Environment and Social Psychology (2024) Volume 9 Issue 4
doi: 10.54517/esp.v9i4.2274

ORIGINAL RESEARCH ARTICLE

The level of depression in parents of children with physiologic immaturity

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ABSTRACT

Study: The study aimed to identify the actuality of prone depression. At its center is the level of depression, which is what analyzes those who want to have children with physical immaturity, as well as the techniques needed for his issues, seeing him related to a range of issues: what is this physiological immaturity, why there is a need to get accurate information about it, the psychological state of parents with children with physiological immaturity and coping with it, and the impact of children with physiological immaturity on other family members. **Purpose:** The objectives of the study dealing with depression related to depression were to find gender differences in the level of depression in children with physiological immaturity, for the reason that some of them are those whose targets hypothesized that children with physiological immaturity are at a moderate level" and the second hypothesis: "Women as parents have a higher level of depression than men as parents. **Methodology:** A sample of 70 participants was independently surveyed, and the measuring instrument was Beck's inventory for depression as well as demographic data to determine the gender of participants. Before determining the inventory, the parents were explained the purpose of realizing that some of the data that will be obtained will remain anonymous and confidential. The data from the results supports our hypothesis: physiological immaturity is moderate. As well as *t*-test analysis, it was shown that the female gender has a higher level of depression than the male gender. **Results:** To derive the results obtained from the paper, we used the *t*-test analysis, which showed that there are differences between women (between 21.79 + 5.2) and men (between 17.91 + 6.1) in terms of the level of depression. It seems that women showed higher levels of depression ($t = –2.844$, $p = 0.006$).

Keywords: depression; parents; physiological immaturity; symptoms; children

1. Introduction

"Family is the natural and fundamental group of society and has the right of protection prof society and the state."

Universal Declaration of Human Rights

The decision to become a parent and start a family is a fundamental right and brings joy, meaning, and fulfillment to many who start it. It is also a choice that conveys responsibility, both to the parents and their family in terms of meeting the needs of each of its members and also to the wider community to support these processes and the unit as a whole. Parental depression can increase a family's vulnerability and create risk for all family members[1]. Rates of depression among parents can vary from 10%–42%[2]. with mothers

ARTICLE INFO
Received: 29 November 2023 | Accepted: 27 December 2023 | Available online: 11 January 2024

CITATION
Shemsedini N, Spahiu D, Obertinca B. The level of depression in parents of children with physiologic immaturity. *Environment and Social Psychology* 2024; 9(4): 2274. doi: 10.54517/esp.v9i4.2274

outnumbering fathers by approximately 2 to 1[3,4].

To this end, professionals working with adults experiencing mental illness must devote adequate attention and resources to identifying, understanding, and strengthening potentially vulnerable family units. Parental depression has experienced a sustained focus among researchers for at least the past 20–30 years, as evidenced by the many review papers and special journal issues devoted to this topic[5]. A parent's ability to enjoy and maintain close personal relationships with their children can be compromised by depressive symptoms[6]. Some have suggested that parenting practices, along with marital discord, have the greatest effect on child outcomes[7]. For example, among 697 fathers and 1320 mothers from a community sample, parents who were depressed were less likely to play with, read to, or cuddle with their children and were more likely to report frustration with the parenting process compared to those without emotion[8]. Others have reported that children of depressed parents are more likely to be exposed to higher levels of irritability and anger than those of nondepressed parents[9]. Parents appear to benefit from behavioral interventions. Mothers' depression scores decreased significantly after participating in a self-directed intervention for child behavior problems[10,11]. Hammen asserts that parental behaviors associated with depression are experienced as stressful by children, who then use maladaptive coping strategies and develop internalizing and externalizing behavior problems[12,13].

Depressive symptoms may also influence parenting style in terms of rejection, control, and warmth[14]. Parental warmth and involvement were negatively associated with rates of externalizing behaviors in children of depressed parents[15], while longitudinal ratings of parental rejection of children were associated with insecurity in close adult relationships[16]. Children who report negative attachment to their parents also report greater levels of depressive symptoms following increased levels of their parents' depression, indicating that their parenting style may also make them more vulnerable to the effects of depression theirs[17]. Other studies have reported that depressed parents risk the opposite extreme of over-involvement. Radke-Yarrow discusses the tendency for some depressed mothers to view their children as a source of comfort, forming overly close and emotional relationships with their children[18–20].

Theories regarding the transmission of risk to children and families exposed to parental depression have guided a variety of interventions aimed at protecting them. However, it is not yet clear what constitutes the essential components of the intervention needed to effect change and whether some components are more effective than others in helping families to ameliorate child risk and improve the parenting experience. Furthermore, a better understanding of the ways in which families respond to and apply the skills and lessons learned from interventions and how families work together in the context of parental depression is a valuable next step to modernizing an approach based on evidence of best practice. Rather than a sequential story, we hope that the results of each study will provide unique and complementary information on how to better understand and support families where one parent has depression.

Depression is a psychological disorder that can be categorized by the experience of a certain set of symptoms on most days for at least two weeks. These symptoms include, but are not limited to: a loss of interest in things that once brought pleasure; difficulty sleeping; fatigue; and feelings of sadness, worthlessness, and hopelessness[21,22]. Importantly, although depression is often considered to be an emotional state, it also affects one's executive functioning, perceptions, attention, and cognitions[23]. Thus, depression can affect a person's thoughts, perspectives, and behaviors through a variety of mechanisms. Furthermore, although depression is often considered and treated as an individual mental health issue, research makes it clear that depression is an essentially relational condition that affects one's interactions and relationships with others[24]. As a relational condition, it becomes important to understand the role that depression can play within the family context.

