INLAND EMPIRE CHAPTER OF CAMFT NEWS

(California Association of Marriage and Family Therapists) MAY 2006

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UPCOMING TRAINING

Topic:

Temperament Theory
(Which Type Are You?)
And Its Therapeutic Applications

Date/Time:

May 26, 2006 / 8:15AM

Location:

Loma Linda University Family Therapy Clinic
164 West Hospitality Lane, Suite 15
San Bernardino, California 92408
Phone: (909) 558-4934, Fax: (909) 558-0334

Presenter's Background:

Jan Hackleman is the founder and director of the Family Connection, a for-profit counseling center that focuses on self-management and parent-child relationships of all ages. She is a registered nurse, earned a Master of Science degree in Marriage, Family and Child Counseling from Loma Linda University and is a licensed Marriage and Family Therapist (License # MFC16132). Her work has been significantly influenced by post graduate studies at UCLA's Neuropsychiatry Institute under William Hans Miller, Ph.D., founder and then director of the Institute's Parent Training Clinic. In 1982, Jan founded and directed for six years a non-profit clinic specializing in parenting for high risk, special-needs and abused children. She developed one of the most comprehensive self-management and parenting intervention program for high-risk, and abusive parents offered in Southern California; and was named "*Alumnus of the Year*" in 1999 by Loma Linda University School of Nursing for her innovative contributions in those areas.

Jan is certified in EMDR (Eye Movement Desensitization Reprocessing), an innovative therapy that has demonstrated exceptional effectiveness for repairing the after effects of trauma in children and adults. For more than twenty years Jan has provided the community with individual, couple and family therapy and a variety of parenting skills groups: parenting teens, self management and the basics of parenting. She frequently conducts seminars for schools, churches, business professional groups. Jan Hackleman has been married almost 30 years to her writer husband, Doug, and has two daughters: Hillary and Deirdre. She enjoys discussing issues related to spirituality, theology, sociology, psychology, politics and how an integrated understanding of them effects personal growth, parenting, marriage and family relationships and attitudes about the world at large.

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Youth Violence: An Increasing Problem

By: National Center for Injury Prevention and Control

Youth violence is defined as: "The intentional use of physical force or power, threatened or actual, exerted by or against children, adolescents or young adults, ages 10–29, which results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (Mercy et al. 2002).

Violence is widespread in the United States and disproportionately affects youth ages 10–29. The young person can be the victim, perpetrator, bystander, or any combination of these roles. Violence can occur in the context of a dating relationship or among peers (for example, in schools or neighborhoods). Youth violence includes aggressive behaviors such as verbal abuse, bullying, hitting, slapping, or fist fighting. These behaviors have major consequences but do not generally result in serious injury or death. Youth violence also includes serious violent and delinquent acts such as aggravated assault, robbery, rape, and homicide, committed by and against youth.

Youth violence is a dynamic and complex public health problem. However, research in past decades has uncovered much information on the causes of youth violence and strategies for preventing it. This fact sheet addresses interpersonal violence. Other forms of violence that affect youth are suicide, child maltreatment, and dating violence.

Occurrence

Youth violence is an important public health problem that results in deaths and injuries. The following statistics provide an overview of youth violence in the United States.

- In 2003, 5,570 young people ages 10 to 24 were murdered—an average of 15 each day. Of these victims, 82% were killed with firearms (CDC 2006).
- Although high-profile school shootings have increased public concern for student safety, school-associated violent deaths account for less than 1% of homicides among school-aged children and youth (Anderson et al. 2001).
- In 2004, more than 750,000 young people ages 10 to 24 were treated in emergency departments for injuries sustained due to violence (CDC 2006).
- In a nationwide survey of high school students (CDC 2004):
  - 33% reported being in a physical fight one or more times in the 12 months preceding the survey.
  - 17% reported carrying a weapon (e.g., gun, knife, or club) on one or more of the 30 days preceding the survey.
- An estimated 30% of 6th to 10th graders in the United States were involved in bullying as a bully, a target of bullying, or both (Nansel et al. 2001).

Consequences

- Direct and indirect costs of youth violence (e.g., medical, lost productivity, quality of life) exceed $158 billion every year (Children's Safety Network Economics & Data Analysis Resource Center 2000).
- In a nationwide survey of high school students, about 6% reported not going to school on one or more days in the 30 days preceding the survey because they felt unsafe at school or on their way to and from school (CDC 2004).
- In addition to causing injury and death, youth violence affects communities by increasing the cost of health care, reducing productivity, decreasing property values, and disrupting social services (Mercy et al. 2002).

