Supporting Children and Strengthening the Family when the Parent is Depressed:

A Three-Tiered Approach

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Abstract

Children of parents with depression are at increased risk for behavior problems, academic difficulties, and psychopathology as compared to children of non-depressed parents. A review of the literature gives support to various school-based programs that support children of parents with depression, including mental health awareness, mindfulness-based curriculum, social and emotional learning, peer support groups, positive youth development, individual and family counseling, and parent psychoeducation. These supports are divided into three tiers utilizing the Public Health Model of prevention and intervention, and aim to provide children of parents with depression with a positive and stable learning environment that allows them to cope with challenges and stressors. In addition, emphasis is placed on strengthening family functioning and parent-child interactions for families affected by parental depression. Lastly, focus is placed on the role of the school psychologist in creating a school climate that promotes mental health literacy and reduces stigmatizing attitudes toward mental illness.

Keywords: parental depression, mental health literacy, stigmatization, Public Health Model, school-based intervention

Supporting Children of Depressed Parents within the Public Health Model

Parental depression not only strains the resources of the family unit, it is also a significant risk factor for emotional and behavioral problems among children and adolescents (Beardslee, Versage, & Gladstone, 1998). According to a National Comorbidity Survey, almost one-third of men and women in the United States fit criteria for having clinical depression within the past 12 months (Nicholson, Biebel, Hinden, Henry, & Stier, 2001). Furthermore, half of these men and two thirds of these women were parents, and one in five children in the U.S. live in households with a parent who has major depression (National Research Council and Institute of Medicine, 2009). Research suggests rates of depressive symptoms in children of depressed parents far exceed base rates in the population (i.e., children whose parents are not depressed; Hammen, 2000). In addition, these children are at increased risk for other internalizing disorders and externalizing problems, including anxiety, depression, conduct disorder, and eating disorders (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003). This increased risk can be accounted for by both genetic and environmental factors. Research indicates that around 37 percent of the risk for developing a depressive disorder is genetic (Sullivan et al. 2000), and first degree relatives of a person with depression have a two to three times greater chance of developing depression than the general population (Levinson, 2006).

In addition to genetic factors, parental depression can negatively impact the child's primary environment, which has several implications for the child's development (Riley et al., 2008). Children are often dependent on parents for their care and support of their healthy

development. However, depression can be disabling for a parent, resulting in the child's reduced sense of security, belonging, and nurturance, which are imperative for children to grow healthfully and competently (Weissman et al., 2006). The negative affect and behaviors of the depressed parent may contribute to a chronically stressful environment for children of these parents, which has been associated with negative psychological consequences (Hammen, Brennan, & Shih, 2004). Research utilizing direct observations of parent–child interactions has depicted notable differences in interactive communication styles between depressed parents and their children as compared to non-depressed parents and their children (Champion et al., 2009). Depressed parents are more likely to display negative parental behaviors (e.g., more critical and disengaged, less nurturing) as compared to control parents who do not have a history of depression (Lovejoy, Graczyk, O'Hare, & Neuman, 2000). The two particular patterns of behavior that appear to be the most prominent risk factors associated with internalizing and externalizing symptoms in children of parents with depression are parental withdrawal (e.g., spending time alone in room, crying frequently, and emotionally nonresponsive to children) and parental intrusiveness (e.g., irritability, moodiness, and worrying; Cummings & Davies, 1994).

Protective Factors

Given the various negative implications associated with parental depression and children's psychological distress, recent research in this area has shifted from focusing exclusively on pathology to understanding factors that allow these children to cope effectively. It is essential that children of parents with depression find other sources of support to compensate for the possible lack of stability and warmth in their home environment. Research suggests there are three primary protective factors for children of parents with depression: (a) open dialogue

regarding depression; (b) participation in meaningful activities; (c) close relationships with other capable adults (Beardslee, 2002). In regard to open dialogue about depression, it is important for children to understand depression is a treatable disorder that impacts their parent's ability to be attentive and caring. The more a child understands that depression is common and treatable, the less they view it as a frightening, stigmatizing condition (Diamond & Josephson, 2005). A clinical study by Beardslee (2002) indicated that outcomes for children of parents suffering from depression significantly improved when the parent or another trusted adult identified and explained the mental illness to the child, as well as the effect it had on the parent's well-being. Furthermore, participants' self-reports described some positive aspects of having a parent with depression, such as personal strength, discipline, self-sufficiency, tolerance, and empathy (Marsh & Dickens, 1997).

