taking and psycho-education regarding depression and resilience. An individual session with every child of the family follows. Children's psychosocial status and family experiences are recorded and possible questions regarding parental mental illness are elicited in this phase. In the planning session, parents discuss with the clinician how to respond to their children's questions, how to talk about depression with the other family members being present and how to cope effectively with possible family problems. In the family session, parents put mental illness into words and respond to children's questions with clinician's help. Finally, the intervention is reviewed and future plans are discussed with parent in a follow-up session. In a family with an only child, six sessions are implemented. The number of sessions increases depending the number of children in the family.

The LTC is a brief, evidence-based method that trains professionals adult mental health settings, primary health care, child mental health and child and youth services to have a structured discussion with parents who experience mental illness (or mental health problems) about parenting and their child's needs (Solantaus et al., 2010). It is a manualized discussion focused on children that is implemented with the patient and possibly his/her partner in order to assess children's status and to inform about ways that parents can support their offspring. It aims to make this conversation a routine part of the alliance between parents and professionals

where they can explore the wellbeing and development of children and how their parent's mental illness is understood by them. Thus, the method supports healthy parent-child relationships, promote protective factors for the child's wellbeing, and improves understanding of issues facing parents when they have a mental illness. The minimum duration of this discussion is 15 minutes and the maximum is two sessions of 45 minutes each.

Parents are also given a self-help book entitled "How can I help my children – A guide for parents with mental health problems". In case that a need for other services (e.g. child psychiatric or welfare services) is emerged, families are assisted in their access. Due to the high risk for psychosocial problems among children of parents diagnosed with depression, a non-intervention condition would be unethical, so the present study does not include a true control group.

2.3. Measures

Parents and their offspring filled in self-reported questionnaires in the services offering the interventions at each time point of assessment. Parents complete a 17-item demographic questionnaire, the 13-item Beck Depression Inventory-Short Form (Beck & Beck, 1972), the 20-item Spielberger State Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970), the 25-item Strengths and Difficulties Questionnaire (Goodman, 1997) assessing children's emotional and behavioural problems, the 5-item Screen for Child Anxiety Related Emotional Disorders Scale-Short Form (Birmaher et al., 1999), the 27-item KIDSCREEN—27 children's quality of life measure (Ravens-Sieberer et al., 2007), the 5-item Social Adjustment Scale-Parental Role (Weissman, 2006), the 12-item Family Assessment Device-General Functioning Subscale (Miller et al., 1994), the 3-item Oslo Social Support Scale (Brevik & Dalgard, 1996) assessing parents' instrumental and emotional support from others, and a 10-item questionnaire measuring parents' experience with and perceived impact of the intervention. Children complete by themselves the 27-item Children's Depression Inventory (Kovacs, 1985), the 25-item Strengths and Difficulties Questionnaire (Goodman, 1997), the 5-item Screen for Child Anxiety Related Emotional Disorders Scale-Short Form-Child Version (Birmaher et al., 1999), the 27-item KIDSCREEN—27 (Ravens-Sieberer et al., 2007), and the 3-item Oslo Social Support Scale (Brevik & Dalgard., 1996), measuring children's self-perceived social support that receive from significant others.

2.4. Statistical Analyses

Possible significant differences between the two groups prior to interventions will be examined using independent sample t-test for continuous measures and chi-square test for categorical variables. Comparisons will be made between the two groups regarding the differences in questionnaire scores using repeated measures ANOVA (measure prior to interventions vs. 4 months, prior to interventions vs. 10 months and prior to interventions vs. 18 months post-intervention). Due to the fact that parental depressive symptoms may alter our findings, there will be statistical control for Beck Depression Inventory-Short Form score models in the measure prior to interventions and in the score changes during the various time points of post-intervention measures. Linear mixed-effects models with two random effects will be used in order to compare prospectively the mean changes in each group and to take the dependence between siblings into account.

3. Conclusion

The present study is designed to examine the effectiveness of preventive interventions in children and families with parental depression in Greece. We hypothesize that both interventions will result in decreasing self-reported and parent-reported children's emotional/behavioral problems and in increasing children's health-related quality of life as reported by parents and children themselves. Moreover, we hypothesize that the FTI, in which children participate in family meeting with their parents, will be faster in improving family functioning and children's outcomes compared to the LTC intervention that involves the parents only. A third research hypothesis is that potential improvements of parent-child relationships, family functioning and social support perceived by children rather than decreases in parents' depressive symptoms per se (possibly as a result of their psychiatric treatment) will better explain positive changes in children's psychosocial outcomes and health-related quality of life. This study will offer an evidence base for developing relevant initiatives in a national level and for integrating preventive actions for child mental health in routine clinical practice with adult depressed patients. Last, we strongly hope that the upcoming findings of our work will encourage decision makers, mental health services

and clinicians themselves to respond to families struggling with depression through cost-effective interventions during the great Greek depression and societal adversity.

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