Groups at Risk

- Among 10 to 24 year olds, homicide is the leading cause of death for African Americans, the second leading cause of death for Hispanics, and the third leading cause of death for American Indians, Alaska Natives, and Asian/Pacific Islanders (CDC 2006).
- Of the 5,570 homicides reported in 2003 among 10 to 24 year olds, 86% were males and 14% were females (CDC 2005).
- Male students are more likely to be involved in a physical fight than female students (41% vs. 25%; Center for Disease Control 2004).

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Risk Factors

Research on youth violence has increased our understanding of factors that make some populations more vulnerable to victimization and perpetration. Many risk factors are the same, in part, because of the overlap among victims and perpetrators of violence.

Risk factors increase the likelihood that a young person will become violent. However, risk factors are not direct causes of youth violence; instead, risk factors contribute to youth violence (Mercy et al. 2002; DHHS 2001).

Research associates the following risk factors with perpetration of youth violence (DHHS 2001; Lipsey and Derzon 1998; Resnick et al. 2004):

Individual Risk Factors

- History of violent victimization or involvement
- Attention deficits, hyperactivity, or learning disorders
- History of early aggressive behavior
- Involvement with drugs, alcohol, or tobacco
- Low IQ
- Poor behavioral control
- Deficits in social cognitive or information-processing abilities
- High emotional distress
- History of treatment for emotional problems
- Antisocial beliefs and attitudes
- Exposure to violence and conflict in the family

Family Risk Factors

- Authoritarian childrearing attitudes
- Harsh, lax, or inconsistent disciplinary practices
- Low parental involvement
- Low emotional attachment to parents or caregivers

- Low parental education and income
- Parental substance abuse or criminality
- Poor family functioning
- Poor monitoring and supervision of children

Peer/School Risk Factors

- Association with delinquent peers
- Involvement in gangs
- Social rejection by peers
- Lack of involvement in conventional activities
- Poor academic performance
- Low commitment to school and school failure

Community Risk Factors

- Diminished economic opportunities
- High concentrations of poor residents
- High level of transiency
- High level of family disruption
- Low levels of community participation
- Socially disorganized neighborhoods

References

Anderson MA, Kaufman J, Simon TR, Barrios L, Paulozzi L, Ryan G, et al. School-associated violent deaths in the United States, 1994–1999. Journal of the American Medical Association 2001;286:2695–702.

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2006) [cited 2006 Feb 8]. Available from: URL: www.cdc.gov/ncipc/wisqars.

Centers for Disease Control and Prevention. Youth risk behavior surveillance—United States, 2003. MMWR 2004;53(SS02):1–96.

Obstacles are those frightful things you see when you take your eyes off your goal.

Henry Ford (1863-1947)

"Life is not measured by the number of breaths we take, but by the moments that take our breath away."

Anonymous

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President's Message

Piggy backing on to the theme of the 42nd annual CAMFT conference: "Relax, Re-charge, Re-engage". We ought to practice what we teach, savor the moment, take a vacation, spend time with people who inspire and invigorate you...This theme strikes me as vital to combating burn out and isolation. Our chapter provides monthly meetings as an oasis for members to network, share a light delicious brunch, experience stimulating presenters, earn 2 free CEU's and promote their private practice. What could be better!

The latest news is that our chapter had the honor of co-hosting the 42nd annual CAMFT Conference. Special recognition goes to board members, Wendy Hallum, Patrick Griffiths, Marj Lucas and Pam Hart for hosting our table.

Last and most importantly, our chapter encourages you to support the MFT PAC, which supports advocacy for MFT's at the state level. Details are in this newsletter and I encourage you to peruse the information and take ACTION.

Warm Regards,

Sheri Rambharose, MFT
Chapter President.

COMMITTEE POSITIONS

Membership: Patrick Griffiths
CEU Coordinator: Carolyn Dodd
Hospitality: Open
Networking Lunches/Socials: Wendy Hallum
Newsletter Editor: Edward Siahaan
Program Chair: Sheri Rambharose
Webmaster: Patrick Griffiths

If you are interested in serving on a committee, please contact Sheri, President.

Get involved! It's fun and your input helps the chapter stay strong.

NEWSLETTER ARTICLES

As a reminder, if you have an article you would like to submit to the newsletter, please e-mail it to the newsletter editor by the last day of the month. The newsletter is e-mailed (unless a hard copy has been requested) to all members by the second Friday of every month.

MEMBERSHIP REMINDER

For those who have not yet renewed your annual membership, please be aware that as of June 1, you will no longer receive the newsletter or be eligible for the discounted rate of seeing our wonderful presenters, and the chance of earning CEUs.