Another protective factor for this population is participation in meaningful activities outside the home environment, which can act as a source of support to counteract the lack of stability in the home environment. In a clinical study of well-functioning young adults whose parents suffered from diagnosable depression, Beardslee (2002) found that nearly all participants engaged in meaningful activities, with school-based activities ranking highest. These meaningful activities allow the individual to engage with the environment in ways that promote learning and adaptation, resulting in feelings of satisfaction associated with perceived accomplishment. This mastery motivation is crucial for children of parents with depression, as it allows them a sense of agency and control over their life, regardless of the lack of stability in their home environment (Masten, 2014). According to Bandura (1997), self-efficacy and a sense of agency are constructed through interactions with the environment. Therefore, even if a child is exposed to a

negative home environment due to parental depression, their engagement in meaningful activities can act as a protective factor by providing them with a sense of security and mastery over their environment (Masten, 2014).

In addition to mental health awareness and meaningful activities, a strong support system or a close relationship with another capable adult are key protective factors for children of parents with depression. In a clinical study by Nasser and Overholser (2005), individuals of parents with depression named, on average, about six people they could count on for some sort of social support in childhood, with grandparents, peers, and school personnel receiving the highest social support ratings. Several other studies have further supported the idea that relationships with other capable adults can serve to buffer the impact of the parent's depression, as these relationships provide the child with an alternative caretaker or support system they can trust and rely on (Solomon & Draine, 1995). This supplemental support mediates family stressors and strengthens the child's sense of ability to cope with stressful situations (Sandler, Tein, Mehta, Wolchik & Ayers, 2000).

Support for Children of Parents with Depression using Three-Tier Model

Research suggests that the child's school environment is the primary avenue to promote the aforementioned protective factors for children who have a parent with depression (Sandler, Tein, Mehta, Wolchik & Ayers, 2000). Although parental depression cannot be prevented, a growing body of literature has begun addressing the effectiveness of school-based mental health awareness and intervention programs to support both the child and the family unit as a whole when the parent is depressed (Salerno, 2016). Furthermore, a three-tiered Public Health Model can be utilized to both address and ameliorate the risk factors associated with parental depression

(Atkins, Hoagwood, Kutash & Seidman, 2010). The Public Health Model is typically displayed as a pyramid with three tiers of service. This three-tiered model is designed to provide the appropriate amount of support, based on the differing levels of need at each tier. Therefore, students can be treated through the least intensive level of intervention possible that appropriately meets their needs (Vaughn and Wanzek, 2007). At the bottom are universal, whole school strategies for promoting positive mental health in all students, including those who do not have a parent with depression. This level emphasizes promotion and prevention through approaches that focus on mental health literacy, social and emotional learning, and mindfulness-based relaxation techniques. For those students who have a parent diagnosed with depression, tier two offers targeted interventions focusing on small support groups and embedded strategies (e.g., peer-support groups, positive youth development, and adaptive coping strategies). Lastly, the third tier offers more intensive, individualized interventions for students exposed to parental depression who are experiencing internalizing or externalizing symptoms. At this level, school personnel collaborate with mental health providers and families to provide a coordinated system of support for both the child and the depressed parent. This paper will examine a comprehensive approach to the compensatory properties of school-based intervention for children of parents with depression using the three-tiered Public Health Model.

