

**Refocussing the lens on parent depression, family functioning and the impact of interventions on families.**



**PhD confirmation and progress report**

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## **Introduction**

“The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.”

*Section three, Article 16, Universal Declaration of Human Rights*

The decision to become a parent and begin a family is a basic right, and brings joy, meaning and fulfilment to many who embark upon it. It is also a choice that conveys responsibilities, both for the parent(s) and their family in terms of meeting the needs of each of its members, and also for the wider community to support these processes and the unit as a whole. Parental depression can increase a family’s vulnerability and confer risk for all family members (Rutter, 1990; Weissman, Gammon, John, & et al., 1987; Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997; Weissman, Wickramaratne, Nomura, Warner, & et al., 2006). Rates of depression amongst parents can vary from 10-42% (Horwitz, Briggs-Gowan, Storfer-Isser, & Carter, 2007), with mothers outnumbering fathers approximately 2 to 1 (Roy, Zoccolillo, Gruber, Boivin, & et al., 2005). To this end, professionals who work with adults experiencing mental illness are beholden to deliver appropriate attention and resources to identifying, understanding and strengthening potentially vulnerable family units.

## **Thesis Overview**

Parental depression has experienced a continued focus amongst researcher for at least the last 20-30 years, as evidenced by the many review papers and special journal editions dedicated to this topic (for example, see Rutter, 1990; Zahn-Waxler, 1995). Theories regarding transmission of risk to children and families exposed to parental depression have guided a variety of interventions aimed to protect them. It is not as yet clear, however, what constitute the essential intervention components necessary to effect change, and whether some components are more efficacious than others in helping families to ameliorate risk to children and improve parenting experience. Furthermore, better understanding the ways in which families respond to and implement skills and learning garnered from interventions, and the way families function together in the context of parental depression is a valuable next step to streamline a best practice evidence based approach. We propose to explore these issues within this thesis by conducting four studies (Figure One). Rather than a sequential story, we hope that the outcomes of each study will offer unique and complimentary information regarding how to best understand and support families where a parent has depression.

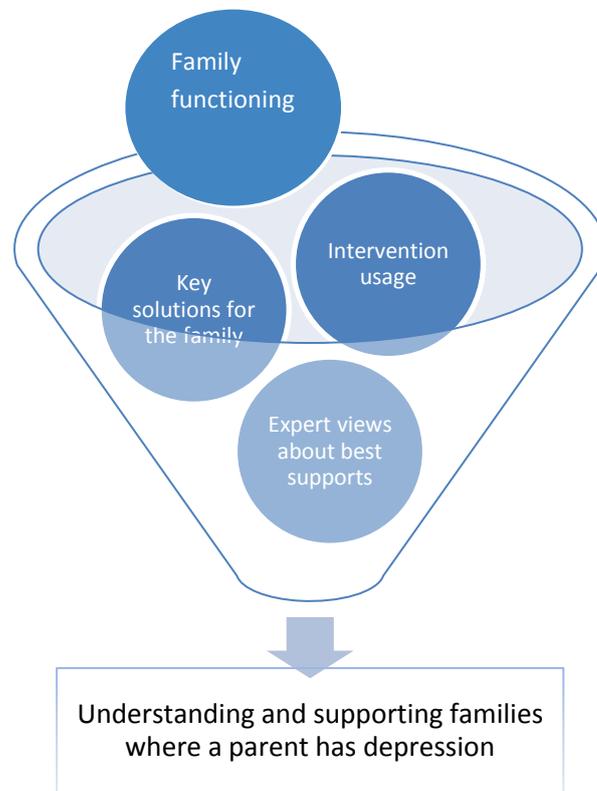


Figure One. A conceptual model of the “Refocussing the lens” PhD.

## Study One and Two

### Background Research and Theory

#### Family outcomes of parental depression

All family members can be affected by parental depression, although risks and outcomes differ for parents and children. Living with a depressed parent can adversely impact a child’s emotional experience of home life (Sarigiani, Heath, & Camarena, 2003). Furthermore, they are significantly more likely to use maladaptive coping strategies, and experience difficulties with their academic, cognitive, social and psychological functioning, as well as the potential risk of developing mental health concerns of their own, both during childhood, as well as later in adulthood (Beardslee, Versage, & Gladstone, 1998; Downey & Coyne, 1990; Goodman & Gotlib, 1999; Weissman, et al., 1987; Weissman, et al., 1997; Weissman, Wickramaratne, et al., 2006). For instance, higher levels of depressive symptoms in parents was found to be associated with greater levels of internalising symptoms in children, whose use of secondary control coping responses, such as acceptance, distraction and perceptions of self blame was also significant, independent predictors of internalising and externalising symptoms (Fear et al., 2009). Children of depressed parents are six times more likely to be diagnosed with depression themselves than children whose parents do not experience an affective disorder (Downey & Coyne, 1990).

For parents, depression can impede the parenting experience (Friedmann et al., 1997; Keitner & Miller, 1990) and detrimentally affect a parent's sense of competence and self-efficacy with regard to raising their children (Teti & Gelfand, 1991). Spouses, too, can experience distress in the form of anxiety, frustration, shame or guilt, worry and grief (Kahn, Coyne, & Margolin, 1985). The variability of effects for parents and children has prompted the comment that, "mental illness is a family experience – shared together, but suffered separately" (Marshall, Bell, & Moules, 2010, p.197).

### Factors provided to explain family outcomes

Moving beyond descriptors of outcomes, research has turned to elucidating the causative pathways. Effects of parental depression are complex and can vary widely according to mental health characteristics (e.g., number of episodes, severity, and symptoms), parenting variables, external and available supports, financial and other demographic factors, and child characteristics such as resilience (Goodman & Gotlib, 1999, 2002). Similarly, many factors have been proposed to explain family outcomes; some of the more researched ones are briefly reviewed here.

**Parent symptoms.** Severity of symptoms has been linked to worsening effects for children, although "in none of the studies are the associations impressive" (Radke-Yarrow & Klimes-Dougan, 2002, p.163). Child problems such as externalising behaviours and poor parent-child interaction appear to continue, even after a depressive episode has abated (Keitner & Miller, 1990; Stein et al., 1991), however there is some evidence that child psychopathology improves in a delayed fashion after depression has ceased (Garber, Ciesla, McCauley, Diamond, & Schloretdt, 2011). It is increasingly recognised that treatment of depression can help lower the risk for children (Weissman et al., 2006).

