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**Childhood depression, expressed emotion and psychotherapy:
associations and interactions**

by

Debbie de Wet

(DWTDEB001)

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This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signed by candidate

Debbie de Wet

20/09/03

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Abstract

This study is concerned with the pursuit of ascertaining the efficacy of psychodynamic psychotherapy in the treatment of childhood depression. Additionally, it is concerned with exploring possible associations between childhood depression and expressed emotion and whether expressed emotion, changes in relation to changes in levels of childhood depression following a therapeutic intervention. Twenty-four children diagnosed with major depressive disorder, and their parents, were treated on an out-patient basis with either individual psychotherapy or systemic family therapy. Children exclusively between the ages of 11 and 15 were selected for the study. There was a significant improvement in these Children's Global Assessment Scale scores, indicating improved mood and functioning at end of therapy. This change was seen to persist six months later. No significant differences were found between individual therapy and family therapy. No significant association was found between expressed emotion by the parents and childhood depression and there were no significant changes in expressed emotion over time. Further research into the efficacy of psychodynamic psychotherapy in the treatment of childhood depression are needed.

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Chapter 1

Introduction

Sadness and misery occur in people of all ages. This was recognised by the DSM III (American Psychiatric Association [APA], 1987), which stated that the average age of onset of a depressive episode was in the late twenties, but that it could begin at any age, *including infancy*. It is only in the last 20 years, however, that depressive syndromes in childhood have been considered seriously (Carlson & Cantwell, 1982). This study explores the occurrence of childhood depression and its associated features with a particular interest in impaired interpersonal relationships, especially those with parents. It raises the notion of expressed emotion by the parent as one of the associated features of depression, although it does not deliberate the causal effect of this association. This work then explores the question of appropriate intervention to treat childhood depression and the need for more outcome based research into treatment efficacy. The method used in this study is described in detail, i.e. the subjects, the research design and the interventions used. Data was collected before treatment began, at the end of treatment and six months later. The data was subjected to a number of statistical procedures in order to ascertain whether depression levels changed following a therapeutic intervention. The results of these investigations are discussed in detail and appropriate conclusions drawn from them. Further relevant studies are explored in the final chapter.

When Kovacs and associates embarked on their longitudinal study of childhood depression in 1978, there were many professionals who did not believe that the topic was scientifically defensible or clinically relevant (Kovacs, 1997). Part of the problem with identifying

childhood depression is that in contrast to adults, children may not be capable of identifying or reporting the symptoms associated with a depressive episode (Kovacs, 1986, in Kolvin, 1995). It is unlikely that a child of nine years of age (average age of Ryan's depressed group) (Ryan et al., 1987) is able to associate feelings of hopelessness, guilt, self-denigration, etc. with depression. Additionally, depression often occurs covertly as *masked depression*. This is characterised by a wide range of symptoms, e.g. aggression, learning disorders, hyperactivity, rather than a change in mood (Kolvin, 1995). In the later primary school years, children are more able to reveal thoughts of worthlessness, self-denigration and shame (Kovacs, 1986, in Kolvin, 1995), although this does not mean that parents necessarily recognise these as depressive features. In a study of depressed children, Fleming, Offord and Boyle (1989) found that adolescents identified themselves as depressed about six times more often than parents identified them as depressed. They also found that teachers were better able to identify depression in pre-adolescents than were the parents of those children. Thus, masked depression and lack of parental awareness contribute to lower levels of detection and preclude early intervention and treatment.

Not only does clinical depression exist in the young, but it is not a transitory phenomenon. Numerous follow-up studies have shown that children who suffer from depressive disorders are at risk for recurrent episodes throughout life (Asarnow, et al., 1988; Harrington, Fudge, Rutter, Pickles & Hill, 1990; Kovacs et al., 1984a, 1984b; Lewinsohn, Clarke, Seeley & Rhode, 1994). In the Kovacs study of outpatient, school-aged children diagnosed with major depressive disorder, 26% experienced a new episode of major depression within the first year after recovery. This figure rose to 40% by the second year and 72% by the fifth year (Kovacs et al., 1984b). In the Asarnow et al. study, 35% of their depressed inpatients (age 7-

14 years) diagnosed with either a major depressive disorder or with dysthymic disorder, were re-hospitalised within one year. This increased to 45% in the second year. Their findings are of particular concern as their control group consisted of children with schizophrenic spectrum disorders, which are considered to be the most severe and chronic form of psychiatric impairment in children. Additionally, outcome is particularly poor for schizophrenic patients (Asarnow et al., 1988). These authors found no significant differences in rates of re-hospitalisation among children with depressive disorders compared to those with schizophrenic spectrum disorders. In fact, there was a slightly higher rate of re-hospitalisation amongst the depressed group.

These findings are consistent with the view that depressive disorders in childhood tend to have a relatively episodic course as well as an increased risk for an affective disorder in adult life (Harrington et al., 1990). Although the majority of children do not outgrow their mood disorders, most have episodes of recovery from a depressive episode within a year (Carr, 1999). The statistics for duration of episodes are not encouraging. The DSM IV (APA, 1994) states that an untreated episode of depression typically last six months or longer, regardless of age of onset. However, this is often accompanied by a prodromal period that includes mild depressive and anxiety symptoms, and which may last for months before the onset of a major depressive episode. Approximately 45% of depressed children have an insidious onset to their major depressive episode (Ryan et al., 1987). Not including a prodromal period, a major depressive episode tends to last on average between 26 weeks (Asarnow et al., 1988; Lewinsohn et al., 1994) and 32 weeks in school-aged children, whereas dysthymic disorder lasts for an average of four years (Kovacs et al., 1984a). Further, one-in-five children in the Kovacs' et al. sample had a chronic first episode that

lasted longer than 18 months. Longer episodes of depression seem to be associated with (i) age of onset - the earlier the onset the longer the recovery period (Kovacs et al., 1984a; Lewinsohn et al., 1994) and (ii) *double depression* (i.e. a major depressive episode superimposed on an existing dysthymia) (Kovacs et al., 1984b; Lewinsohn et al., 1994; Ryan et al., 1987). The prognosis for double depression is poor. It tends to be long-standing, i.e. up to 24 months (Ryan et al., 1987) with a high chance of relapse - 80% within two years of discharge (Asarnow et al., 1988).

Many of the studies on childhood depression have examined the differences between pre- and post-pubertal depression. Because of the greater preponderance of female adult depressed patients, childhood gender variations have been of interest. Although some studies have found evidence to the contrary, most studies have shown that there is a shift from a male preponderance of preadolescent boys (62%) to a female preponderance of adolescent girls (54%) suffering from depression (Ryan et al., 1987).

Ryan et al. (1987) found no significant difference between pre-pubertal and adolescent children with regards to severity of depression; however, there were differences regarding the predominance of symptoms. Pre-pubertal children tended to have a greater occurrence of somatic complaints, psychomotor agitation, separation anxiety and phobias, whereas adolescents had greater anhedonia, hopelessness, hyposomnia, weight change and substance abuse. The two groups did not differ with respect to frequency and severity of suicidal ideation (60%), although 25% of the children and 34% of the adolescents in their sample had made one or more suicide attempts. Other figures for suicide attempts are equally sobering. In Asarnow et al.'s (1988) study, suicidal behaviour led to a 45% chance of re-

hospitalisation within two years. Kovacs et al. (1993, in Kovacs, 1997) found that 50% of youngsters who had made one suicide attempt eventually made further attempts. Most distressingly, there is evidence of suicidal behaviour in children as young as five-years-old (P.A. Rosenthal & S. Rosenthal, 1984).

In addition to studies providing evidence of early onset depression, long duration of episodes, frequent recurrence and suicidal behaviour, the comorbidity between depression and other child psychiatric disorders has also been highlighted (Harrington et al., 1990). Depression in children quite commonly occurs in conjunction with anxiety disorders, attention deficit disorders and conduct disorders (Carr, 1999). Other noticeable features of depression in this age group include aggressive behaviour, somatic symptoms and attention problems. Further, not only do these children have a depressed affect, but they are also at risk for interpersonal difficulties. Altmann and Gotlieb (1988, in Kovacs, 1997) found that although depressed children made overtures for social contact, they seemed unable to maintain social interactions and consequently spent significant amounts of time alone. Depressed children are also likely to precipitate negative moods in others and provoke reactions that further reinforce their sense of rejection, unhappiness or low self esteem (Cohen et al., 1991, in Kovacs & Bastiaens, 1995). Thus, depression seems to cause delays in the progression of social cognition and social skills acquisition (Cook, Asarnow, Goldstein, Marshall & Weber, 1990; Kovacs, 1997). Additionally, depression has been associated with a decline in academic performance, behaviour problems in school - including difficulties with teachers (Puig-Antich, 1985a) and school phobia (Berney et al., 1991).

