Transmission and Prevention of Mood Disorders Among Children of Affectively Ill Parents: A Review

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Objective: To provide a conceptual review of the literature on children of depressed parents over the past 12 years. Method: This selective review focused on published studies that delineate the diagnosis of depression in parents, have large samples, describe children 6 to 17 years old, and are methodologically rigorous. The review emphasized conceptual advances and major progress since 1998. Recent efforts in prevention research were discussed, gaps in the existing literature were noted, and directions for targeted research on children of depressed parents were highlighted. Results: Over the past 12 years there has been considerable progress in delineating the gene-by-environment interplay in determining the range of outcomes in children. In addition, progress has been made in identifying risk mechanisms and moderators that underlie the transmission of disorder and in developing effective prevention programs. Conclusions: This review highlights directions for further research, including different areas affected by parental depression in parents and children, and in understanding the underlying mechanisms involved in the intergenerational transmission of depression, so that preventive and treatment efforts can be tailored effectively. J. Am. Acad. Child Adolesc. Psychiatry, 2011; 50(11):1098–1109. Key Words: depression, prevention, children, adolescents

Depression is the most common psychiatric disorder in the United States, with more than 16% of the population reporting a major depressive episode (MDD) during their lifetime. It is one of the leading causes of morbidity and mortality in the world, places a significant economic burden on society, and often becomes a chronic recurrent illness.

Depression is remarkably common among parents. According to an Institute of Medicine (IOM) report, at least 15 million children are living with a depressed parent. Moreover, the number of children exposed to parental depression is much larger when the entire span of childhood is considered, rather than a single year, and when other forms of parental mood disorders are included. In addition, because many parents who recover from an episode of depression continue to experience subclinical levels of depressive symptomatology, many children are repeatedly exposed to depression and to associated disruptions in parenting.

One of the most potent risk factors for developing depression is having a depressed parent, and children of depressed parents are, in general, at a two- to fourfold risk of developing depressive disorders. Likewise, these children are at risk for other internalizing and externalizing disorders, cognitive delays, medical difficulties, and academic and social failure. At the same time, there are many children who grow up in homes with depression who do not develop impairments. In fact, it is the balance of risk factors and protective resources that determines outcome.

The literature on the children of depressed parents was reviewed in this Journal in 1998. Since then, there has been dramatic progress in understanding the multiple domains in which parental depression may affect children and the multiple mechanisms through which depression in parents exerts its effects. There also has been significant progress in the development and evaluation of preventive intervention strategies. Two IOM reports have addressed these issues (the senior author was a coauthor of these reports).
In this report, the progress in this area is reviewed with a focus on published studies that delineate the diagnosis of depression in parents, have large samples, describe children 6 to 17 years old, and are methodologically rigorous.

THE MATURING OF LONG-TERM LONGITUDINAL STUDIES

Over the past 12 years, data have accumulated on several longitudinal samples of depressed parents and their offspring.13-16 Weissman et al.14 followed a sample of the offspring of depressed and nondepressed parents (n = 47) over the course of 20 years, and all the offspring are now adults and have their own children.14 At the last assessment, rates of diagnoses of mood disorders and other disorders were threefold in the now adult offspring compared with the comparison group.17 Among grandchildren (mean age = 12 years, n = 161) of depressed grandparents, there was a twofold increased risk of anxiety and other disorders when the grandchildren’s parents were depressed compared with grandchildren of nondepressed parents.14 These findings suggest that anxiety disorders in at-risk children may be an early sign of psychopathology, thus providing a possible focus for prevention efforts.