In particular, the impact of depression on parenting and parent-child interactions has been of interest in recent child development research[25]. This may be due to the prevalence of depression as well as the fact that levels of depression tend to be higher in age groups that are more likely to have children[26,27]. Research conducted over the past several decades suggests that children of parents with mental health problems are at higher risk for a variety of social, emotional, and physical problems[28–32]. For example, parental depression has been found to be a risk factor for a variety of poor physical, social, and emotional outcomes in children and adolescents[33]. Studies have also found that children with depressed mothers are at risk of experiencing insecure attachments, developing depression, and having less than optimal cognitive development. Furthermore, within the current literature on parental depression, some studies have examined depressed versus non-depressed parents based on clinical levels of depression[34], and other studies have examined a continuum of parental depressive symptoms[35]. The research reviewed will include findings from both types of studies; however, it is important to note that the current study will examine current levels of depressive symptoms in parents of children with physiological immaturity.

The purpose of the research

Children's mental health has long been a subject of great interest to researchers and clinicians, due to its harmonious and long-term impact on children's development and psychological health. However, in Kosovo, these studies have rarely had as a sample a group of children with physiological immaturity; therefore, this current study aims to make it authentic. The purpose of this study is to see if there is a high, moderate, or low level of depression in parents of children with physiological immaturity. Therefore, the objectives of this study were: 1). To test the level of depression in parents. 2). To find gender differences in the level of depression in parents of children with physiological immaturity. The research is based on two hypotheses: H1: The level of depression in parents of children with mental retardation is moderate. H2: Female parents have a higher level of depression than male parents.

2. Methodology

The research was carried out in Kosovo, namely in Pristina, and aimed to measure the level of depression in parents of children with physiological immaturity and to find gender differences in the level of depression in parents of children with physiological immaturity. As for the research method, during this study the quantitative method was used where the study data were collected through the questionnaire. Meanwhile, Beck's Inverter was used as a measuring instrument for depression. The first part of the questionnaire contained demographic questions asking for age, gender, while the second part included the actual questionnaire. Quantitative, descriptive, statistical and analysis methods were also used for this research.

2.1. Questionnaire characteristics

Data were collected through a structured, anonymous, self-administered questionnaire, including socio-demographic characteristics (age, marital status and gender); and Besk's Depression Inventory-II (BDI II) – BDI-II[36], which is a standard and proven psychometric instrument that shows high reliability, ability to discriminate between subjects with and without depression, with improved validity substantive and structural. Based on available psychometric evidence, the BDI-II can be viewed as a low-cost questionnaire for measuring depression severity, with broad applicability for research and clinical practice worldwide. The BDI assesses 21 symptoms of depression, 15 of which cover emotions, four cover behavioral changes, and six somatic symptoms. Each symptom is rated on a four-point intensity scale and the scores are summed to give a total ranging from 0 to 63, and divided into four levels: from 0 to 13 minimal level of depression, from 14 to 19 mild level, from 20 to 28 moderate level and from 29 to 63 high level of depression. Of the 21 articles, 13 form

an abbreviated version, as shown in the list below. The 21 items cover sadness, pessimism, past failure, loss of pleasure, feelings of guilt, feelings of punishment (dislike of self), self-criticism (suicidal thoughts or wishes), crying (agitation, loss of interest), indecisiveness, feeling worthless, loss of energy, changes in sleep patterns (irritability), changes in appetite, difficulty concentrating (fatigue or exhaustion), and loss of interest in sex.

From the results presented in the tables below, we can see that the measuring instrument which measures depression satisfies the important condition for the application of the measuring instrument, respectively the reliability values for Cronbach's Alpha method Alpha = 0.89 and Gutman = 0.85 reach the reliability values a = 0.80.

2.2. Participants

70 parents aged 26–58 were part of this research. Their average age was 40.7 years while the standard deviation + 7.4. The parents were selected based on the children's diagnosis, i.e., those parents whose children were diagnosed with physiological immaturity through tests carried out mainly in the KKUK (University Clinical Center of Kosovo)—Department of Child Psychiatry, but also in private offices where tests are applied to measure intellectual capacities. The sample consists of 50% women and 50% men so that gender differences can also be seen. 66.7% of them had secondary education while 33.3% had higher education. The questionnaire was administered after the purpose of the study was explained to the parents and after their consent was obtained, we completed the questionnaire.

Table 1 shows that a total of 35% or 50% female parents and 35% or 50% male parents participated in the study. So here we see that we have an equal distribution of the sample between the female and male genders.

Table 1. Tabular representation of the number of participants in the study, their gender and relative percentage.

	Frequency	**Percentage**	
Valid	Female	35	50%
	Male	35	50%
	Total	70	100.0

2.3. Procedure

In the beginning, permission was obtained from the Center for the Development and Education of Children with Special Needs, the Knowledge Center in Pristina, for the realization of the research. After the approval and permission from the center in question, we have started the realism of the research with the parents of the children who bring their children to this center. The research was carried out in order to discover the level of depression of parents whose children have been diagnosed with physiological immaturity and the gender differences in relation to that level. The selection of the sample was not problematic because the majority of the sample was taken from the client registration diary of the center for the development and education of children with special needs: "Kendra Dija". The parents were very cooperative and this came as a result of the good cooperation they had with the institutions in the past and in the present. Before the distribution of the questionnaires, the parents were told the purpose of this research and they were told that the data obtained will remain completely anonymous and confidential. After receiving consent from the parents, they started filling out the questionnaire and for any ambiguity they were free to ask for additional clarifications. Filling out the questionnaires took 30 days. After the administration of the questionnaires, the data analysis was carried out using the SPSS (Statistical Package for Social Science) program.

