

A Review of Child and Adolescent Depression: Family Factors and Treatment

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Abstract. Depression in child and adolescent is a big problem since it impairs normal functioning of the youth. Since Youth are known to be closely related to their families, this review is focused on examining the family risk factors and family based treatment for youth depression based on the past researches. Parenting, attachment styles, family conflicts, and parents' depression and cognitive styles which has been identified to correlated with depressive symptoms are integrated in this paper. In terms of treatment, two effective family treatments are reviewed in this paper: Attachment-based therapy (ABFT), and Family-Focused Treatment for Childhood Depression (FFT-CD).

1. Introduction

Major depressive disorder (MDD), also commonly known as depression is a mood disorder that interferes one's life. Recent estimates of the prevalence of major depression indicate that 16.6% of adults have been depressed at their life time (Kessler et al, 2005). Child and adolescent have with an estimated prevalence of 4%-8% (Brimaher, Ryan, Williamson, Brent et al., 1996). The prevalence of MDD increased significantly across adolescence (Swendsen et al, 2015).

Adolescent depression has a high rate of comorbidity (40-95%) with other mental disorders (Biederman, Mick, Lelon, 1995). It is comorbid with anxiety disorder, conduct disorder, antisocial disorder, personality disorder and substance abuse with anxiety disorder having the highest comorbid rate. Depression is a significant problem for youth since it impairs school performance, interpersonal relations and increases suicide behaviors; many patients are also vulnerable to recurrent episodes and suffer MDD in adulthood later in their life (Brimaher et al., 1996). In terms of gender, the rate of depression are little difference in childhood but a higher (near twice) likelihood for female than of male adolescences (Lewinsohn et al, 1994, Kessler et al, 1994, Fleming et al. 1990).

The clinical features of adolescent depression are mostly in common with depression in adulthood. However, adolescence MDD has some different clinical features. According to a review by Nardi and colleague, somatic symptoms, irritability, suicidal ideation were some common features for depressed youth. These clinical features varied from gender and age. In terms of gender, negative symptoms such as sadness, irritability, crying, eating disorders, negative body image which associated with the mood appeared more in females while males showed more somatic complaints, decreased think, concentrate, decision ability, restless and anhedonia feeling. In terms of age, younger patients were more likely to present somatic complaints, anxiety and irritability while older patients had more emotional and cognitive symptoms (Nardi et al. 2013).

2. Risk factors of depressive disorder in youth

A study done by Lewinsogn pointed out that there were both factors which are associated with being depressed (cannot be detected before the onset of a depressive episode) and factors which are predictive for subsequent episodes (Lewinsogn et al., 1994). Self-rated social competence, social support from friends, interpersonal attractiveness, poor self-rated health, impairment due to injury or illness, current smoking and substance use history, disruptive behavior, anxiety disorder are correlated with being depressed but not with subsequent depression. In the contrast, factors like conflicts with parents, grade dissatisfaction, failure to do homework, and current miscellaneous

diagnoses were predictive of a future depression. The study also found out that some factors like pubertal status was not related on concurrent depression (Lewinsogn et al., 1994).

Besides the variables that are discussed above, youth are closely related to their family and family factors plays an essential role in the psychosocial functions of adolescents. Family is the first environment that children learn about relationships, therefore, it related to the future interpersonal relationships and expectations for how other will treat the self. Since family risk factors for child and adolescent depression is multi-dimensional, a review for the parent and youth characteristics as well as the interactions between them is essential.

3. Family factors for depressive disorder in youth

Psychosocial family factors can be discussed from several aspects, in this review we will discuss three domains of factors: parent-child interaction patterns, inter-parent relationship as well as parents' personal characteristics.

Parents' own characteristics

Parent Cognitive styles

Beck's cognitive triad (1976) is commonly accepted as a understanding of depression in a cognitive aspect. The triad includes negative thoughts about the self (e.g. "I am worthless"), the world (e.g. "the world is bad"), and the future (e.g. "things will never get better"). These negative cognitive errors were considered to be related with emotional, somatic, and motivational symptoms of depression. Parents' maladaptive cognitive styles may influence cognitive styles of children and therefore increase the potential risk of depressive symptoms for the youth. Stark, Schmidt & Joiner (1996) assessed 133 children with depressive and anxiety symptoms from age 9-15 years old and their parents. The children completed measures of depression and anxiety as well as a perceived parental cognition about self, world, and future. Parents of the children also completed a measure of their own cognitive triad. The results indicated that parents' cognition influences perceived parental messages by children, and thus influences the children's cognitive triad that is related to depressive symptoms. The findings also suggested that this chain of influence was more powerful in a mother-daughter relationship. Little studies examine this family factors, but from the cited results we can see negative parent cognitive perceptions could function as a potential risk for youth depression.