Espejo et al.,18 in a sample of depressed parents drawn from a larger representative sample (n = 816), found that children who experienced greater adversity in childhood and/or had an anxiety disorder exhibited more depressive symptoms after low levels of episodic stress. The investigators speculated that early anxiety disorders, in the context of adverse life events, may be indicators of a dysfunctional stress response that may help explain the connection between anxiety and depression.18 Several other studies have similarly found that a history of anxiety increases the risk of depression for offspring of depressed parents.13,14,18 Likewise, studies of other longitudinal samples have demonstrated that, when parental depression is comorbid with other disorders, risk to offspring increases.19

Bidirectionality of Impact

A major advance in the past 12 years in understanding the transmission of risk from parent to child has been the increasing awareness that this is a bidirectional process across the span of development. That is, although parental behaviors influence child outcome, the child’s behavior likewise influences the parent.21,22 Similarily, Goodman and Gotlib’s integrative model is strengthened by the bidirectionality inherent in its structure, in that the mechanisms for transmission of risk are proposed to overlap and interact with one another.

Risk Moderators

Risk for depression can be grouped into two classes: those specific for depression, such as having a depressed parent; and those nonspecific risk factors that affect a wide range of psychiatric outcomes including depression (e.g., poverty, child abuse). This review focuses on the specific risk factors of parental depression, but it should be noted that nonspecific risk factors convey an increased lifelong risk for depression and other disorders5,12 and that comprehensive prevention efforts need to address both domains.12,23

Other Parent’s Availability and Mental Health.

In recent years, paternal depression has been found to make unique contributions to offspring outcomes.24 For instance, father-child conflict has been found to mediate the contribution of paternal depression to offspring’s internalizing and externalizing symptoms.25 Moreover, having a father and a mother with depression increases the risk of offspring having an emotional disorder, emphasizing the need to examine maternal and paternal depression when considering adolescent outcomes in this high-risk population.26,27

Timing and Course of Parental Depression.

Increased chronicity and severity of parental depression have long been shown to increase the likelihood that children will become ill.6,15,28 Recently, Campbell et al.13 followed mothers and children (N = 1,357) from 1 month to 12 years of age with follow-up at age 15, and found that adolescents whose mothers had more severe and chronic depression had more internalizing and externalizing problems and reported engaging in more risky behavior than adolescents whose
mothers were never depressed. Similarly, in a sample of 4,953 young children, Brennan et al. found that the severity and chronicity of self-reported maternal depressive symptoms were significantly associated with lower vocabulary scores and more behavioral problems.

Characteristics of Child.

Temperament. Some researchers have demonstrated that difficult child temperament is associated with parental depression. Specifically, in Weissman et al.’s 20-year longitudinal study, Bruder-Costello et al. found that offspring of...
depressed parents who had a difficult tempera-
ment early in life were twice as likely to develop
MDD as those who did not have a difficult temper-
ament. Keeping in mind the work of Forbes et al.21
and the bidirectionality of the model of Goodman
and Gotlib,20 however, it is not clear whether difficult
child temperament contributes to parental depres-
sion, if difficult child temperament is partially
the result of parental depression, or if parental depression
and difficult child temperament may be due to an
additional underlying factor.

**Gender.** Compared with their male counterparts,
female individuals have been found to be more
vulnerable to depressive disorders from adoles-
cence through adulthood.5,27 However, many of the
studies looking at the effects of maternal depression
on offspring outcomes have failed to consider the role
of offspring gender.30 The studies that have looked at
the role gender plays in offspring outcomes, in the
context of parental depression, have yielded inconsis-
tent findings. Some recent studies have found that
parental depression signals risk for male and female
offspring, but for different disorders.31,32 For example,
Essex et al.31 found that maternal depression and
exposure to family conflict were associated with more
externalizing problems for male offspring and more
internalizing problems for female offspring.

**Mechanisms of Transmission**

**Heritability of Depression and Genetic Effects.**

In the past 20 years, there has been rapid progress
in examining heritability and the interaction be-
tween genes and environment. In a recent review,
Bagot and Meaney33 described findings from animal
studies indicating that early environmental influences
can have significant effects on later stress responsive-
ness and that environmental modifications of gene
expressions can occur across development. These
insights and advances in quantitative genetics and in
génomewide association studies form an essential
cornerstone to current scientific knowledge.