Methods

Research was collected utilizing the ERIC-EBSCO database through the Chapman University Library website. The keywords used in the search were “parental depression,” “protective factors,” “mental health awareness,” “school-based mental health,” and “three-tiered public health model.” For the purposes of this paper, several pilot studies examining the effectiveness of

school-based mental health interventions were included. Although there is a vast amount of research on parental depression and the associated risk factors for these children, research in the field of school psychology focusing exclusively on the promotion of protective factors for this population in the context of a three-tiered Public Health Model is more recent and narrow in scope. Therefore, due to the novelty of this topic, this paper relies heavily on current research proposals and suggestions. Additional research articles were retrieved utilizing references from previously cited articles, and supplementary books were referenced to provide knowledge from professionals in the school setting.

Tier 1: Primary/Universal Prevention and Intervention

Primary, or universal, interventions are intended to provide students with a safe, supportive, and caring school environment. This first tier of the Public Health Model aims to reach approximately 80 percent of all students (Tilly, 2013). Therefore, these primary prevention programs emphasize mental health promotion for all students, not just those who are exposed to parental depression in their home environment. When students are exposed to a supportive and caring school climate, they are less likely to engage in problem behaviors and more likely to develop positive attitudes toward themselves and others (Schaps, Battistich, & Solomon 1997). This can be especially crucial for children who are not receiving the appropriate amount of support and nurturance in their home environment.

Mental Health Awareness

Mental health is a crucial public health issue in the United States (Murray, Atkinson, & Bhalla, 2010). Furthermore, childhood and adolescence are opportune times to intervene, as many mental health issues, such as depression and anxiety, have an onset before the age of 20

(Kessler, Berglund, & Demler, 2005). In regard to children of parents with depression, stigma and mental health literacy play an important role in the trajectories of these children (Corrigan, 2004). In a clinical study of children, aged 12 to 16, who have a parent suffering from depression, Salerno (2016) found that 88 of the 102 participants reported fear of friends, peers, and school teachers/staff discovering that their parent suffered from depression. Furthermore, a majority of the students reported moderate to high levels of mental illness stigma and low levels of mental health literacy as primary factors contributing to their fear. This highlights the importance of mental health education in schools to promote a more comprehensive and accurate understanding of mental health among students. Current research proposals suggest that mental health education should be incorporated into the standard health curriculum along with physical health education (Durlak, 2015). Further, it is argued that if the same importance that is placed on physical health education in schools were placed on mental health education, the stigma surrounding mental health would be significantly reduced (Salerno, 2016). Moreover, for school-aged children, many of the poor outcomes associated with parental depression can be prevented by universal interventions introduced early in life (Tsao, Tummala, & Roberts, 2008; T. Moses, 2010; J.P. Salerno, 2016). Considering children spend a majority of their day at school, this is an obvious setting to implement these universal mental health awareness interventions (Srikala & Kishore, 2013).

Before examining specific tier one interventions, it is important to assess the effectiveness of these programs. A systematic review of empirical literature pertaining to the improvement of mental health related outcomes (Salerno, 2016) synthesized 15 studies published within the past 20 years in the U.S. The programs reviewed examined the effectiveness of

universal mental health awareness interventions in K-12 school settings, focusing on such topics as improving mental health knowledge, improving attitudes toward mental illness, and increasing help-seeking behaviors. The content of the programs included primarily instructor-led mental health education curriculums, and presentations or videos implemented in the classroom.

All 15 studies found significant improvement in mental health knowledge at completion of the programs. Mental health knowledge was conceptualized by knowledge of depression, depression risk factors, mental health myths and facts, and mental health literacy (Salerno, 2016). In addition, attitudes toward mental health (i.e., attitudes toward depression, opinions about mental health, desire to hear more about mental health issues, attitudes toward psychologists, mental illness stigma) significantly improved in nine of the eleven studies. Lastly, and perhaps the most important for students who have a parent with depression, help-seeking behaviors were assessed (i.e., likelihood to seek help, attitudes toward seeking psychological help, help-seeking knowledge), with five of the seven studies demonstrating significant improvement in help-seeking behaviors. Specifically, in one study examining the effectiveness of an eight-week mental health awareness program, there was a significant increase in the percentage of students who reported that they would feel comfortable talking to a teacher or a counselor about mental health concerns after completion of the program (from 37% at pretest to 77% at posttest); there was no significant increase for the control group of students who did not partake in the program (Tacker & Dobie, 2015). Furthermore, they found that school-based mental health awareness programs reduced stigmatizing attitudes in 87 percent of participants (Tacker & Dobie, 2015). These results have critical implications for students who have a parent with depression. As previously mentioned, open dialogue about depression and relationships