2.4. Ethical consideration

Regarding the ethical consideration, the parents were informed that they would be free to ask any

questions regarding the questionnaire and the purpose of the research. They were also informed that parents who did not feel comfortable completing the questions could withdraw from the research at any time. The parents were informed that the questionnaire is anonymous, the data are confidential and will never be published for different interests that would harm them. Also, the parents who were selected for the research had enough time to complete all the questions.

2.5. Statistical analysis

The Statistical Package for Social Sciences Software (SPSS version 21.0) was used for data analysis.

3. Results

Study results

This paragraph presents the results of this paper obtained through the questionnaires used in line with the goals and hypotheses of this study. The results are descriptive and are presented through graphs, tables and inferential analyzes that show differences or changes between groups. As for the differences between the groups and the level of depression of the two variables of education and age groups, we performed the *t*-test and ANOVA analysis, but we did not find significant differences.

In **Figure 1**, we have presented the levels of depression categorized, where it can be seen that 49.3% of the respondents showed moderate levels of depression, 24.6% mild levels, 21.7% minimal levels and 8.6% severe levels of depression.

Figure 2 shows the age group in proportion to the levels of depression, where it can be seen that 55.6% of the 25–35 age group have moderate levels, 38.9% mild levels and 5.6% minimal levels. While in the 36–45 age group, 54.8% showed moderate levels of depression, 25.8% minimal levels and 6.5% severe levels. 35% of the age group over 65 years showed moderate levels of depression, from 30% to mild and minimal levels, while only 5% showed severe levels of depression.

Figure 3 shows the levels of education in proportion to the levels of depression, where it can be seen that 65.2% of the respondents with a high level of education showed moderate levels of depression, with 13% showing mild and minimal levels and 8.7 % severe levels of depression. While 41.3% of respondents with a medium level of education showed moderate levels of depression, 30.4% mild levels, 26.1% minimal levels and only 2.2% severe levels of depression.

In **Figure 4**, females showed moderate levels of depression with 70.6%, mild levels 17.6%, 8.8% minimal levels and only 2.9% severe levels of depression. 34.3% of male respondents showed minimal levels of depression, 31.4% mild levels, 28.6% moderate levels and 5.7% severe levels.

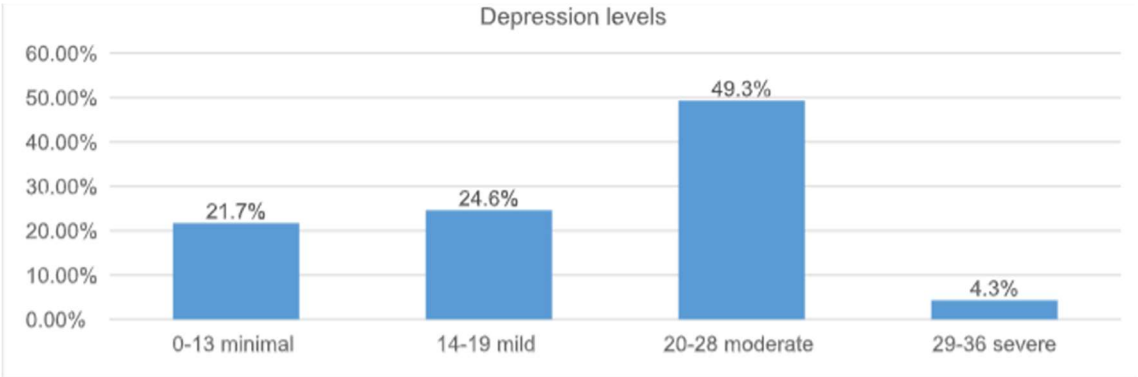

Figure 1. Categorized depression levels.

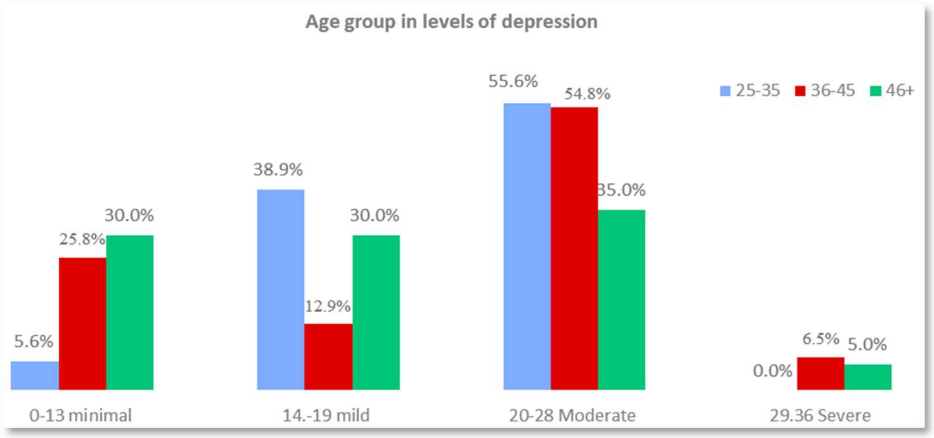

Figure 2. Age group in proportion to the level of depression.

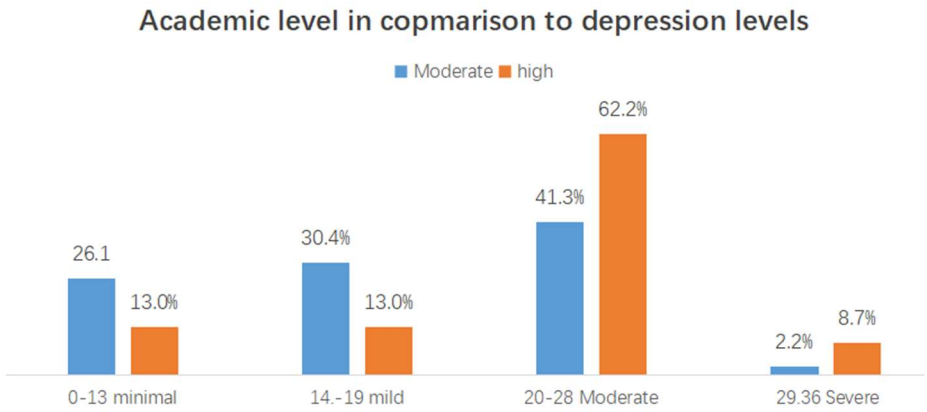

Figure 3. The level of education in proportion to the level of depression.

