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# Translating Intergenerational Research on Depression Into Clinical Practice

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**D**EPRESSION IS HIGHLY PREVALENT (ESPECIALLY among women during the childbearing years), frequently recurrent, often untreated, and associated with several adverse health outcomes. Anxiety, depressive, and disruptive behavior disorders are more common in the children of depressed than nondepressed parents.<sup>1</sup>

Three recent studies suggest clinical opportunities for attenuating the intergenerational transmission of depression. In the first study, an observational analysis, successful treatment of depressed mothers to remission was associated with a significant reduction of symptoms in their children,<sup>2</sup> while persistence of maternal depression was associated with increased risk of child psychiatric disorders and symptoms.<sup>2</sup> In the second study, a randomized clinical trial, interpersonal psychotherapy compared with treatment as usual for depressed mothers of school-aged children decreased depressive symptoms in the mothers and their children.<sup>3</sup> The third study, also a randomized clinical trial, reported that group cognitive behavioral therapy was effective in preventing high-risk adolescents from developing depression over the 9-month follow-up<sup>4</sup> except when living with a parent who was currently depressed.

Strong linkages between parental depression and youth symptoms highlight potential clinical benefits of treating depressed parents and coordinating mental health care of parents and their children. Yet few health care professionals are adequately trained to assess and treat parents and their children, and many service settings are not configured to address the intergenerational dimensions of depression.

## Basic Training Challenges

Glaring deficits exist in the training, skill, and competence of health care professionals in managing adult depression and related child psychiatric disorders. Even though most primary care residency programs offer training in the diagnosis and treatment of mood disorders, program directors report high levels of dissatisfaction with this training.<sup>5</sup> Most primary care residents do not feel well prepared to counsel their depressed patients. Concern also exists regarding training of mental health specialists. Roughly two-thirds of so-

cial work and clinical psychology training programs do not require training in any evidence-based psychotherapy.<sup>6</sup> Without a foundation in skills necessary to deliver evidence-based treatments, initiatives to improve parent and child mental health care are likely to falter.

## Pediatricians and Parental Depression

Pediatricians are well positioned to follow up identification of child mental health problems with assessments of maternal depression. Although most pediatricians believe they are responsible for recognizing maternal depression, only 1 in 7 have been trained in adult mental health interviewing techniques.<sup>7</sup> Many pediatricians are unfamiliar with adult depression screening instruments and few have sufficient time to treat or make referrals.

Brief screens for adult depression can simplify the preliminary evaluation of maternal depression in pediatric practice. In one survey, more than 40% of women bringing young children for pediatric care reported that they would welcome being screened for depression.<sup>8</sup> Of course, screening alone is unlikely to improve child or maternal outcomes. Referral networks and close collaborative relationships between pediatricians and adult mental health professionals need to be established to smooth the transition of depressed parents into specialty mental health care.

Under prevailing time and reimbursement constraints, it is unreasonable to expect pediatricians to perform complex mental health assessments of parents who accompany their children to appointments. In some treatment settings, however, pediatricians or their staff may have opportunities to offer brief depression screens to parents whose children exhibit significant psychiatric symptoms. Where financially feasible, consideration should be given to hiring nonphysician primary care clinicians with training in treatment of psychiatric problems. Similar opportunities may exist in internal medicine and, especially, in family practice. Family practitioners, especially those who care for depressed mothers and their high-risk children, may be well positioned to assess whether treating depressed mothers to remission reduces psychiatric symptoms in their children.

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Referral mechanisms are needed that enhance access from pediatric offices to adult mental health care professionals for distressed parents who seek further mental health evaluations. Unfortunately, serious impediments exist to referrals from primary care to specialty mental health. Approximately two-thirds of primary care physicians report that they cannot obtain outpatient mental health care for their patients with mental health problems.<sup>9</sup> Regional shortages in specialists (especially in less populated areas), inadequate health care coverage, and health plan barriers are frequently cited by primary care physicians as obstacles to specialty mental health care.<sup>9</sup> Collocation of primary care physicians and mental health care professionals within the same building, which tends to increase professional interaction and collaboration, could facilitate access. Greater use of the telephone may also smooth transitions. New mental health parity legislation may further improve access. This federal law requires that if private insurers offer mental health benefits, the benefits can be no more restrictive than those for medical/surgical services.

### Collaborative Care and Child Mental Health

Little attention has been devoted in the internal medicine or family practice literature to mental health assessment of the children of depressed parents. A rationale exists for extending the role of health care professionals who treat depressed parents to include monitoring the mental health of these high-risk children. One approach involves extending collaborative care models in internal medicine practices to collaborations with pediatricians or other health care professionals who treat high-risk children of depressed parents.

Collaborative care is an empirically supported model for organizing primary care management of adult depression.<sup>10</sup> It usually involves a nurse practitioner or case manager who assists with management of depressed patients through structured delivery of interventions, mechanisms to foster communication between primary care clinicians and mental health specialists, and collection and sharing of information on patient progress. Collaborative care for depressed parents may offer clinicians opportunities to inquire about the mental health of children who live with depressed parents. If significant problems are suspected, brief mental health screening of youth may be offered on a voluntary basis. Given the critical shortage of child psychiatrists and other child mental health specialists, mental health referrals may not be feasible in many settings.

### Summary

An increasing recognition that treating maternal depression tends to ameliorate transmission of depression to the next generation will hopefully stimulate interest in treating depressed mothers and monitoring the course of their high-risk children. Mental health benefits for children might also flow from successfully treating depressed fathers.

Progress in this area will likely require confronting several barriers. At the individual level, many psychiatrically ill adults do not perceive a need for mental health treat-

ment, are stigmatized by seeking care, remain pessimistic about its effectiveness, and are unable to afford it. At the practitioner level, deficits in training, lack of confidence, time pressures, and reimbursement constraints can all impede mental health care delivery. At a systems level, a scarcity of mental health specialists and historically poor communication across the primary care/specialty mental health interface pose additional barriers.

Health care spending continues to increase at a rapid and unsustainable pace. The debate over health care reform is occurring in an environment in which few new resources will likely become available in the near term to meet the needs of depressed parents and their high-risk children. In this context, it is especially important to focus on the delivery of high-quality health care by training practitioners in evidence-based depression management, selectively screening parents for depression, and coordinating the care of depressed parents with care of their high-risk children.

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