Thank you for your kind consideration!

Patrick Griffiths – Membership Coordinator

Advertisement Needs

To place an ad, kindly contact Garry Raley @ garral@sbcglobal.net or @ (951) 640-5899

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INLAND EMPIRE CAMFT MEMBERS...

COME TO THE AIDE OF YOUR PROFESSION. CAMFT needs support to be effective. Please read the following message by CAMFT's executive director, Mary Riemersma. Then send your contribution with the form.

Sheri Ramharose

President, IE-CAMFT

2006 PAC Chapter Contest!

Please read the letter below from Mary Riemersma to understand the importance of PAC contributions. The CAMFT PAC contest begins on February 11, 2006 and will end on December 31, 2006. Two chapters will be announced as winners during the 2007 Chapter Leadership Conference in Ontario, CA on February 3, 2007.

As an incentive to help the Inland Empire chapter be one of the winning chapters, our chapter will hold a drawing at our November 2006 meeting. Every member that contributes any amount to the CAMFT PAC will get his or her name entered in the drawing. There will be three prizes for the November drawing: $25, $50, and $100 gift cards. Please use the form in this newsletter to send in your contribution today!

CAMFT PAC/Federal PAC

CAMFT can't change the system. But CAMFT must be able to work within the political and legislative system as it exists in California and Washington. Political Action is a necessary accompaniment to our legislative program. All things considered, we have been successful with very limited political action funds; but think how much of a difference we could make with greater Political Action Resources. This letter will help you understand the process, how political action impacts legislation, and how it benefits you and your profession.

PAC Stands for Political Action Committee

CAMFT has CAMFT-PAC for state political action and CAMFT Federal PAC for federal political action. These PACs are used to make political contributions to legislators to help them reduce the large campaign debts that they amass. Legislators are dependent upon such contributions to pay off that debt. The PACs are not used for legislative activities. CAMFT resources fully fund CAMFTs involvement in state and federal legislation.

You might ask, "Why can't we just use CAMFTs resources to fund political action?" We do not because we can't it is not lawful. CAMFTs resources, derived largely from your dues, can be used to underwrite legislative programs at both the state and federal level, however, member dues and other Association resources may not be used for political contributions. Each of CAMFTs PACs has its own bylaws and functions as a separate entity. We use a law firm in Sacramento to administer the PACs to make certain that we do everything according to the letter of the law.

PAC Dollars Help To Build Good Relationships With Legislators

PAC contributions opens doors. Our PAC contributions are used to participate in fundraisers where CAMFT and our lobbyist are able to socialize with legislators, their staffs, and others with whom we can build relationships. The lobbyist, who regularly attends these events, makes it clear that he is attending on

our behalf. CAMFT gives its PAC dollars to legislators who are champions for our cause and supporters of the profession.

PAC Contributions Are NOT Used To Buy Votes!
In fact, it is unlawful to tie a contribution to a request for a vote on a bill. Contributions and requests for support are kept separate and are distinct from one another. Other competing professions and organizations build a war chest of PAC funds, and often contribute over $1 million per year in expenditures from their PACs (like the CA Medical Association and the CA Association of Consumer Attorneys).

Obviously, these organizations get attention. We often to go head to head with these organizations in the legislature. CAMFT, on the other hand, collects about $20,000 per year in political action contributions. Think how much of a difference we could make with greater PAC resources.

CAMFT Has Been Successful With Very Limited PAC Funds
Think about it, CAMFT has 27,500 members. If each member gave only $10, a PAC fund of $275,000 would be the result. If this figure were split between the Federal and State PAC, we would have nearly seven times what we currently receive in each fund. The amount given need not be great if everyone gave something. For example, if each member gave only $1 per PAC, we would have a fund greater than we currently collect in any given year.

The Amount Given Does Not Need To Be Huge; But Giving Something Is Important!
Cast the expense in light of a minor luxury forgone like a Starbucks Frappachino for two days. It takes only a couple cups of coffee to equal a worthwhile PAC contribution. The PACs are necessary accompaniments to our legislative program.

CAMFT Can't Change The System
The system is what it is and the only thing we can do is operate within it. To be successful in furthering the interests of marriage and family therapists, we must be one of the players by making political action contributions.

CAMFT-PAC and CAMFT Federal PAC help to ensure that your future and the future of your profession are not only protected, but enhanced. Don't put it off; take the time to send your checks, no matter how large or small, to CAMFT-PAC and CAMFT Federal PAC.

