Caregiver Depression and Youth Disruptive Behavior Difficulties

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Caregiver Depression and Youth Disruptive Behavior Difficulties

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This study examines the rates of depressive symptoms and service use among caregivers whose children receive treatment for disruptive behavior disorders. Descriptive analyses examined preliminary baseline data from the Family Groups for Urban Youth with Disruptive Behaviors study for 212 caregivers to determine rates of caregiver depressive symptoms and lifetime mental health service use. Findings indicate that caregivers manifest substantially higher rates of depressive symptoms compared to national norms. Of those caregivers with clinically significant depressive symptoms, less than half reported ever receiving mental health services. Findings

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suggest that greater attention should be paid to identifying and
treating caregiver depression among children receiving treatment
for disruptive behavior disorders.

KEYWORDS caregiver depression, disruptive behavior disorders,
child mental health treatment

Parents who bring their children to mental health clinics frequently man-
ifest high rates of mental health difficulties themselves (Ferro, Verdeli,
Pierre, & Weissman, 2000; Rishel, Greeno, Marcus, & Anderson, 2006; Swartz
et al., 2005). However, many of these parents do not receive their own
psychiatric treatment (Ferro et al., 2000; Swartz et al., 2005), which can
result in negative treatment outcomes for their children (Brent et al., 1998;
Rishel et al., 2006). Parental depression, in particular, can have deleteri-
ous consequences in terms of child disruptive behavior difficulties (Aikens,
Coleman, & Barbarin, 2007; Cummings, Keller, & Davies, 2005; Marchand,
Hock, & Widaman, 2002). However, little research has examined rates of
mental health service use among low-income, urban depressed caregivers
whose children receive treatment for disruptive behavior disorders, specif-
ically oppositional defiant disorder (ODD; a recurrent pattern of hostile,
disobedient, and defiant behavior beginning in childhood or adolescence;
American Psychiatric Association, 2000) and conduct disorder (CD; extreme
externalizing behaviors, such as fighting, stealing, and property destruction;
American Psychiatric Association, 2000). Consequently, the principal aim of
this study is to examine the rates of caregiver depressive symptoms and
lifetime mental health service use among parents bringing their children to
community-based mental health clinics for treatment of ODD or CD.

CAREGIVER DEPRESSION AND MENTAL HEALTH SERVICE USE

In recent years, studies demonstrate that a substantial number of parents
seeking mental health treatment for their children also experience clini-
cally significant levels of depressive symptoms (Rishel et al., 2006). For
instance, among parents whose children met diagnostic criteria for atten-
tion deficit hyperactivity disorder (ADHD) and received care through the
public service sector, 41% manifested clinical levels of depression (Leslie,
Aarons, Haine, & Hough, 2007). Rishel et al. (2006) found that 64% of moth-
ers whose children received psychiatric treatment also met criteria for one
or more current psychiatric diagnosis. Among these caregivers, 34% met
criteria for major depressive disorder. Ferro et al. (2000) also found that
nearly one-third (31%) of mothers whose children met diagnostic criteria for
unipolar depression screened positive for current major depression, while
22% expressed suicidal ideation or intent. Among a sample of mothers who brought their children to a rural community pediatric mental health clinic, Swartz et al. (2005) found that 35% of mothers met criteria for a depressive disorder. In combination, these findings are striking, given that only 1–7% of adults nationwide suffer from depressive disorders (Kessler, Chiu, Demler, & Walters, 2005). Moreover, up to 2/3rds of caregivers with mental health difficulties whose children receive psychiatric treatment frequently do not receive mental health treatment themselves (Ferro et al., 2000; Swartz et al., 2005).