with other capable adults are primary protective factors for this population (Beardslee, 2002). Therefore, the results suggest that school-based mental health awareness programs can promote these protective factors by granting these children the opportunity to talk with trusted adults about their mental health concerns (Calear, Christensen, Mackinnon, & Griffiths, 2013).

Meditation and Mindfulness

Providing students with a positive, safe, and supportive school climate ameliorates problem behaviors and promotes prosocial behaviors (Schaps, Battistich, & Solomon 1997). Furthermore, mindfulness-based instruction has emerged in the field of school psychology as an effective universal intervention program for mental health (Dooris, 2006). Several studies with middle and high school students have found significantly reduced levels of anxiety and improved concentration when students were encouraged to practice mindfulness skills on a regular basis (Hassed, 2004; Hooker & Fodor, 2008; Paul, Elam, & Verhulst, 2007). Furthermore, a study involving elementary students found that a mindfulness-based well-being program was associated with improvements on all measured elements of psychological and physical well-being, including stress, anxiety, and depression (Hassed, de Lisle, Sullivan, & Pier, 2009). It is asserted that mindfulness meditation programs are emotionally, socially, and academically beneficial for children when implemented in the school setting (Hooker & Fodor, 2008). Specifically, in regard to children who have a parent with depression, mindfulness-based instruction in the schools can serve to ameliorate the negative psychological consequences associated with a chronically stressful home environment (Hammen, Brennan, & Shih, 2004).

In one pilot study of 178 students, ages 10 to 13 in grades five and six, a self-awareness and relaxation program was incorporated as a component of the standard health curriculum

(Spence & Shortt, 2007). The program consisted of ten 45-minute lessons, including an introduction to relaxation and meditation, body and breath awareness, exploration of the stress response, observation of thought, and stillness meditation. Each session allowed for group discussion and examination of themes, combined with an inner-awareness practice. The results of the students' self-completion surveys at the end of the program indicated significant improvements in emotional health (i.e., decreased anxiety and depression levels), especially for students who had reported struggling with depressive symptoms prior to beginning the program. In addition, students reported increased confidence in their ability to deal with stressful situations, as well as higher levels of self-awareness (Spence & Shortt, 2007). This could prove especially beneficial for students who have parents with depression, and are in turn exposed to more stressors in their home environment. Although the child cannot control the impact of the parent's negative affect on family functioning, they can learn to control how they react to stressful situations by developing adaptive coping mechanisms (Bishop, 2002). This increased confidence in their ability to cope in a stressful environment could give them a sense of control, thus reducing the risk factors associated with living in a household with a depressed parent (Hammen, Brennan, & Shih, 2004).

In regard to implementation, it is important to note that all twelve teachers who participated in the aforementioned study reported that the program was easy to implement, and that they would continue utilizing it as part of their curriculum (Spence & Shortt, 2007). This has positive implications for educators, as it suggests that meditation practices are not only effective in reducing anxiety and depression levels among students, but they can also be easily learnt and implemented. In a six-month follow up with the teachers, all except one reported that they had

continued to observe the benefits of the program, which included students' ability to use breathing strategies regularly and an increased willingness to take on new ideas (Spence & Shortt, 2007).