When you submit your PAC contributions, it is necessary for us to have certain information from you. Therefore, we ask that you also take the time to complete the information on the PAC Contribution Form prior to enclosing your contributions. We thank you for understanding the value that political action adds to the process of moving the profession forward.

Sincerely,

Mary Riemersma
Executive Director

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Yes I want to support CAMFT-PAC and/or CAMFT Federal PAC and its efforts to elect legislators responsive to the concerns of marriage and family therapists!

Please accept my voluntary contributions(s):

CAMFT-PAC $_____ CAMFT Federal PAC $_____

Contributions designated to CAMFT-PAC will only be used in connection with State elections and CAMFT Federal PAC with Federal Elections.

Credit Card Number _____ Expiration Date _____

Name _____

Name of CAMFT chapter to which you belong:

_____

CAMFT Member ID# _____ License # _____

If self-employed, check here [ ] and indicate address and city of business.

Address _____ City _____ State ____

Zip _____

Phone _____

Occupation _____ Employer/position held_____

* Above information required by law; please complete this information and submit with your check.
Separate checks must be made payable to **CAMFT-PAC** or **CAMFT Federal PAC**

Contributions or gifts to CAMFT-PAC or CAMFT Federal PAC
are not deductible as charitable contributions.

Please send your form and check to the chapter coordinator, Pam Hart. She will put your name in for the November drawing and forward all forms and checks to CAMFT.

Pam Hart, Inland Empire Chapter of CAMFT

9708 SVL Box
Victorville, CA 92395

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MENTAL HEALTH SERVICES IN CALIFORNIA
WHAT WE HAVE AND WHAT WE NEED

By:

California Non-profit Community Mental Health Agencies

This is a simplified outline of mental healthcare and major gaps in services.

Six levels of care

1. Monthly - high functioning individual with occasional brief needs for attention either someone who does not have a serious mental illness or someone who has "fully recovered" and needs only maintenance and monitoring.

   Generally an entitlement for anyone with any type of insurance and even available for others but seldom sought due to stigma ignorance or misdiagnosis by those in a position to see problem. Very few people with serious mental illness reach this level. More could especially with better early intervention strategies.

2. Weekly - someone without serious mental illness during acute episode or someone with serious mental illness who is generally able to live a normal life but still needs significant mental healthcare.

   Too many people who need more extensive care only get this level. Too few, who have been at higher levels, are we succeeding enough with, to get them to this level.

3. Daily - extensive community mental healthcare.

   Needs are for significantly expanded access and funding and in some areas poor use of available resources.

4. Several hours a day - intensive phase of community mental healthcare.

   This is generally starting phase of adults or children's system of care programs. Need funding for expansion of these type of programs and for conversion of other intensive programs into system of care models and for incentives to demonstrate fuller recovery for more people by getting more people into lower levels of care.

5. 24 hour care short term - brief hospitalization or crisis placement for stabilization.

   Unfortunately this is the place where too many people begin their care and we should be able to reduce utilization of this level by increasing access to other levels and particularly by steps to recognize and treat people before they become so disabled.

6. 24 hour care long term - institutional care for those who can't function in community.

California has and continues to lead the nation by successfully minimizing this level of care except in the criminal justice system where too many people wind up because we didn't intervene soon enough.

California has and continues to lead the nation by successfully minimizing this level of care except in the criminal justice system where too many people wind up because we didn't

THREE-DIMENSIONAL INTEGRATION

A. Vertical integration/coordination/continuum of care (above) - Goals for treatment of people with serious mental illness are to move as many people as possible (#s) as expeditiously as possible (time) and as inexpensively as possible (cost) to lowest possible level of care reflecting maximum normalization of life in terms of educational/work, living situation, and socialization (outcomes).

Expand funding with strong financial incentives tied to quantified outcomes measuring #s served successfully in relation to available resources.

For treatment of people without serious mental illness - Provide care to all who need it (#s) as quickly as possible (time) and as inexpensively as possible (cost) that avoids need for higher levels of care/ disability due to mental illness (outcomes).

Establish information systems to measure success of services in avoiding need for higher levels of care and as necessary provide financial incentives.

B. Horizontal integration/coordination/continuum of care - Mental Healthcare integration/coordination with other service needs especially for children and adults with

multiple life skills and functioning problems.

Expand funding for children's and adults systems of care with strong financial incentives to convert more of existing services to these models and establish and fund models for transition youth and older adults.

C. Integration/coordination/continuum of care over time - Steps to identify problems and get treatment before they are disabling through education of partnership with those (outside the mental health system - such as family members, teachers coworkers, primary care physicians) in a position to see the symptoms and recognize the need for treatment and steps to monitor work/ school performance and other indicators of success after successful discharge from treatment.