CAREGIVER DEPRESSION AND CHILD DISRUPTIVE BEHAVIOR DISORDERS

However, little research has examined the rates of mental health service use among depressed caregivers whose children receive treatment in community-based outpatient clinics for disruptive behavior disorders, such as ODD and CD. These disorders are the most common reasons for referral to child mental health care in community clinics (Frick, 1998; Kazdin, 1995; 2008). Studies indicate a substantial association between caregiver depression and childhood disruptive behavior problems (Civic & Holt, 2000; Gross, Shaw, Burwell, & Nagin, 2009), where caregivers experiencing higher levels of depression consistently report elevated rates of behavior problems in their children (e.g., Spieker, Larson, Lewis, Keller, & Gilchrist, 1999), including attention problems, hyperactivity, defiance, aggression, and delinquency (Chronis et al., 2007). As many as half of mothers bringing their children to treatment for behavior problems may manifest clinically significant depressive symptoms themselves (Alpern & Lyons-Ruth, 1993; Hutchings, Appleton, Smith, Lane, & Nash, 2002). Compared to the general population, rates of caregiver depression and child disruptive behavior difficulties are higher in low-income, inner-city communities (McKay, Harrison, Gonzales, Kim, & Quintana, 2002; Miranda et al., 2003; Siefert, Bowman, Heflin, Danziger, & Williams, 2000; Tolan & Henry, 1996). Such environments render both parents and children more vulnerable to developing mental health problems as a result of multiple socio-environmental hardships, including poverty, community violence, unemployment, as well as insufficient housing, health, and mental health resources (Attar, Guerra, & Tolan, 1994; Belle, 1990; Gustafson, Larsson, Nelson, & Gustafsson, 2009; Ingoldsby & Shaw, 2002; Leventhal & Brooks-Gunn, 2000; Siefert, Finlayson, Williams, Delva, & Ismail, 2007).

Untreated, parental depression can lead to increased child disruptive behavior difficulties (Aikens et al., 2007; Cummings et al., 2005; Marchand et al., 2002). Caregiver depression can result in poor parent–child attachment, which increases the likelihood of school-age children exhibiting
behavior problems (Moss, Rousseau, Parent, St-Laurent, & Saintonge, 1998). Furthermore, depressed parents often have difficulty fulfilling parenting roles and responsibilities (Downey & Coyne, 1990; Goodman & Gotlib, 1999), manifest inconsistent or ineffective discipline and control, emotional unavailability, and insensitivity toward children (Cummings & Davies, 1994; Field, 1998; Susman, Trickett, Iannotti, Hollenbeck, & Zahn-Waxler, 1985), and demonstrate an increased likelihood of utilizing corporal punishment (Chung, McCollum, Elo, Lee, & Culhane, 2004). Unfortunately, such poor child management skills, discipline practices, family communication, and interactional patterns are consistently implicated in the development and maintenance of disruptive behavior problems (Keiley, 2002; Loeber & Stouthamer-Loeber, 1987; Tolan & Henry, 1996). As a result, children who are already exhibiting disruptive behaviors are less likely to improve if their caregivers' depression hinders the development of ameliorative parenting practices and family processes.

It is not surprising, then, that parents' untreated mental health problems have been associated with diminished child mental health treatment success (Brent et al., 1998; Ferro et al., 2000; Leslie et al., 2007; Rishel et al., 2006; Swartz et al., 2005), as well as reduced compliance with children's psychiatric medication regimen (Leslie et al., 2007). Significant parental stressors are also known to hinder families' ability to seek and retain mental health treatment for their children (Thompson et al., 2007). When there are substantial family problems, including parental mental health difficulties, parents are less likely to have the resources or motivation to seek help, or to comply with their children's treatment needs (Harrison, Mckay, & Bannon, 2004; Leslie et al., 2007).

Given the pervasiveness of caregiver depression and child disruptive behavior disorders in inner-city, low-income communities, as well as the impact that caregiver mental illness can have on child mental health and treatment outcomes, it behooves providers and policymakers to understand the prevalence of caregiver depression among parents whose children receive psychiatric treatment for disruptive behavior disorders, as well as the rates of service use among depressed caregivers. While previous studies have documented the prevalence of caregiver depressive symptoms and service use among children receiving psychiatric treatment for a variety of disorders (i.e., Ferro et al., 2000; Rishel et al., 2006; Swartz et al., 2005), there is little information identifying mental health service use rates for depressed caregivers within a sample of low-income, inner-city minority families bringing their children to community mental health clinics for treatment of ODD and CD. Consequently, the current study examines (1) rates of caregiver depressive symptoms among those parents bringing their children to treatment for disruptive behavior disorders and (2) percentages of caregivers with clinically significant levels of depressive symptoms who report ever receiving mental health treatment. Based on the extant literature, we expect that
caregivers whose children receive treatment for ODD and CD will manifest disproportionately high rates of depressive symptoms compared to national norms. Additionally, it is further hypothesized that the majority of caregivers with high levels of depressive symptoms will have never received mental health treatment. Data were collected in the context of a prospective intervention study examining the effectiveness of a Multiple Family Group service delivery model to reduce childhood disruptive behavior disorders (“Family Groups for Urban Youth with Disruptive Behaviors”). The current study begins to fill in a notable gap in research regarding mental health service use for depressed parents whose children currently receive psychiatric treatment for ODD and CD.