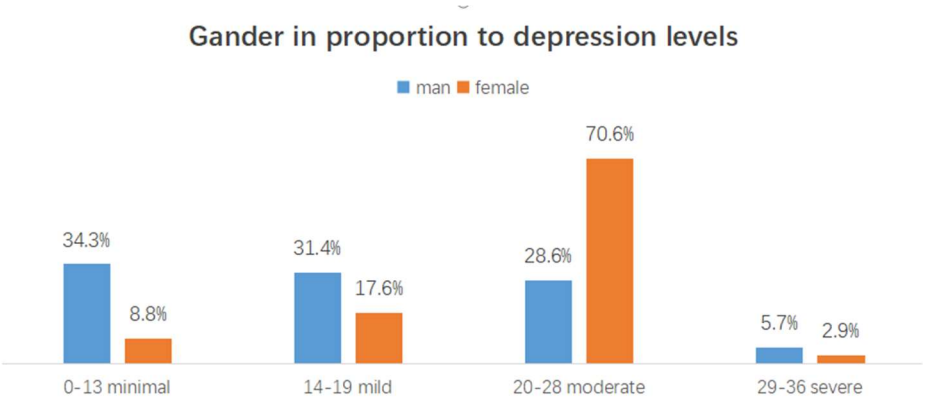

Figure 4. Gender in proportion to the level of depression.

In **Table 2**, the *t*-test analysis has shown significant differences between women (between 21.79 + 5.2) and men (between 17.91 + 6.1) regarding the level of depression where it can be seen that women have shown higher levels of depression, $t = –2.844$, $p = 0.006$.

Table 2. Differences between women and men regarding the level of depression (*t*-test).

	n	**Mean**	***SD***	***T***	***df***	***p***
Male	35	17.91	6.1	–2.844	67	0.006
Female	34	21.79	5.2			

4. Discussion

The main goal of this paper was to identify the level of depression experienced by parents of children with physiological immaturity. Therefore, this study had two main pillars on which it was worked until its results. The first pillar was to test the level of depression in the parents of these children, i.e., children with physiological immaturity. Whereas the second pillar was to find gender differences among these parents, that is, to see which of the parents (male or female) has a higher level of depression. In order to arrive at results consistent with these goals, we established two hypotheses. The first hypothesis was that "the level of depression in the parents of children with physiological immaturity is a moderate level" so we believed that the parents of these children would have a moderate level of depression, as we know that it is not easy to deal with the challenges of caring for these children. Meanwhile, the second hypothesis was that "female parents have a higher level of depression than male parents", so we believed that female parents, in this case mothers, tend to have a higher level of depression, since attachment to children is bigger and the daily stay with them is higher compared to male parents or fathers.

The hypotheses of this study can be said to have come true almost completely since our results show such a thing and we will try to present it as follows. The first hypothesis was that parents of children with physiological immaturity have a moderate level of depression, to achieve this result we used Beck's instrument and following the instructions of this instrument we also achieved the result as seen in **Figure 1** here are the levels of depression divided into its levels. We can see that over 49% or almost half of the parents had presented a moderate level of depression, so through these results we have managed to prove our hypothesis, since the other levels of the degree of depression were significantly lower, exactly with 24.6% were in mild levels of depression, 21.7% minimal levels and 8.6% severe levels of depression.

Moreover, we can also say that the second hypothesis has been fully confirmed, since our results show such a thing. The second hypothesis was that female parents or mothers show higher levels of depression than male parents or fathers. To measure this hypothesis we used statistical analysis for differences of two groups or *t*-test. This analysis has shown significant differences between women (between 21.79 + 5.2) and men (between 17.91 + 6.1) regarding the level of depression, $t = –2.844$, $p = 0.006$, so it is observed that women or mothers have shown average higher level of depression compared to male parents or the father

The results of our research are in line with many researches carried out in the past from around the world. But we will mention the research carried out by Moses[37,38], where he shows that over 60% of parents who have a child with physiological immaturity, create stress, constant worry, fear of the future and many other symptoms that send to depression[39]. So here is the explanation for our results, because as we know, facing these challenges in Kosovo, especially when you have a child with physiological immaturity, is extremely difficult. Therefore, our results also show almost the same data, where it can be seen that over 50% of the parents interviewed for our research were in moderate and severe levels of depression.

The reasons for such experiences of parents can be different, however there are many researchers who try to find some of the causes that lead to such a state of mental health. A rather interesting research by Judge[40] shows a number of reasons why parents may face such emotional problems that lead to depression. In many different countries of the world that are in transition, the stigmatization of these parents who have such a child is quite widespread, so these parents every day have to face the pressure from the social circle to manage to carry out their daily theirs and especially the help towards their children[40]. Re-examining the statements from this research, we can confidently say that Kosovar parents face similar problems almost every day, we can even argue this with our results where we see that over 60% of parents feel pessimistic, so they do not hesitate to have a positive energy to continue their future.

