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[Sherryl H Goodman](#), *Emory University*

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Challenges to Identifying Depression in Men and Women Who Are Parents

MANY CHILDREN ARE EXPOSED TO DEPRESSION in their mothers and fathers. Between 6% and 17% of women experience a major depressive episode,¹ and rates of subsyndromal depression are even higher.² Rates in men are considerably lower but still substantial. Further, owing to depression being a highly recurrent disorder,³ many children are exposed multiple times.

Well-documented outcomes in children include not only elevated rates and earlier onset of depression but also children's other disorders and problems in affective, cognitive, interpersonal, neuroendocrine, and brain functioning.⁴ Although depression in both mothers and fathers has been shown to affect children's psychological functioning, problems are more strongly associated with depression in mothers relative to depression in fathers.⁵

See also page 1038

One of the greatest challenges to studies of depression in parents and its effects on children is that sources of information on depression in adults (parents) and in children are generally disconnected. Few are able to generate data on rates of depression in adults who are parents given that parental status is rarely recorded in

adult treatment settings and certainly not in the detail required to describe children's full spectrum of exposure (eg, first exposure, onsets, offsets, recurrences) during their childhoods. This problem was strongly noted as an impediment to progress in this area of study by a report issued by the National Research Council and Institute of Medicine.⁶

The article by Davé et al in this month's *Archives* made good use of data available in primary care databases to explore ways of identifying depression in men and women who are parents of children aged up to 12 years, and then determining incidence rates for parents' depression and sociodemographic correlates. In these ways, they addressed this important need. The methods were generally very strong. The authors were able to use unique family identification numbers, followed with checks to make sure that birth dates and delivery dates matched. Identification of fathers was a bit more tenuous but the researchers took all of the reasonable precautions to increase the likelihood that the identified man was the father. The approach to identifying depression in the parents was conservative and well justified, although readers may want more information on criteria used to assign a diagnosis of unipolar depression (routine screens relative to self-identification). The identification of subsequent episodes of depression relied on records that failed to show an entry for depression or antidepressants, which likely

could occur for multiple reasons other than there being no depression (eg, the topic did not come up during the physician visit). Finally, the deprivation index was tied to the community in which families resided and may not accurately reflect the individual household.

Major strengths of this work are the knowledge generated on children's exposure to depression in their parents. These findings reflect depression's qualities of being recurrent as well as the commonality of a spouse/partner also being depressed.⁸ The study stands in sharp contrast to many studies of children of depressed parents, which relied on a single measure of depression, capturing depression symptom levels only at that time. The work also responds to the call for a more developmentally sensitive approach to describing children's exposure to parents' depression⁶ by detailing children's first exposures. The authors also appreciated that adult depression's onset may precede the birth of the child.⁹ Given concerns about prenatal depression, an important next step in this line of research will be to capture children's true first exposure (during fetal development) rather than merging all depression prior to the birth of the child.

Of most importance in considering this work is the promise it holds for future findings in that the authors indicate that data will be available for children aged up to 12 years. For the article in this month's *Archives*, only 5% of the sample had data to 12 years of age. Ultimately, the authors will be able to fulfill their promise of presenting "the first ever study assessing the incidence of depression in both parents recorded in general practice across the course of their offspring's childhood."⁷

Given the preliminary nature of the data, the numbers may dramatically underrepresent children's potential exposures and overly represent early (postpartum) exposures given that most of the sample had not yet had the opportunity to provide data for the child's first 12 years of life. For example, the finding that 77% of mothers had only 1 episode of depression in children's first 12 years of life must be considered in light of 83% of mothers having had data only through children's first year of life. Thus, readers might greatly anticipate the findings from the completed study once the youngest children in the cohort attain 12 years of age. Also important will be to pursue the potential influence on the data of a noted cohort effect (the incidence was found to increase over the years of study). The authors are likely correct in suggesting that the change reflects an increasing trend toward prescribing antidepressants. Along with incidence data, the interesting findings from the multivariate analyses

require the same caution in interpreting the findings beyond the first-year data.

In all, by innovatively linking data on depression in adults with data on children, Davé et al took important steps toward addressing the need for knowledge on the rates of depression in adults who are parents of young children and on factors that increase or decrease those rates. Readers will obtain valuable knowledge from these early findings and look forward to the findings from the completed study. Even these early findings have important implications for policy and practice. In particular, the findings underscore the need to determine the parenthood status of adults being screened or treated for depression and reducing obstacles toward coordinated care that takes a developmentally sensitive approach to assessing and addressing the needs of the children.

Sherryl H. Goodman, PhD

Author Affiliation: Department of Psychology, Emory University, Atlanta, Georgia.

Correspondence: Dr Goodman, Department of Psychology, Emory University, 36 Eagle Row, Atlanta, GA 30322 (psysg@emory.edu).

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Correction

Error in Figure. In the article titled "Shortened Night-time Sleep Duration in Early Life and Subsequent Childhood Obesity" by Bell and Zimmerman, published in the September issue of the *Archives* (2010;164[9]:840-845), an error occurred in Figure 2 on page 843. The solid line should have indicated 1997 nighttime sleep, and the dashed line should have indicated 2002 nighttime sleep.