One of the most concerning problems associated with childhood depression is impaired

parent-child relationships (Armsden, McCauley, Greenberg, Burke & Mitchell, 1990; Cole & Rehm, 1986; Coyne, 1976; Kovacs & Bastiaens, 1995; Puig-Antich et al., 1985a & b), particularly as such relationship difficulties may persist even after the depression has lifted (Puig-Antich et al., 1985b). The causal direction of this relationship has been of much interest to researchers. Those examining the influence of childhood depression on parental-child relationships have queried how negative behaviour in the child precipitates a negative mood in the parent and how this reinforces a sense of rejection, unhappiness and low self-esteem (Cohen et al., 1991, in Kovacs & Bastiaens, 1985). Cook et al.'s (1990) study of verbal reciprocity between mother and child found that depressed children were more negative when interacting with their mothers, even though their mothers did not respond to them in a less positive or reinforcing manner. Additionally, the behaviour of depressed children was not significantly predicted by their mothers' prior behaviour. Furthermore, these children showed impairments in their ability to regulate their affective responses, suggesting that their level of "negative affect overwhelms their ability to respond contingently to micro social events" (Cook et al., 1990, p. 81). A child who is irritable, unresponsive and unaffectionate is likely to stop providing positive reinforcement to their caretakers (Kovacs & Bastiaens, 1985). The parent in turn may respond in a negative, dismissive or punitive fashion (Coyne, 1976).

Another focus of research into the impaired parental-child relationship has been on the familial interactional patterns that place the child at risk for developing depression. One finding that has been consistent in this regard is the presence of parental depression, which places the child at risk for developing depression themselves (Hibbs et al., 1991; Jaenicke et al., 1987; Kovacs, 1997; Mufson, Moreau, Weissman & Klerman, 1993; Weissman &

Jensen, 2002). Rates of depressive disorders amongst first-degree relatives of depressed children range from 34% to 54% (Kovacs, 1997). Depressed parents were found to be less responsive and affectionate and more irritable, hostile and critical towards their offspring. Negative maternal attitudes and behaviour towards the child promote negative self-cognition in the child (Jaenicke et al., 1987) as well as difficulties in regulating their affects (Zahn-Waxler et al., 1990, in Kovacs, 1997).

In the Starke et al. (1987, in Kovacs & Bastiaens, 1995) study of depressed youths, family problems were identified as the main source of their difficulties. Childhood depression has been associated with low family cohesion (Fendrich et al., 1990, in Mufson et al., 1993) as well as a parental style that is less caring and supportive (Kashani et al., 1987) and more punitive (Puig-Antich et al., 1985a), with higher standards set for performance (Cole & Rehm, 1986). These practices have been confirmed by retrospective studies of adults who suffered from childhood depression. They perceived their parents as inconsistent in their care and support as well as exercising excessive control, criticism and rejection (Blatt & Zuroff, 1992).

The current study makes no assumptions about the causal direction of the relationship between childhood depression and impaired parental-child relationships. Rather it is interested that this association exists and works on the premise that it appears that the two interact and become mutually reinforcing. Perhaps this is most aptly stated in the following way,

Depressive symptomatology is congruent with the developing interpersonal situation

of the depressed person, and the symptoms have a mutually maintaining relationship with the response of the social environment. Essentially, the depressed person and others within his social space collude to create a system in which feedback cannot be received, and various efforts to change become system-maintaining. (Coyne, 1976, p. 39).

What is of paramount importance in this study is the emotional climate in which this mutually regulating parental-depressed child system occurs. If this climate is such that it helps to reinforce the depression of one child, it might then be asked why one child in the household may be depressed and the others symptom-free. One way of looking more closely at the parental-child relationship is by examining the expressed emotion (EE) of a parent towards a particular child as it represents an 'unshared variance' (Plomin, 1986, in Hirshfeld, Biederman, Brody, Faraone & Rosenbaum, 1997) rather than examining the shared context e.g. divorce, socio-economic hardships, etc.

EE is one of the most thoroughly investigated psychosocial research constructs in psychiatry (Jenkins & Karno, 1992; McCleary & Sanford, 2002). It refers to "a global index of particular emotions, attitudes and behaviours expressed by a relative about a family member" (Jenkins & Karno, 1992, p. 9). The concept derived out of a study of recovered schizophrenic patients characterised by high relapse rates. It was found that patients who returned home to live with relatives who were highly emotionally involved with them were more likely to suffer relapse than those returning to homes low on this characteristic (G.W. Brown, Birley & Wing, 1972). High emotional involvement became known as expressed

emotion (EE) and was characterised by high levels of criticism, hostility¹ and emotional over-involvement.

Numerous studies have replicated these early results, finding a strong association between high EE by a relative and relapse of schizophrenic patients (Butzlaff & Hooley, 1998; Leff, Kuipers, Berkowitz, Eberlein-Vries & Sturgeon, 1982; Vaughn & Leff, 1976). Following these studies of schizophrenia, EE has also been used to characterise the attitudes of family members towards those suffering from other psychiatric disorders. High parental EE has also been associated with obsessive compulsive disorder (Hibbs et al., 1991), attention deficit hyperactive disorder (Marshall, Longwell, Goldstein & Swanson, 1990), substance abuse (Schwartz, Dorer, Beardslee, Lavori & Keller, 1990), eating disorders (cited in Butzlaff & Hooley, 1998) as well as asthma (F.S. Wamboldt, O'Connor, S.L. Wamboldt, Gavin & Klinnert, 2000). More specifically, high parental criticism has been related to both childhood inhibition (Hirshfeld et al., 1997) and disruptive behaviour disorders (Hibbs et al., 1991; Schwartz et al., 1990; Stubbe, Zahner, Goldstein & Leckman, 1993), whereas high parental over-involvement has been associated with separation anxiety disorders (Hirshfeld et al., 1997).

There is a growing body of evidence highlighting the relationship between high EE and childhood depression. High EE has been associated with the presence of depressive symptoms in adolescents (McCleary & Sanford, 2002). Additionally, mothers' critical comments have been connected with a significantly higher risk for developing childhood depression, conduct disorders or substance abuse (Schwartz et al., 1990). There is some

¹ Hostility is now included with criticism as it appeared to be highly related to criticism.

evidence to suggest that high levels of criticism are associated more with depressive symptoms than high levels of emotional over-involvement (Asarnow, Tompson, Hamilton, Goldstein & Guthrie, 1994; McCarty & Weisz, 2002; Vaughn & Leff, 1976), and Hooley, Orley and Teasdale (1986) found that depressed patients relapsed at lower rates of criticism than schizophrenic patients. Additionally, critical remarks by the parents are likely to be internalised by the child and promote critical remarks directed towards the self (Jaenicke et al., 1987) a key characteristic of depression (Blatt & Zuroff, 1992).

Not only is there an association between EE and depression, but also one with outcome. In their broad study of published research involving EE, Butzlaff and Hooley (1998) found that EE was a strong predictor of relapse for those suffering from a mood disorder. In fact, the mean figures for relapse were significantly higher in mood disorders than for schizophrenia. The association between EE and relapse has been replicated in studies with depressed children (e.g. Asarnow, Goldstein, Tompson & Guthrie, 1993), depressed adults (Uehara, Yokoyama, Goto & Ihda, 1996) as well as depressed spouses (Hooley et al., 1986). However, this correlation has not been replicated in all studies (Andrew, Hawton, Fagg & Westbrook, 1993; Goering et al., 1992, in Uehara et al., 1996).

One criticism of EE studies is that they fail to show the causal direction of the association between EE and child psychopathology (Hibbs et al., 1991; Hirshfeld et al., 1997; Schwartz et al., 1990; Seifer, Sameroff, C.P. Baldwin & A. Baldwin, 1992; Vaughn & Leff, 1976) and do not solve the conundrum as to whether high EE emerges as a result of how difficult a depressed child may be to manage or whether depression emerges as a result of exposure to high EE. Satisfactory family and marital environments have been shown to be associated

with low EE whereas family conflict and achievement orientation have been associated with high EE (Hibbs, Hamburger, Kruesi & Lenane, 1993). It would appear that low EE serves as a protective factor in families where a member is suffering from a psychiatric disorder (Hibbs et al., 1993; McCleary & Sanford, 2002). Moreover, some studies have suggested that parent-child relationships may change over time. Puig-Antich (1985b) found that the quality of the parent-child relationship improved when the child remained depression-free for four months. Likewise, EE ratings are not static and may change over time (G.W. Brown, 1972, in Vaughn, 1989; Lefley, 1992) and intervention programmes have taken this into account and attempted to lower the EE status in the household. Leff et al. (1982) were able to lower relapse rate in a group of schizophrenic patients using family therapy and psychoeducation to lower parental EE.