Education to eliminate stigma ignorance and misdiagnosis which prevents those who see the problems from seeking treatment and information systems to track success of people after discharge

Related Topic: California M.H.S.A. – Proposition 63

Most People with Major Depression Lack Treatment

Millions of Americans suffer from major depression each year, and most are not getting proper treatment for this debilitating disorder, according to a two-year nationwide study reported in the June 18 *Journal of the American Medical Association.*

The study, led by HMS researchers, found high rates of major depressive episodes (MDE) in all segments of the U.S. population. "This is the first study to assess clinical severity of depression in a community sample," said survey leader **Ronald Kessler,** HMS professor policy. "Critics have suggested that depression overestimated in earlier studies because of many people with mild depression being included even though they really don't need treatment. But we built in a state-of-the-art clinical severity assessment, and we found that the majority of people with MDE are severe cases and only a small minority are mild cases." The average person with MDE in the past year reported an average of 35 days he or she was unable to work or carry out other normal activities because of depressive episodes. "These findings confirm that depression is an enormous societal problem, both in terms of the number of people involved and in terms of clinical severity," Kessler said.

Reporting depression in the past 12 months got some treatment--an improvement over earlier findings--only one in five received treatment that met minimum standards established by the Agency for Health Care Policy and Research. The study found that inadequate treatment was due to inappropriate dosing of antidepressants on the part of physicians, patient discontinuation of treatment, and the use of unproven treatments outside the medical and mental health systems.

'While recently increased treatment is encouraging, inadequate treatment is a serious concern," Kessler and his co-authors write. "Emphasis on screening and expansion of treatment needs to be accompanied by a parallel emphasis on treatment quality improvement."

Heightened Activity in Brain Region Tied to Inhibited Temperament

Psychologists have brooded for centuries over why some individuals seek out new people, things, and places while others shun them. Researchers have suspected that the difference between shy and outgoing people lies to some extent in their biological makeup, in particular their brains. But they have been unable to locate where the neurological roots lie. Now, a team of HMS scientists reports that the amygdala, an almond-shaped cluster of neurons buried below the prow of the brain, may provide clues to this fundamental human distinction.

Carl Schwartz and his colleagues found that adults who had been identified as having shy, inhibited temperaments when they were two years old exhibited greater amygdalar activity when shown pictures of unfamiliar faces than did adults who had been classified as uninhibited or outgoing. The findings, which appear in the June 20 *Science,* are of more than theoretical interest. Inhibited temperament is a risk factor for generalized social anxiety disorder and, indeed, a better understanding of how biological structures such as the amygdala interact with environmental factors could lead to a better understanding of the causes and treatments of this destructive psychiatric disease. "There is no way to intervene early in the life of a child to prevent suffering without understanding these developmental risk factors," said Schwartz. An HMS assistant professor of psychiatry at Massachusetts General Hospital, Schwartz began to explore the possibility that the amygdala might play a role in temperament nearly 15 years ago while working with **Jerome Kagan,** the Daniel and Amy Starch research professor of

psychology at Harvard University. Kagan and his colleagues had shown that inhibited children exhibit striking physiological features. Their heart rate is faster and more variable; their pupils dilate more when solving problems; and they produce more cortisol than uninhibited individuals.

"The question was, what part of the brain had to be hyperactive to produce those physiological effects?" said Schwartz.
Though the amygdala is best known for its role in emotion, it also regulates autonomic responses. Kagan and Schwartz became intrigued by the possibility that the structure might play a role in temperament. But it was years later, after becoming trained in functional magnetic resonance techniques, that Schwartz would have a chance to explore the idea along with Kagan and colleagues.
While their findings appear to add another feather to the amygdala's hat, they raise questions about its old image as a master of emotion. For example, this nerve cell cluster is often associated with the fear response. Yet the unfamiliar faces shown to Schwartz's subjects were neutral, not threatening. He thinks that the amygdala's real function may be to detect new and ambiguous stimuli and that fearful stimuli might fall into that broader category. "So a wider role for the amygdala could be that it is involved in the detection of novelty and ambiguity," he said.

