The needs of children of depressed mothers in primary care

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Background. Maternal depression has a number of adverse effects on children. Although most depression is treated in primary care, assessment or support is rarely given to children of depressed mothers on a routine basis.

Objective. Our aim was to examine the needs of children, aged 5–11 years, whose mothers are being treated for depression in primary care.

Methods. Mothers being prescribed antidepressants by their GP (n = 30) and mothers not being prescribed antidepressants (n = 30) were interviewed, and comparisons were made between their children (n = 48 and 50).

Results. The mothers who were prescribed antidepressants were more depressed than the other mothers, and their children had more dysfunctional symptoms.

Conclusions. The needs of children must be considered when depressed mothers are being treated in primary care.

Keywords. Children, depression, primary care, women.

Introduction

Numerous epidemiological1 and clinical studies2 have demonstrated that maternal depression is related to an excess rate of problems in children. Such studies have consistently revealed a wide range of associated difficulties (e.g. impairment in cognitive ability and academic performance; increased risk of affective disorders; impairment in social competencies and peer relationships; and negative self-image), but the frequency, severity and nature of the problems differ between studies.3

Women with children are at risk from depression, a condition that is largely managed by GPs in primary care,4 and which can be treated effectively with medication and psychological interventions. In the UK, mothers with postnatal depression frequently will receive support and monitoring for themselves and their babies from health visitors. No such contact is provided routinely for depressed mothers with older children. This study examined the needs of primary school children whose mothers currently are being treated for depression by their GP.

Methods

Three primary care teams in West London participated in this research project. The teams selected had expressed an interest in the project and a willingness to co-operate with the data collection. They covered urban/suburban areas with practice populations of 6400, 9000 and 10 400, respectively. Cases were identified from the practice databases as (i) having one or more children between the ages of 5 and 11 years; and (ii) having been prescribed an antidepressant within the previous 3 months by their GP. For each case, controls were selected by identifying the next woman on the alphabetical practice list, who also had children between the ages of 5 and 11 years, but who had not been prescribed an antidepressant within the previous 3 months. Three controls were selected for each interviewed case, to allow for non-responders.

The Beck’s Depression Index (BDI-II)5 was completed for each mother, and the Strength and Difficulties Questionnaire (SDQ)6 for each child. The SDQ is a brief behavioural screening instrument for 3–16 year olds; the informant-rated version suitable for parental scoring was used in this study. Additional data collected included: details regarding hospitalization and current medication of both mother and child; mother’s past antidepressant medication; the child’s school attendance and after-school care arrangements; periods of separation from mother and the reasons why; involvement with Social Services; family history of depression; and demographic details.
Results

A total of 54 women who met the criteria as a suitable case for inclusion in the study were identified, and 37 (69%) agreed to participate, of whom 30 were interviewed. In the control group, a total of 69 women were contacted, of whom 34 (49%) agreed to participate and 30 were interviewed. The two groups were similar in terms of socio-demographic characteristics. The depressed mothers had 48 children who met the study criteria, whereas the control mothers had 50 children.

Mean BDI-II scores for the cases corresponded to the top end of mild depression, and confirmed that they were more depressed than the control mothers (18.7 versus 7.0, *t*-test *P* = 0.00). Sixteen (53%) of the cases scored >17 (the recommended case threshold for research studies) on the BDI-II, compared with two (7%) of the control mothers. Twenty-one (70%) of the cases reported one or more previous episodes of depression compared with seven (23%) of the control mothers. Of the mothers prescribed antidepressants, 23 (76%) reported actually taking their medication.

Table 1 compares the two groups of children. The guideline for total SDQ scored by a parent is deemed normal between 0 and 13, borderline between 14 and 16 and abnormal when 17 and over. Most of the children were below the abnormal threshold score. Of the 16 children who had an abnormal score, 11 were children of mothers being prescribed antidepressants, and this group had a statistically significantly higher mean SDQ score. Examination of the SDQ subscales revealed a statistically significant difference between the groups’ emotional symptoms score, and non-significant trends in the same direction for the other subscales.

Discussion

Mothers being prescribed antidepressants by their GP are a clinically heterogeneous group. They were selected for this study because they can be identified easily and reliably for research and practice-based interventions. The main findings of this small study were that overall the children of such mothers had more emotional problems than children whose mothers were not being treated for depression. The control children had a similar proportion of problems (10%) as the rate identified in a recent epidemiological survey of British children, whereas nearly a quarter of the children with depressed mothers had significant dysfunctional symptoms. Despite being prescribed relevant medication, over half of the mothers were depressed at the time of interview, and a quarter were not taking their medication.

There are a number of important limitations to this study. The three practices included had expressed an interest in the project, and may have had a higher depression identification index than other practices. The relatively small sample size restricted the number of statistically meaningful comparisons that could be made between the two groups. The interviewer was not blind to the mothers’ status, and no external objective assessment of the children was conducted.

Our findings are in line with other research based outside primary care. We can conclude that the rapid recognition and effective treatment of depressed mothers must be a priority in primary care, and that the needs of children must be considered when their mothers are found to be depressed. At the very least, doctors should ask mothers if they have concerns about their children, and try to follow-up any problems raised. If resources allow, Table 1.

### Table 1

<table>
<thead>
<tr>
<th></th>
<th>Cases (<em>n</em> = 48)</th>
<th>Controls (<em>n</em> = 50)</th>
<th><em>F</em></th>
<th><em>P</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (years)</td>
<td>8.0</td>
<td>7.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% male</td>
<td>54.0</td>
<td>44.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days off school in previous month</td>
<td>1.7</td>
<td>0.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days separated from mother</td>
<td>8.6</td>
<td>7.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of days in hospital</td>
<td>4.3</td>
<td>4.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean total SDQ (SD)</td>
<td>11.3 (6.3)</td>
<td>8.2 (6.4)</td>
<td>5.7</td>
<td>0.02</td>
</tr>
<tr>
<td>Subscales</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SDQ-E (emotional symptoms)</td>
<td>3.6</td>
<td>2.3</td>
<td>7.7</td>
<td>0.01</td>
</tr>
<tr>
<td>SDQ-C (conduct problems)</td>
<td>2.1</td>
<td>1.5</td>
<td>2.3</td>
<td>0.13</td>
</tr>
<tr>
<td>SDQ-H (hyperactivity/inattention)</td>
<td>3.7</td>
<td>3.2</td>
<td>0.7</td>
<td>0.40</td>
</tr>
<tr>
<td>SDQPEER (peer relationship problems)</td>
<td>1.9</td>
<td>1.2</td>
<td>2.9</td>
<td>0.09</td>
</tr>
<tr>
<td>SDQPS (pro-social behaviour)</td>
<td>8.6</td>
<td>8.3</td>
<td>0.8</td>
<td>0.38</td>
</tr>
<tr>
<td>SDQ caseness (%)a</td>
<td>11 (23)</td>
<td>5 (10)</td>
<td>n/a</td>
<td>0.07b</td>
</tr>
</tbody>
</table>

*a* Total SDQ of 17 or more.

*b* Fisher’s exact test.
consideration should be given to a more formal assessment of children, on a routine basis. A number of mothers in this study reported favourably of the support they had received from health visitors, but this was only available because they had babies as well as older children. Many depressed mothers with older children probably could benefit from the support and advice of health visitors.

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References