**Parent-child interaction.** A parent's ability to enjoy and maintain close, personal relationships with their children can be compromised by symptoms of depression (Billings, Cronkite, & Moos, 1983; Compas et al., 2010; Lovejoy, Graczyk, O'Hare, & Neuman, 2000). Some have suggested that parenting practises, along with marital discord, have the greatest effect on child outcomes (Budman & Butler, 1997). For example, amongst 697 fathers and 1320 mothers from a community sample, parents who were depressed were less likely to play with, read to, hug or cuddle their children and were more likely to report frustration with the parenting process as compared to those without affective disorder (Lyons-Ruth, Wolfe, & Lyubchik, 2000). Others have reported that children of depressed parents are more likely to be exposed to higher levels of irritability and anger than those with non-depressed parents (Rutter, 1990). Parents appear to benefit from behavioural interventions; the depression scores of mothers were significantly reduced after participating in a self-directed intervention for child behavioural problems (Morawska & Sanders, 2006). Hammen (2002; 2004) postulates that parent behaviours related to depression are experienced as stressful by

children, who subsequently use maladaptive coping strategies and develop problems with internalising and externalising behaviours.

Symptoms of depression may also affect a parent's style in terms of rejection, control and warmth (for a review, readers are referred to Rapee, 1997). Using data gathered from the Canadian National Longitudinal Survey of Children and Youth, child reports of amounts of parental nurturance, rejection and monitoring mediated the relation between parental depression and child adjustment, including internalising and externalising behaviours and pro-social behaviour (Elgar, Mills, McGrath, Waschbusch, & Brownridge, 2007). Parenting warmth and involvement was negatively related to rates of externalising behaviours in children of parents with depression (McKee et al., 2008), whilst longitudinal child-ratings of parental rejection was associated with insecurity in adult close relationships (Shelton & Harold, 2008). Children who report negative attachments with their parents also reported greater levels of depressive symptoms following increases in their parents' depression levels, indicating that parenting style can also render children more vulnerable to the effects of their depression when it occurs (Abela, Zinck, Kryger, Zilber, & Hankin, 2009). Other studies have reported that depressed parents risk the opposite extreme of becoming overly involved (Cox, Puckering, Pound, & Mills, 1987). Radke-Yarrow (1998) discusses the propensity for some depressed mothers to view their children as a source of comfort, forming excessively close and emotionally enmeshed relationships with their children.

**Parent cognitions.** Researchers have turned to tenants of cognitive psychology to extend investigations of parenting style, behaviour and depression. For some families, this reflects problems with parents feeling apprehensive and inefficient in their role. For instance, the ill effects for children's academic performance of parental depression was mediated by their confidence (Oyserman, Bybee, Mowbray, & Hart-Johnson, 2005). Providing psycho-education to families about parenting and depression held significant effects for parenting competence and family functioning and reduced parent conflict (Sanford et al., 2003).

Effects of parental attributions, too, have been identified in parental depression research. Parental depressive symptoms and levels of negative attributions concerning their teenager's behaviours predicted depressive symptoms in an adolescent cohort (Chen, Johnston, Sheeber, & Leve, 2009). Similarly, Callender and colleagues (2012) found that level of depressive symptoms in parents was associated with more negative attributions about child behaviours, and which increased the usage rates of physical punishment. This in turn predicted later child externalising behaviour. Poorer family functioning has been linked with the tendency of family members to attribute serious mental illness to a family member, as opposed to genetics or other circumstances (Robinson, 1996). In related

studies, level of parent guilt induction was positively related to children's internalising behaviours (Rakow et al., 2009) which accounted for the relationship between parent depression and child internalising problems (Rakow et al., 2011). In other words, when parents intoned to their children that they were somehow responsible for their symptoms, such as fatigue, children demonstrated more problems with internalising behaviours. Children of parents with depression may also display distorted cognitions, including guilt attributions, as compared with children from families free from this mental health concern (Zahn-Waxler, Kochanska, Krupnick, & McKnew, 1990). It appears interventions for parents that comprise a cognitive behavioural component are efficacious in improving parent skills and coping in children (Compas, et al., 2010; Compas et al., 2011) and in mitigating disruptive behaviours in children (Sanders & McFarland, 2000).

**Family environment.** Other research has endeavoured to take a broader perspective when understanding the transmission of symptoms from parents to children. Depression in parents has been associated with family discord, which was identified as a significant risk factor for major depression and / or substance use in adult children at a 20 year follow up (Pilowsky, Wickramaratne, Nomura, & Weissman, 2006). Providing family therapy to families who experience parental bipolar affective disorder helped those parents who were most unwell enjoy a longer remission and less frequent depressive periods (Miller et al., 2008). Depressed parents were found to be less able to facilitate or sustain social interactions with their children than non depressed controls (Cox, et al., 1987; Stein, et al., 1991). This has contributed to an argument that exposure to parental depression and deficiencies in both the parent-child relationship and the social environment of the family, may render children less able to form solid future relationships in adulthood (Beardslee, Schultz, & Selman, 1987). Researchers acknowledge the reciprocity that exists between parental depression and family experience. Depressed parents have been noted to have children who exhibit more challenging behaviours, arguably because they have not received the necessary modelling and social learning due to their parent's mental health status (Hammen, Burge, & Stansbury, 1990). Lyons-Ruth (2002; 2000) suggests that just as parental depression posits risk for children, so does rearing young children pose a risk for the onset of adult depression.

Continuing the focus on the family milieu, Beardslee and colleagues postulate that depressive symptoms such as fatigue, apathy, irritability and trouble with decision making drive a family's misunderstanding about depression and poor communication, which they view as the two core factors associated with the intergenerational transfer of depression (Beardslee & Knitzer, 2004). According to the Family Mental Health Alliance (2006), areas of need for families include information and education about mental health, training in skills such as communication and support

(MacFarlane, 2011). Risk is not the same as destiny, and not all children with a depressed parent will experience psychopathology (Beardslee & Podorefsky, 1988). Beardslee and colleagues make the point that this indicates resilience factors are at play, and could act to protect families at risk (Beardslee, Solantaus, Morgan, Gladstone, & Kowalenko, 2012). Beardslee and Knitzer (2004) suggest that “the key, however, is to distinguish between having a mental illness and being a parent and to emphasize supporting the parents' actions as parents” (p.162).

