Family-Based Interpersonal Psychotherapy for Depressed Preadolescents: Examining Efficacy and Potential Treatment Mechanisms

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Objective: To conduct a randomized controlled trial to evaluate the preliminary efficacy of family-based interpersonal psychotherapy (FB-IPT) for treating depression in preadolescents (aged 7–12 years) as compared to child-centered therapy (CCT), a supportive and nondirective treatment that closely approximates the standard of care for pediatric depression in community mental health.

Method: Preadolescents with depression (N = 42) were randomly assigned FB-IPT or CCT. Pre- and posttreatment assessments included clinician-administered measures of depression, parent- and child-reported depression and anxiety symptoms, and parent–child conflict and interpersonal impairment with peers.

Results: Preadolescents receiving FB-IPT had higher rates of remission (66.0% versus 31%), a greater decrease in depressive symptoms from pre- to posttreatment, and lower depressive symptoms at posttreatment ($R^2 = 0.35$, $\Delta R^2 = 0.22$; $B = -8.15$, $SE = 2.61$, $t[37] = -3.13$, $p = .002$, $F^2 = 0.28$) than did preadolescents with depression receiving CCT. Furthermore, preadolescents in the FB-IPT condition reported significant reductions in anxiety and interpersonal impairment compared with preadolescents in the CCT condition. Changes in social and peer impairment from pre- to posttreatment were associated with preadolescents' posttreatment depressive symptoms. There was a significant indirect effect for decreased social impairment accounting for the association between the FB-IPT and preadolescents' posttreatment depressive symptoms.

Conclusion: Findings indicate FB-IPT is an effective treatment for preadolescent depression and support further investigation of interpersonal mechanisms by which FB-IPT may reduce preadolescent depression.

Clinical trial registration information—Phase II Study of Family Based Interpersonal Psychotherapy (FB-IPT) for Depressed Preadolescents; http://clinicaltrials.gov; NCT02054312.

Key Words: depression, preadolescent, randomized controlled trial, IPT, treatment

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Depression in children increases markedly during the transition from childhood to adolescence, and elevated depressive symptoms in preadolescent youth (aged 7–12 years) are strong predictors of adolescent depression.[1] Although study results have yielded estimations that 0.4% to 2.5% of preadolescent children experience depression, these data underestimate the number of preadolescents who do not meet full diagnostic criteria for major depressive disorder (MDD) but present for outpatient treatment with clinically significant depressive symptoms and functional impairment.[2] As such, preadolescents with depressive disorders may be underdiagnosed and go untreated.

Because preadolescent depression occurs during a sensitive period of pubertal, social, and neural development, it may disrupt socio-affective processes and increase preadolescents' risk of recurring depression across adolescence and young adulthood.[3] Although longitudinal studies indicate that most children with depression recover within a 9-month period, the children remain at significant risk for having repeated and more severe episodes of depression within the subsequent 2-year period.[4] Longitudinal studies also reveal that compared to normal controls, preadolescents with depression continue to experience significantly more difficulties in interpersonal relationships with parents and peers after their symptoms remit.[5] Because symptom improvement does not always result in improved interpersonal functioning, residual impairment in preadolescents' interpersonal functioning may be a pathway for depression recurrence.

Prevention-of-depression research on offspring of parents with depression identifies poor parent and peer relationships as risk factors for adolescent depression.[6] Parental depression is associated with parent–child conflict and less frequent positive interactions with children.[7] In prospective longitudinal studies of school-aged children, higher levels of family conflict predict higher levels of depressive symptoms over a 1-year follow-up period.[8] Because parental depression is related to poor interpersonal communication, preadolescents may model poor family communication and problem solving in other relationships, thereby increasing the likelihood of experiencing interpersonal stress and subsequent depression.[9] Peer stressors, such as peer exclusion and rejection, are also consistent predictors of depressive symptoms from middle childhood to early adolescence[10]; experiences of peer victimization in preadolescence are associated with suicidality and poor mental health outcomes in young adults.[11] Peer stress may intensify preadolescents' depressive symptoms and increase social withdrawal. The high rates of comorbid anxiety disorders (up to 70% in clinically referred

youth)[12] may further impair their ability to engage in social situations.[13] Positive parent–child relationships may buffer preadolescents from the stress of peer relationships, and in so doing may decrease their risk for depression in adolescence.[14]