Depressed parents

Study has showed that the offspring of depressed parents had a higher risk of depression as well as higher mortality (Weissman et all 2016). Children of depressed parents had a nearly three times higher possibility of experiencing a lifetime depressive episode compared to non-depressed parents (Lieb et al., 2002; Weissman et al., 1997). Studies had focused on the effect of depressed mothers in the past, however, in addition to the impact of depressed mother, fathers' depression also plays an essential role in children's maladaptive development. Kane & Garber (2004) found out that similar to depressed mothers, fathers' depressions are also positively associated with internalizing and externalizing symptoms of child and conflicts between father and child. There are four widely cited explanations for this transmission, namely, genetics, neuro-regulation difficulties that impact affect regulation, exposure to negative maternal affect and behaviors, and stress and the environmental context where youth lives (Goodman and Gotlib, 1999). Some multidimensional approaches suggested that parental depression alone did not function as risk factors, and have to combine with other factors. The relationship between depressed parents and offspring depression is mediated by several factors, including: paternal negative expressiveness, hostility, and marital conflicts (Sweeney et al. 2016). The effect of parent depression could be buffered by several factors. One study did by Brennan, LeBrocq, and Hammen, found out that lower parental psychological control, higher maternal warmth, and low over-involvement to buffer youth from depression in combination of maternal depression decreased the risk of youth depression.

Marital relationship

Marital conflicts

Conflicts within a family setting are associated with higher risk of developing depressive episodes. According to the scale from Moos and Moos (1994) and the Straus Conflict Tactics Scale

(1979), family conflicts contained 14 assessed behaviors such as losing one's temper, hitting each other, throwing things, threatening to hit, and yelling at each other. And marital conflict, which is one type of family conflicts has been shown as a risk factor for its negative impacts on parent and child relationship (Wilson&Gottman, 2002). A dysfunctional model of marital and family relationship would influence a child's future maladaptive approached, which is a stressor that may generate depressive symptoms (Auerbach et all. 2012).

A study done by Bond and his colleague (2005) examined a cluster of factors related to depression with a sample of 8984 adolescents shown that family conflicts was the strongest predictor of adolescent depression. In terms of gender difference, one study did by Mazza and colleagues in 2009 showed that family conflicts were associated with higher levels of depression for girls than for boys, and this may due to the different coping styles: girls may internalize the conflicts (Mazza et all, 2009). Family conflicts also interact with genetic risks. In a gene-environment perspective, children with a family history of depression may be at an increased risk of developing depressive symptoms in response to family conflicts (Rice et all, 2006).

In terms of how Family conflicts impact risk of adolescent depression, Auerbach analysis the dependent interpersonal peer stress' mediating effect between family conflict and depressive symptoms. The study showed that family conflicts positive correlated with dependent interpersonal peer stress over time and high levels of family conflicts were associated with greater levels of depressive symptoms. However, depressive symptoms did not predict higher levels of peer stressors. This result indicated that a higher level of family conflicts contributed to greater dependent interpersonal stressors and flowing depressive symptoms. It was also found out that individuals who had negative perception of self, had a higher level of depressive symptoms as they may perceive themselves to be blamed for the family conflicts (Auerbach et all 2012).