Due to early onset, episodic course, risk for recurrent depression as well as suicide and negative parental interactions, it would seem that early and aggressive intervention is needed. How best to intervene becomes an important question, particularly as research on treatment of depressed youths is sparse and more than a decade behind that of adults (Moreau, Mufson, Weissman & Klerman, 1991). The use of pharmacology to treat childhood depression is very controversial and the superiority of tricyclic antidepressants has not proven to be more effective than placebos (Gadow, 1992; Jensen, Ryan & Prien, 1992). Additionally, some parents are averse to medication because of possible side effects, e.g. tachycardia and liver damage (Cytryn & McKnew, 1979). Certain studies have reported success with selective serotonin re-uptake inhibitors (SSRIs), which have the additional benefit of few side effects (American Academy of Child & Adolescent Psychiatry [AACAP], 1998). However, little is known about continuation and maintenance of treatment for

children and adolescent depression (Emslie, Mayes & Huges, 2000), as its effects on maturation and development have not been explored (AACAP, 1998). It has been argued that antidepressants should be considered for patients with psychosis, bipolar depression, severe depressions and those who do not respond adequately to psychotherapy (AACAP, 1998). Notwithstanding the controversy regarding the use of antidepressants to treat childhood depression, depression occurs in a psychosocial context and “pharmacotherapy is never sufficient as the sole treatment. There is evidence that the environmental and social problems associated with major depressive disorder remain when the patient’s mood has been stabilised with medication-only treatment” (AACAP, 1998, p. 72S). Hence, psychotherapy may be an alternative option in the treatment of depressed youths.

There appears to be varying opinions as to the efficacy of psychotherapy to treat childhood disorders. Although research on the efficacy of psychotherapy has advanced considerably over the last few decades, there is still a dearth of valid and reliable, empirically supported, psychosocial interventions for children and more outcome studies are needed (R.T. Brown & Levers, 1999; Kazdin, 1993; Pearsall, 1997; Target & Fonagy, 1994; Weiss, Catron, Harris & Phung, 1999; Weissman & Jensen, 2002). Psychotherapy received bad press in the 1960s from Levitt (1963, in Pearsall, 1997) who argued that children who did not receive psychotherapy improved as rapidly as children who did receive therapy. It is only in the last few decades that research has shown that psychotherapy is efficacious in treating childhood disorders (AACAP, 1998; Carr, 1999; Kolvin et al., 1981; Lonigan, Elbert & Johnson, 1998; Sigelman & Rider, 2003). It has been found to be particularly beneficial for externalising problems (e.g. aggression) as well as internalising problems (e.g. anxiety and depression) (Carr; Sigelman & Rider) and appears to be a useful initial treatment for treating childhood

depression (AACAP, 1998; Kovacs & Bastiaens, 1995).

Although there is an abundance of outcome studies exploring the efficacy of psychotherapy with adult populations, literature on optimal treatment guidelines for depressed children and adolescents has lagged behind that of adults (Asarnow, Jaycox & Tompson, 2001; Kaslow & Thompson, 1998; Kovacs, 1997; Moreau et al., 1991). It is likely that this was due to the general resistance to recognise depression in children as a clinical problem until the 1980s. Research on psychotherapeutic treatments is critically important (Asarnow et al., 2001; Harrington, 1995; Kazdin, 1993) as “identification of specific interventions for specific problems and diagnoses is required to best serve children in need of mental health services” (Lonigan et al., 1998, p. 139). To date, psychosocial treatments with depressed children have shown limited efficacy - 40 - 50% of studies have failed to show significant recovery or remission (Asarnow et al., 2001). These statistics indicate the need to develop more effective treatment strategies. Further, results of outcome studies are often puzzling as they are counter to clinical experience and expectations (Petti, 2000).

Due to the association between childhood depression and impaired social relationships, individual psychotherapy provides the child with an opportunity to develop an alliance with the therapist (an important element in any intervention) as well as a foundation on which to incorporate new experiences in a helpful rather than unhelpful way (Trowell, 1992). It can help youths understand themselves, identify their feelings, improve self-esteem and change maladaptive patterns of behaviour. It provides the space to explore the ways in which the person reverts to familiar, unproductive and harmful ways of thinking and relating as well as examining ways of coping with past and current stressors and interpersonal conflict

(AACAP, 1998). Not only is depression associated with disrupted interpersonal relationships, but also distorted negative self-concepts (Blatt & Zuroff, 1992). The identification of interpersonal and self-critical factors in depression is consistent with both behavioural and psychoanalytic theories in which helplessness and negative feelings about the self are seen as central issues in depression.

The majority of psychotherapy treatment outcome studies with depressed children have typically examined outcomes of cognitive behavioural therapy (CBT) (Harrington, 1995; AACAP, 1998; Nathan, Stuart & Dolan, 2000). Interestingly enough, although most research studies of treatment have focused on CBT, in clinical practice clinicians tend to use non-behavioural treatments (Weiss et al., 1999). To date, the only treatments that have demonstrated efficacy in treating childhood depression are CBT and the use of SSRIs (Asarnow et al., 2001). In addition there are only two reports demonstrating the efficacy of interpersonal psychotherapy for adolescent depression (Mufson et al., 1993; Rosello & Bernal, 1999, in Asarnow et al., 2001). CBT lends itself well to treatment because it works on identifying and changing negative and distorted self-cognitions, which are typically associated with depression. "Cognitive theory postulates that it is not stressful events themselves that cause depressed mood. Rather, it is the negative or dysfunctional interpretations that are made about such events that create and maintain depressed mood." (Asarnow et al., 2001, p. 34). However, while CBT approaches have yielded successful results they have also been associated with a high rate of relapse at follow-up (AACAP, 1998). For example, Vostanis et al. (1996, in Asarnow et al., 2001) found a relapse rate of 40% within 6 to 12 months following a CBT treatment.

Another form of individual psychotherapy is psychodynamic psychotherapy. This type of therapy is concerned with more fundamental modifications of the child's inner world rather than changing distorted cognitions and maladaptive behaviour, as in CBT. It is based on working with the child on the here-and-now relationship (Trowell, 1995). It provides the space to identify and deal with transference issues² as a current replay of earlier distortions and interactions. Attention is also given to defences and unconscious processes as well as issues concerning individuation (particularly in adolescents) as they become manifest in interpersonal current problems (Kolvin, unpublished). This type of intervention may help in altering the youth's internal representational models³ and sense of a secure base (Kolvin, unpublished) as well as improving interpersonal functioning and relationships. It thus holds the potential for more lasting changes (Moreau et al., 1991).

Not only is there a paucity of outcome research regarding optimal treatment of depressed youths, but a noticeable void with regards to that dealing with the efficacy of psychodynamic psychotherapy (Bemporad, 1994; Muratori et al., 2002). Single case studies are the most frequently published accounts of psychodynamic psychotherapy (Trowell, 1995). Although psychodynamic psychotherapy is one of the most long-standing treatment approaches, there is still a lack of controlled research on its effectiveness with depressed children. As it is likely to be used in clinical practice it "merits closer empirical examination, preferably in

² The process by which a patient displaces feelings or ideas derived from other figures in his/her life onto the therapist (Rycroft, 1972).

³ Concept derived by John Bowlby. Each person has an internal model of self and external reality which develops over the years and helps them to negotiate current reality by predicting possible outcomes. This internal working model often distorts current reality due to past experiences. Although internal working models are very stable, they are not fixed templates and able to change in particular situations. "Clinical experience shows that patients are more likely to be consciously and unconsciously predisposed to rediscovering those representational models which are associated with painful emotions when they feel safe with a kind and empathic therapist." (Marrone, 1998, p. 78).

controlled treatment-outcome investigations” (Lewinsohn et al., 1994, p. 317).

The use of psychodynamic psychotherapy to treat other disorders/difficulties has proved beneficial in a number of outcome studies. Trowell et al. (2002) found a substantial reduction in post traumatic stress disorder symptoms in a group of girls who had been sexually abused, following an intervention of individual psychodynamic psychotherapy. Target and Fonagy (1994) undertook a retrospective study of over 700 children with emotional disorders, treated using psychoanalysis at the Anna Freud Centre. Of those treated for at least six months, 72% showed reliable improvement in adaptation as measured by the Children’s Global Assessment Scale (CGAS). Their group of depressed children did not fare as well as the others and was less likely to move into the functional range as measured by the CGAS. However, more than 50% of their depressed group had a comorbid diagnosis that may have impacted on outcome. Baruch and Fearon (2002) evaluated the mental health outcome of youths who received psychodynamic psychotherapy at a community centre. They found a significant decrease in both externalising and internalising problems. These changes held a year after treatment. A significant reduction in behavioural problems and externalising problems was also found in a group of children with emotional disorders 18 months after a brief intervention of psychodynamic psychotherapy (Muratori et al., 2002). Further, psychodynamic psychotherapy has the potential of continuing benefits of therapy after the termination of therapy, i.e. sleeper effects (Muratori et al., 2001).