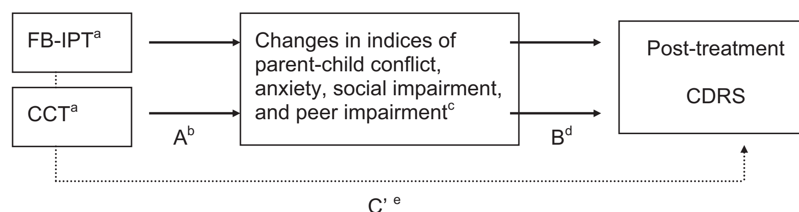
To date, no psychosocial intervention has been established as the superior treatment for preadolescents diagnosed with depression.[15] Although there is well-established support for the efficacy of cognitive-behavioral therapy (CBT) relative to no-treatment control conditions in treating community samples of preadolescents with elevated depressive symptoms,[15] no differences have been found in the few studies of preadolescents with depression randomized to CBT or relaxation training[16] or to supportive, nondirected therapy.[17] Two CBT treatment protocols, Taking ACTION[18] and Primary and Secondary Control Enhancement Training (PASCET),[19] have demonstrated promise in effectively treating children with elevated depressive symptoms as compared to waitlist control groups, but have not been compared to active treatments. However, a recent efficacy trial found no differences between PASCET and supportive therapy in reducing depressive symptoms in preadolescents with irritable bowel disorder.[20]

A primary limitation of existing CBT models may be the lack of parental involvement in treating children with depression. Because they are embedded in a family context, parental involvement in treatment for preadolescent depression is a critical developmental concern.[21] Multi-family psychoeducation therapy (MF-PEP) has been found to be an effective augmentation strategy to treatment as usual in children between the ages of 8 and 12 years with a diagnosed depressive or bipolar disorder as compared to treatment as usual alone.[22] In addition, small, uncontrolled treatment development trials involving a family-focused CBT intervention ($N = 9$)[23] and a contextual emotion regulation therapy for conjoint parent–child delivery ($N = 20$)[24] have demonstrated promise in reducing depressive symptoms but have not examined parent–child conflict and social impairment, pathways that may sustain poor interpersonal functioning in preadolescents with depression.

To date, there are very few controlled treatment studies for preadolescent depression, and a clear need exists for treatments that actively involve parents and address interpersonal impairment in these preadolescents. Interpersonal psychotherapy for depressed adolescents (IPT-A)[25] is an effective, time-limited, psychosocial treatment for depression in adolescents that focuses on the relationship between interpersonal stressors and depressive symptoms and aims to decrease depressive symptoms by improving adolescents' interpersonal functioning.[26,27] Treatment is structured around 1 of 4 "problem areas" temporally associated with the onset of depressive symptoms (loss, role disputes, role transitions, and interpersonal deficits). Family-based interpersonal psychotherapy (FB-IPT) is an adaptation of IPT-A that actively involves parents in weekly sessions and directly addresses parent–child conflict and interpersonal impairment, 2 domains that may contribute to preadolescents' depression. In an open-treatment trial,[28] Dietz *et al.* demonstrated the feasibility and acceptability of FB-IPT with high rates of treatment compliance and significant reductions in depressive and anxiety symptoms in preadolescents from pre- to posttreatment.

The current study examined the efficacy of FB-IPT in a sample of 42 treatment-seeking preadolescents (aged 7–12 years) who met *DSM-IV* criteria for a depressive disorder. Preadolescents with depression were randomized to FB-IPT or child-centered therapy (CCT), a supportive and nondirective treatment that closely approximates the standard of care for pediatric depression in community mental health.[29] We hypothesized that preadolescents receiving FB-IPT would evidence higher rates of remission, endorse fewer depressive symptoms at posttreatment, and demonstrate a greater reduction in depressive symptoms from pre- to posttreatment than participants receiving CCT. We also hypothesized parent–child conflict, anxiety, and interpersonal impairment would significantly decrease in the FB-IPT condition compared to CCT (Figure 1, path A), and that decreases in these domains would be correlated with lower

FIGURE 1 Illustration of planned analyses for hypotheses testing. Note: CCT = child-centered therapy; CDRS = Children's Depression Rating Scale; FB-IPT = family-based interpersonal psychotherapy. [a]Each treatment condition is represented by a dummy-coded variable: FB-IPT = 1, CCT = 0. [b]Path A represents the association between treatment condition and changes in hypothesized mediators, parent–child conflict, anxiety, social impairment, and peer impairment. [c]Parent–child conflict, indexed by the Conflict Behavior Questionnaire, Child and Parent Report (CBQ-C/P), anxiety, as indexed by the Self-Report for Childhood Anxiety Related Emotional Disorders, Child and Parent Versions (SCARED-C/P), and social impairment and peer impairment, as indexed by subscales on the Social Adjustment Scale–Self-Report (SAS-SR), were assessed before and after treatment. [d]Path B represents the association between changes in hypothesized mediators, parent–child conflict, anxiety, social impairment, and peer impairment on posttreatment depression severity as indexed by the CDRS-Revised (R). [e]Path C′ (the prime symbol denotes an indirect path) represents the indirect effects of treatment condition on posttreatment CDRS-R scores through changes in hypothesized mediators, parent–child conflict, anxiety, social impairment, and peer impairment.



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