Accepting children as they are is extremely important, not only for parent-child relationships and the development of parents, but also for the parents themselves, i.e., for their mental health. From our results we see that over 60% of children feel guilty for what has happened and therefore we believe that these parents have a hard time accepting their child as they are, and this can have a huge impact on their mental health[41], in their research, show that most parents who have not managed to accept their child and cooperate with them, create a very stressful situation for themselves, which in many cases leads to depression. It is natural to have difficulties in acceptance, since the whole course of the parents' lives will change in those moments when they realize that they will have a child with physiological immaturity, however, if the parents are also involved in this journey, there will be improvements and progress in the child and the parents will have an emotional and mental stability, so they will be able to cooperate with their child[42].

Our *t*-test results, as we have shown above, show that female parents, i.e., mothers, show a higher degree of depression than fathers. There are few researches carried out in the world where the purpose was to make a difference between the sexes, however we mention the research of Lyons-Ruth et al.[8] which is in the same line with our research even though the differences were minimal, in the research of with over 2000 male and female respondents, he observed that mothers experience more of their own state of depression, reflecting this directly on their children. According to them, the mother is more connected to their children, stays with them longer and takes care of them more, so it is natural that there are more experiences and emotional damage of mothers compared to fathers. We argue similarly, since it is known that even in Kosovo, mothers take care of their children more, stay more time with them at home, and necessarily the impact will be greater on the mother.

When we analyze **Figure 3** of the age groups in relation to the level of depression, we see very interesting results. Moreover, we see that although the youngest age group of parents (25–35 years old) showed more depression at moderate levels with 55% and mild with 38%, while we have no cases of severe depression. So, from this result they understand that parents who are younger in age show levels of depression up to a degree but manage to manage it by not sending it to the most severe degree. Similarly, it did not happen with the age group 36–45 years where we see that this age group is most affected by depression based on the results of our research, where we see that over 50% have moderate levels of depression and in addition about 6% of this age group has severe levels of depression. We believe that the reasons for such a thing may also be the recent effects of Covid-19, where many parents have lost their jobs, the opportunity to help their children, isolation for a long time, etc., so this can to be one of the reasons why this age group has shown higher levels of depression, even Brooks et al.[43] conducted a study on the psychological consequences and the impact of Covid-19 on mental health, where they pointed out that the longest severe isolation, inadequate supplies, difficulties in obtaining medical care and medicines, heavy financial losses and loss of jobs sent many people into high levels of depression[44–47].

5. Recommendations

Based on the literature review and the findings of our research, we recommend:

- We recommend that adequate and special programs be developed to inform, advise, and help all parents who have one or more children with physiological retardation throughout Kosovo[48].
- We recommend that special schools be created that would accept these children or that these children be sent to attached classes in order to ease the burden on the parents and not have forced care throughout the day[49–53].
- We recommend urgently creating a team of different psychologists who would contact or consult with all these parents, with the aim of helping to overcome this condition and reduce the level of depression among them.

- We recommend that all these parents be trained by clinical psychologists in order to successfully face all the challenges that come from the continuous care of these children[54,55].

6. Study limits and restrictions

The research work for this thesis was limited by several factors[56–63]:

- The questionnaire was intended for both parents to complete for themselves, which they were reluctant to do.
- The small sample size represents another limitation in this study[64–71]. A larger sample number, I believe, would provide deeper and more complete results related to the research topic.
- The financial cost is the limiting factor for more detailed research with wider involvement.
- The epidemic situation has also been a part of the limitations of the rese.

Author contributions

Conceptualization, NS and DS; methodology, NS and BO; software, NS and DS; validation, NS, BO and DS; formal analysis, NS and DS; investigation, BO and DS; resources, NS, BO and DS; data curation, NS, BO and DS; writing—original draft preparation, NS and DS; writing—review and editing, BO; visualization, NS, BO and DS; supervision, NS; project administration, NS, BO and DS. All authors have read and agreed to the published version of the manuscript.

Conflict of interest

The authors declare no conflict of interest.

References

1. Weissman MM, Wickramaratne P, Nomura Y, et al. Offspring of depressed parents: 20 years later. American Journal of Psychiatry. 2006; 163(6): 1001–1008. doi: 10.1176/ajp.2006.163.6.1001
2. McCue Horwitz S, Briggs-Gowan MJ, Storfer-Isser A, Carter AS. Prevalence, correlates, and persistence of maternal depression. Journal of Women's Health. 2007; 16(5): 678–691. doi: 10.1089/jwh.2006.0185
3. Roy CA, Zoccolillo M, Gruber R, et al. Construct Validity of an instrument to assess major depression in parents in epidemiologic studies. The Canadian Journal of Psychiatry. 2005; 50(12): 784–791. doi: 10.1177/070674370505001208
4. Shiers D, Jones PB, Field S. Early intervention in psychosis: Keeping the body in mind. British Journal of General Practice. 2009; 59(563): 395–396.
5. Zahn-Waxler C. Introduction to special section: Parental depression and distress: Implications for development in infancy, childhood, and adolescence. Developmental Psychology. 1995; 31(3): 347–348. doi: 10.1037/h0092676
6. Compas BE, Forehand R, Thigpen JC, et al. Family group cognitive–behavioral preventive intervention for families of depressed parents: 18- and 24-month outcomes. Journal of Consulting and Clinical Psychology. 2011; 79(4): 488–499. doi: 10.1037/a0024254
7. Budman SH, Butler SF. The Lilly family depression project: Primary care prevention in action. In: Cummings NA, Cummings JL, Johnson JN, Baker NJ (editors). Behavioral Health in Primary Care: A Guide for Clinical Integration. Psychosocial Press; 1997. pp. 219–238.
8. Lyons-Ruth K, Wolfe R, Lyubchik A. Depression and the parenting of young children: Making the case for early preventive mental health services. Harvard Review of Psychiatry. 2000; 8(3): 148–153. doi: 10.1080/hrp_8.3.148
9. Rutter M. Commentary: Some focus and process considerations regarding effects of parental depression on children. Developmental Psychology. 1990; 26(1): 60–67. doi: 10.1037/h0092669
10. Morawska A, Sanders MR. Self-administered behavioural family intervention for parents of toddlers: Effectiveness and dissemination. Behaviour Research and Therapy. 2006; 44(12): 1839–1848. doi: 10.1016/j.brat.2005.11.015
11. Sanders MR, McFarland M. Treatment of depressed mothers with disruptive children: A controlled evaluation of cognitive behavioral family intervention. Behavior Therapy. 2000; 31(1): 89–112. doi: 10.1016/s0005-7894(00)80006-4