Parent-youth relationship

Parenting: rejection and control

Parental rejection has been defined as encompassing excessive disapproval, criticism, and lack of contact with the child (e.g., Clark & Ladd, 2000; Maccoby, 1992; Rapee, 1997). With its negative effect on self-esteem, sense of helplessness, and development of negative self-schemas, parent rejections are hypothesized to associate with child and adolescent depression (Garber & Flynn, 2001; Hammen, 1992; Kaslow, Deering, & Racusin, 1994). In one of the studies of youth depression, McLeod and co-workers studied parenting as a factor for depression. They used a meta-analysis method to examine the strength of relations between parenting (mainly rejection and control) and childhood depression by synthesizing effect size of a representative collection of 45 cross-sectional studies from 1985 to 2005, including children and adolescents from age 5.1 to 18.8 years (McLeod et all, 2006). The findings suggested that higher levels of parental rejection correlated with more childhood depressive symptoms. In addition, a comparison of results examined the relationship of parent rejection's sub dimensions (e.g. warmth, withdraw, and aversive parental behavior) with depression indicated that each dimension related to depression differently and in various strength: parental warmth, withdrawal, aversiveness correlated with childhood depression, with aversiveness weight most (McLeod et all, 2006). Another study examined the relationship between perceived parental rejection (i.e. the perceived lack of concern and interest) and adolescent depression also found out that perceived parental rejection was significantly related to adolescent depression (Hale et all, 2004). The result also indicated that the strength of correlation varied among different age and gender groups: perceived parental rejection is more strongly associated with for girls and younger age than that is for boys and older age (Hale et all, 2004). From the studies, we can see that parent rejection (lack of warmth, withdraw and aversiveness) and children perceived negative parenting increase the risk of depressive symptoms among the youth.

Parent control is another risk factor related to parenting styles. It has been defined as behaviors including excessive regulation of children's activities, encouraged dependence on parents, supervision, and strict discipline. Parental control can reduce perceived mastery, personal control and helplessness, thus is hypothesized to be related to child and adolescent depression (Chorpita &

Barlow, 1998; Weisz, Southam-Gerow, & McCarty, 2003; Garber & Flynn, 2001b; Kaslow et al., 1994; McLeod et all, 2006). McLeod and colleagues (2007) discussed parent rejection which is discussed above also examined the relation of parent control and depression. Parental control consisted a sub dimension: involvement which means an interference of children's age-normal independence. The results showed that a higher level of parental control was associated with more depressive symptoms but had weaker effect than parental rejection. And the sub-dimension over-involvement was negatively associated with youth depression.

Attachment Styles of the youth

Attachment theory developed by Bowlby provided some basic models for examining the relationship of attachment factors and adolescent depression. Originally, there are three kind of attachment styles: secure attachment, anxious-avoidant attachment, and anxious-ambivalent attachment. A secure attachment style formed from a responsive caregiver allows children to explore their environments (Ainsworth, Blehar, Waters, & Wall, 1978). Insecure attachment children are more likely to perceive the world as unpredictable or scary and show less exploration, competence and more helplessness, which is hypothesized to increase the risk of development of depression. Study showed that depressed children endorsed less secure attachment to parents than the non-depressed children, and that less secure attachment was related to greater severity of depression (Armsden et al, 1990). Maternal harsh punishment and conflict tactics were showed to link with less secure attachment in childhood (Lyons-Ruth, Connell, Zoll, & Stahl, 1987). Adolescent attachment security is termed differently from that in infancy and childhood. It is assessed in terms of behaviors and cognitions that may influence intrapsychic development and for aspects of ongoing relationships (Sroufe & Waters, 1977).

One longitudinal study examined the relationship between attachment security and depressive symptoms over the adolescence. 167 adolescence participants were assessed in a three-year period. Measures included structured interview asking the participants to describe the relationships with parents as well as observations of parent-child interactions. The results showed that attachment security was significantly related to the overall level (intercept) of depressive symptoms but not to trajectories of change in depressive symptoms (Allen et al., 2017).

Several studies showed that attachment security is related with depressive symptoms. In addition, there were some research finding the mediators between the two variables. One study about the mediation model of adult attachment styles and depressive symptoms gave an insight of the role of dysfunctional attitudes and self-esteem (Robert et al., 1996). Individuals who were less secure tended to have higher levels of dysfunctional attitudes, lower self-esteem, and elevated symptoms of depression. The study also found that the relation between adult attachment and depression is mediated almost entirely by maladaptive contingencies of worth and low self-esteem. Even the targeted population is adult, we can learn from the study that problematic parent-child relationships may lead to these relatively negative attitudes and assumptions which, in turn, increases the stressors and risk of depression. In 2011, a study did by Roelofs found out that the maladaptive schema domains of disconnection and rejection and other-directedness mediated the relation between quality of attachment relationships and symptoms of depression (Roelofs et al. 2011).