Social and Emotional Learning

Social and emotional learning (SEL) is a framework used to guide the process of helping children recognize and manage emotions, regulate behavior based on thoughtful decision making, and acquire key social skills for developing healthy relationships (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). For children of parents with depression, perhaps the most noteworthy aspect of SEL programs is that they help children think about how feelings influence behavior (Elias, 1997). A primary protective factor for children of parents with depression is their ability to view depression as a treatable disorder that impacts their parent's ability to be attentive and caring (Wyman, Sandler, Wolchik & Nelson, 2000). The more a child understands that depression is common and treatable, the less they view it as a frightening, stigmatizing condition (Diamond & Josephson, 2005).

In a recent evidence-based review, there was strong support for the use of social emotional learning programs at the universal level to enhance social emotional functioning and reduce problem behaviors among students (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). Currently, all 50 states have adopted preschool SEL standards, and many states have integrated SEL into their academic standards through the elementary, middle, and high school levels (Zinsser, Weissberg, & Dusenbury, 2013). The five core SEL skills include self-awareness, self-management, social awareness, relationship skills, and responsible decision-making (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). One of the most prominent SEL curriculums

being implemented in K-12 schools is the PATHS Program (Promoting Alternative Thinking Strategies). Several clinical studies examining the academic and behavioral outcomes of this program suggest significant improvement in students' ability to tolerate frustration, increased academic engagement, and reduced behavior problems (Durlak, Domitrovich, Weissberg, & Gullotta, 2015). Therefore, it is suggested that SEL programs in schools can serve as effective primary prevention programs by developing skills that promote positive mental health at an early age (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011).

Role of the School Psychologist at the Primary Level

School psychologists play in integral role in promoting the mental health of all students. Within this role, it is recommended that campus-wide mental health assessments are administered to identify students that will benefit from more targeted interventions. As research suggests, children of parents with depression may not willingly seek help, in part due to the stigma associated with mental health problems (Salerno, 2016). Stigma is a significant barrier to seeking mental health services in schools, especially in the middle and high school years (Doll & Cummings, 2008). Therefore, school psychologists should collaborate with teachers and school personnel to combat this stigma by embedding mental health awareness into the school-wide curriculum. School psychologists can further promote this by providing psychoeducation on the importance of mental health literacy, promotion of positive mental health, and awareness of warning signs. Due to the current lack of education on mental health in many schools, it is imperative that school psychologists take a leadership role in reducing stigmatizing attitudes toward mental health and improving mental health related outcomes among students.

Tier II: Targeted Intervention

Secondary interventions target those students who are exposed to parental depression in their home environment, and are therefore at greater risk for displaying internalizing or externalizing behaviors. Unlike the universal mental health awareness programs that are implemented school-wide to all students, secondary interventions are exclusively intended to promote protective factors for children of parents with depression. At this tier, interventions are designed to compensate for the possible lack of stability and nurturance in the child's home environment by providing them with a supportive school climate that offers opportunities for personal development, healthy relationships, and adaptive coping strategies.

Peer-support Programs

There have been several pilot studies involving peer-support groups targeting children ages 10-18 that have a parent with depression (Reupert et al., 2012). The 12 peer-support groups that were examined were offered as after-school programs, and aimed to develop peer relationships and strenghten adaptive coping skills by adopting a group, strengths-based approach (Reupert et al., 2012). One specific program, PATS (Paying Attention to Self), is an early intervention peer-support group for 13-18 year-olds who have a parent with depression (Hargreaves, O'Brien, & Bond, 2008). This program is facilitated by a peer leader who is also the child of a parent with depression, thereby providing opportunities for the development of leadership skills. It is an eight-week program for two hours each week, consisting of four to eight adolescents, a peer leader, and a health professional. Results of the program indicate significant reduction in depressive symptoms and experience of stigma, as well as increased social support and problem solving skills (Hargreaves, O'Brien, & Bond, 2008).