Twin and adoption studies have established that
genetics explain approximately 30% to 40% of the
variance of adult MDD. Family studies have found
significantly higher risks for depression among first-
degree relatives. The highest rates of heritability have
been found in the offspring of depressed parents.34

The impact of the environment on the expres-
sion of certain genes depends on the degree to
which an individual is exposed to a particular
environment, the degree to which an individual’s
behavior influences the environment, and the de-
to which an individual’s behavior is itself
subject to genetic influences. In an extensive litera-
ture review, Kendler and Baker35 noted that, al-
though genes do influence the environment, for
example, in the areas of life stress and parenting,
the degree of influence is modest, with heritability
estimates generally ranging from 15% to 35%.

Recently, there has been increased interest in
epigenetics as a driving force behind the gene/en-
vironment influences present in various psychi-
atriatric disorders, including depression.33 The reviews
by Hochberg et al.36 and Bagot and Meaney33
described the way in which epigenetics may ac-
count for the role the environment plays in modi-
fying certain genotypes that predispose individuals
to certain disorders. These investigators described
the process of phenotypic plasticity as potentially
resulting from epigenetic remodeling, a process in
which the environment interacts with an individu-
al’s genome to produce specific individual differ-
ences in the expression of certain traits. Applying
this model to the heritability of depression, a child
who inherits a certain genetic makeup from a
depressed parent has the raw materials for devel-
oping depressive symptoms, but only when certain
environmental effects come into play does the
combination of gene and environment create the
finished product, namely a depressive disorder.

Molecular genetics has focused on finding spe-
cific genes that may affect outcomes. Some identi-
fied genes include one or two S alleles in the
serotonin transporter promoter region polymor-
phism (5HTTLPR) in the context of chronic stress
(girls),37 the gene brain-derived neurotrophic fac-
tor,38 homozygous carriers of the T allele methyl-
enetrahydrofolate reductase (MTHFR), and carriers
of the 9/10 genotype compared with the 10/10
genotype (SLC6A3 allele).39 Genes involving sero-
tonin (5HT) transmission have been extensively
studied by Caspi et al.40 who found that depressive
symptoms in offspring can be predicted by the
interaction among environment (maternal criti-
cism), 5HT transmission, and child depressogenic
cognitive style and among chronic stress, 5HT
transmission, and gender (female offspring).37,41

Unfortunately, some recent meta-analyses have
failed to replicate these findings.42,43 The lack of
replication points to an overarching problem
plaguing these genetic studies. Often, these studies
look at one specific or “candidate” gene and its role
in the presentation of various diseases and disor-
ders. However, disorders rarely result from the
expression of a single gene. For instance, the meta-
analysis performed by Munafò et al.43 found no
support for the effect of stressful life events on the serotonin transporter gene in causing various psychopathologies. The investigators concluded that, owing to a lack of statistical power and the logistic regression models used in the studies, the positive results found in the replication of the findings of Caspi et al. are no better than chance findings.

Because of the difficulty in finding significant gene-by-environment interactions and effects, research has begun to develop more sensitive ways of studying these important interactions. For instance, cytogenetics, the study of chromosomal variation at high resolution using microarray-based detection, has provided the field with a closer look at how DNA can be structurally and sequentially different in individuals with and without certain disorders. Likewise, imaging-genetics studies represent an area of research that has immense potential to shed light on various genetic and environmental processes underlying many common mental disorders, such as adolescent depression, and may make it possible to link genes directly to specific neural systems using a noninvasive procedure. However, Pine et al. pointed out that one of the downsides of using imaging-genetics to look at complex phenotypes, such as mood disorders, is that many of these show only small associations with individual genes. Consequently, until techniques are refined further, looking at a specific gene, such as the 5HT transporter gene, may continue to produce mixed findings.