### Family focussed interventions for depression

There are few family programs available for parents with depression, and especially for families with children, as opposed to infants or toddlers (Reupert & Maybery, 2011). Families of children are an important unit for service delivery, as it is between ages 8-15 that children are at greatest risk of developing depression themselves (Beardslee, Gladstone, Wright, & Cooper, 2003). Family interventions for parental depression currently available are summarized in Table One overleaf.

It would appear these interventions work. The outcomes of a recent meta-analysis of programs including those in Table One along with five others for either anxiety or substance abuse, concluded that programs deliver success, in terms of lowering the risk for children of developing mental health diagnoses, internalising and externalising symptoms (Siegenthaler, Munder, & Egger, 2012). The authors raised the question, however, of what might be underpinning these findings, given the variations of active conditions across programs. Similarly, from their review of programs for parents with mental health concerns, Hinden and colleagues (2006) concluded that “... research is needed to better define and test key ingredients and theoretical models” (p. 36). Others, too, point to the need to identify how interventions are working, now that research has largely found that they do (Beardslee et al., 1993). Nicholson and her team (2009) rationalise that “...the additional research question from this perspective is how best to attain desired outcomes, rather than simply whether the desired outcomes are attained.” (p.108).

**Research Question One:** what are the active ingredient(s) common to interventions for families where a parent has depression?

Defining and interviewing experts has been used previously for distinguishing the successful and extraneous components of programs for parents with mental health concerns (Hinden, et al., 2006). In this study, program directors of services for parents with mental illness and their families

spontaneously identified moderators that affected the outcomes, which included factors at a family level, such as support and symptom management, community resources such as availability of social services and transportation, and agency factors such as innovation in mental health care and supportive leaders. This study raises both the possibility of utilising a similar methodology to determine what are the most important constituents in supporting families where a parent has depression, including available programs, but extending this to encompass all levels of service delivery as well as informal avenues of support. In addition, program directors alone were interviewed in Hinden and colleagues (2006) study, which begs the question regarding how other key stakeholders, such as experienced family researchers, or family members themselves might reply when asked how to best support families where a parent has depression, and whether these perspectives may reach a consensus.

**Research Question Two:** what do experts identify as core components to supporting families where a parent has depression?

Table 1

*Comparison of family-based interventions for parents with depression*

Intervention	Description	Intervention format	Participants	Outcome data	Hypothesized active ingredients for parents, children and families
Family Talk	Psycho-education, improve communication, help seeking, parenting skills, confidence, resilient behaviours in children	Either lecture format, given over two sessions to parents only, or clinician-led 6-11 weekly sessions	Parents with depression, and their children aged 8-15 years, randomly assigned to either the lecture series or clinician-led format	The clinician-led intervention resulted in significant changes in parent attitude and child understanding when compared to families given the lecture format. All groups showed significant changes in parents' child-related behaviours, family relations and children's level of internalizing symptoms up to 4.5 years following the intervention.	Increase family communication; develop shared family understanding of illness and its impact; increase child-centred attitudes in parents; parents to increase resilience behaviours in children and to seek help for symptoms in children promptly
Let's Talk	Psycho-educational discussion held with parents with depression and their partner.	One to two sessions of between 15 to 45 minutes.	Families with a parent with depression; randomized to receive "Let's Talk" or a version of "Family Talk"	There were reductions in children's emotional symptoms, level of anxiety and hyperactivity, and increases in their pro-social behaviours for children in both groups. Children whose families received PIP demonstrated effects earlier, whilst effects of "Let's Talk" emerged later.	Increase parent understanding about the effects of parental mental health on children increase the use of behaviours and attitudes to increase resilience in children.

Intervention	Description	Intervention format	Participants	Outcome data	Hypothesized active ingredients for parents, children and families
EFEKT-E	Parent module: psycho-education, teaching positive parenting, adequate discipline, encourage help seeking Child module: teaching problem solving to enhance social-cognitive skills	6 sessions each for mothers and children	Mothers with depression, and their children aged 4-7 attending mother-child rehabilitation clinics, randomized to intervention or treatment-as-usual	Mothers reported greater parenting self-efficacy and competence, as well as satisfaction with the program; children were observed as displaying less internalizing symptoms and less hyperactive behaviour	Parent training and skills; social skills training for children
FGCB	Psycho-education; monitor and manage stress; increase parenting skills; increase child coping strategies	12 sessions	Parents with depression, and their children aged 9-15; families randomized to treatment or written-information comparison condition	Both parent and child symptoms as measured by the CES-D, BDI, CBCL and YSR decreased from baseline, with effects maintained at 18 and 24 months follow up	Psycho=education about depression and it's impact, learning new parenting skills and teaching coping behaviours to children.
KFS	Psycho-education, improving communication, parenting skills and confidence, increasing positive family experience and cohesion, increasing child coping skills	10 sessions, including family, parent and child meetings	Mothers with depression and their families and children, aged 9-16	Mothers report improvements in child behaviours and family functioning and cohesion, and in their well being. Children report more positive experience of maternal behaviours such as warmth, and decreased negative experiences, such as family stress.	Cognitive behavioural strategies and solution-focussed and narrative therapies to move towards shared understanding of parental depression, an acceptance of their experiences and help identify strengths and solutions .

Intervention	Description	Intervention format	Participants	Outcome data	Hypothesized active ingredients for parents, children and families
Family Options	Rehabilitation program, tailored to the individual needs of families	Weekly sessions, ongoing for 12-18 months	Mothers with serious mental health issues, and their children aged 1 <sup>1</sup> / <sub>2</sub> - 6	Mothers report increased well being, functioning, levels of support and resources available to them 6 months following the intervention	“Engagement and relationship building, empowerment, availability of and access to services and liaison and advocacy activities” (p.107)

*Family Talk* (Beardslee, et al., 2003; Beardslee, Wright, Gladstone, & Forbes, 2007); *Let’s Talk* (Solantaus, Paavonen, Toikka, & Punamaki, 2010); *EFEKT-E* (Bühler, Kötter, Jaursch, & Lösel, 2011); *FGCB- Family Group Cognitive Behavioral Preventative Intervention* (Compas, et al., 2011); *KFS- Keeping Families Strong* (Valdez, Mills, Barrueco, Leis, & Riley, 2011); *Family Options* (Nicholson, et al., 2009).