METHODS

Sample
The current study utilized baseline data from the Family Groups for Urban Youth with Disruptive Behaviors study, currently in its fourth year of 5-year National Institute of Mental Health (NIMH) funding (5R01 MH072649). This parent study evaluates the effectiveness of a Multiple Family Group service delivery model to reduce childhood disruptive behavior disorders. Institutional Review Board approval for the parent study was obtained through the Mount Sinai School of Medicine. Children, aged 7–11 who met diagnostic criteria for ODD or CD and their adult caregivers were recruited from 12 urban child mental health clinics in the New York City metropolitan area. Potentially eligible youth and their families (based on an intake diagnosis of ODD and CD made by clinical service providers) were informed of the parent study by their providers first. If the family expressed interest in learning more, parents were contacted by a member of the research staff. After describing the parent study to the participants, research staff obtained written informed consent and administered the Parent/Teacher Disruptive Behavior Disorders Rating Scale (Pelham, Evans, Gnagy, & Greenslade, 1992; Pelham, Gnagy, Greenslade, & Milich, 1992) to determine if youth met symptom criteria for ODD or CD. Participants included both English and Spanish speakers. Participants were excluded from the study if children or caregivers manifested significant cognitive impairment that would interfere with understanding of program content or the informed consent process, or emergency psychiatric needs requiring services beyond those provided within an outpatient setting (e.g., hospitalization, specialized placement outside the home). Participants were also excluded if children resided in foster care or their legal guardian could not provide formal consent. Adult caregivers and youth of eligible families immediately completed baseline interviews consisting of structured assessment instruments. Based on the inclusion and exclusion criteria for the parent study, 237 caregivers and their children screened in as
eligible for inclusion during the period beginning November 2, 2006 through December 1, 2009. Of these, 212 (89%) adult caregivers completed valid baseline assessments regarding caregiver depressive symptoms and mental health service use.

Measures

CENTER FOR EPIDEMIOLOGICAL STUDIES-DEPRESSION SCALE (CES-D)

The CES-D is a 20-item non-diagnostic, self-report measure of depressive symptoms that is widely used in community-based epidemiological studies (Perez Foster, 2007). The Center for Epidemiologic Studies developed this measure (Radloff, 1977). Respondents are asked to rate, on a 0 to 3 scale (ranging from “Rarely/None of the Time” to “Most/All of the Time”), how often in the past week they felt or behaved a certain way, such as “I was depressed,” or “I did not feel like eating; my appetite was poor.” Total possible scores range from 0 to 60, with higher scores indicating greater depressive symptoms. The items cover both depressed mood and physiological manifestations of depression, such as loss of appetite and sleep disturbance. A score of 16 or higher has been used extensively as the cut-off point indicating clinical levels of depressive symptoms (Knoche, Givens, & Sheridan, 2007). The internal consistency of the CES-D was reported to be .85 for the general population (Radloff, 1977), and in this study, the Cronbach’s alpha was .89. Caregivers with a score of 16 or higher met with research staff to discuss their clinical levels of depressive symptoms and were provided resources to accommodate and/or initiate caregivers’ reception of mental health services.

CAREGIVER MENTAL HEALTH SERVICE USE

Caregivers responded whether they had ever received mental health services for themselves (e.g., outpatient individual therapy, medication management, substance abuse treatment, inpatient hospitalization, day treatment, residential treatment, case management, psychological/psychiatric evaluation). Caregivers responded “Yes” or “No” to this question.

Analyses

Analyses utilized SPSS Version 17 statistical software (SPSS for Windows 17.0., 2008). Descriptive statistics determined overall CES-D means for the sample, as well as the percentage of caregivers reporting clinically significant depressive symptoms (scoring ≥16 on CES-D). Percentage of caregivers ever receiving mental health services for themselves were computed for all caregivers, organized by clinically significant depressive symptom status.
RESULTS

Table 1 presents demographic information for this sample. Overall, the majority of caregivers for the current study identified as either Black/African American ($n = 64, 30.5\%$) or Hispanic/Latino ($n = 118, 56.2\%$). Most primary caregivers ($n = 171, 81.8\%$) were mothers, with a mean age of 35.8 ($SD = 8.3$) years old. Only 1/3rd of caregivers reported being married or cohabiting. The majority of caregivers (66\%) reported an annual income of less than $20,000. Overall, a greater percentage of caregivers manifesting clinically significant levels of depressive symptoms reported having incomes lower than $9,999 and less than an eighth-grade education, compared to caregivers in the normal range on the CES-D.