He and his colleagues made yet another pot-stirring discovery, one that could have implications for the diagnosis and treatment of generalized social anxiety. As it turned out, two of the inhibited subjects in the study were diagnosed with the disorder. Yet they displayed the same pattern of amygdalar activity as the inhibited subjects who did not have a psychiatric diagnosis. "If I had started with people with anxiety disorder, we would have found a difference in the amygdala. I might have gone on to say this is a marker for the disease. Wrong," he said. "This a marker for the risk factor of inhibited temperament."
Schwartz believes the rush to discover new drug targets could lead some to confuse disease markers with risk factors, not just in the case of social phobias but in other psychiatric disorders. "If nature is being that subtle in this case--well, she is usually kind of consistent in that way."
--Misia Landau

Depression Among Moms: Prevalence, Predictors, and Acting Out Among Third Grade Children

By Kristin Anderson Moore, Ph.D., Elizabeth C. Hair, Ph.D., Sharon Vandivere, M. P. P., Cameron B. McPhee, Michelle McNamara, and Thomson Ling March 2006

OVERVIEW

Depression can adversely affect just about every aspect of a person's life, but when the depressed person is a mother, her children can be affected adversely as well. This brief examines the factors related to depressive symptoms among mothers and explores the implications for acting out behavior in their third grade children.

In line with other research, we find that mothers' depressive symptoms are related to more acting out behavior problems in their children. For both mothers in general and also for low-income mothers, one reason that depression appears to increase children's acting out is that depression affects parenting, particularly effective discipline. However, we also find that maternal depressive symptoms are directly related to more acting out behavior.

Considering the total effects (the combination of both the indirect and direct effects) of a mother's prior circumstances on a child acting out, we find that maternal depression, welfare receipt, financial problems, longer work hours, and working during the child's preschool years are related to more subsequent acting out behavior among third graders, while higher parental education, being married, better relationship quality with a partner, and higher family income are related to less acting out behavior.

ABOUT THE RESEARCH SOURCE FOR THIS BRIEF AND THE METHODOLOGY USED

Child Trends used data from the Early Childhood Longitudinal Study: Kindergarten Class of 1998-99 (ECLS-K), a nationally representative study that has been following nearly 20,000 children who entered kindergarten in the fall of 1998. Thus, these children were born prior to the 1996 welfare reform and were preschoolers during the early years of Temporary Assistance to Needy Families(TANF). The survey includes interviews with parents, teachers, and school administrators, as well as direct assessments of children in the fall and spring of kindergarten, and, later, in the spring of first and third grade. e limited our sample to 9,037 children whose mother or female guardian responded in the spring of 1999 and 2000 to the parent

questionnaire, which included questions about depressive symptoms.

To measure depressive symptoms, the ECLS-K has used an abbreviated version of the original 20- item Center for Epidemiological Studies of Depression Scale (CES-D),1 developed by the National Institute of Mental Health. We used the threshold established in prior research on the CES-D scale administered to mothers to indicate the presence of symptoms of depression at the spring of kindergarten.

Prior circumstances that we hypothesized would lead to mothers' depressive symptoms (and that may be amenable to policy intervention) include: welfare receipt, maternal work, income, financial difficulties, marital status, relationship quality, and mother's educational attainment. We also used these data to examine four measures of parenting behavior: cognitive stimulation, positive communication, disengaged parenting, and discipline. Discipline was measured as a lack of inappropriate discipline (spanking, hitting, ignoring, making fun of, and or yelling at the child).

In our analyses, we accounted for relevant factors that might also be related to maternal depression and/or child outcomes, including: child's gender, child's race/ethnicity, child's age at the fall of kindergarten, low birth weight (below 5.5 pounds), child's disability status, language spoken in the home other than English, and mother's fair or poor health status or inability to work because of health issues.

In addition, because we wanted to explore how policy-relevant and background factors affect children through parental depression, we examined the pathways of influence from the antecedents, to depression, to parenting behaviors, to a child outcome.

The child outcome on which we focus here is child externalizing, or "acting out" behaviors, as reported by the child and the child's teacher. Although we did study other outcomes (internalizing, self-control, and math and reading test scores), we focus on acting out behavior in this brief because it is an important measure of child development in the early elementary years and is related to poorer academic outcomes and problem
behaviors when children are older. Additionally, acting out in class disrupts learning not only for the child who misbehaves, but also for the child's classmates.

EARLIER FINDINGS

This brief builds on a foundation of previous research on maternal depression and child outcomes. Here we share some highlights to place the new analyses in a larger context.

The prevalence of depressive symptoms varies with the measure used and the population studied, but recent estimates indicate that four to seven percent of adults suffer from major depression in any given year,2-4 and between seven and 17 percent experience major depression in their lifetimes.5 Studies consistently find that the prevalence of depressive symptoms is higher among those with lower incomes and socioeconomic disadvantage. For example, low income and welfare receipt are associated with depression rates at least twice that of the general population. Additionally, unemployment, particularly due to job loss, is associated with increased depression.