## Proposed procedure

Study One: What are the core components that make interventions successful for families who experience parental depression?

### *Research Aims*

To identify which are the active components necessary to ensure a family-targeted intervention delivers positive change for children and families where one or more parents has depression.

### *Study Design*

We propose to conduct a systematic review of family-focussed interventions for families where a parent experiences depression, examining treatment manuals and results published in peer reviewed journals.

### *Methodology*

The systematic review of the components and outcomes of these interventions will follow the prescribed protocol that is in accordance with the Cochrane Collaboration (Perry & Hammond, 2002).

**Background:** A scoping review has indicated that at least five interventions exist to support families where a parent has depression, and whilst reviews, both narrative and systematic, have endorsed the ability of these programs to instil positive change in terms of child outcomes such as decreased symptomatology, externalising and internalising behaviours, the exact components of the interventions that deliver these effects are not as yet distinguished. Systematically reviewing the components included in the interventions, and the results attained by each may help shed light on this question.

**Review questions:** What are the necessary components to effect positive change in children and families where one or more parents experiences depression?

**Search strategy:** Search engines including The Cochrane, MEDLINE, EMBASE, and PsycINFO will be searched using the following search terms: parent depression, family focussed intervention, prevention. Ancestral searches of review papers of family focussed interventions of parental depression will also be conducted.

**Methods of study selection:** Interventions shall be included if they target families where one or more parents are experiencing depression, and with children aged 5 and over. Interventions will be

included if they are defined as being family-focussed, meaning that they aim to effect change in both parents and children.

**Quality assessment:** Intervention manuals will be sought - at least three are known to be publically available - and the methodology in these regarding the design and implementation of each intervention will be assessed in combination to the review of publications detailing evidence of their efficacy.

**Data extraction and synthesis:** A data extraction sheet shall be designed to record necessary components of each intervention, how these are operationalized, by what measures they were evaluated including aspects of sound study design such as randomised control treatments, and what the outcomes were. A synthesis of the salient findings from each intervention shall be compiled and presented.

## Study Two: A multi-perspective account of supporting families affected by parental depression

### *Research Aims*

To identify the components and strategies that will support families with a parent with depression and that can be used by the family members, mental health workers and the research community.

### *Study Design*

We propose to conduct a Delphi study, seeking response to and consensus regarding the research question from a panel consisting of experts in the field of families with a parent with depression.

### *Methodology*

**Participants.** Proponents of the Delphi method recommend three essential groups of stakeholders take part: those experts who will use the outcomes of the Delphi study in their capacity of decision makers, professional staff members, including those who publish within the literature area, and those who are primary stakeholders and share a firsthand relationship with the topic area (Hsu & Sandford, 2007). 10-18 experts are suggested as sufficient to form a panel (Okoli & Pawlowski, 2004)

Following these guidelines, experts of research into families with parents who have depression will be defined, according to criteria such as seniority of research position, and length of time in research, amount and quality of publications and other research output such as grants and funding. Expert workers will be defined using criteria such as position held, type of qualification, years of

experience working with families where a parent has depression, amount of formal training and supervision undertaken to work with this cohort. Advice regarding these expert workers will be sought from the coordinator of the FAPMI initiative. Expert families will be defined using criteria such as either being or having a parent who has depression. Advertisements calling for family volunteers will be placed in the public domain. The top candidates from each group will be invited to participate.

**Procedure.** The Delphi technique entails conducting group communication processes with the aim of achieving a convergence of opinion from chosen experts within a topic area. Delphi technique utilises a series of questionnaires to help collect data from experts, by asking each to respond to a given questionnaire designed to answer a predetermined question, which is then read and summarised on an individual level and collated with other responses. Both these summaries are returned to panel members. In providing this feedback, each expert is able to change, extend or modify their position, as well as assess the comments and feedback of other panel members whilst moving toward convergence of opinion. Delphi studies offer the advantage of anonymity, and an equality of position and opinion.

**Round One:** use an open ended questionnaire to gather specific information about the content area. The investigator uses the responses to compose a well structured questionnaire, which comprises a summary of the items identified by the experts.

**Round Two:** use the second questionnaire, sometimes also asking experts to rank or identify the priority of items and perhaps include a rationale for their responses. At the conclusion of this round, agreement and discord amongst opinion is demonstrated, and the consensus and outcomes may begin to form and be presented.

**Round Three:** each panellist is presented with a questionnaire that comprises the items and rankings, and is asked to either revise their opinion where there is discord, or to elucidate their reasons for their divergence of opinion of the majority.

There may be further 1-2 rounds, which depends upon the ease of which panel members reach a consensus.

### *Analytical technique*

Qualitative analysis of the questions and the interview is based upon the methods adopted by other qualitative evaluation studies in this area (Hinden, et al., 2006; Reupert, Foster, Maybery, Eddy, & Fudge, 2011). Item rankings shall be used to determine consensus of opinion. A percentage of 70-

80% or above may be viewed as indicating agreement has been achieved. Alternatively, statistical descriptions of range – namely median and mode – can be used to determine the predominant view.

### **Study Three: The “Family Focus” DVD and how it helps families affected by parental depression.**

#### Background Research and theoretical framework

##### Taking a family-centred approach to delivering interventions

The delivery of interventions for depression to families, rather than to individuals confers several advantages. It allows the needs and experiences of each family member regarding the parent’s depression to be understood and addressed, which is especially important in the context of reports that mental health care reaches few if none of the family members, and that depression itself can act as a barrier for help seeking (Beardslee & Knitzer, 2004). Others note that the gap between the need for services and their availability means that family members often act as “informal case managers” in supporting adults with mental health concerns (Hinden, et al., 2006, p.58); supporting them in these endeavours not only makes fiscal sense, but assists with outcomes such as treatment compliance, improved family relations, and reduced burden to both the family and to the wider health care system (MacFarlane, 2011).