4. Treatment for youth depression

Medical as well as psychological are now identified to be useful for depressed youth, and one of the best studied treatment is cognitive behavioral therapy (CBT). One review of treatment for this population examined several treatment and prevention studies, and showed that cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT) had positive outcomes immediately after the treatment. However, 25%-50% of participants relapsed after 6 months (Clarke et al., 1999; Mufson et al., 1999; Rosselló and Bernal, 1999, Birmaher et al., 2000). Though there are several empirically studied treatment like medication, CBT, interpersonal therapy, few well-studied and empirically-supported treatments are focused on the family. However, family as a first environment that people are exposed to plays an important role for the underlying problems.

Attachment-based therapy (ABFT):

Attachment-based therapy (ABFT) is an empirically supported family therapy which is grounded in attachment theory. ABFT aims to uncover the experiences and relational processes that damaged trust in family relationships to achieve the goal of repairing attachment and promoting autonomy (Diamond et al., 2016). The goals are achieved through five specific tasks:

(1). The Relational Reframe Task: shifting the focus from patients' symptoms to improving the relationships in family

The Adolescent Alliance-Building Task: is designed to getting knowledge about strength and interest of adolescents and to build therapist-adolescent rapport. This task also explores family conflicts that have damaged the attachment and help the adolescents to understand and articulate their disappointment in a better way to their parents.

(2). The Parent Alliance-Building Task: exploring the current stressors and the own history of attachment failures of parents. Therapists offer empathy and support to the parents as a way to enhance their love and empathy for the adolescent as well as increase their motivation to learn other parenting skills.

(3). The Attachment Task: in these sessions, adolescents talk about their emotions (anger, grievances) related to the problems such as betrayal, abandonment, abuse. If the adolescent receive empathy from their parents, their internal working models of parent start to be revised.

(4). The autonomy-promoting task: practicing new skills to consolidate the new security. Therapists focus on promoting the autonomy outside home and other causes of depression.

Researches and studies have examined the efficacy of ABFT in treating depressed adolescents. Diamond et al (2002) tested 32 adolescents with major depressive disorder(MDD) in a 2-year period. Participants were randomly assigned to either a 12-week of ABFT or a 6-week waitlist group. The results reflected that patients in the ABFT group had a significant difference in depressive symptoms. Patient also showed significant decrease in depressive symptoms and family conflicts.

Family-Focused Treatment for Childhood Depression (FFT-CD):

FFT-CD is a developmentally based family treatment for preadolescent children. It Integrates with interpersonal theories of depression, family psychoeducational approaches, family-focused treatment, and CBT. In terms of family centered method, FFT aims at understanding the interaction processes in the family. The ideas that interpersonal interactions are related to mood are introduced to the families. FFT helps parents form positive feedbacks on children's achievements, and build skills for family members to cope with the problems within the family. It consists of 5 modules:

(1). Rapport-building and education about depression, including introduction of an interpersonal modal: the goal is to build rapport with family, to present the interpersonal model, and to outline upward and downward spiral.

(2). Communication training: is designed to increase the positive feedback, active listening, and negative feedback skills.

(3). Fun activities scheduling: the underlying idea is that things we do affect how we feel. This module helps identify pleasurable events and promote assertiveness.

(4). Problem solving: consists of both identification and solution of problems.

(5). Termination: the goal is generalizing the skills and empowering the family to keep the progress going on in the future.

A recent study did by Langer and colleges tested the efficacy of FFT through 3 case studies. The trained FFT therapists implement FFT interventions to the 3 families each with the five modules and introduction of new skills but in a different interpersonal process depend on the situation. The results showed that in 2 of the 3 cases, the parent rating depressive symptoms decreased sharply while the global functioning scores increased, especially in the 4 and 9-month follow up period. The study reflected that FFT can be used by families with different structures, and is useful for a wide range of problems (e.g. Academic problem, peer stress, family conflicts) that depressed children often confront by turning the downward depressive spirals upward (Tompson & Langer & Hughes & Asarnow, 2017).

5. Summary and prospect

Several evidences based family factors that increase the risk of child and adolescent depression and family treatment are reviewed in this paper. However, in general, family models for youth depression is still developing. There are few study that focus on the mediators of the association between underlying factors and depression, which impedes our ability to understand the mediating relationship of family risk factors and youth depression. In addition, evidence-based family treatment for child and adolescent is sparse. Future research therefore could concentrate on identifying the mediating variables that translate the effect of family risk factors to the depressive symptom. Understanding the relationship between family factors can further help to develop related psychosocial treatment for the depressed youth in a family setting.

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