Economic pressure is related to parents' depressed mood and to marital conflict, which, in turn, decreases parents' ability to be nurturing, involved parents. As a result, children of economically stressed parents have been found to have poor school performance, less satisfactory peer relations, and lower self-confidence. Parental depression has been linked to less effective parenting behaviors, and, in turn, to child outcomes. For example, in a study of welfare mothers with pre-school children, the combination of low literacy and depressive symptoms was particularly related to poorer child development, and parenting was found to explain or "mediate" this association.

Thus, an extensive body of research has established links between maternal depression and negative child outcomes. Yet, research gaps remain. For example, little work has been done to assess how the prior conditions or circumstances that can lead to maternal depression can indirectly affect children. That is, researchers have not examined the connections between the predictors or antecedents of maternal depression and how parental depression is in turn connected to child outcomes over time. Further, while some studies have revealed links between depression and parenting behaviors over time, this work did not examine groups that were representative of the larger

CURRENT FINDINGS

Here we summarize the results of Child Trends' new analyses of the prevalence of depressive symptoms among mothers; the antecedents to these symptoms; and the intersection of these antecedents and symptoms with parenting and acting out behavior.

PREVALENCE

Overall, 6.4 percent of children in the kindergarten class of 1998-99 had a mother who reported symptoms of depression in the spring of the children's kindergarten year. As expected, we found that

depressive symptoms are more common among mothers of children in low-income families: About one in 10 children in families with incomes below 200 percent of the poverty threshold have mothers who reported this level of depressive symptoms (10.4 percent), compared with about one in 50 children (2.3 percent) in families with incomes at or above 400 percent of the poverty threshold.

Depressive symptoms are also more common among mothers who received TANF within the past year, with 15.7 percent of these mothers reporting depressive symptoms compared with 4.4 percent of mothers who had not received TANF since their child's birth. Prevalence also varies by marital status and relationship satisfaction, with the lowest rate found for children whose mothers are either married and "very happy" (3.2 percent) or cohabiting and "very happy" with their relationship (3.2 percent). The highest prevalence of depressive symptoms is for those women who are either married but are "not too happy" with their relationship (28.9 percent) or cohabiting but "not too happy" (30.8 percent). Of those who are not in a cohabiting or married relationship, 13.0 percent reported symptoms suggestive of depression.

ANTECEDENTS

A number of important demographic and background characteristics are found to predict depressive symptoms, even with other relevant factors taken into account:

Maternal depressive symptoms tend to be more common if the mother's education level is lower, the family received TANF, the family has had financial problems, family income is low, the mother's relationship with her spouse or partner is poor, and (after accounting for relationship quality, income and other factors) if the mother is married. As noted above, depressive symptoms are most common among mothers who are either married and cohabiting, but are "not too happy" with their relationship. These findings suggest the importance of distinguishing relationship quality and financial hardship from marital status. Depressive symptoms are also more likely if
the mother's health is fair or poor, or if her child has a disability.

Work hours and work histories are not found to be related to symptoms of maternal depression. The findings are similar for children and their mothers in low-income families. When looked at separately though, among that subgroup, family income and marital status do not predict depressive symptoms.

"ACTING OUT"

Nearly all of the factors examined in our study (except relationship satisfaction) affect children's acting out behavior directly. Increased maternal educational attainment, higher income, and marriage are found to be directly associated with less acting out behavior among the mothers' children. Longer working hours, working before the child entered kindergarten, receiving welfare, and a history of financial problems are also directly associated with more acting out behavior.

In addition, we found evidence in some instances that the influence of these factors is also indirect, influencing children's behavior through their effect on mothers' depressive

Parental discipline and communication are pathways through which maternal depressive symptoms affect the child's acting out. The greater the symptoms of depression, the more likely mothers are to engage in inappropriate discipline, such as hitting or making fun of the child. Mothers with more symptoms of depression are also less likely to communicate positively with their children. These mothers are less likely to encourage their child to share feelings or concerns than are mothers with fewer or no depressive symptoms. however, that the remaining direct effect of maternal depressive symptoms on acting out behavior is substantially larger than these indirect effects, which suggests that additional parenting behaviors or family factors may be involved that are not measured by this study, or possibly that there may be a hereditary component underlying the association.)