In addition to peer support groups, several mentoring programs have emerged that provide children of parents with depression with support in the form of "Big Brothers/Big Sisters" (Orel, Groves, & Shannon, 2003; 2010). One program that has been implemented throughout K-12 schools in the U.S. is called Positive Connections, which targets 13-18 year-olds who have a parent with depression and who also report experiencing depressive symptoms (Clarke, Hombrooke, & Lynch, 2005). This program matches the children, or mentees, with a volunteer mentor based on compatibility surveys that are filled out by both parties prior to beginning the program. Results indicated significant improvements in self-esteem and perceived social support among the mentees, and diminished use of maladaptive coping strategies (Dierks, 2008). It is known that, for children of parents with depression, social support can serve to buffer the negative impacts of the parent's depression (Nasser & Overholser, 2005). Therefore, it is crucial that schools continue to implement peer support groups that strengthen these children's perceived sense of support and ability to cope with family discord.

Positive Youth Development

Two of the most prominent sources of risk associated with internalizing and externalizing symptoms in children of parents with depression are parental withdrawal and parental disengagement (Cummings & Davies, 1994). Consequently, these children may not have the same opportunities as children of non-depressed parents to participate in out-of-school activities due to a lack of resources (Provenzano, 2014). Considering participation in meaningful activities, specifically school-based activities, is one of the primary protective factors for children of parents with depression, it is imperative for interventions at the secondary level to

provide this population with appropriate resources that encourage equal opportunity to participate in activities (Beardslee, 2002). Positive Youth Development (PYD) reflects the implementation of programs that promote participation in structured leisure activities (e.g. sports, arts, and organized clubs) for children of parents with depression by compensating for their possible lack of resources (Provenzano, 2014). The two most prominent resources provided by these programs are transportation and meal services. Transportation is one of the biggest challenges for children of parents with depression (Lovejoy, 2000). Therefore, these programs utilize volunteers from community agencies and community buses to meet the transportation needs of the students. In addition, meals are provided at all PYD activities, as well as free lunches on school days. The purpose of these PYD resources is to compensate for the impact depression can have on a parent's ability to perform certain daily functions and parental responsibilities (Provenzano, 2014).

Research examining the effectiveness of these PYD programs has indicated positive outcomes for students of parents with depression, such as improved academic achievement and personal/interpersonal development (Provenzano, 2014). Namely, there was a positive association with identity and skill development, as well as social skills and quality of friendships (Larson, 2010). Seligman (2012) argues that PYD programs are imperative for children of parents with depression because of their emphasis on the development of initiative. Providing this population with opportunities to engage with the environment in ways that promote learning and adaptation results in feelings of satisfaction associated with perceived accomplishment (Seligman, 2012). This is especially crucial for children of parents with depression, as it allows

them a sense of agency and control over their life, regardless of the lack of stability in their home environment (Beardslee, 2010).

Bibliotherapy

Bibliotherapy presents children with literature involving characters that are in similar positions to themselves. This enables children to normalize their situation, gain insight into the problem-solving techniques of the characters, and apply this new insight to their own lives (Tussing & Valentine, 2000). Anecdotal research suggests that employing bibliotherapy with children of parents with depression offers significant benefits, including increased empathy and reduced levels of anxiety (Anderson, 2015). One pilot study examined the effects of bibliotherapy when incorporated into an after school support group for children of parents with depression (Marrs, 2011). Results suggested that the inclusion of the books, in conjunction with discussions about the material with a mental health professional, increased student participation in the therapeutic process and improved the students' overall ability to discern and interpret emotion in others (Anderson, 2015).

Although further research is required to yield more details on the efficacy and benefits of bibliotherapy for children of parents with depression, it is currently gaining popularity among mental health professionals for its versatility and success with young children and adolescents (Anderson, 2015). Bibliotherapy is particularly relevant for children of parents with depression when considering its ability to normalize the child's situation by using imaginative literature to explain the impact depression has on their parent's ability to be attentive and caring in an age-appropriate way (Reupert et al., 2012). In turn, the goal is for the child to view depression as

something that is common and treatable, rather than frightening and stigmatizing (Diamond & Josephson, 2005).

