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Family-Focused Treatment for Childhood Depression: Model and Case Illustrations

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Although the evidence base for treatment of depressive disorders in adolescents has strengthened in recent years, less is known about the treatment of depression in middle to late childhood. A family-based treatment may be optimal in addressing the interpersonal problems and symptoms frequently evident among depressed children during this developmental phase, particularly given data indicating that attributes of the family environment predict recovery versus continuing depression among depressed children. Family-Focused Treatment for Childhood Depression (FFT-CD) is designed as a 15-session family treatment with both the youth and parents targeting two putative mechanisms involved in recovery: (a) enhancing family support, specifically decreasing criticism and increasing supportive interactions; and (b) strengthening specific cognitive-behavioral skills within a family context that have been central to CBT for depression, specifically behavioral activation, communication, and problem solving. This article describes in detail the FFT-CD protocol and illustrates its implementation with three depressed children and their families. Common themes/challenges in treatment included family stressors, comorbidity, parental mental health challenges, and inclusion/integration of siblings into sessions. These three children experienced positive changes from pre- to posttreatment on assessor-rated depressive symptoms, parent- and child-rated depressive symptoms, and parent-rated internalizing and externalizing symptoms. These changes were maintained at follow-up evaluations 4 and 9 months following treatment completion.

Despite substantial advances in the evidence base for treatment of *adolescent* depression, there are no established treatments for *children* with depressive disorders (for review, Tompson, Boger, & Asarnow, 2012). Developmental considerations during middle to late childhood, including greater dependence on parents and rapidly changing cognitive capacity, make it unlikely that adult treatments and their adaptations for adolescents can simply be extended downward, pointing to a need for developmentally informed treatment specifically for children. Parents provide support and feedback throughout this period, and children are dependent on their parents' abilities to interface with the community, support their development, and model and teach coping and other key life skills (Ladd, 1999; Steinberg, 2001). Family-inclusive interventions, therefore, are likely to be particularly beneficial during this childhood period.

Family-Focused Treatment for Childhood Depression (FFT-CD; Tompson et al., 2012; Tompson et al., 2007), a developmentally tailored approach for children ages 7 to 14, includes up to 15 sessions focusing on psychoeducation about depression and skill-building in a family context to enhance coping and increase generalization. FFT-CD addresses the needs of school-aged children and their parents by fostering positive, supportive parent-child interactions to scaffold the development of a positive self, helping parents provide positive feedback on developmentally appropriate achievements, and enhancing family and child coping by focusing on communication, behavioral activation, and problem solving within the family. This article describes FFT-CD, illustrates its implementation with three children and their families, provides case-specific data on outcomes, and discusses common challenges that arise.

Keywords: depression; child; family; family functioning; treatment

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Underlying Conceptual and Empirical Roots

The FFT-CD protocol was influenced by interpersonal theories of depression (Joiner & Coyne, 1999), the evidence supporting family treatment approaches for mood disorders in adults and adolescents (O'Connor, Tompson, & Miklowitz, 2015), cognitive behavioral approaches for youth depression (Tompson et al., 2012), an understanding of factors impacting the development and course of child depression (Beardslee,

Gladstone, & O'Connor, 2012), and developmental studies of middle childhood/early adolescence (Ladd, 1999; Steinberg, 2001). These influences led to creation of the treatment model and specific adaptations for children.

Interpersonal theories of depression (Joiner & Coyne, 1999) emphasize interpersonal stress and functioning as both risk and maintaining factors. Indeed, recent research underscores the bidirectional association between depression and stress, particularly increased interpersonal conflicts and stressors, and emphasizes how depression leads to "stress-generating" interpersonal interactions which further fuel depression (Hammen, 2006; Liu & Alloy, 2010). This approach views depression as a biopsychosocial phenomenon. Biological and environmental factors contribute to its onset, and negative cognitive processes and interpersonal stress impact course and outcome, leading to a downward spiral of escalating symptoms, negative cognitive processes and stressful events/interactions (Asarnow, Jaycox, & Tompson, 2001). In FFT-CD the therapist focuses on understanding the family's unique interpersonal processes and, using an integrated family systems and cognitive behavioral model, provides expanded psychoeducation and skills building within the family to increase positive and decrease negative interactional sequences.