A family focussed approach is respectful and empowering. Families are regarded as holding strengths and expert knowledge (Foster, O'Brien, & Korhonen, 2012), and support is viewed to assist them to determine how they might address the problem of parental depression collectively, and competently. This in turn can sustain the relationships between family members, and help reduce the adverse effects of depression, such as the need for temporary care for children away from the home (Beardslee & Knitzer, 2004). Including all family members in interventions helps avert stigmatizing children as different or problematic (Bramesfeld, Platt, & Schwartz, 2006), and is in keeping with the wishes of parents surveyed and who indicated they preferred family member involvement to individual treatment (Wang & Goldschmidt, 1996).

##### How do families use interventions to meet their needs?

Key messages can be drawn from reports of past intervention usage and success. Firstly, it appears possible to effect family change by delivering interventions to parents, who take the information and learning back to their family and implement new behaviours, attitudes and skills to improve child

and other family member outcomes. For example, the Family Talk intervention of Beardslee and colleagues (Beardslee, et al., 2003; Beardslee, Keller, Lavori, Staley, & et al., 1993; Beardslee, Salt, et al., 1993; Beardslee et al., 1997) was developed into a clinician-led package as well as a lecture format. When comparing outcomes, both conditions delivered similar and significant effects in behaviour and attitude change, and in children's symptoms after interventions and at a 2.5 year follow up (Beardslee, et al., 2003). These effects can be explained by the "Transfer of control" model, whereby knowledge, skills and methods that can bring about positive change in coping is passed from a therapist to parent, and then parent to child (Ginsburg, Siqueland, Masia-Warner, & Hedtke, 2004, p.38).

Secondly, families appear to respond favourably to self administered interventions, and behaviours can be altered using such methods. Parents of children with disruptive behaviours undertook a self-administered version of the Triple P Parenting program and reported positive changes in child behaviour, parenting style, confidence, personal and marital adjustment, which was maintained at a three month follow up (Morawska & Sanders, 2006). Similar findings were attained with a sample of parents who learning adaptive skills from videos in relation to child behavioural problems for children with ADHD (Ogg & Carlson, 2009), or conduct disorder or behaviour problems (Webster-Stratton, 1992, 1994; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). From the success of the lecture-only intervention of Family Talk, a Family Depression Program (FDP) was developed including the same information but via video format (Budman & Butler, 1997; Butler, Budman, & Beardslee, 2000). 100% of the 74 parents with depression who took part in the trial had spoken with their children about their mental health by week 12, and parent reports indicated the FDP had a significant impact on the functioning of children both at school and at home. The authors further described the advantages of using a video format, including wide spread dissemination and overcoming parental barriers to accessing lecture-led conditions such as motivation and confidentiality. This which would appear to echo comments from a family focus group in the Ross Memorial Hospital, Canada, who called for "... access to written and video resources and information about a variety of mental illnesses that may affect their loved one". (MacFarlane, 2011, p.65).

Stemming from Family Talk, a new intervention has been designed for an Australian context. The "Family Focus" DVD also targets communication, shared knowledge and understanding of mental health, help seeking and resilient behaviours, but differs from Family Talk in its brevity (60 minute viewing time), its delivery (family-led), and its expansion to include families with depression and / or anxiety. Whilst these changes offer exciting possibilities for addressing a wider audience in a time-efficient and family-driven fashion, the ability of "Family Talk" to achieve its goals needs to be

confirmed before it is rolled out to those in need. Understanding the mechanism behind its efficacy may explain why it works and facilitate future intervention refinement and development.

**Research Question Three:** how do families use a new DVD intervention to meet their needs when one or more parent has depression and / or anxiety?

Proposed procedure

#### *Research Aims*

To investigate in what ways, if any, families use the "Family Focus" DVD to meet their needs in terms of addressing parental depression and / or anxiety.

#### *Study Design*

A mixed methods preliminary evaluation of the "Family Focus" DVD was conducted with families with one or more parent with depression and / or anxiety, using pre and post measures of family behaviours, knowledge, attitudes and beliefs and satisfaction before and after watching the DVD.

#### *Methodology*

**Participants.** Families were recruited via their health care worker and from advertisements placed in the public domain (COPMI website). To be eligible for inclusion, one or more parent needed to have depression and/or anxiety, and either to be currently receiving or have recently completed mental health treatment. They also needed to have one or more child aged 8-12 years. A total of 49 packs were mailed to prospective participants; 31 completed pre and post questionnaires were returned, giving a participant response rate of 63.3%. A subsample of 15 parents took part in the qualitative interviews.

Participants were aged between 30 to 49 years, and most were female (87.1%). Participants were enrolled from 6 Australian states, with the majority residing in South Australia (32.2%) and Victoria (22.6%). Most of the sample were born in Australia (83.9%). 77.4% of participants had completed education at either TAFE or University, and household income varied from less than \$20,000 per annum (25.8%) to over \$100,000 per annum (25.8%).

19.4% of the sample had never married, 61.3% were married or in de facto relationships and a further 19.4% were separated or divorced. All participants had at least one child aged 7-12, and in

addition, 9 households had preschoolers, 10 had adolescent children, and 4 had toddlers or newborns. The average number of total children was 2.4, and ranged from one to six. 87.1% of parents lived with their children full time, and the remainder (12.8%) saw their children anywhere between 0 to 20 days per month.

Mothers were identified as the parent with the mental health concern in 67.7% of cases, fathers in 9.7% of cases and both parents in 22.6% of cases. For those mothers, 46.2% had illnesses with depressive features, 11.5% had illnesses with anxious features, and the remaining 42.3% identified illnesses that featured both depression and anxiety. For those fathers, 62.5% were diagnosed with depression or bipolar affective disorder, 25% identified having an anxiety disorder and 12.5% reported experiencing both depression and anxiety. 89.5% of the sample were receiving treatment for the mental health.

### **Materials.**

"Family Focus" DVD. The "Family Focus" DVD was developed by project staff at the national COPMI initiative. It comprises three chapters (approximate running time of 20 minutes each), two for parents and the third designed for an audience aged 8 and above. The parent chapters aim to provide information concerned with the importance of seeking help for mental health concerns, its treatability, the impact of mental health on family members and ways to support effective coping and resilience in family members. The child chapter aims to relay psycho-education about mental illness, and strategies for coping and seeking support from external sources such as extracurricular activities, other adults and friends.

### Self-Constructed Questionnaires

All questionnaires were developed by the research team in conjunction with project staff at the COPMI national initiative.