Clearly, there is tremendous potential in the future for using various genetic strategies in investigating outcomes in children of depressed parents. For example, additional research in genome sequencing among families with parental depression may increase the understanding of the multiple genes involved in the transmission of genetic risk. In the discussions of various phenomena associated with offspring of depressed parents that follow, it should be emphasized that there are undoubtedly important genetic influences that contribute to these phenomena. The more precise the descriptions of manifest behavior, the more likely it will be that behavior can be linked to underlying processes of gene expression.

Dysfunctional Neuroregulatory Mechanisms.

Structural factors. Brain asymmetry. Many researchers have found brain asymmetry and cortical activity to be associated with vulnerability to depression. Rao et al. found that adolescents who were depressed or who had a depressed parent had significantly smaller left and right hippocampal volumes than adolescents who were not at risk for depression. Smaller hippocampal volume partly mediated the effect of early-life adversity on depression. Right hemisphere thinness. Peterson et al. in a study spanning multiple generations, found that individuals who were descendants of parents or grandparents with MDD (at high risk) had greater cortical thinness in the right hemisphere compared with individuals who were at low risk. The cortical thinning was found to be associated with current symptom severity, inattention, and visual memory for emotional and social stimuli. The results indicated that cortical thinness mediated the association between familial risk and inattention, visual memory, and clinical symptoms. It is important to note, however, that many of these brain imaging studies are the first of their kind because the ability to connect behavior to brain anatomy and structure is relatively recent. These findings are intriguing but need confirmation from larger and more diverse samples.

Process-related factors. Reward/loss. Anomalies in the processing of reward and loss also have been linked to vulnerability for depression. Gotlib et al. examined neural activity in reward and loss in 10- to 14-year-old girls who were at high risk (mother had history of recurrent depression) and low risk. High-risk girls showed less activation in their reward processing areas in the brain when presented with the possibility of a reward compared with girls who were low risk. Girls who were at risk for developing depression exhibited neurologic anomalies in certain areas of the brain even before they developed depressive symptoms, indicating a potential mechanism by which offspring of depressed parents are at increased risk for depression.

Sleep disturbances. Depression and sleep processes are often regulated by similar neural processes, and insomnia has been documented as a risk factor for depression onset and relapse. In the 20-year longitudinal study by Weissman et al., Ong et al. examined eating and sleeping in children of depressed and nondepressed parents. Irregularities in eating and sleeping schedules in childhood were correlated with adolescent-onset major depression and anxiety disorder and childhood-onset anxiety disorder. Unfortunately, the sample of children of nondepressed parents was too small to use as a comparison with children of depressed parents. Therefore, at this point, all one can conclude for this
specific population is that sleep irregularities may be a marker for depression in offspring of depressed parents. One cannot claim that sleep disturbance acts as a risk factor for depression until more research has been conducted comparing children of depressed parents with children of nondepressed parents.

**Birth weight.** In the longitudinal study by Weissman et al., Nomura et al. examined the effect of birth weight on medical and psychological outcomes in the offspring of depressed and nondepressed parents. They found that the low-birthweight offspring had significant increases in risk of MDD, anxiety disorders, phobia, suicidal ideation, impaired functioning, hypertension, and allergies compared with the reference group. The association between depression and low-birthweight offspring was stronger among the offspring of depressed parents. The investigators postulated that parental depression may increase the detrimental effects that low birth weight can have on offspring, especially in terms of risk for depression.

**Early menarche.** Hormone regulatory systems also have been identified as possible vulnerability markers for depression in adolescence, especially for girls. Some studies have found that early-maturing girls are at an increased risk for depression. Ellis and Garber found that a history of maternal depression predicted earlier pubertal timing in daughters, and this association was mediated by dyadic stress, the absence of the biological father, and the presence of a stepfather. The investigators theorized that father absence and stepfather presence affect pubertal timing because these create a more stressful home environment, which has been found to be associated with earlier pubertal timing.