Maternal education and the mother's marital or cohabiting relationship quality are directly related to parenting behaviors. Mothers with higher levels of educational attainment and "happier" relationships tend to engage in more positive parenting. In addition, lower income, welfare receipt, financial problems and marital status all affect parenting indirectly through maternal depressive symptoms. In turn, as noted above, these symptoms affect children's acting out behavior through parental discipline practices. Most of the variables studied have direct (as well as indirect) effects on parenting. For example, being married has a direct effect, which is related to less acting out. Mothers who have sons use more inappropriate discipline, but also participate in more enriching activities with their boys. Children with siblings and children who were older at the start of kindergarten have mothers who use less positive parenting practices. Moreover, nearly all of the policy relevant antecedents have direct effects on acting out.

LOW-INCOME FAMILIES

Child Trends repeated these analyses with a subgroup of children in low-income families
(those with 1998 family incomes below 200 percent of the poverty line). The results are substantively very

similar, with maternal depressive symptoms affecting acting out behaviors directly and also indirectly. However, among low-income children, the only parenting practice that depressive symptoms affect is discipline, whereas among children more generally it affects acting out indirectly through communication as well as discipline.

Shared joy is a double joy; shared sorrow is half sorrow. - *Swedish proverb*

TOTAL EFFECTS

As discussed above, many variables have both direct and indirect effects on children's acting out. The sum of these direct and indirect effects yields the total effect that variable has on acting out. Total effects on acting out, indicate that all of the variables except disengaged parenting are significantly related to acting out. Parent education has the largest protective effect against acting out behavior, while more recent welfare receipt has the largest negative effect, contributing to more acting out behavior. Maternal depressive symptoms have a smaller but still important total effect on subsequent acting out. Much of the effect of maternal depressive symptoms is direct, although, as noted above, depressive symptoms also work indirectly to affect children's acting out behavior through parental discipline and communication. Both marriage and relationship satisfaction each have total effects similar in magnitude to depressive symptoms and both are associated with less acting out behavior. Finally, an early return to work, extensive work hours, a lower income-to-poverty ratio, and financial problems are all modestly and similarly related to more frequent acting out. Findings for the low-income sample are similar, with all variables (except disengaged parenting, cognitive stimulation and work hours) affecting acting out behavior. In the low income sample, however, a mother's marital status has the largest protective effect on children's acting out behavior.

DISCUSSION

We found that children's acting out (externalizing) behavior in the third grade can be affected by a variety of difficulties in the lives of their mothers. Some of these difficulties include financial problems, welfare receipt, relationship unhappiness, and low income, which may be amenable to policy intervention. Considering the total effects (the sum of both the indirect and direct effects; of policy-relevant factors on child acting out, we find that higher parental education, marriage, better relationship quality, and a higher family income are related to less child acting out (externalizing) behavior. On the other hand, welfare receipt, financial problems, longer work hours, and working during the child's preschool years are related to more subsequent acting out (externalizing) behavior. The analyses presented here both confirm and extend previous studies. We find, again, that parental marital status and also relationship quality are related to children's development. Relationship quality has consistently positive effects. Mothers in happier relationships are less likely to report depressive symptoms and are likely to engage in positive parenting. This finding is important because it indicates that efforts to strengthen marriage – not simply by encouraging marriage, but by helping couples build, enhance, and sustain healthy marriages – can enhance children's development. Over and above the effect of relationship quality and economic factors, married mothers more often express depressive symptoms, yet overall their children are less likely to act out. This positive total effect reflects a large and positive direct effect whereby children of married mothers are less likely to act out.

These findings link welfare receipt, financial problems, and low income to poorer child outcomes. At the same time, these findings show that poorer child outcomes are directly linked both with substantial work hours and early maternal employment during the preschool years. This seemingly divergent set of findings suggests that a middle ground – one that avoids very long work hours but also avoids poverty and dependency – may be most supportive of children's development. Combined with the findings about marriage and relationship quality, these results suggest that married couples with positive relationships who combine their earnings, or with sufficient income to allow one parent to remain at home when children are very young, may be patterns that enhance children's development.

The important direct effect of maternal education on maternal depressive symptoms suggests that it may be advisable to offer educational opportunities for mothers who need them, and also to encourage delaying childbearing until after education is complete.

The fact that child disability and poor parental health are both linked to higher levels of maternal depressive symptoms suggests the value of preventive and ameliorative health care.

Finally, these results indicate that identification and treatment of maternal depressive symptoms, as well as efforts to address the circumstances that elevate maternal depression, are appropriate directions for private and public policy attention – not just as a way to improve the lives of adults, but to improve the lives of children as well.

Note: A manuscript with a more detailed report of these analyses was presented at meetings of the American Association for Public Policy and Management and is under review: Hair, E.C., Moore, K.A., Vandivere, S., McPhee, C., Ling, T. and McNamara,

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