*"Parenting and Mental Illness" (pre and post DVD).* This questionnaire comprises 21 statements about perspectives of mental illness and parenting, such as "It is good to talk to your child/ren about the mental health problems of family members". Parents rate the extent to which they agree or disagree with each statement using a 1 ("strongly disagree") to 5 ("strongly agree") point likert scale.

*"Family Focus" DVD Screening (post DVD).* The "Family Focus" DVD screening invites participants to respond to five questions concerned with the way in which they utilized the DVD, including which parts of the DVD they watched, whether and whom they watched it with, whether children watched

the DVD on their own, and whether parents would recommend other parents watch the DVD and / or show it to their children.

*“Family Focus” DVD Evaluation (post DVD).* The “Family Focus” DVD evaluation is an 11 item scale which invites participants to rate the extent to which they agree with statements pertaining to the DVD, such as “The DVD helped me understand mental illness”. Responses are given using a 1 (“strongly disagree”) to 5 (“strongly agree”) likert scale.

Interviews. The purpose of the interview was to explore parent’s experience of viewing “Family Focus” and any subsequent discussions they held with their family. The parent interview schedule was developed in house and comprised 16 open ended questions including whether the DVD had encouraged change to parenting or relating to partners or children, whether their children viewed the child’s chapter, and whether they discussed it afterwards. The interviews were semi-structured, and allowed for further questioning of the DVD experience beyond anchor questions. Interviews ran for an average of 45 minutes, with a range across interviews of 30 to 90 minutes. All interviews were conducted over the telephone, and were audio-taped and transcribed following participant permission. Each participant was given the opportunity to perform member checks, whereby they were emailed a copy of their interview transcript and invited to add to, alter or delete any material they believed to be potentially identifiable or incorrect (respondent validation).

**Procedures.** The "Family Focus" DVD and a pack containing the explanatory statements and consent forms and the pre and post questionnaires were distributed to interested parents. Participants were asked to complete demographics plus a parenting and mental illness questionnaire before watching the “Family Focus” DVD, and then wait five to seven days before completing three questionnaires in the post period. Telephone interviews with an interested subsample were conducted approximately two to four weeks after exposure to DVD. Parents received financial reimbursement for their time.

### *Analytical technique*

Change across time as measured by the self constructed questionnaires was assessed with paired *t* tests. For the interviews, thematic content analysis was conducted to systematically describe and quantify the views of the parents in an objective fashion (Braun & Clarke, 2006). Data was analysed using a coding system, attaching labels to lines or paragraphs of data and then describing the data at a concrete and more conceptual level (Anfara, Brown, & Mangione, 2002).

## Preliminary Findings

Paired samples t-tests indicated that there was a significant difference in parent response to questions one, nine, 12 and 14 of the “Parenting and Mental illness” scale.. After watching the DVD parents agreed significantly more strongly that it is good to talk to their children about mental health issues (1), that their own or their partner's mental health concerns are a problem for their family (9), that children are encouraged to seek help in coping with mental health issues of family members (12) and that they understand how a parent’s mental health condition can impact upon children (14). 93% of parents watched the entire DVD, and 100% would recommend it to other parents, and 85% that these parents show it to their children. The vast majority (>80%) found it useful and helped them to understand the impact that a parent’s mental health concern may have on children and families. The majority (>50%) believed the DVD helped them speak with their children, and their children talk with them about parental mental illness.

Interview data indicated many parents embarked upon a journey, where they first reflected on their former practice of trying to conceal or minimise their mental health issues from their family, believing that managing them alone would be less of a burden for other members. Many parents shifted to a position of believing that open communication and honesty brought about relief, empowerment, new knowledge and corrected misunderstandings in children, and which contributed to an emotional relief for parents from the pressures of pretence, sense of honesty and an allowance to ask for help and understanding.

## **Study Four: A snapshot of family life when parents have depression: case studies in family functioning.**

### Family functioning and parental depression

The components of family focussed interventions - namely communication, shared understanding of parental depression, parenting behaviours and promoting resilience in children- could be categorised more broadly under the umbrella of family functioning. The role of family functioning in shaping the behaviours, beliefs and ultimately the emotional health of family members has been established (Skinner, Steinhauer, & Sitarenios, 2000), although less is known about this in families with parental depression. Child outcomes of parental depression have traditionally been defined as the presence or absence of problems such as disorders (Radke-Yarrow & Klimes-Dougan, 2002).

Those studies of parental depression that have examined family functioning have frequently conceptualised this with static and generalized variables such as marital discord or financial strain , which fall within the notion of stress (Radke-Yarrow & Klimes-Dougan, 2002). As Radke-Yarrow and Klimes-Dougan (2002) discuss, this approach does not tease out the various positions of different family members: in terms of how they experience this, what they contribute, and how they vary between and within families. Using a family functioning model allows for a richer understanding of strengths and of areas for attention, and further facilitates the notion of reciprocity, and multiply determined effects and factors between each member of the family.

Research suggests that parental depression may adversely affect family unity and accord (Pilowsky, et al., 2006). As stated by Radke-Yarrow and Klimes-Dougan (2002), “many of the depressed parent’s and the child’s problematic behaviours are embedded in turbulent family relationships” (p.170). In one study the Family dynamics measure 11, based on Barnhill’s Healthy Family Cycle was given to families before and after the birth of their first child, and associations between mothers’ postnatal depression scores and family dynamics were correlated. Family dynamics was significantly and negatively correlated with postnatal depression in terms of stability, mutuality, communication role reciprocity and flexibility (Tammentie, Tarkka, Åstedt-Kurki, Paavilainen, & Laippala, 2004). Whether similar findings would be determined with other family functioning measures, or when parents experiencing other depressive illnesses and with older children were included is an intriguing question.

### Models of family functioning

Popular models of family functioning include the Beavers System Model (Beavers & Hampson, 2000), the Olson Circumplex Model of Family Functioning (Olson, 1991, 2000, 2011) , the McMaster Model of Family Functioning (Epstein, Baldwin, & Bishop, 1983; Epstein, Bishop, & Levin, 1978; Miller et al., 1994; Miller, Ryan, Keitner, Bishop, & Epstein, 2000) and the Process Model of Family Functioning (Skinner, et al., 2000; Steinhauer, Santa-Barbara, & Skinner, 1984). Table Two, overleaf, offers a brief overview of the theoretical constructs of models of family functioning, their associated means of assessment, and their strengths and weaknesses.

