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A longitudinal evaluation of the Resilient Families randomized trial to prevent early adolescent depressive symptoms



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ABSTRACT

This study aimed to evaluate whether an intervention prevented the development of depressive symptoms through the early years of secondary school (Grades 7 to 9 – mean ages 12.3 to 14.5 years) in Victoria, Australia. Twelve schools were randomized to a universal preventative intervention (including a student social relationship/emotional health curriculum, and parent/caregiver parenting education); 12 were randomized as control schools. Multivariate regression analyses used student self-report to predict depressive symptoms at 26-month follow-up (13-months after intervention completion) from baseline measures and intervention status ($N = 2027$). There was no overall intervention effect on depressive symptoms. However, intervention students with moderate symptoms whose parents attended parent education events had a significantly reduced risk of depressive symptoms at follow-up. Future evaluations of interventions of this type should investigate: therapeutic processes; methods to increase recruitment into effective parent education events; and the potential to target assistance to students with high depressive symptoms.

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Preventing mental disorders such as depression is an important public health priority ([National Research Council and Institute of Medicine, 2009](#)). In children and early adolescents, prevention approaches may seek to reduce the rise in depressive symptoms that occur around puberty, and to prevent escalation to depressive disorders for those with sub-clinical depressive symptoms ([Toumbourou, Williams, Letcher, Sanson, & Smart, 2011](#)). Recent meta-analyses (e.g., [Horowitz & Garber, 2006](#); [Merry & Spence, 2007](#); [Merry et al., 2011](#)) suggest that both psychological and educational preventative

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interventions in childhood and adolescence show positive reductions in symptoms of depression immediately following intervention and at follow up 6–12 month post-intervention completion. However, these effects have generally not been maintained past 12 months. The aim of the present study was to evaluate the longer-term (13-month post-intervention) effectiveness of a universal school-based intervention that sought to improve social-emotional competence and to enhance social and environmental protective factors, such as adolescent relationships with their parents/caregivers to prevent the increase in depressive symptoms during early adolescence.

Adolescent depressive symptom profiles vary in severity. Research modelling of the Centre for Epidemiological Studies – Depression scale (short form) found that symptoms of adolescent depression can be accurately classed into low, moderate (sub-clinical) and high (clinical) symptom profiles (Poulin, Hand, Boudreau, & Santor, 2005). Different levels of depression symptoms in early adolescence arise due to differences in childhood aetiology (Letcher, Smart, Sanson, & Toumbourou, 2009; Toumbourou et al., 2011) and have potentially important prognostic implications (McKenzie et al., 2011). High depression symptoms in early adolescence: are predicted by childhood risk factors such as poor maternal-child attachment and early child behaviour problems (Letcher et al., 2009); have been associated with more entrenched neurocognitive disabilities (Anda et al., 2006); and increase the likelihood of clinical depression levels being maintained over the course of adolescence (McKenzie et al., 2011). Depressive symptoms that show increasing trajectories during adolescence are predicted by risk factors in adolescence such as: peer and family relationship problems; low social-emotional competence (Toumbourou et al., 2011); and substance abuse (Mathers, Toumbourou, Catalano, Williams, & Patton, 2006). Compared to adolescents with lower levels of reported depressive symptoms, those with moderate depressive symptoms (sub-clinical levels) are at greater risk of progressing to clinical depression over the course of adolescence (McKenzie et al., 2011). For the majority of children who start adolescence with relatively few symptoms of depression, the risk of developing depression in later adolescence remains low but is not eliminated (McKenzie et al., 2011).

Understanding the development of depressive symptoms in early adolescence requires an understanding of psychosocial risk factors (McKenzie et al., 2011; Thapar, Collishaw, Pine, & Thapar, 2012). Negative social environments including family conflict and poor family management, as well as peer victimization, have all been identified as potential risk factors (Bond, Carlin, Thomas, & Patton, 2001; Hawker & Boulton, 2000; Hemphill, Kotevski et al., 2011). Individual characteristics may also be risk factors such as poor emotional control (Nolen-Hoeksema & Girgus, 1994; Patton et al., 2008; Piccinelli & Wilkinson, 2000) and externalizing behaviour problems (Rockhill et al., 2013).

Protective factors may reduce the risk of future adolescent depression (Thapar et al., 2012), particularly among those with moderate levels of depressive symptoms (Merry & Spence, 2007). Protective factors such as enhanced adolescent-parent attachment can develop when parents actively engage with adolescents in, for example, family intervention programs, and this has been linked to the prevention of depression in children with moderate levels of depressive symptoms (Shochet & Ham, 2004).

To date, many universal prevention programs for adolescent depression have been evaluated. The findings of these programs have been well summarised in a number of recent reviews (e.g., Horowitz & Garber, 2006; Merry & Spence, 2007; Merry et al., 2011; Spence & Shortt, 2007) and show promising effects (Merry et al., 2011). The Merry et al. (2011) review identified 41 studies that evaluated programs focussing on the delivery of an average of 8–12 curricula sessions to enhance individual cognitive behavioural and psychological mental health skills. Family-based interventions have been less commonly evaluated but show promise both as stand-alone interventions (Shochet & Ham, 2004) and when combined with individual mental health curricula (Gillham et al., 2006). Coordinating individual and family interventions to enhance the school environment has been argued as a potentially important direction for universal depression interventions (Gillham et al., 2006; Shochet & Ham, 2004). The present study aimed to extend prior research by evaluating effects 13-months after a universal intervention that targeted both *individual* and *social environmental* factors during early adolescence (Shortt, Hutchinson, Chapman, & Toumbourou, 2007).

Prevention theory suggests that by minimising exposure to cumulative risk factors and enhancing protective factors in critical domains including the school, family and peer social environments, reductions in a range of health and social problems are achievable (e.g., Bond, Toumbourou, Thomas, Catalano, & Patton, 2005; Toumbourou & Catalano, 2005). Within the cumulative risk reduction framework secondary schools are an ideal setting for mental health promotion due to the opportunity to directly target environmental change through engagement with the school, parents, teachers, peers and students. Resilient Families is a school-based program that incorporates both parental and adolescent education about modifiable risk and protective factors influencing depression in adolescents (Shortt et al., 2007).

The present paper is part of a larger evaluation of the Resilient Families program that aims to investigate whether reducing the cumulative number of risk factors and increasing family protective factors can prevent the development of adolescent depression and related health and social problems. Prior studies reporting changes from baseline to wave 2 have shown the Resilient Families intervention was associated with increases in: school attendance; school rewards; and family attachment (Shortt et al., 2007). In analyses at wave 3 the intervention was associated with reductions in adolescent alcohol misuse and parental improvements in family management practices (Toumbourou, Douglas Gregg, Shortt, Hutchinson, & Slaviero, 2013). An earlier version of the universal program had success in reducing risk factors such as substance use, antisocial behaviour, family conflict and poor family attachment that may increase early adolescent depression (Toumbourou & Gregg, 2002).

The first aim of the present research was to examine whether the Resilient Families intervention prevented the development of depressive symptoms 13-months after intervention completion (26-months after baseline) in Grade 9 secondary

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