Role of the School Psychologist at the Secondary Level

As demonstrated by the three-tiered model, students have varying levels of need for mental health support in the school setting. Primary mental health promotion may not be sufficient for those students who are more vulnerable to developing mental health problems due to the presence of risk factors in their life, such as a parent with depression (NASP, 2016). Thus, it is important for school psychologists to be aware of the effects parental depression can have on a child's social, personal, and academic performance. In addition, school psychologists can create open lines of communication with the parents of these children by offering them support and resources as well. Specifically, the National Association for School Psychologists offers several up-to-date handouts on mental health promotion and support that provide parents with proven, solution-based strategies and resources (NASP, 2016).

Tier III: Intensive Interventions

At the top tier of the Public Health Model are intensive interventions provided for children of parents with depression who are experiencing mental health challenges that limit their participation and functioning throughout their day (Tilly, 2013). In addition to diminishing internalizing and externalizing symptoms for these children, it is also critical to focus on optimizing positive mental health and enhancing familial communication. Therefore, this level focuses on both individual and family therapy for the intervention and treatment of children of parents with depression who are also suffering from mood disorders. Furthermore, it is imperative that school personnel have resources and connections to professionals with a

background in mental health to make outside referrals for students and families whose level of needs are outside the scope of school-based interventions.

Individual Counseling

It is known that children of parents of depression are at significantly greater risk for experiencing mental health challenges than children of non-depressed parents (Avenevoli & Merikangas, 2006). Furthermore, depression is one of the most common yet under identified mental health problems among children and adolescents (Huberty, 2010). School personnel have the ability to identify and intervene with children who are displaying depressive symptoms and provide them with appropriate counseling services in the school setting. For this population, it is important to remember that these children are often times seeking guidance and support from caring adults (NASP, 2010). However, they may not know how to go about seeking help, and their depressive symptoms could be exhibited as behavior problems associated with academic or social difficulties, such as apathy, low performance, or uncooperativeness (Huberty, 2010).

Therefore, it is important to develop a working and collaborative relationship with the student by providing them with nurturance and support. It is also important to recognize that these students may require adjustments or accommodations on tasks due to a lack of personal resources that inhibits their ability to do their best work (NASP, 2010). This approach does not mean that expectations of the student are lowered; however, breaking assignments into smaller pieces, offering extra help in setting up schedules or study habits, and pairing the student with peers who express an interest in helping are examples of effective strategies (NASP, 2010). Such accommodations are often provided for students with learning disabilities, and students with depression are entitled to the same considerations (Huberty, 2006). Furthermore, for students

whose depression seriously limits their ability to benefit from schooling, they are eligible for state and federal services under protection as a student with a disability, including classroom accommodations, an Individualized Education Program (IEP), or Section 504 plan (Huberty, 2008; NASP, 2010).

Parent Support and Education

It is suggested that outcomes for children of parents with depression significantly improve when parents identify and explain their mental disorder to the child, as well as its effects on their well-being (Beardslee, 2002). Therefore, the goal of parent education groups is to reduce the negative impact of depression on parenting behaviors. In a pilot study of a parent-education groups for families affected by depression, 44 parents with a child, age 6 to 13, were recruited who had a clinical diagnosis of major depressive disorder in the previous 12 months (Sanford et al., 2003). Parents were randomly assigned to an experimental parent group or a wait-list control group. The eight-week program consisted of two-hour sessions each week, in which parents were able to discuss their experiences with depression, watch videos of difficult parenting situations, learn about depressive symptoms, and receive weekly homework assignments. In the evaluation, the experimental group parents reported a significant improvement in family functioning. Additionally, experimental group children showed significant increases in school functioning, and significant impacts were found for measures of family conflict, children's participation in out-of-school activities, and child depressive symptoms (Sanford et al., 2003). The ability of these parent education and support programs has positive implications for families affected by depression. Resilience in children of parents with depression is promoted when they have a supportive and responsive parent, which is demonstrated through expressions of warmth and

caring (Wyman et al., 2000). Thus, if parents with depression are given tools that reduce the negative impacts depression has on their parenting behaviors, interactive communication between the parent and the child can significantly improve (Beardslee, 2002).