The mean baseline CES-D score for this sample was 18.8 ($SD = 11.2$), which is significantly higher than the reported national norm of 8.7 among U.S. adults (Sayetta & Johnson, 1980). Moreover, as indicated in Table 1, 56.6\% ($n = 120$ out of the $n = 212$) of caregivers reported manifesting clinically significant levels of depressive symptoms at baseline, scoring 16 or higher on the CES-D. Finally, Table 2 indicates that, among those caregivers manifesting clinically significant levels of depressive symptoms, only 49.1\% ($n = 59$ out of $n = 120$) reported ever receiving any type of mental health service.

DISCUSSION

Findings are consistent with prior research indicating caregivers who bring their children to psychiatric treatment manifest substantially higher levels of mental health difficulties than adults in the general population. Indeed, over half (56.6\%) of all caregivers in the current sample manifested clinically significant levels of depressive symptoms. In comparison, studies indicate only 17–21\% of the general population scored above 16 on the CES-D (McCue Horwitz, Briggs-Gowan, Storfer-Isser, & Carter, 2007; Radloff, 1977). At the same time, results from the current study suggest that slightly over half of caregivers (50.8\%; $n = 61$ out of $n = 120$) with clinically significant levels of depressive symptoms have never received mental health services themselves. These findings are concerning, given the deleterious effect that untreated caregiver depression can have on child mental health and treatment outcomes.

Limitations

Findings from this study should be interpreted in light of certain limitations. Wording of questions used to assess mental health service use asked if caregivers have “ever” used mental health services. As a result, the current
### TABLE 1 Demographic Characteristics of Caregivers (n = 212)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total</th>
<th>Normal range (≤15 on CES-D)</th>
<th>Clinical range for depressive symptoms (≥16 on CES-D)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Ethnicity:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>18</td>
<td>8.6</td>
<td>9</td>
</tr>
<tr>
<td>Black/African American</td>
<td>64</td>
<td>30.5</td>
<td>33</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>118</td>
<td>56.2</td>
<td>47</td>
</tr>
<tr>
<td>Native American</td>
<td>1</td>
<td>0.5</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>4.3</td>
<td>1</td>
</tr>
<tr>
<td>Primary Caregiver:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>171</td>
<td>81.8</td>
<td>65</td>
</tr>
<tr>
<td>Father</td>
<td>4</td>
<td>1.9</td>
<td>1</td>
</tr>
<tr>
<td>Mother and Father</td>
<td>17</td>
<td>8.1</td>
<td>11</td>
</tr>
<tr>
<td>Grandparent</td>
<td>6</td>
<td>2.9</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>5.3</td>
<td>10</td>
</tr>
<tr>
<td>Age (mean ± SD)</td>
<td>35.8 ± 8.3</td>
<td>36.4 ± 9.6</td>
<td>35.4 ± 7.2</td>
</tr>
<tr>
<td>Caregiver Marital Status:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>97</td>
<td>46.2</td>
<td>40</td>
</tr>
<tr>
<td>Married or Cohabiting</td>
<td>70</td>
<td>33.3</td>
<td>32</td>
</tr>
<tr>
<td>Divorced</td>
<td>11</td>
<td>5.2</td>
<td>5</td>
</tr>
<tr>
<td>Separated</td>
<td>23</td>
<td>11.0</td>
<td>8</td>
</tr>
<tr>
<td>Widowed</td>
<td>5</td>
<td>2.4</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>1.9</td>
<td>3</td>
</tr>
<tr>
<td>Income:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than $9,999</td>
<td>88</td>
<td>44.2</td>
<td>29</td>
</tr>
<tr>
<td>$10,000 to $19,999</td>
<td>52</td>
<td>26.1</td>
<td>27</td>
</tr>
<tr>
<td>$20,000 to $29,999</td>
<td>27</td>
<td>13.6</td>
<td>11</td>
</tr>
<tr>
<td>$30,000 to $39,999</td>
<td>15</td>
<td>7.5</td>
<td>12</td>
</tr>
<tr>
<td>$40,000 to $49,999</td>
<td>4</td>
<td>2.0</td>
<td>2</td>
</tr>
<tr>
<td>Over $50,000</td>
<td>13</td>
<td>6.5</td>
<td>6</td>
</tr>
<tr>
<td>Education Status:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8th Grade or Less</td>
<td>28</td>
<td>13.5</td>
<td>9</td>
</tr>
<tr>
<td>Some High School</td>
<td>56</td>
<td>26.9</td>
<td>20</td>
</tr>
<tr>
<td>Completed H.S./G.E.D.</td>
<td>51</td>
<td>24.5</td>
<td>24</td>
</tr>
<tr>
<td>Some College</td>
<td>49</td>
<td>23.6</td>
<td>23</td>
</tr>
<tr>
<td>Completed College</td>
<td>13</td>
<td>6.3</td>
<td>9</td>
</tr>
<tr>
<td>Some Grad/Prof. School</td>
<td>3</td>
<td>1.4</td>
<td>0</td>
</tr>
<tr>
<td>Competed Grad/Prof. School</td>
<td>8</td>
<td>3.8</td>
<td>5</td>
</tr>
<tr>
<td>Employment Status:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed Full-Time</td>
<td>56</td>
<td>26.5</td>
<td>32</td>
</tr>
<tr>
<td>Employed Part-Time</td>
<td>37</td>
<td>17.5</td>
<td>16</td>
</tr>
<tr>
<td>Student</td>
<td>9</td>
<td>4.3</td>
<td>5</td>
</tr>
<tr>
<td>Retired</td>
<td>4</td>
<td>1.9</td>
<td>4</td>
</tr>
<tr>
<td>Disabled</td>
<td>23</td>
<td>10.9</td>
<td>6</td>
</tr>
<tr>
<td>Unemployed</td>
<td>72</td>
<td>34.1</td>
<td>21</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>4.7</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>212</td>
<td>92</td>
<td>43.4</td>
</tr>
</tbody>
</table>