Due to impaired parent-child relationships associated with childhood depression, Kovacs and Bastiaens (1995) have argued that the salient goal of a psychotherapeutic treatment should be to re-establish and preserve the parental-child bond. One way of including the parents is

in a family-based treatment, which addresses and treats conflictual and pathological family relations (Asarnow et al., 1994; Hibbs et al., 1993). A family systems approach concentrates on the environment in which the youth finds him/herself rather than on the individual. An interactional model of depression (Asarnow et al., 1994; Coyne, 1976) sees dysfunctional family interactional patterns, parental depression and criticism, and family stress as contributing to ongoing depression in the child. This in turn fuels family stress and dysfunction. "Thus, regardless of their role in depression aetiology, family factors may impact depressive symptoms and the depressed individual impacts the family system." (Asarnow et al., 2001, p. 41). Further, greater family stress has been associated with a longer initial depressive episode and lower social competence (McCauley et al., 1993, in Asarnow et al., 2001). Family therapy is orientated at understanding and changing the aspects and sequences of dysfunctional family interactions throughout the family system. As depression has been associated with high levels of EE, a systems-based family therapy, which aims specifically to reduce levels of over-involvement and criticism within the family, as well as focusing on altering interactions between family members, may be particularly pertinent in the treatment of depressed youths.

In the study reported here, family therapy was used instead of a no-treatment control group. Therefore, less emphasis has been placed on family therapy and family therapy outcome studies in this project. Research into family based interventions to treat childhood depression is sparse (Kaslow & Racusin, 1994) and is not comprehensive enough to allow conclusions regarding its effectiveness with regards to treatment of childhood depression (Pearsall, 1997), as existing trials provide contradictory evidence as to their value (Asarnow et al., 2001).

Because parents form an important component in their child's milieu, it would seem expedient to include them in some way in the treatment of their child (AACAP, 1998; Kovacs & Bastiaens, 1995; Sherrill & Kovacs, 2002), particularly if that child was receiving individual therapy. Rushton and Miles (2000) provided support to the carers of sexually abused girls in treatment. They found that this parallel service helped to promote a positive attitude in the mothers towards the treatment of and improvement in their offspring. This was found to be related to improvement in the girls' psychosocial adjustment. Further, they found that these mothers experienced considerable benefit themselves from a professional listening to their difficulties. They hypothesised that it was likely that this may have reduced the possible decline in the parent-child relationship and may have led to the "re-establishment of a more positive parent-child interaction" (Kovacs, 1997, p. 294). Unfortunately, there have been very few studies in which provision of care to the carer has been investigated.

Since so little is known about the effect of psychodynamic psychotherapy in the treatment of childhood depression, and "there is a critical need for further research aimed at clarifying the efficacy of different treatment strategies" (Asarnow et al., 2001, p. 35) a research team at the Tavistock Clinic was interested in exploring this further. This was the objective of the *Psychotherapy for Childhood Depression* project at the Tavistock Centre. Due to the interest in EE in psychiatry, and reported links between EE and depression in the literature (Asarnow et al., 1994; McCleary & Sanford, 2002; Schwartz et al., 1990) a part of this project was set aside to explore possible relations between EE and depression, as well as the prospect of changes in EE following a therapeutic intervention. The present study reports on the findings

of this spin-off project. In particular, this study was interested in answering the following questions:

1. Does depression change following a therapeutic intervention?
2. Is there an association between EE and depression?
3. Does EE change in relation to variance in depression?

The team involved in the current study had previously evaluated the efficacy of psychodynamic psychotherapy in the treatment of girls who had been sexually abused (Trowell et al., 2002) and were all affiliated to the Tavistock Clinic, which is a UK National Health Service Trust situated in London. The clinic is involved in clinical mental health work, research, training and scholarship. It is an out-patient facility that treats children, adolescents, adults, couples and families with mental health problems. The Tavistock Centre has traditionally been associated with a psychodynamic orientation towards treatment. The research for this study was funded by the European Medical Research Council Brussels (BIOMED). In order to obtain a larger sample and to explore the implications of cross-cultural exportability, the exact study was replicated at the Universities of Helsinki and Athens.

Chapter 2

Method

There is much evidence showing that childhood depression does exist, and has been observed in children as young as three years old (Lous, De Wit, De Bruyn & Riksen-Walraven, 2002). As elucidated in the previous chapter, it has a debilitating effect on the child and is associated with impaired social functioning. Not only does there seem to be a need for early and aggressive intervention, but a need also to increase our knowledge of the efficacy of different treatment approaches given the paucity of research in this area (AACAP, 1998; Kovacs, 1997). The current study hopes to contribute to this field of knowledge.

Participants

Twenty-four children with depressive disorders were recruited from the Child & Family Department (out-patients) at the Tavistock Centre in London, and participated in this study with their parents. Children were 11 - 15 years of age with a mean age of 12 years 1 month. There were 16 boys and 9 girls. At the time of entry into the study nine children were living in two-parent homes and fifteen children were living in single-parent homes. Inclusion criteria included:

1. 11-15 years of age. This age range was selected for the following reasons: first, to ensure the child was old enough to understand the self-completion instruments; second, in order to obtain continuing information about educational progress and school behaviour over at least two years whilst the child attended school.
2. The subject cohabited with at least one biological parent so as to enable reasonable comparability of families in the study.

3. The child met the DSM IV (APA, 1994) criteria for major depressive disorder.

Additionally it was necessary to ascertain whether the child would co-operate in treatment and whether s/he would be able to form a therapeutic alliance with a therapist.

Exclusion criteria included:

1. Subjects using anti-depressants (unless they agreed to stop the use of medication).
2. Subjects with one of the following comorbid diagnoses: conduct disorder; panic disorder; learning disorder; bipolar affective disorder; schizoaffective disorder or any other psychotic disorders. Additionally, those at risk of suicide or who needed to be hospitalised were excluded from this study.
3. Children whose parents suffered from a psychiatric disorder.

Study design

A randomised control trial design was used to investigate these questions. For ethical reasons, a control group in which treatment was withheld was not possible. Since our interest was in individual child psychodynamic psychotherapy, it was decided that this type of therapy would be compared to a systems integrative family therapy that served as a form of control group.

Procedure

Children who are believed to suffer from a psychiatric disorder or from emotional distress are generally referred to the Tavistock Centre by their general practitioners, if they reside in the centre's catchment area. On their initial presentation at the Child & Family Department, children are screened for the probability of suffering from depression (using the Child

Depression Inventory, Kovacs, 1985) during their initial interview. In this study, those who screened positive were referred to the project's psychiatrist to be interviewed using the Schedule for Affective Disorders & Schizophrenia (Kiddie-SADS) (Chambers et al., 1985), complemented by a clinical diagnosis using DSM IV criteria. A senior clinician then reviewed the materials to confirm the diagnosis. Children diagnosed with major depressive disorder and their parents then met the research team in order to obtain informed consent from both parent and child to participate in the study. A further battery of assessments took place within the week of the initial assessment. These provided the study with baseline data. As there are age variations (Kashani et al., 1987) and gender differences (Fleming et al., 1989) in children with depressive symptoms, adjustments were made prior to assignment to treatment types. Children were first classified according to age and gender so that pairs of children of the same gender and similar age were randomly allocated to one of the two treatment groups.

Subjects assigned to individual therapy received 30 sessions (of 50-minutes each). Additionally, the child's primary caretaker was seen for 15 sessions by a social worker or senior psychiatric registrar (for those receiving individual therapy). This provided the caretaker with a space in which they could discuss management of their child or their own personal difficulties. Additionally, it was felt that this would help with compliance of therapy attendance.

Those assigned to family therapy received 14 sessions (of 90-minutes each). Both interventions had a maximum time period of nine months in which to complete their treatment. Thus, they fell within the treatment time of 6 to 12 months as recommended by

the AACAP's practice parameters for child and adolescent depression (AACAP, 1998).

Within 10 days after the final therapy session, children and parents were reassessed using the same battery of instruments used at baseline. These tests were repeated again six months later in order to obtain follow-up data.

Twelve psychotherapists and two supervisors took part in the study. In order to match levels of competence and equivalence of skills of the therapists, the six individual therapists were all in their final year of psychotherapy training at the Tavistock Centre. Thus they were known to the institution and did not have to go through further screening to establish their suitability.