Table Two.

*A brief summary of popular models of family functioning*

Model of Theory Family Functioning	Recommended application	Associated Measure	Psychometric properties	Strengths / Weaknesses	
Beavers Systems Model of Family Functioning	Families can be classified according to their competence (rated in terms of their structure and flexibility) and style (quality of family interactions, including issues of power, parental coalitions, behaviour, autonomy and affect).	For use in clinical setting where an understanding of a family's current functioning is required.	Beavers Self Report Inventory: using 5-point likert scales, rates families across 5 domains (health/competence, conflict, cohesion, leadership and emotional expressiveness).	The authors report high internal consistency reliabilities, test-retest reliabilities and validity, although it has been suggested that many of these have been reported in non-peer reviewed publications.	Classifies families into 9 subtypes, called "optimal", "adequate", "midrange", "borderline" and "severely dysfunctional"; such terms could be experienced as pejorative.

Model of Theory	Recommended application	Associated Measure	Psychometric properties	Strengths / Weaknesses
Olsen Circumplex Model of Family Functioning	Views families as understood along a continuum of flexibility and cohesion, which allows families to be classified within a circumplex.	Designed for diagnosis of relationships, in the context of marital and family therapy.	Family Adaptability and Cohesion Scales (FACES IV): uses a 5-point likert scale to seek responses within 6 subscales that measure high and low cohesion and flexibility.	Scale reliabilities were reported as adequate; test-retest reliabilities were high and validity measures adequate to good. Six family types are rated from most functional to most problematic; this classification could be pejorative. In addition, the curvilinear relationship proposed to exist between extremes of flexibility and cohesion has not always been supported in the literature, which has demonstrated linear relationships with family functioning.
McMaster Model of Family Functioning	Perceives families to be an open system comprising many subsystems (e.g., marital, dyadic) and their transactions. The family's goals are to achieve essential tasks, including basic requirements, developmental goals and hazardous tasks. Families navigate these tasks via including problem solving, communication, roles, affective responses, affective involvement and behavioural control.	Designed for research and clinical use, especially in conjunction with the family treatment model, Problem Centred Systems Therapy of the Family.	The Family Assessment Device: uses 4-point likert scales to measure the 6 dimensions of the McMaster Model of Family Functioning, plus a general family functioning subscale.	Internal consistencies reported are good to high, test-retest reliabilities are between .66 and .76, and construct validity with the FAM is reported as good. Capacity to accommodate external systems, such as school, extended family, community, in its understanding. Does not label the family as problematic, but looks instead to what is happening within the system to create problem.

Model of Theory	Recommended application	Associated Measure	Psychometric properties	Strengths / Weaknesses	
Family Functioning					
Process Model of Family Functioning	Posits that the role of the family is to achieve basic, developmental and crisis tasks, and evaluates these in the context of a family's performance across seven domains: task accomplishment, communication, affective expression, role performance, control, involvement, control and values and norms.	A model designed for research and clinical use, which emphasizes it's application as understanding families, and not as a model for family therapy.	Uses a 4 point likert scale to measure functioning within each of the seven domains of the Process Model of Family Functioning	Internal consistencies were excellent, test-retest reliabilities range from .55 to .66, and it has demonstrated both good construct and discriminant validity.	Like the McMaster Model of Family Functioning, this does not assess a family's functioning as successful or problematic per se, but allows exploration of difficulties in the context of functioning in different domains. Although highly similar to the McMaster Model of Family Functioning above, this differs in its ability to view the family simultaneously from the perspective of multiple members, in context of the larger community (e.g., values and norms), and across multiple domains (e.g., intra-individual, dyadic and general family functioning).

The Beavers System Model (Beavers & Hampson, 2000), the Olson Circumplex Model of Family Functioning (Olson, 1991, 2000, 2011) , the McMaster Model of Family Functioning (Epstein, et al., 1983; Epstein, et al., 1978; Miller, et al., 1994; Miller, et al., 2000) and the Process Model of Family Functioning (Skinner, et al., 2000; Steinhauer, et al., 1984).

## The FAM, and families where a parent has depression

The Process Model of Family Functioning, along with the Family Assessment Measure as a means of qualifying it, would appear to offer several advantages in exploring the functions of families where a parent has depression. Previous studies allow for cautious expectations that the domains in the FAM will marry well with reports of challenges faced by families. For instance, when thinking of the FAM's "role performance", Marshall, Bell and Moules (2010) describe the role divisions amongst families where a parent has depression as different to families without depression. Similarly, others have commented that "most, if not all, depression-related behavior is relevant to specific parenting roles and responsibilities" (Radke-Yarrow & Klimes-Dougan, 2002, p.170). With regards to the FAM's "Affective expression", regression models indicated that low family expressiveness correlated with parental depressive symptoms (Horwitz, et al., 2007). Cummings and Davies (1992) review the importance of involvement and control as supporting children to develop an emotional security, and a freedom to express their emotional needs.

The FAM delivers the additional advantage of asking each family member to consider their individual position in the family, a dyadic relationship and the family in general when completing items about each of the seven aspects of family functioning. In addition, the FAM's capacity to collect perspectives of functioning from all family members aged 10 and over may help the validity of data collected. Research has recently highlighted the importance of considering variation in rating as potentially dependent on individual perspective, and questions the validity of whole family measures as rated by individual members (Cook & Kenny, 2006). Indeed, "families differed from one another not so much in terms of the cohesion and adaptability of the dyadic subsystems but more because of differences in the perspectives of the raters and in the characteristics of the individuals participating in each dyadic subsystem" (Manders et al., 2007, p.605). Furthermore, studies of family function have found that parents and children may disagree with their perceptions concerning the functioning of the family, with children often perceiving family functioning as worse (Ginsburg, et al., 2004). Moreover, their reports are not always consistent with therapist ratings or those derived from observational methods (Rapee, 1997). Recalling the premise of Beardslee and colleagues that a shared family understanding of depression is the lynchpin for adjustment, it would appear valuable to be able to reflect on differences in perceptions of functioning for a family in each of the domains potentially affected by the depression.