*aNumbers may not add up to n = 212 due to missing data.

*b% is out of n = 212.

*c% is out of total sample size within each demographic characteristic category.
TABLE 2 Lifetime Service Use for Caregivers (n = 212)

<table>
<thead>
<tr>
<th>Mental health service use</th>
<th>Normal range (≤15 on CES-D)</th>
<th>Clinically significant depressive symptoms (≥16 on CES-D)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Received Any Mental Health Service</td>
<td>25</td>
<td>11.8</td>
</tr>
<tr>
<td>Did Not Receive Any Mental Health Service</td>
<td>66</td>
<td>31.1</td>
</tr>
<tr>
<td>Total</td>
<td>91</td>
<td>43.4</td>
</tr>
</tbody>
</table>

Numbers do not add up to n = 212 due to missing data. +percentages are out of n = 212.

study was unable to distinguish between caregivers’ current service use and history of service use prior to engaging their children into treatment. Given that prior studies (e.g., Ferro et al., 2000; Swartz et al., 2005) find that up to 2/3rds of depressed caregivers do not currently receive mental health treatment, we expect that rates of mental health service use from the current study would decrease if focusing on current service use.

As this was not an epidemiological study, we cannot conclude that rates of caregiver depressive symptoms detected in this sample are representative on a national basis. Moreover, findings from the current study are limited to those families with children between the ages of 7–11 years old, as was specified by the intake criteria for the parent study (i.e., Family Groups for Urban Youth with Disruptive Behaviors study). Consequently, findings are not necessarily generalizable to families with older or younger children. This is not to say, however, that caregiver depression is applicable for school-age children exhibiting behavior problems alone. Certainly, aside from managing behavioral difficulties among teens, a substantial number of parents may experience lowered self-esteem, diminished life satisfaction, increased anxiety and depression, and more frequent ruminations about middle age during the transition through adolescence (Steinberg & Steinberg, 1994). Furthermore, caregivers of younger children with behavioral difficulties are also likely to experience mental health problems themselves (Gross, Shaw, Moilanen, & Dishion, & Wilson, 2008).

Implications

Most importantly, findings from the current study underscore the need for ensuring that depressed caregivers receive appropriate treatment, especially given evidence indicating that caregivers’ psychological well-being affects their children’s treatment outcomes (Brent et al., 1998; Rishel et al., 2006; Weissman et al., 2006). Consequently, targeting caregiver depression may be an important element not only in the treatment of child
disruptive physical behavior problems, but also in the maintenance of treatment results.