12. Hammen C. Context of stress in families of children with depressed parents. In: Goodman SH, Gotlib IH (editors). Children of Depressed Parents: Mechanisms of Risk and Implications for Treatment. American Psychological Association; 2002. pp. 175–199. doi: 10.1037/10449-007
13. Hammen C, Burge D, Stansbury K. Relationship of mother and child variables to child outcomes in a high-risk sample: A causal modeling analysis. Developmental Psychology. 1990; 26(1): 24–30. doi: 10.1037/0012-1649.26.1.24
14. Rapee R. Potential role of childrearing practices in the development of anxiety and depression. Clinical Psychology Review. 1997; 17(1): 47–67. doi: 10.1016/s0272-7358(96)00040-2
15. McKee L, Forehand R, Rakow A, et al. Parenting Specificity. Behavior Modification. 2008; 32(5): 638–658. doi: 10.1177/0145445508316550
16. Shelton KH, Harold GT. Interparental conflict, negative parenting, and children's adjustment: Bridging links between parents' depression and children's psychological distress. Journal of Family Psychology. 2008; 22(5): 712-724. doi: 10.1037/a0013515
17. Abela JRZ, Zinck S, Kryger S, et al. Contagious depression: Negative attachment cognitions as a moderator of the temporal association between parental depression and child depression. Journal of Clinical Child & Adolescent Psychology. 2009; 38(1): 16–26. doi: 10.1080/15374410802575305
18. Radke-Yarrow M. Children of Depressed Mothers: From Early Childhood to Maturity, 1st ed. Cambridge University Press; 1998.
19. Radke-Yarrow M, Klimes-Dougan B. Parental depression and offspring disorders: A developmental perspective. In: Goodman SH, Gotlib IH (editors). Children of depressed Parents: Mechanisms of Risk and Implications for Treatment. American Psychological Association; 2002. pp. 155–173. doi: 10.1037/10449-006
20. Rakow A, Forehand R, Haker K, et al. Use of parental guilt induction among depressed parents. Journal of Family Psychology. 2011; 25(1): 147–151. doi: 10.1037/a0022110
21. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 4th ed. American Psychiatric Association; 2000.
22. American Association on Mental Retardation, Edwards W, Luckasson RA. Mental Retardation: Definition, Classification, and Systems of Supports, 10th ed. American Association on Intellectual and Developmental Disabilities; 2002.
23. Lee TW, Yu YWY, Chen MC, Chen TJ. Cortical mechanisms of the symptomatology in major depressive disorder: A resting EEG study. Journal of Affective Disorders. 2011; 131(1–3): 243–250. doi: 10.1016/j.jad.2010.12.015
24. Wilson S, Durbin CE. Effects of paternal depression on fathers' parenting behaviors: A meta-analytic review. Clinical Psychology Review. 2010; 30(2): 167–180. doi: 10.1016/j.cpr.2009.10.007
25. Paulson JF, Keefe HA, Leiferman JA. Early parental depression and child language development. Journal of Child Psychology and Psychiatry. 2009; 50(3): 254–262. doi: 10.1111/j.1469-7610.2008.01973.x
26. Kane P, Garber J. The relations among depression in fathers, children's psychopathology, and father–child conflict: A meta-analysis. Clinical Psychology Review. 2004; 24(3): 339–360. doi: 10.1016/j.cpr.2004.03.004
27. Kane P, Garber J. Parental depression and child externalizing and internalizing symptoms: Unique effects of fathers' symptoms and perceived conflict as a mediator. Journal of Child and Family Studies. 2008; 18(4): 465–472. doi: 10.1007/s10826-008-9250-x
28. Goodman SH. Depression in mothers. Annual Review of Clinical Psychology. 2007; 3(1): 107–135. doi: 10.1146/annurev.clinpsy.3.022806.091401
29. Goodman A, Joyce R, Smith JP. The long shadow cast by childhood physical and mental problems on adult life. Proceedings of the National Academy of Sciences. 2011; 108(15): 6032–6037. doi: 10.1073/pnas.1016970108
30. Goodman R. Mental health problems of children in the community: 18 month follow up. BMJ. 2002; 324(7352): 1496–1497. doi: 10.1136/bmj.324.7352.1496
31. Goodman SH, Gotlib IH. Transmission of risk to children of depressed parents: Integration and conclusions. In: Goodman SH, Gotlib IH (editors). Children of Depressed Parents: Mechanisms of Risk and Implications for Treatment. American Psychological Association; 2002. pp. 307–326. doi: 10.1037/10449-012
32. Goodman SH, Brumley HE. Schizophrenic and depressed mothers: Relational deficits in parenting. Developmental Psychology. 1990; 26(1): 31–39. doi: 10.1037/0012-1649.26.1.31
33. Johnson PL, Flake EM. Maternal depression and child outcomes. Psychiatric Annals. 2007; 37(6): 404–410. doi: 10.3928/00485713-20070601-04
34. Pelaez M, Field T, Pickens JN, Hart S. Disengaged and authoritarian parenting behavior of depressed mothers with their toddlers. Infant Behavior and Development. 2008; 31(1): 145–148. doi: 10.1016/j.infbeh.2007.06.002
35. Ewell Foster CJ, Garber J, Durlak JA. Current and past maternal depression, maternal interaction behaviors, and children's externalizing and internalizing symptoms. Journal of Abnormal Child Psychology. 2007; 36(4): 527–537. doi: 10.1007/s10802-007-9197-1