**Parental Behaviors and Cognitions.** Depressed parents often exhibit deficits in parenting skills. In an early article, Rutter pointed out that the proximal mechanism through which risk is transmitted from depressed parents to offspring is through their interactions with their children, and this remains true.

**Parent-child interactions.** Attachment. Children of depressed mothers are less likely to exhibit secure attachment relationships than are children of mothers who do not have depression, and the attachment relationship is an important predictor of child outcome. Milan et al. demonstrated that variability in the course of maternal depression predicted depressive symptoms in 11-year-old offspring, but only if the offspring demonstrated insecure attachment to the mother at age 3. Secure attachment history acted as a protective factor in predicting better outcomes for children of depressed mothers, but only when the mother had a long-term history of depression.

**Parenting style.** Some studies have investigated how parenting style, in the context of maternal depression, accounts for various child and adolescent outcomes. Parental disengagement, responsiveness, unpredictability, expressed emotion, and hostility have been found to affect offspring in the context of parental depression, as has parent–child conflict. For example, in a classic early study, Schwartz et al. demonstrated that high expressed emotion had a substantial impact on poor outcome over and above the chronicity and severity of parental depression. More recently, Tompson et al. found that high levels of maternal criticism and emotional involvement were associated with maternal depression history, thereby increasing the chance that offspring will be exposed to critical parenting, potentially increasing their risk for displaying depressive symptoms.

**Family System.** Because the family is clearly a dynamic system, it follows that the marital and family subsystems in the face of parental depression will have far-reaching consequences, as mediated by factors such as parental and marital conflict, divorce, and family structure, and history of depression and other psychopathology. For instance, higher levels of parental depressive symptoms have been associated with higher levels of interparental conflict and higher levels of internalizing symptoms in offspring. Moreover, children of depressed mothers have been found to be more reactive to stressful family environments (e.g., marital dissatisfaction, less parental warmth/acceptance) than children of depressed mothers. Also, depressed women tend to exhibit spouse similarity for depressive disorders and for antisocial and substance-use disorders, creating further opportunity for parental conflict.

**Exposure to Stressful Environment.** Adverse life events greatly increase the likelihood that offspring of depressed parents will be negatively affected by parental illness. Sources of stress include exposure to violence, rejection, abuse, marital and family discord, or chronic stress, such as poverty. Individuals with depression may inadvertently select environments of higher stress because of poor choices, individual or marital psychopathology, or downward social mobility due to a depressive disorder.
men et al. demonstrated that early adverse circumstances might sensitize those with depressed parents, increasing their risk for later depression.

Vulnerabilities

These mechanisms of risk are associated with the emergence of vulnerabilities in children of depressed parents, such as psychobiological dysfunction and skills deficits. These vulnerabilities can then lead to various child outcomes such as depression or other disorders. These vulnerabilities are in some cases in and of themselves outcomes that are worthy of prevention and treatment efforts.

Psychobiological Dysfunction.

Although depressed mood has been found to be a marker of risk for subsequent depressive syndromes, to date researchers have not presented data that address the relation between subsyndromal depression and depressive disorder specifically in children of depressed parents. Although depressive symptoms likely are associated with subsequent depression in the offspring of depressed parents, future research is needed to address this issue.

Skills Deficits or Maladaptive Styles or Behaviors.

Depressogenic cognitive style. Some studies have demonstrated that how a child interprets the world and the way in which he or she responds to it will affect the likelihood of developing psychopathology or other adverse outcomes in the context of parental depression. For example, Garber and Flynn found that maternal depression history is positively associated with depressive cognitions in adolescent offspring, specifically hopelessness, self-worth, and attribution style.