The six family therapists were all qualified therapists working at the Tavistock Centre. Prior to the project commencement, all 12 therapists attended workshops (one day a week for 10 weeks). These were run by the projects supervisors and aimed at training in the following:

1. Adherence to treatment techniques as stipulated by a manual (consisting of statements of the aims, objectives and techniques of therapy). This was to ensure treatment was standardised. "Manualised treatments ... provide the means of determining when results apply to specific interventions" (Lonigan et al., 1998, p. 141). This manual was developed by clinical staff at the Tavistock Centre.
2. Reviewing of video and audio-tapes
3. Discussion of therapy vignettes
4. Training on the completion of therapeutic rating scales

Family therapists were required to video-tape their family therapy sessions and a supervisor from behind a one-way mirror observed every second session. One-in-four individual therapy sessions were audio-taped and these therapists received supervision in groups of two every second session, where they discussed four cases. Adherence to the manual was checked from the video-tapes and audio-tapes by supervisors. Difficulties with the manual were raised so that it could be rectified at a later stage in order to improve and upgrade the manuals. Therapists were also asked to complete rating scales of their perceptions of each therapy session in order to contribute to an understanding of the process.

Of the twenty-four subjects who participated in the study, two subjects dropped out and three were non-completers. Dropouts were defined as those subjects who attended less than half of their therapy sessions. Non-completers were those who attended more than half but not all of the allotted therapy sessions. This was anticipated as some studies have suggested higher rates of premature termination in depressed children, e.g. Target and Fonagy (1994).

Instruments used in the study

Instruments were selected according to the applicability to both individual and family therapies and included a mix of self-rating scales and face-to-face interviews.

Diagnostic screening

The following instruments were used as part of the screening for suitability to the project. DSM IV (APA, 1994) diagnoses were obtained during the initial assessment based on the following:

1. *Child Depression Inventory* (CDI) - Kovacs (1985). This is a self-rating

inventory for assessing depression in school-aged children and adolescents.

2. *Kiddie-SADS* - Chambers et al. (1985). This is a semi-structured interview with children aged 6-17 years. It is a reliable and valid instrument for measuring symptoms of depression, emotional disorder and conduct disorder. Interviews were conducted with the child as well as their caretaker in order to ensure a valid diagnosis.

Not only were these instruments used for screening (and thus formed baseline data) but also at the end of therapy and at follow-up.

Additional ratings pertinent to the current study

Expressed Emotion: The Five Minute Speech Sample (FMSS) - the FMSS (Magaña et. al., 1986) was used to assess EE towards the child by one of their parents. The FMSS involves asking a parent to speak about their child and their relationship to their child, without interruption, for five minutes. It attempts to ascertain information such as the relationship between the relative and the patient, the patient's psychiatric history and the relative's attitude towards the illness. The speech samples were rated by a trained rater, blind to the rest of the study. They were rated according to a scoring manual. A second rater, rated 10% of the samples. There was substantial agreement between the raters (75%). Parents were rated as high EE or low EE on two dimensions - criticism (EE CRIT) and emotional over-involvement (EE EOI). The following criteria led to a classification of high EE based on criticism. One of the following:

- (i) A negative initial statement about the child;
- (ii) A negative relationship;

- (iii) One/more critical comments about the child (based on content or tone of the respondent).

The following criteria led to a classification of high EE based on emotional over-involvement. One of the following:

- (i) Crying during the five minutes;
- (ii) Overprotective or self-sacrificing behaviour (e.g. “I don’t spend money on myself so that I can buy her whatever she wants.”);

Or, two of the following:

- (iv) Excessive detail about how the child behaved in the past;
- (v) Expression of very strong feelings of love or a willingness to do anything for the child;
- (vi) Excessive praise (i.e. five or more positive remarks).

Those not meeting the above mentioned criteria were rated as low EE. Additionally, a classification of borderline EE was given to those who displayed some features indicating EE but not sufficient to gain a score of high EE. Only one of the parents was screened using the 5MSS. High EE was assigned to families when one parent had a high EE rating.

The 5MSS is a briefer measure of expressed emotion than the Camberwell Family Interview (CFI) (Leff & Vaughn, 1985, in Asarnow et al. 1994) which was designed to assess intrafamilial attitudes. The drawback of using the CFI is that it takes approximately two hours to administer and three to four hours to rate (Magaña et al., 1986). Based on the finding that the bulk of EE was identified in the early part of the CFI, the FMSS gives the

respondent only five minutes to talk, with the expectation that critical, hostile or over-protective feelings will be evoked under this time pressure (McGuire & Earls, 1994). Although the FMSS relies on listening to the tone and content of the recordings, it takes less time to administer and score than a full interview.

Children's Global Assessment Scale (CGAS) - Shaffer et al. (1983). This is an assessment scale that allows the rater to measure the overall severity of disturbance and condense it into a single, clinically meaningful index. It was designed to reflect the lowest level of functioning for a child during a given time period and in this study was used to assess levels of depression. Its values range from 1 to 100 (i.e. from functional impairment to healthiest level of functioning). The cut-off score of 70 distinguishes a dysfunctional range (< 70) from a normal range (> 70). Test-retest stability as well as discriminate and concurrent validity has been demonstrated for this scale.

Statistics

For statistical analysis, the *Statistica 6.1* (StatSoft. Inc., 2002) suite of statistical programmes was employed. Multiple regression analysis was used to examine a continuous dependent variable (i.e. depression) with various other independent variables (i.e. EE, type of intervention and time). Analysis of Variance (ANOVA) was employed to contrast means of the CGAS scores at three different time periods and *t* tests used to see if these changes were significant. Finally Chi-square analysis was used to explore possible changes in the EE data.

Chapter 3

Results and discussion

The following questions became the focus of this study:

1. Does depression change following a therapeutic intervention?
2. Is there an association between depression in the child and EE by the parent?
3. Does EE shift in relation to changes in depression?

The data was subjected to a number of statistical procedures in order to investigate the relationships between the following variables:

- EE (as measured by the Five Minute Speech Sample)
- depression (as measured by the CGAS)
- time (at baseline, end of therapy, and follow-up)
- therapy (individual psychodynamic psychotherapy and systems integrative family therapy)

A multiple regression analysis (Table 1) was conducted to ascertain whether there were any associations between the variables. In this analysis, the depression scores (i.e. CGAS scores) were treated as measures of the dependent variable and EE, therapy and time were treated as the independent variables.

Table 1: Results of multiple regression analysis

Dependent variable: CGAS No. of cases = 57 (i.e. 19 subjects x 3 time points) Standard error = 8.147	Multiple R = 0.616 $R^2 = 0.379$ Adjusted $R^2 = 0.344$	$F = 10.78$ $p = 0.00$
Intercept = 47.619 Standard error = 8.147	$p = 0.00$	
Independent variables: Therapy: $\beta = 0.15$ Time: $\beta = 0.581$ $p < 0.05$ EE: $\beta = -0.06$		

The R^2 value of 0.34 indicated that 34% of the variance is accounted for by the regression model. No significant associations between the extent of the child's depression and the level of EE by the parent were found. Further, there was no significant difference between individual and family therapies. What was significant was changes in depression over time. The beta values indicated that the independent variable of time was the only variable which was significantly predictive of depression scores ($\beta = 0.581$, $p < 0.05$).

In order to examine these changes over time more thoroughly, the CGAS data was subjected to an Analysis of Variance (ANOVA) (Table 2). Using the CGAS scores as the dependent variable and time as the independent variable, the ANOVA results confirmed the results of

the multiple regression analysis ($F = 30.94, p < .01$). A number of t tests were performed on the CGAS scores in order to ascertain whether changes in depression levels over time were significant. Because there was no significant difference between the different types of interventions (i.e. individual therapy and family therapy), the CGAS data from both treatment groups was pooled. Significant differences between CGAS scores were found between baseline and end of therapy ($t = -5.65, p < .01$) as well as between baseline and follow-up ($t = -8.39, p < .01$). Thus, not only had depression levels changed between baseline and end of therapy but the child's mood continued to improve six months after termination of therapy. The average CGAS score at baseline was 47. This increased to 69 by follow-up. Thus, six months after termination, the average child's global level of functioning fluctuated around the borderline level of normal functioning (CGAS = 70).