36. Beck AT, Steer RA, Brown G. Beck Depression Inventory–II (BDI-II). American Psychological Association; 1996. doi: 10.1037/t00742-000
37. Moses T. Exploring parents' self-blame in relation to adolescents' mental disorders. Family Relations. 2010; 59(2): 103–120. doi: 10.1111/j.1741-3729.2010.00589.x
38. Moses T. Parents' conceptualization of adolescents' mental health problems: Who adopts a psychiatric perspective and does it make a difference? Community Mental Health Journal. 2009; 47(1): 67–81. doi: 10.1007/s10597-009-9256-x
39. Fear JM, Champion JE, Reeslund KL, et al. Parental depression and interparental conflict: Children and adolescents' self-blame and coping responses. Journal of Family Psychology. 2009; 23(5): 762–766. doi: 10.1037/a0016381
40. Judge SL. Parental coping strategies and strengths in families of young children with disabilities. Family Relations. 1998; 47(3): 263. doi: 10.2307/584976
41. Wachtel K, Carter AS. Reaction to diagnosis and parenting styles among mothers of young children with ASDs. Autism. 2008; 12(5): 575–594. doi: 10.1177/1362361308094505
42. Richardson M, Cobham V, McDermott B, Murray J. Youth mental illness and the family: Parents' loss and grief. Journal of Child and Family Studies. 2012; 22(5): 719–736. doi: 10.1007/s10826-012-9625-x
43. Brooks SK, Webster RK, Smith LE, et al. The psychological impact of quarantine and how to reduce it: Rapid review of the evidence. The Lancet. 2020; 395(10227): 912–920. doi: 10.1016/s0140-6736(20)30460-8
44. Boulter E, Rickwood D. Parents' experience of seeking help for children with mental health problems. Advances in Mental Health. 2013; 11(2): 131–142. doi: 10.5172/jamh.2013.11.2.131
45. Beardslee W, Knitzer J. Mental health services: A family systems approach. In: Maton KI, Schellenbach CJ, Leadbetter BJ, Solarz AL (editors). Investing in Children, Youth, Families, and Communities: Strengths-Based Research and Policy. American Psychological Association; 2004. pp. 157–171. doi: 10.1037/10660-009
46. Beardslee WR, Solantaus TS, Morgan BS, et al. Preventive interventions for children of parents with depression: International perspectives. Medical Journal of Australia. 2013; 199(S3): 23–25. doi: 10.5694/mja11.11289
47. Beardslee WR, Gladstone TRG, Wright EJ, Cooper AB. A Family-based approach to the prevention of depressive symptoms in children at risk: Evidence of parental and child change. Pediatrics. 2003; 112(2): e119–e131. doi: 10.1542/peds.112.2.e119
48. Ahmann E. Making meaning when a child has mental illness: Four mothers share their experiences. Pediatric Nursing. 2013; 39(4): 202–205.
49. Barnett OW, Miller-Perrin CL, Perrin RD. Family violence across the lifespan: An introduction, 2nd ed. Sage; 2005.
50. Conger RD, Patterson GR, Ge X. It takes two to replicate: A mediational model for the impact of parents' stress on adolescent adjustment. Child Development. 1995; 66(1): 80. doi: 10.2307/1131192
51. Chen M, Johnston C, Sheeber L, Leve C. Parent and adolescent depressive symptoms: The role of parental attributions. Journal of Abnormal Child Psychology. 2008; 37(1): 119–130. doi: 10.1007/s10802-008-9264-2
52. Callender KA, Olson SL, Choe DE, Sameroff AJ. The Effects of parental depressive symptoms, appraisals, and physical punishment on later child externalizing behavior. Journal of Abnormal Child Psychology. 2011; 40(3): 471–483. doi: 10.1007/s10802-011-9572-9
53. Campbell SB, Cohn JF, Meyers T. Depression in first-time mothers: Mother-infant interaction and depression chronicity. Developmental Psychology. 1995; 31(3): 349–357. doi: 10.1037/0012-1649.31.3.349
54. Dunedin Multidisciplinary Health & Development Research Unit. About us. Available online: https://dunedinstudy.otago.ac.nz/about-us (accessed on 9 January 2024).
55. Downey G, Coyne JC. Children of depressed parents: An integrative review. Psychological Bulletin. 1990; 108(1): 50–76. doi: 10.1037/0033-2909.108.1.50
56. Edwards VJ, Holden GW, Felitti VJ, Anda RF. Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: results from the adverse childhood experiences study. American Journal of Psychiatry. 2003; 160(8): 1453–1460. doi: 10.1176/appi.ajp.160.8.1453
57. Fayyad JA, Jahshan CS, Karam EG. Systems development of child mental health services in developing countries. Child and Adolescent Psychiatric Clinics of North America. 2001; 10(4): 745–762. doi: 10.1016/s1056-4993(18)30028-2
58. Geller B, Zimerman B, Williams M, et al. Bipolar disorder at prospective follow-up of adults who had prepubertal major depressive disorder. American Journal of Psychiatry. 2001; 158(1): 125–127. doi: 10.1176/appi.ajp.158.1.125
59. Green H, McGinnity A, Meltzer H, et al. Mental Health of Children and Young People in Great Britain, 2004. Palgrave Macmillan; 2005. doi: 10.1037/e557702010-001
60. Hinshaw SP. The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs. Journal of Child Psychology and Psychiatry. 2005; 46(7): 714–734. doi: 10.1111/j.1469-7610.2005.01456.x