Interpersonal functioning. Certain characteristics of a person may lead that person to experience more acute stressors, potentially increasing the risk for depression. Rudolph and Klein found that depressive personality traits in children were correlated with maternal depressive personality traits and with maternal major depression. These findings highlight the need for effectively treating parental depression as soon as it occurs to avoid adverse long-term effects on offspring.

Affective expression. Forbes et al. examined the relation between maternal childhood-onset depression and offspring (3–9 years old, n = 74) affective expression. Results showed that mothers who had childhood-onset depression whose offspring had right frontal EEG asymmetry exhibited increased depressive symptoms over time, and maternal depressive symptoms were associated with high child negative affect. Further analysis indicated that there were bidirectional effects of child affective expression and maternal depressive symptoms.

Reflections on this Model

Goodman and Gotlib’s model provides an important structure for a review of new literature on children of depressed parents. However, this model fails to consider protective resources and the interplay between risk and resilience in the transmission of depression from parent to child. Although some studies have examined some aspects of resilience, the area is worthy of much more study.

PREVENTION-INTERVENTION

In the past several decades, research on the prevention of youth depression has blossomed, and as a result, much more is known about ways to maximize the efficacy of prevention efforts. To date, selective prevention efforts targeting children of depressed parents have been conducted with groups of teens, with families, and within the community setting. Examples of different promising prevention strategies identified in the IOM reports are presented.

Teen Groups

Clarke et al. developed the Coping With Stress (CWS) course, a manual-based psychoeducational group program targeting at-risk adolescents with depressed parents. They found that over a 15-month follow-up period, compared with teens assigned to the usual-care condition, teens in the CWS program reported fewer depressive symptoms, fewer symptoms of suicide, and better overall functioning. A four-site effectiveness study by Garber et al. is being conducted using a variant of the CWS program. Known as the Prevention of Depression in At-Risk Adolescents study, Garber et al. modified the CWS program to include eight weekly and six monthly continuation sessions and recruited 316 teens who were assigned randomly to the Cognitive Behavioral Prevention Program or the usual-care condition. Results indicate that, through the 8-month follow-up assessment, significantly fewer teens in the Cognitive Behavioral
Prevention Program group had a probable or definite episode of depression compared with adolescents in the usual-care condition. A long-term follow-up of this sample is currently underway.

**Family Based**

Some intervention programs for children of depressed parents have incorporated the family system as an integral target of intervention. For example, Compa et al. assessed the efficacy of a family cognitive-behavioral preventive intervention aimed at preventing depression in the offspring of parents with a history of depression. They found that the intervention compared with the control condition produced significant parent and child benefits, including significantly fewer depressive episodes, up to 24 months after randomization. Beardslee et al. also developed family-based, public health interventions for families when parents are depressed: a clinician-based program and a lecture program. Both approaches emphasize a cognitive orientation, focus on building strengths and resilience in youth and their parents, and highlight the importance of treatment for parental depression. Although both intervention approaches were associated with positive family changes compared with the lecture group, the clinician-facilitated condition was associated with greater understanding by children of their parents’ depressive illness and improved family communication. This work has been adapted for use with single-parent African-American and Latino families and has been used widely in countrywide programs for children of the mentally ill in Holland, Finland, Norway, Sweden, and Costa Rica.

**Community Based**

Although this review generally focuses on school-age children, the period from conception through 5 years of age is crucially important for intellectual and emotional development, and infants and very young children are especially vulnerable to certain types of environmental stressors. Thus, intensive efforts are warranted to help depressed parents and their children negotiate this crucial developmental epoch. Comprehensive efforts are needed for multi-risk families and such efforts should cover multiple domains. Nurse home visitation and center-based care such as Early Head Start provide important models for all high-risk families. Embedding additional outreach and support services for depressed parents, such as enriching nurse home visitation programs with mental health interventions or training and consultation programs about parental depression for Head Start and Early Head Start teachers, appear to be useful strategies.