Family-Focused Therapy

One of the primary protective factors for an individual struggling with depression is a strong support system (Nasser & Overholser, 2005). For a family in which the parent's depression has affected the psychological well being of the child, it is crucial to provide the entire family unit with tools for re-establishing healthy communication and problem-solving (Beardslee, 2002). As mentioned in the previous section, resilience is promoted in children of parents with depression when they are exposed to supportive and responsive parenting (Wyman et al., 2000). Therefore, family-focused therapy aims to reduce the negative impacts of depression on parenting behaviors, and promote positive family functioning (Riley et al., 2008).

One clinical research group has developed an evidence-based preventative intervention program known as Keeping Families Strong (KFS). This program is based on the idea that, just as an individual can recover from depression, families can also recover from the effects of depression by building understanding and interpersonal supports (Riley et al., 2008). The approach used in this program is to promote understanding of depression, and enhance effective family communication and children's coping skills. Based on a preliminary trial consisting of 15 children who completed the KFS program, self-reports of internalizing symptoms indicated that 60% of children who were in the at-risk range at pretest were no longer in the at-risk range post intervention. Furthermore, they reported a significant improvement in their sense of efficacy for coping with stressful situations and large improvements in family togetherness (Riley et al.,

2008). These results indicate the potential for family intervention programs to improve the well-being of children and parents affected by depression by strengthening family communication and parent-child interactions.

Role of the School Psychologist at the Tertiary Level

At this level, the school psychologist can act as the liaison between the child, the family, and community mental health resources. For school-based support, they can organize and promote after school parent support/education groups. In addition, they are responsible for identifying risk factors associated with parental depression so that they can employ early intervention strategies when children of depressed parents are exhibiting internalizing or externalizing behaviors. In regard to collaboration with outside resources, school psychologists should be knowledgeable about cost-effective family-focused therapy options that are available in the community so they can make the appropriate referrals when school-based interventions are insufficient. Lastly, and arguably most importantly, school psychologists can provide students with a strong adult role model, which can be especially crucial for children of parents with depression. By engaging in positive interactions with these children on a regular basis and providing them with a supportive, caring adult figure, school psychologists have the power to compensate for the negative impact parental depression can have on the child's development.

Conclusions and Implications for Practice and Further Research

Based on current research, the three-tiered Public Health Model appears to be effective in addressing the needs of children of parents with depression on all three tiers. Tier I interventions aim to provide students with a supportive school environment that fosters mental health awareness, leading to more positive mental health outcomes among students and reduced mental

health stigmatization in schools. Tier II offers more targeted interventions for children of parents with depression who require more specialized programs, such as peer support groups, positive youth development, and bibliotherapy. Finally, Tier III offers the most intensive avenues of support that aim to diminish the mental health challenges faced by children of parents with depression, as well as strengthen family functioning for families affected by depression. Although many of the interventions at this final tier may be outside the scope of school-based interventions, school personnel continue to play an important role in providing these families with resources and support.

As previously mentioned, addressing the needs of children of parents with depression in the context of a three-tiered Public Health Model is a novel topic, resulting in more limited school-based research. However, there are a sufficient amount of pilot studies and research proposals that have been implemented in school settings (Salerno, 2016). Results of these studies suggest strong evidence for the implementation of school-based mental health interventions to support children of parents with depression. Furthermore, considering the school environment is the primary avenue to promote protective factors for this population, future research should utilize current research proposals as building blocks in the development and implementation of mental health interventions at all three tiers of the Public Health Model.

The research examined throughout this paper suggests the importance of a child's school environment in the promotion of healthy development. Specifically, for children of parents with depression, providing this population with a safe, supportive, and stable environment in which they can develop healthy relationships, positive self-esteem, and emotional awareness is crucial in counteracting the risk factors associated with their parent's depressive behaviors. Overall,

school psychologists have the opportunity to be leaders in the fight against mental health stigma in schools, thus fostering a school climate that promotes positive mental health outcomes for all students.

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