Table 2: ANOVA results of CGAS scores at three different time points

Individual & Family Therapy	Baseline	End of therapy	Follow-up
Mean	47	65	69
Std deviation	7.6	14.8	12.8

These results are similar to those found by Muratori et al. (2002). They found significant changes in their depressed group's global level of functioning following an intervention. These changes continued for six months but did not persist up to 18 months. They argued that major improvement in global level of functioning of depressed children who have been treated, appear within the six month follow-up period. As with the current study, the Muratori et al. study used psychodynamic psychotherapy to treat children with emotional disorders. However, their intervention was briefer and consisted of six sessions of family

therapy and five sessions of individual therapy with the child. In a retrospective outcome study of children with emotional disorders treated with psychoanalysis, Target and Fonagy (1994) used CGAS scores to measure outcome. Although their depressed group received a more intensive intervention (1-5 times per week) than the current study or the Muratori et al. study, the bulk of these children remained in the dysfunctional range of functioning (which they defined as < 68). In contrast, Muratori et al.'s experimental group fell well within the normal range of functioning six months after intervention (CGAS = 77). In all three studies there was an increase in the global level of functioning of between 13 (Target & Fonagy, 1994) and 22 points (the current study). Thus, from these studies it appears as if psychodynamic psychotherapy is effective in increasing a depressed child's global level of functioning - although it may be that depression is more resistant to shifting to normal levels of functioning than other emotional disorders.

The same multiple regression analysis (Table 1) was used to explore the second research question, i.e. possible associations between high EE in parents and the existence of depression in their offspring. The beta value (-0.06) indicated that there was no significant association between these two variables. These results stand in contradiction to some other studies, e.g. Mc Cleary & Sanford (2002), Asarnow et al. (1994) and Schwartz et al. (1990) who all found an association between high EE and childhood depression. One conclusion could be that there simply is no relationship between childhood depression and EE. Of course, it is also possible that this study failed to show an association. We cannot find an immediate explanation for why our findings should be so different. Initially, we thought it was because we had used only the most available parent to determine EE status. The customary approach is to classify a family unit as high if one parent receives a high EE score

(Asarnow et al., 1994), hence, by testing only one of the parents, high EE parents may have been missed leading to an overall familial classification of low EE. Only one parent was chosen in this study primarily because 62% of the cohorts lived with one parent. However, like this study, both McCleary and Sanford and Schwartz et al. used only one parent to obtain their EE rating, and yet their results showed a positive association between high EE and depression as did the Asarnow et al. study, which used both parents.

We queried whether it could be the use of the 5MSS as opposed to the Camberwell Family Interview. McCleary and Sanford (2002) have argued that the 5MSS provides more false negatives and thus has lower rates of high EE than the CFI. Magaña et al.'s (1986) study showed that approximately one third of high EE cases were recorded as low EE when the 5MSS was used. It is likely that more families would have been classified as high EE had the CFI been used in this study. The 5MSS was chosen as there were no trained CFI coders working on this project and there was less investment in EE as it was a spin-off study. However, of the three studies which showed positive associations between high EE and depression, only Schwartz et al. (1990) used the CFI the other two used the 5MSS.

The EE scores were examined a little more closely in order to see if there were any differences between EE Crit and EE EOI. The raw data was converted into percentages in order to aid comparisons. These results are displayed in Figure 1.

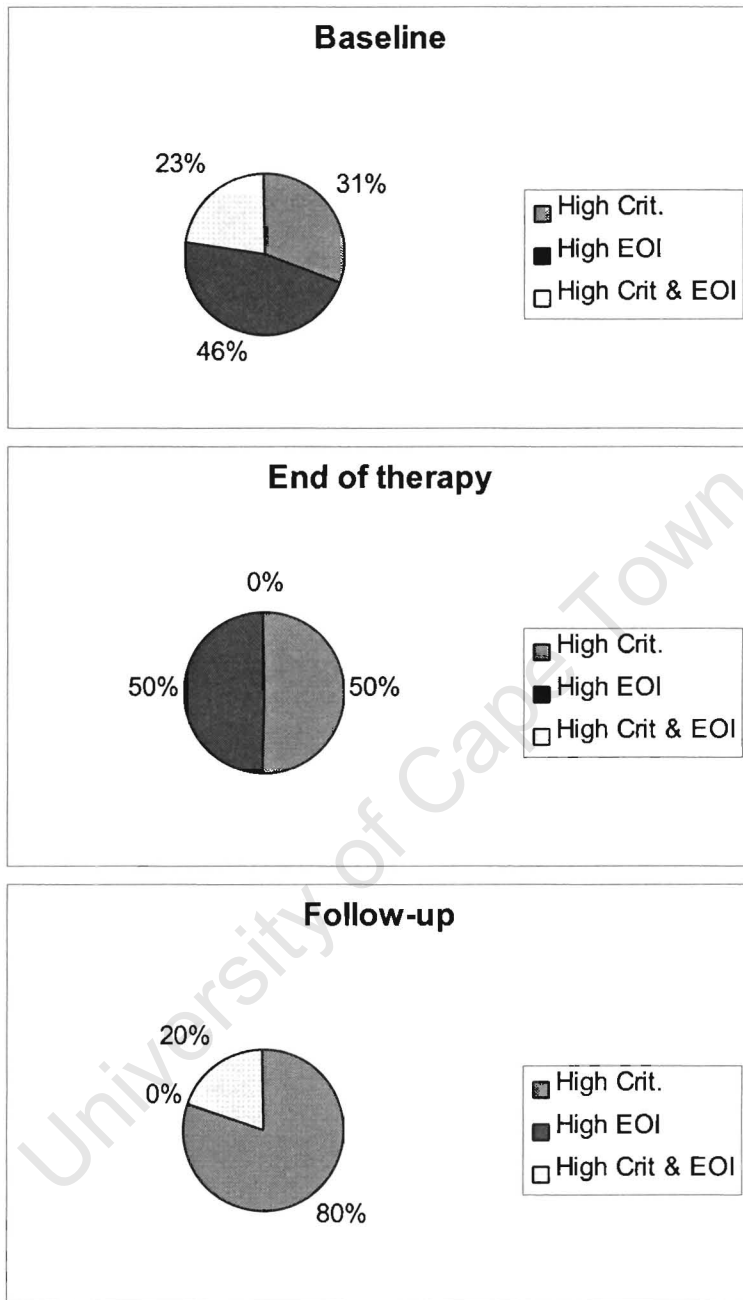


Figure 1: High EE data: changes in percentages of high EE Crit, high EE EOI and high EE Crit & EOI at three different points in time

Some studies which have found an association between EE and depression have attempted to look more specifically at the critical comments category of EE (EE Crit), concluding that parental criticism is a more specific predictor of depression in offspring (Asarnow et al., 1994; Hibbs et al., 1991; Schwartz et al., 1990). These studies back the notion that depressed children are more likely to encounter criticism and rejection in their interpersonal environments (Cole & Rehm, 1986; Coyne, 1976) and that parental criticism is likely to reinforce the depressed child's already negative view of him/herself (Jaenicke et al., 1987). Distorted and negative self-cognitions have been associated with childhood depression (Asarnow et al., 2001; Blatt & Zuroff, 1992). The baseline data was as follows: in this study EE Crit accounted for 31% of the high EE cohorts (17% of the total) whereas EE EOI accounted for 46% (25% of the total sample); 23% (13% of the total cohorts) were classified as both high EE Crit and high EE EOI. Unfortunately there is a dearth of research examining the impact of emotional over-involvement on depression. Miklowitz et al. (1983, in Lefley, 1992) found a strong association between EOI and withdrawn behaviour in adolescents. Stubbe et al. (1993) found a correlation between high EOI and anxiety disorders. Given the high prevalence of anxiety comorbid with depression (Carr, 1999; DSMIV; Sigelman & Rider, 2003), it may be possible that EOI is just as prevalent in depression as criticism. EOI accounted for more of the high EE ratings of this study. Jacobsen, Hibbs and Ziegenhain (2000) found an association between high maternal EE and ambivalent attachment with offspring. Ambivalent parenting styles are characterised by inconsistent parenting as well as enmeshed and intrusive relationships, which are the salient characteristics of EOI. They are associated with clingy children who consistently seek reassurance and fear separation (Blatt & Zuroff, 1992; Holmes, 1993). This behaviour is prone to provoke negative responses from the parents so that a vicious cycle develops (Holmes, 1993). After an extensive review

of literature on childhood depression, Blatt and Zuroff concluded that most studies identified two salient characteristics associated with depression:

1. Disrupted interpersonal relationships - which relate to dependency, helplessness and fear of loss or abandonment.
2. A negative and distorted sense of self - which relate to self-criticism and feelings of failure and guilt.

As ambivalent attachment is associated with dependency, helplessness and fear of abandonment in the child, and enmeshment and intrusiveness in the parent (i.e. EOI), it seems likely that emotional over-involvement may be just as an important component as criticism in childhood depression. The most significant result of the multiple regression was the change in depression, which decreased over time. When comparing this to the EE data (Figure 1) the most noticeable change was in the EOI data, which dropped from 46% of the high EE sample at baseline to 0% at follow-up. It is likely that these figures are more related to the changes in depression than EE Crit, which increased from 17% at baseline to 21% at follow-up. However, it must be noted that the number of parent's classified as high EE Crit remained the same ($n = 4$) but they formed a larger percentage of the total sample, which decreased because of a smaller sample size due to drop out and non-completers.