A few options exist currently to address caregiver mental illness among parents whose children have psychiatric difficulties. An 8-session version of Interpersonal Psychotherapy developed for depressed mothers whose children received treatment for depression (IPT-MOMS; Swartz et al., 2007; 2008; Verdelli et al., 2004) focuses on the specific challenges associated with managing children with mental health difficulties and negotiating the child mental health service system (Swartz et al., 2007). A recent randomized trial indicated that mothers receiving IPT-MOMS manifested significantly lower depressive symptoms and higher levels of functioning compared to mothers in the control group. Moreover, children whose mothers received IPT-MOMS demonstrated significantly lower levels of depression than mothers receiving treatment as usual (Swartz et al., 2008).

However, several trials of IPT-MOMS have reported difficulties engaging depressed mothers (Swartz et al., 2007; Verdelli et al., 2004). The literature points toward specific barriers endemic to individuals residing in low-income urban areas, such as high treatment costs, lack of insurance, limited time and competing priorities, loss of pay from missing work, inconvenient or inaccessible clinic locations, limited clinic hours, transportation problems, and child care difficulties (Armstrong, Ishiki, Heiman, Mundt & Womack, 1984; Maynard, Ehreth, Cox., Peterson & McGann, 1997). For those caregivers with significant economic difficulties, seeking treatment may be seen as an additional financial burden (Hall, 2001). Mothers may also fear that receiving mental health treatment could result in the removal of their child from the home (Anderson et al., 2006). Stigma about mental illness (e.g., concern about what friends and family think, embarrassment around discussing depression, belief that mental health treatment is ineffective) can also prevent depressed, economically disadvantaged women from seeking treatment (Scholle, Haskett, Hanusa, Pincus & Kupfer, 2003). Finally, mental health clinicians may be insensitive or ignorant to cultural factors, which subsequently affect treatment engagement and retention for minorities in general (Miranda, Azocar, Organista, Muñoz, & Lieberman, 1996).

Given difficulties with engaging caregivers into their own mental health treatment, innovative services could co-locate child and adult treatment within the same setting. To date, a few studies have examined the effects of concurrent treatment for child disruptive behavior and caregiver depression. In one study, Chronis, Gamble, Roberts, and Pelham (2006) offered the cognitive behavioral intervention entitled “Coping with Depression Course” (CWDC; Lewisohn, Antonuccio, Steinmetz, & Teri as cited in Chronis et al., 2006) to mothers whose families had participated in a prior 8-week behavioral treatment program for children with ADHD. The authors found that the subsequent CWDC intervention led to improvements in both maternal depression and mother-reported child behavior. Additionally, involvement in the CWDC intervention helped to maintain the positive effects of the initial
ADHD treatment program. Sanders and McFarland (2000) have also developed a Cognitive Behavioral Family Intervention (CBFI), which has been effective in reducing both maternal depression and child disruptive behavior.

Conversely, it has been suggested that child mental health interventions which focus on parent training may be effective in reducing caregiver depression. Specifically, it is argued that as parenting skills increase, youth behavioral difficulties decrease, which in turn, results in decreases in caregiver depression (Barth, 2009). For example, DeGarmo, Patterson, and Forgatch (2004) evaluated the effects of Parent Management Training for recently separated mothers and their sons. DeGarmo et al. found that increases in effective parenting predicted reductions in child behavior problems, while reductions in maternal depression were mediated by reductions on youth behavioral difficulties. Furthermore, lifting of depression contributed to improved parenting and child conduct over the next 18 months. Such evidence suggests that it may be more cost-effective to offer parent training alone as part of child mental health interventions to treat disruptive behavior disorders. Only if there are no improvements in parent functioning should additional interventions be added to target caregiver depression (Barth, 2009).

In sum, findings from the current study indicate the importance of conjointly addressing children’s behavioral difficulties and depressive symptoms among their caregivers. As the current study and previous research demonstrate, caregivers of children receiving mental health treatment often do not receive services themselves, which can have harmful consequences for child mental health outcomes and treatment progress. As a result, future research would examine the most cost-effective and efficient ways of developing integrated treatment and service structures which would address both child and caregiver needs. This may entail co-locating caregiver treatment within child mental health treatment programs as an effective way of ensuring that caregivers with mental health issues engage in needed services. At the same time, the findings by DeGarmo et al. (2004) suggest that future research should determine if the relationships between improved parenting skills, reduced youth behavior problems, and subsequent reductions in caregiver depression also hold across other evidence-based, parent-mediated treatments for childhood disruptive behavior disorders.

REFERENCES