61. Hinden BR, Biebel K, Nicholson J, et al. A survey of programs for parents with mental illness and their families: Identifying common elements to build the evidence base. The Journal of Behavioral Health Services & Research. 2006; 33(1): 21–38. doi: 10.1007/s11414-005-9007-x
62. Kim J, Cicchetti D. Longitudinal pathways linking child maltreatment, emotion regulation, peer relations, and psychopathology. Journal of Child Psychology and Psychiatry. 2010; 51(6): 706–716. doi: 10.1111/j.1469-7610.2009.02202.x
63. Leibson CL. Use and costs of medical care for children and adolescents with and without attention-deficit/hyperactivity disorder. Journal of the American Medical Association. 2001; 285(1): 60. doi: 10.1001/jama.285.1.60
64. Luoma I, Tamminen T, Kaukonen P, et al. Longitudinal study of maternal depressive symptoms and child well-being. Journal of the American Academy of Child & Adolescent Psychiatry. 2001; 40(12): 1367–1374. doi: 10.1097/00004583-200112000-00006
65. Maughan A, Cicchetti D, Toth SL, Rogosch FA. Early-occurring maternal depression and maternal negativity in predicting young children's emotion regulation and socioemotional difficulties. Journal of Abnormal Child Psychology. 2007; 35(5): 685–703. doi: 10.1007/s10802-007-9129-0
66. Mendenhall AN, Mount K. Parents of children with mental illness: Exploring the caregiver experience and caregiver-focused interventions. Families in Society: The Journal of Contemporary Social Services. 2011; 92(2): 183–190. doi: 10.1606/1044-3894.4097
67. Marsh DT, Johnson DL. The family experience of mental illness: Implications for intervention. Professional Psychology: Research and Practice. 1997; 28(3): 229–237. doi: 10.1037/0735-7028.28.3.229
68. McLaren J, Bryson SE. Review of recent epidemiological studies of mental retardation: Prevalence, associated disorders, and etiology. American Journal on Mental Retardation. 1987; 92(3): 243–254.
69. Miller IW, Keitner GI, Ryan CE, et al. Family treatment for bipolar disorder. The Journal of Clinical Psychiatry. 2008; 69(5): 732–740. doi: 10.4088/jcp.v69n0506
70. MacFarlane MM. Family centered care in adult mental health: Developing a collaborative interagency practice. Journal of Family Psychotherapy. 2011; 22(1): 56–73. doi: 10.1080/08975353.2011.551100
71. Marshall A, Bell JM, Moules NJ. Beliefs, suffering, and healing: A clinical practice model for families experiencing mental illness. Perspectives in Psychiatric Care. 2010; 46(3): 197–208. doi: 10.1111/j.1744-6163.2010.00259.x
72. National Institute for Clinical Excellence, Simon J. Eating Disorders. Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders. CG9. The British Psychological Society and Gaskell; 2004.
73. Nicholson J, Albert K, Gershenson B, et al. Family options for parents with mental illnesses: A developmental, mixed methods pilot study. Psychiatric Rehabilitation Journal. 2009; 33(2): 106–114. doi: 10.2975/33.2.2009.106.114
74. Meltzer H, Gatward R, Goodman R, Ford T. The Mental Health of Children and Adolescents in Great Britain. The Office for National Statistics; 1999.
75. Oyserman D, Bybee D, Mowbray C, Hart-Johnson T. When mothers have serious mental health problems: Parenting as a proximal mediator. Journal of Adolescence. 2005; 28(4): 443–463. doi: 10.1016/j.adolescence.2004.11.004
76. Pilowsky DJ, Wickramaratne P, Nomura Y, Weissman MM. Family discord, parental depression, and psychopathology in offspring: 20-year follow-up. Journal of the American Academy of Child & Adolescent Psychiatry. 2006; 45(4): 452–460. doi: 10.1097/01.chi.0000198592.23078.8d
77. Shear MK, Simon N, Wall M, et al. Complicated grief and related bereavement issues for DSM-5. Depression and Anxiety. 2011; 28(2): 103–117. doi: 10.1002/da.20780
78. Perry BL. The labeling paradox. Journal of Health and Social Behavior. 2011; 52(4): 460–477. doi: 10.1177/0022146511408913
79. Perou R, Bitsko RH, Blumberg SJ, et al. Mental health surveillance among children—United States, 2005–2011. Available online: https://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm (accessed on 8 January 2024).
80. Reupert A, Maybery D. Programmes for parents with a mental illness. Journal of Psychiatric and Mental Health Nursing. 2010; 18(3): 257–264. doi: 10.1111/j.1365-2850.2010.01660.x
81. Tronick E, Reck C. Infants of depressed mothers. Harvard Review of Psychiatry. 2009; 17(2): 147–156. doi: 10.1080/10673220902899714
82. Richards M, Parsonage M. Childhood Mental Health and Life Chances in Post-War Britain: Insights from Three National Birth Cohort Studies (Executive Summary). Sainsbury Centre for Mental Health; 2009.
83. Suiter SV, Heflinger CA. Issues of care are issues of justice: Reframing the experiences of family caregivers of children with mental illness. Families in Society: The Journal of Contemporary Social Services. 2011; 92(2): 191–198. doi: 10.1606/1044-3894.4098

84. Sanford M, Byrne C, Williams S, et al. A pilot study of a parent-education group for families affected by depression. The Canadian Journal of Psychiatry. 2003; 48(2): 78–86. doi: 10.1177/070674370304800203
85. Sarigiani PA, Heath PA, Camarena PM. The significance of parental depressed mood for young adolescents' emotional and family experiences. The Journal of Early Adolescence. 2003; 23(3): 241–267. doi: 10.1177/0272431603254292