The third research question posed by this study addressed whether EE changed significantly during the course of treatment. This aspect of the study was particularly interested in whether EE might change in relation to depression changing – in other words, as the child's mood improved, was there a reduction in critical comments or emotional over-involvement by the parent? Pearson Product-moment Correlation was used to examine whether there

were significant changes between the number of high EE parents at baseline, end of therapy and at follow-up. In this study, there were no statistically significant changes in EE over time ($\chi^2 = 3.4$, $p = 0.18$). It might then be easy to assume that high EE in the parent does not result as a consequence of the child's depressed behaviour (because the EE levels did not respond to a change in the child's depression) and that it more likely that high EE leads to the development of childhood depression. However, this assumption cannot be made as no significant association was found between EE and depression at baseline. However, of note was a movement from high EE to low EE over the time period of this study (Figure 2).

When only data from completors was used ($n = 19$) the numbers of subjects classified as high EE at baseline ($n=9$) decreased by end of therapy ($n = 4$) and increased slightly at follow-up ($n= 5$). In comparison, Figure 3 plots the changes in depression scores over time, showing how the children's mood improved from baseline to end of therapy and then tapered off at follow-up. The graph depicted in Figure 3 is almost the inverse of the high EE graph in Figure 2. Thus, as depression scores improved, EE scores decreased. Although this trend was not statistically significant, repetition of the study with a larger sample size may yield interesting results and be able to confirm or refute this trend.

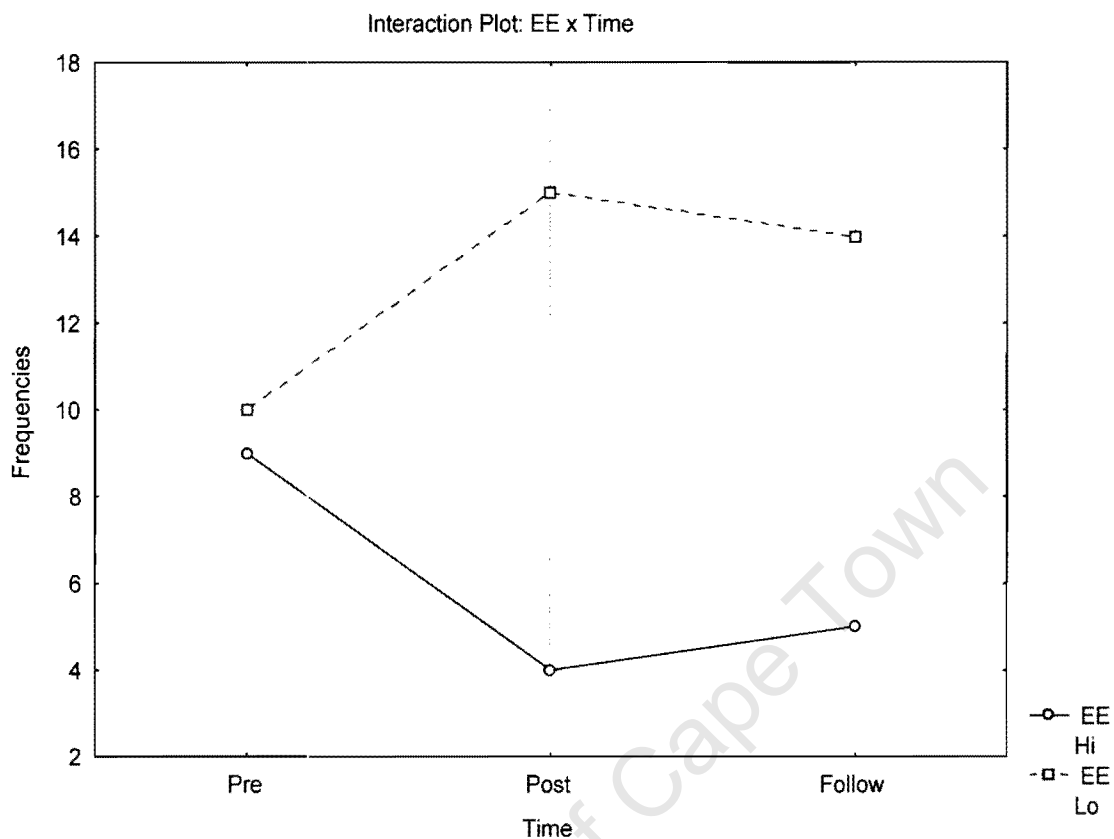


Figure 2: Graph of high and low EE scores over time

Thus, in this study, EE was not significantly associated with depression and EE scores did not change significantly following a therapeutic intervention. Even though there was a significant improvement in depressed mood amongst the children in this sample, EE did not shift significantly in relation to these changes although there were complementary movements (i.e. depression decreased and so did EE).

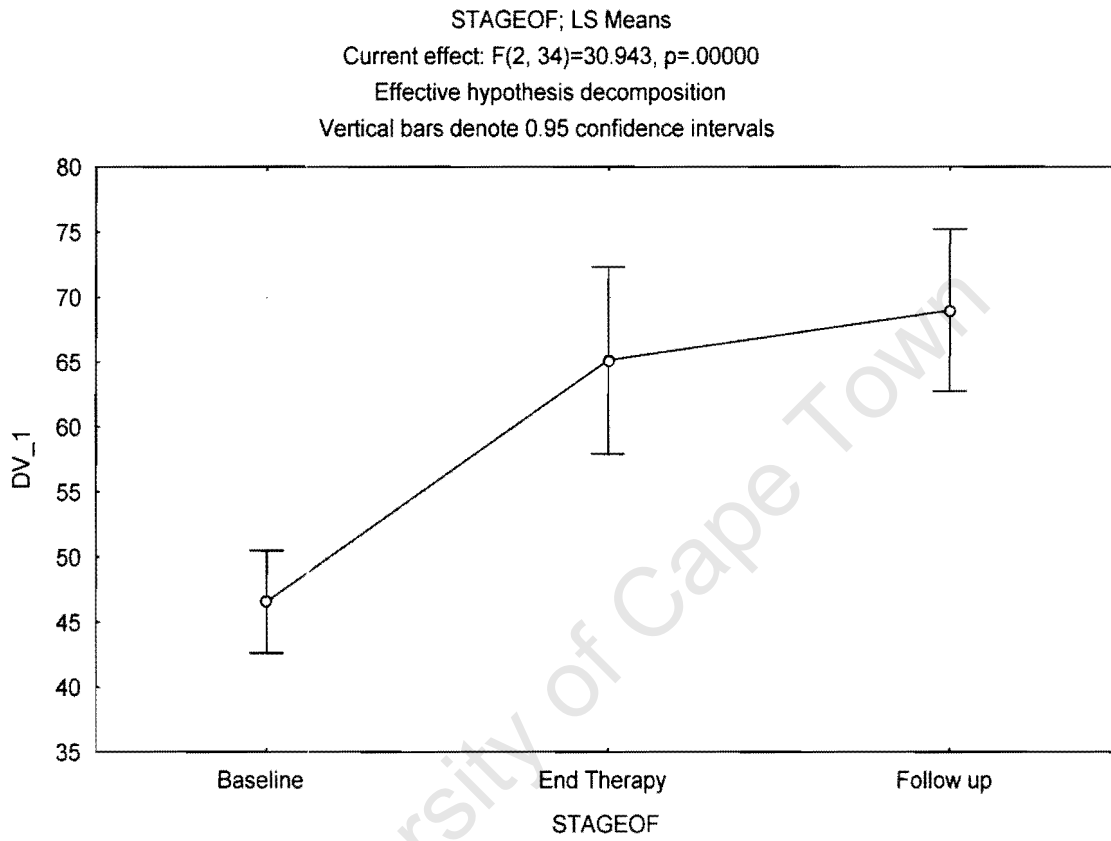


Figure 3: ANOVA results of CGAS scores

Chapter 4

Conclusion

This study found that levels of depression in children decreased following a therapeutic intervention. The global level of functioning of the child improved regardless of whether they received individual or family therapy, thus suggesting that both forms of therapy were equally effective. In this study, there was a significant change in the levels of depression over time. Because the control group also received treatment (family therapy) and there was an absence of a group that did not receive any intervention, we cannot conclude with any certainty that the changes were due to the therapy itself. Instead we can suggest that they are likely to have been, but this would need to be clarified by further research.