Future prevention efforts should include assessment and treatment for depressed parents. There has been a debate in the literature about whether treatment of parents alone is sufficient to help children. It is the reviewers’ view that both treatment of parental depression to significant remission and help with parenting must be essential components of preventive efforts for families with depression. Also, prevention efforts must address nonspecific risk factors that are common in families with parental depression, such as poverty, abuse, and exposure to violence. Given that the genetic effects of depression are expressed in adverse environmental circumstances and that the effects of multiple risk factors are additive, it follows that prevention programs should target the environmental and the psychological risks to children of depressed parents. In addition, new delivery mechanisms for such prevention interventions are indicated. In recent years, Internet-based prevention programs have been developed that have the potential to reach a large number of people, especially populations that may have difficulty accessing more conventional treatment options. Although more intensive, clinician-based interventions may yield greater benefits, even lower-intensity group interventions have yielded meaningful positive results, suggesting that such programs may have an important place in public health approaches to preventing mental illness. Moreover, a recent meta-analysis has shown the value of preventive interventions that decrease depressive symptomatology, and these should be considered for children of depressed parents. Because parental depression is associated with internalizing and externalizing problems in youth, such preventive interventions should target a range of outcomes and may have broad mental health benefits.

**DISCUSSION**

In emphasizing conceptual advances and major progress since 1998, all studies could not be
exhaustively reviewed and the methodologies used could not be presented in detail. Although depression in parents is a heterogeneous entity, this review did not focus on details about this heterogeneity because it is often not discussed in the studies themselves beyond presenting diagnostic information. This review did not focus primarily on families in which depression is one of a number of risks, because, in the reviewers’ opinion, that literature requires a separate review.

Future Research Directions
Remarkable progress has been made in understanding the effects of parental depression on children’s biology and functioning, including brain asymmetry, right hemisphere thinness, dysregulation of sleep, early menarche, and low birth weight, and in understanding the range and kind of impairments associated with these effects. Clearly, there is a connection in the progress between these two areas. For example, sleep dysregulation or right hemisphere thinning affects functioning, which is then manifested in behavior. In the future, it would be useful to study multiple domains simultaneously to better understand their overlap. Also, one limitation of research to date is that the underlying mechanisms involved in the intergenerational transmission of depression have not always been identified. Although certain mechanisms, such as dysfunctional neuroregulatory factors, are known to be involved in the cross-generational transmission of depression, the active ingredients in these mechanisms (e.g., genes, traits, adverse events) are not known. Future studies should emphasize testing alternative hypotheses about underlying mechanisms causing disorder, including gene-environment interactions, and understanding gene expression and epigenesis related specifically to children of depressed parents. Depression is a heterogeneous condition. Better ways of understanding that heterogeneity of parental depression could lead to better matching of preventions to offspring in much the same way that psychogenomics allows better matching of particular treatments to an individual’s particular genetic makeup.

Need for Prevention
Currently, the problem of youth depression is significant, the costs of treatment are high, and most children do not receive treatment, highlighting the need for expanded treatment and prevention efforts targeting youth depression. Parental depression must be recognized as a major public health problem. Much greater emphasis on developing large-scale effective preventive interventions for families with parental depression is needed, with specific examination of how to take promising practices to a broader scale while continuing rigorous research on those they help and on those they do not. Developing the appropriate infrastructure, funding streams, and training for personnel are needed. Moreover, prevention efforts should be integrated into primary care and school systems. Broadly speaking, prevention offers one of the best ways of addressing health disparities, another key public health concern.

Be Bold in a Vision for the Future
In the IOM volume on prevention, the committee tried to envision a future in which the promise of preventive interventions was fully realized. Such a system would involve: ready access to health care for all; a strong emphasis on mental health and physical health prevention; partnerships with families in prevention and treatment; and the ongoing development of new services. As a part of that larger vision, as we think about the next 10 years, we hope there will be continued scientific advances, and that programs will be developed so that all families with parental depression will receive the care they need. &
REFERENCES