**Research Question Four:** what is the family functioning for a family where a parent has depression?

## Proposed Procedure

### *Research Aims*

To explore the family functioning in families where one or more parents have depression.

### *Study Design*

We propose conducting a series of case studies incorporating a mixed methods design to data collection and analysis.

### *Methodology*

**Participants.** Three to four families will be included in this study, if they have one or more parents who experiences depression, and one or more children aged at least 10 years old.

### **Materials**

Family Assessment Measure (FAM) (Skinner, et al., 2000). The FAM is a self report questionnaire that comprises a General scale (50 items), Dyadic Relationship scale (42 items) and Self-rating scale (42 items) to measure family functioning from the perspective of adult and child family members who are aged 10 and over. One to all three scales may be administered, and measure a family member's perception of family functioning at an individual, a family dyad and overall family level for task achievement, role performance, communication, affective expression, involvement, control and values and norms. In addition, the General scale contains measure of social desirability and defensiveness (8 items). Each item is rated on a 4-point likert scale (1="strongly disagree" to 4="strongly agree"), and pertains to the previous week. For example, "My family tries to run my life" (general scale – involvement). Items are summed to provide overall scores for each function construct, within individual, dyadic and family functioning. The FAM reports overall alpha coefficients of .86 to .95, indicating excellent reliability, although some coefficients for the self rating scale were reported as low (Skinner, et al., 2000). Test-retest reliabilities ranging from .56-.66 were judged by the authors as acceptable, in light of the small number of items in each scale.

Qualitative Interview. A semi structured interview schedule will be developed to extend the information gathered from the FAM, including questions about how family functioning changes when parents are depressed and when they are well.

**Procedure.** Following ethics approval, advertisements will be placed in the public domain, calling for families to volunteer for the study. Families will need to have at least one parent and one child aged 10 or over willing to participate in the study. Nominated members of each family will be provided

with general, dyadic and self rating scales of the FAM for completion. Each member will also be invited to take part in a telephone interview, which shall be recorded and transcribed with participant permission.

### Analytical technique

The FAM will be scored according to instructions contained in the manual. This will provide responses from each family member within the seven domains of family functioning for the way they perceive the family functioning in general, the way they perceive their relationship with the parent with depression, and the way they perceive their own functioning within their family. These will be presented visually, and using a narrative framework to describe observations of convergence and divergence of perspective between family members.

Interviews will be recorded with permission from participants, and then transcribed. Scripts will be explored using an open coding system to ascribe labels to paragraphs, with codes evolving from a concrete to conceptual level, whilst remaining context and narrative driven (Thomas & Harden, 2008). Participants will be asked to review their scripts for accuracy. Codes will be combined and collapsed across participants to form consequential themes about attitudes and experience, and inter-rater reliability checks for coding.

### **Timeline**

My candidature for this Master of Psychology (Educational and Developmental) / PhD commenced on 1<sup>st</sup> January, 2012, and is due for completion at the end of 2014. Please refer to Table Three overleaf for the likely outcomes of the projects, the anticipated completion and progress to date. The dates of anticipated completion have been set to allow as much time as possible for the articles that arise from each study to be accepted for publication.

Table Three

*Timeline, including anticipated outcomes and completion, and progress to date, for “Refocussing the lens” thesis.*

Project	Likely outcome	Anticipated completion	Progress to date
Literature review	Introductory chapter to thesis	Literature review: 30/06/2012; introductory chapter 31/12/2012	The literature review has been completed. The introductory chapter will be written from this, and largely based up and following the document prepared for confirmation.
<b>Study One:</b> What are the core components that make interventions for families who experience parental depression successful?	Publication in an A or A* journal that aims to print articles about family research, e.g., The Journal of Family Psychology	01/03/2013	Scoping review has been completed, and 5 studies that meet inclusion criteria identified. Manuals are available for three of them. Initial data extraction (in summary form) has also been completed, as presented within this document in Table One.
<b>Study Two:</b> A multi-perspective account of supporting families affected by parental depression	Publication in an A or A* journal that aims to print articles concerned with service delivery to families who experience mental health issues, e.g., Child and Adolescent Mental Health	01/08/2013	The project proposal has been completed in anticipation of applying for ethical approval.

Project	Likely outcome	Anticipated completion	Progress to date
<p><b>Study Three:</b> The “Family Focus” DVD and how it helps families affected by parental depression</p>	<p>Publication in an A or A* journal that aims to print research studies about supporting families, e.g., The Journal of Psychiatric and Mental Health Nursing</p>	<p>This project has been completed; Submission to journal 31/01/2013</p>	<p>Data has been collected and written into report format, and article draft 90% completed.</p>
<p><b>Study Four:</b> A snapshot of family life when parents have depression: case studies in family functioning</p>	<p>Publication in an A or A* journal that aims to print articles about family research, e.g., The Journal of Family Psychology</p>	<p>01/03/2014</p>	<p>Pilot interview data has been collected, and indicates that parents could provide important insights into the functioning of their families, and the way this may change at times of being depressed. The project proposal has been drafted.</p>
<p>Overarching document/statements that act to guide the reader and link each project, as well as provide a summary and conclusion of the outcomes of the thesis as a whole.</p>	<p>Linking and concluding chapters to thesis.</p>	<p>31/10/2014</p>	<p>Some of the work in this document will be drawn upon to complete these sections.</p>

## **Concluding comments**

Even the most cursory review of the literature regarding parenting, parent depression and families indicates the importance and the complexity of this experience. Although the plethora of research conducted to date stands these families in good stead, in terms of multiple understandings and developed interventions, more is still to be learned about what delivers positive outcomes and what inclusions (if any) can be discarded as extraneous. The family unit must not be viewed as a passive consumer within this context, and better grasping how families use resources may help to further refine them, and also ensure we are best equipped to empower families to implement and facilitate their recovery. From another, but complementary perspective, exploring the functioning of families in their journey of parent depression might allow us to appreciate the changeable position, the strengths and the areas in need of support within these families. Collectively, we hope this information will help researchers, clinicians and families alike to “refocus the lens” on parent depression: how it affects each family member and how to support them to move toward positive change. By doing so, our responsibilities to protect the family, as outlined within the declaration of human rights, will have been upheld, and more significantly, the well being and emotional enjoyment of family members improved.

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