From the current study, the Target and Fonagy (1994) and the Muratori et al.'s (2002) studies, it seems likely that psychodynamic psychotherapy is effective in bringing about improvement in a depressed child's global level of functioning. However, in the case of depressed children it may be particularly difficult to shift this to well within the normal range of functioning, especially if the child has a comorbid diagnosis of anxiety disorder. Approximately half of the depressed children in the Target and Fonagy study were diagnosed with a comorbid anxiety disorder. This may be why most of these children stayed below the normal level of functioning. A diagnosis of a depressive disorder as well as an anxiety disorder is associated with a greater severity of both disorders (Bernstein, 1991, in Target & Fonagy, 1994). Another reason for the lower levels of response in the Target and Fonagy study may be because they failed to include the parents in their treatment plan.

Higher CGAS scores were associated both with this study and the Muratori et al.'s study both of which included the parents, in some way, in the intervention. Parental inclusion may also help with treatment compliance by the child and is likely to reduce the drop-out rate. Target and Fonagy found a higher level of premature termination in their depressed group than in their other groups.

Further outcome studies as to the efficacy of psychodynamic psychotherapy to treat childhood depression are needed. Longitudinal studies are required in order to measure the long-term benefits of this type of individual therapy and to ascertain whether a modification of the child's internal world lowers the risk of subsequent episodes of depression. If effective, as suggested by the decrease in depression levels in this project, it would reduce the need for in-patient care and thus the high costs of hospitalisation. Further, it will improve the quality of life for the depressed individual, both socially and academically.

One of the primary aims of this study was to look at EE and its relationship to depression. Unfortunately, no conclusive links could be made from the results of this study. Strong associations have been found between depression and EE in other studies as well as between EE and relapse. However, this study is not aware of any studies that have explored the shifts in EE over time following a therapeutic intervention. It must be stressed that the Psychotherapy for Childhood Depression project did not attempt to change EE directly in any manner. The EE component was included as a small subsection to see if and how it might relate to depression. Although no positive results were found in relation to EE in this study, there were noticeable trends, which could be explored further with a larger sample.

EE is not static and changes over time. Due to the high prevalence of relapse rate amongst depressed patients reported in other studies (Asarnow et al., 1993; Hooley et al., 1986; Uehara et al., 1996), it was felt that it was particularly significant to query whether there was a parallel shift in EE as depression levels changed. In this study, the major increase in CGAS scores was between baseline and end of therapy and this change held for six months. It would be interesting to do a further follow-up with the same sample to see what happens to this trend, whether the beneficial effects of therapy would continue (sleeper effects), or whether they would start to steady off or even decrease after therapy terminates (wash out effects). If these changes developed concurrently with changes (i.e. a decrease) in EE, then it might be assumed that the chances of relapse would be reduced.

There could be various hypotheses made about shifts in EE in relation to the two theories of impaired parental-child relationships (as discussed in chapter one) and its link with depression.

1. If high EE resulted as a consequence of the child's depression i.e. as concomitant of the parent's inability to cope with the child's depressive behaviour (McCleary & Sanford, 2002) then there would be an expectation that as the child's mood improved, EE would change. G.W. Brown et al. (1972) found that in a third of cases studied, the relative's level of EE Crit decreased following an improvement in the patient's condition. Given this hypothesis, an individual therapy, which helps to reduce the level of depressive features in the child, should have positive spin-off effects in the parental-child relationship. Further, an intervention that helps the carer deal with their child's behaviour, and their feelings about the behaviour, may be additionally beneficial.

2. High EE has also been implicated in the aetiology of childhood depression. If intervention is aimed at the child only then it is likely that the child would be more likely to relapse if the EE level did not alter. Various studies have shown that the high EE is a predictor of poor outcome of psychiatric patients (G.W. Brown et al.; Butzlaff & Hooley, 1998) and more specifically in those who are depressed (Asarnow et al., 1993; Hooley et al., 1986; Uehara et al., 1996). Thus, it might be more expedient to include parents in some sort of intervention as well and family therapy might be the treatment of choice.

Thus far, what has failed to have been explored significantly is whether EE is a general characteristic of families and present in families both with and without disturbed children. One of the problems with EE is that it can be misconstrued in a manner that attributes blame to the parents for the child's condition (Lefley, 1992). In the late 1980s, EE research lost some of its favoured position because it was felt that it gave families unhelpful labels, burdening them with accountability (Kuipers, 1992). Perhaps a more helpful way of viewing EE is to view it as a barometer of family distress that fluctuates in its intensity at any given point in time (Vaughn, 1989). As mentioned previously there is no conclusive evidence to suggest whether it causes the disturbance in the child or whether it represents the parent's inability to cope with a set of disturbing symptoms and behaviours in the child. Aside from this debate, it has a useful role as an indicator of major risk in the course of psychiatric illness (Vaughn, 1989). Hence, it is important that intervention programmes try to intervene at the EE level, particularly as it is modifiable and may be of value in the prevention of psychiatric relapse (Hooley et al., 1986).

An intervention programme that has been utilised in an attempt to lower EE in families with schizophrenic patients has been the psychoeducation programmes devised by Leff et al. (1982). Through psychoeducation and family sessions at home, they were successful in ameliorating critical attitudes in the relatives of schizophrenic patients - there were substantially lower relapse rates in this group. Such an intervention programme may also be of benefit to families struggling with depressed youths. There are no such studies known to this researcher.

Limitations of this study and suggestions for future studies

The conclusions drawn from this study are tempered by some limitations. The sample size was small and so limited the power of the statistical analyses used and prevent generalisations being made to the population at large. However, it fulfilled the requirements of a pilot study. Recruiting more subjects for the study was not feasible. Furthermore, therapy was expensive and time-consuming. As it was, 12 families were initially allocated to family therapy; 13 children to individual therapy and 13 parents to supportive counselling. Treatment continued for up to nine months. Fortunately, this study was part of a larger project and the combined data from all parts of the project will strengthen the tentative conclusions reached in the present study.

One criticism of EE is that it was originally derived empirically from research on adult schizophrenic patients and has subsequently been utilised on parents with younger children with no adjustment in scoring and interpretation. It is possible that some of the criteria used may not be appropriate for parents of juvenile children. Developmental issues may play a role in younger children and they may require more emotional support and aid than parents

with adult offspring (McCarty & Weisz, 2002; Wamboldt et al., 2000). Thus, it may be more discerning to separate the ratings based on EE Crit from those based on EOI. In this study EE Crit and EOI were reported separately. Wamboldt et al. have argued that excessive praise is a reflection of better child and family functioning and should be excluded as a category for classification with children. In this study, only three subjects (out of the total 57, i.e. 19 subjects at three time points) praised their children excessively, (i.e. more than five times in five minutes) and this contributed to only one rating of high EOI. Thus, it might be that parents of depressed children tend to be low on praise and positive remarks. This may tally with Kashani et al.'s (1994) notion that parents of depressed youths are less supportive and set higher standards for performance in their offspring (Cole & Rehm, 1986).

It is also important to bear in mind the cultural specificity of EE. The concept emerged out of research in the United Kingdom and was later extended to the US. It has more recently been utilised in studies amongst other cultures with no perceived difficulties in adaptation, e.g. in Japan (Uehara et al., 1996) and Brazil (Martins, De Lemos & Bebbington, 1992). However, it has also been argued that the "construct of EE is essentially cultural in nature," (Jenkins & Karno, 1992, p. 9) and there is certainly scope for research on both contextual and cultural influences on EE. The children drawn for this study were from North London in the UK, which is a cosmopolitan area with multiple diverse ethnic groups.

There is much scope for further research on EE and depression. Thus far EOI has not been conclusively investigated as a component relating to depression - it is important to do so as this study suggests that it may play a bigger role in depression than has been previously attributed. What is needed is outcome studies that are specifically aimed at reducing EE.

One of the ways Leff et al. (1982) attempted to lower EE was by reducing face-to-face contact between parent and child - this was met with some success. However, further studies, which examine the protective factors of low EE, are also needed so that more effective intervention studies can be implemented.

Another area of interest for further research is the intergenerational transmission of depression - the degree to which the mothers of depressed children are themselves depressed. In fact, Weissman and Jensen (2002) have argued that maternal depression is transmitted across the generations, even to grandchildren. Parental self-reported histories of depression have been associated with EE status (Hibbs et al., 1991) although McCleary and Sanford (2002) found no association. This work is still in its infancy and needs further investigation. The current study intervened by providing support for the carer as well as for the child. This provided carers with a space in which to explore their own struggles with similar issues from their childhood experiences or to discuss ways of coping with their offspring's behaviour. Rushton and Miles (2000) have argued that in their study the carers gained considerable benefit from the support which they received whilst their children were in parallel treatment. Reliable evidence regarding the efficacy of support for the carer is needed given that they too may be struggling with depression or other unresolved difficulties themselves.

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University of Cape Town