FFT-CD's techniques are based in family psychoeducational approaches, family-focused treatments developed for adults and adolescents, and cognitive-behavioral interventions. Family psychoeducational approaches have been used in the treatment of mood disorders in children (e.g., Asarnow, Scott, & Mintz, 2002; Fristad, Arnold, & Leffler, 2011; Miklowitz & Goldstein, 2010) and adults (for review, O'Connor et al., 2015) and combine education about the disorder with skills development to enhance coping and increase medication compliance. Psychoeducation emphasizes the biological and stress factors that contribute to mood disorders and the need to manage these disorders to improve outcomes. Enhancement of communication and problem-solving are targeted to decrease stress, blame, and burden for both families and patients. Cognitive-behavioral approaches to mood disorders in children have also emphasized coping enhancement through skills development (Weisz, McCarty, & Valeri, 2006), including skills focused on behavioral activation (McCauley, Schloredt, Gudmundsen, Martell, & Dimidjian, 2011). In a departure from psychoeducational approaches, our FFT-CD does not explicitly emphasize medication compliance. The role and efficacy of medication intervention for pre-adolescent-onset depression is more equivocal (Cheung, Emslie, & Mayes, 2005), and parents and children often prefer psychosocial treatment alone for internalizing problems (Bradley, McGrath, Brannen, & Bagnell, 2010; Brown, Deacon, Abramowitz, Dammann, & Whiteside, 2007; Jaycox et al., 2006; Lewin, McGuire, Murphy, & Storch, 2014). In our clinical trial, many parents reported that they contacted us because they wanted a non-medication intervention, and just over 10% of participants were on an antidepressant. Thus, though a clear discussion of biological factors is included in our FFT-CD, medication compliance is not a key focus. Where youth are taking medications (for any condition), medication compliance may become a focus of family problem solving, but the primary foci are enhancement of family support and reduction of interpersonal stress.

Depression during this developmental period has a number of clinical characteristics and risk factors that make a family approach, such as FFT-CD, particularly appropriate. First, given the familiality of childhood depression, many depressed children are likely to be living with depressed parents, particularly mothers (Tompson, Asarnow, Mintz, & Cantwell, 2015). Further, depressions tend to be temporally linked across family members, with depressions in one family member seeming to be triggered by stress associated with another family member's depression (Hammen, Burge, & Adrian, 1991), and successful treatment of parental depression is associated with reduction in child depressive symptoms (Cuijpers, Weitz, Karyotaki, Garber, & Andersson, 2015). In the large multisite Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial (Weissman et al., 2006), maternal depression led to reductions in diagnoses of child depression; in a study examining pharmacologic treatment of child depression, improvements in child symptoms were mirrored by improvements in maternal symptoms (Kennard et al., 2008). Interestingly, in neither study were family member symptoms specifically targeted. These findings underscore the potential reciprocal relationship between child and parent depression and further suggest that a family approach, which can address disorders in multiple family members and enhance family functioning, may decrease risk of depressive episodes in the family as a whole. Second, specific family processes and stresses are associated with poor depression outcomes (Tompson, McKowen, & Asarnow, 2009). For example, parental expressed emotion (EE), an index of criticism and emotional overinvolvement in the home, predicts outcome in children with depressive disorders (Asarnow, Goldstein, Tompson, & Guthrie, 1993; McCleary & Sanford, 2002; Silk et al., 2009). The FFT-CD approach was designed to specifically target reduction of EE and enhancement of family support and functioning. Third, depressed children often present with comorbid conditions, particularly anxiety and disruptive behavior disorders (Kessler, Avenevoli, & Merikangas, 2001). Although our FFT-CD may be depression-focused, enhanced family coping, support, and problem solving may have broad effects on child psychopathology.

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