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Effectiveness of Providing Cognitive-behavioral Group Therapy for Both Children and their Parents Separately in the Treatment of Childhood Major Depressive Disorder: A Pilot Study

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Abstract

Background: Three social learning mechanisms were hypothesized to influence the development of depressogenic cognitive styles: modeling of parents' negative cognitive styles; direct learning from negative parental inferential feedback regarding the stressful events in the child's life; and indirect learning from negative parenting practices. In this study, I proposed an approach addressing psychopathology in parents as well as their children through providing cognitive behavioral therapy for both, separately, in treatment of childhood Major depressive disorder. This study's objective is to evaluate the effectiveness of this approach.

Method: Cognitive behavioral group therapy was provided separately to seven children diagnosed with Major depressive disorder, and their parents in 12 weekly 1-hour sessions. Parents' sessions were parallel to children sessions, focused on learning the same skills and techniques taught in the children's groups, targeting modifying negative cognitive styles of parents as well as children. Psychiatric clinical interview by specialized child psychiatrists and Parent-rated Mood and Feelings Questionnaire (PMFQ) were used pre- and post-treatment to evaluate depressive symptoms.

Results: At the end of the treatment, all children no longer met criteria for major depressive disorder. There were statistically significant reductions in scores of parent-rated Mood and Feelings Questionnaire, which also demonstrated that none of the children no longer had a score indicative of depressive disorder.

Conclusion: This study suggested that providing cognitive behavioral group therapy for both children and their parents, separately, is an effective approach for childhood major depressive disorder treatment.

Keywords: Childhood major depressive disorder; Parental psychopathology; CBT for children; CBT for parents

Abbreviations: CBT - Cognitive-behavioral therapy; MDD - Major depressive disorder; DSM-5 - Diagnostic and statistical manual of mental disorders; 5th edition; PMFQ - Parent-rated Mood and Feelings Questionnaire

1. Introduction

According to Beck's cognitive theory of depression, negative thinking styles or 'negative cognitive schemas' play a key role in the development, maintenance, and recurrence of depression, Beck also described cognitive triad of depression that consists of negative view about the self, the world, and the future [1]. Negative schemas attribute to errors in information processing that result in negative biased interpretation of experiences. Information processing errors have been identified as cognitive distortions [1]. Negative schemas are hypothesized to develop from interactions with the environment, primarily during childhood through early learning experiences, especially those within the family [2].

Social-cognitive learning theory proposed that individuals tend to internalize the self-concepts, judgment standards, rules-making, and self-regulatory influences which are encountered in their learning environment, so children can learn cognitive disturbances vicariously through parental modelling [3]. Three social learning mechanisms were hypothesized to play a role in the development of depressogenic cognitive styles: modeling of parents' negative cognitive styles; direct learning from negative parental inferential feedback regarding the causes and consequences of stressful events in the child's life; and indirect learning from negative parenting practices.

Seligman et al. [4] reported a significant correlation between the attributional styles for negative events of mothers and their elementary school children. Similarly, Stark, et al [5] found a significant relationship between mothers' and children's scores on a measure of Beck's negative cognitive triad. Many other studies support that children may learn their cognitive styles in part by observing and modeling significant others, particularly their parents [6-9]. It is hypothesized that the mother's cognitive style is modeled more than the father's cognitive style [10].

In addition to modeling, the feedback that parents provide their children about causes and consequences of negative events in the child's life has also been found to contribute to the child's cognitive risk for depression. Children may develop an inferential style consistent with the parental feedback. Perceived parental messages about the self, world, and future were also shown to be predictive of children's cognitive triad, as well as ratings of depression [5]. The same study found that the relationship between perceived parental messages and depression is completely mediated through children's cognitive triads [5]. Garber and Flynn [11] reported a relation between mothers' attributions for events in the child's life and their child's attributions. Alloy et al. [10] found that both mothers and fathers of

adolescents with high cognitive vulnerability reported that they provided more negative inferential feedback in response to negative events than did parents of adolescents with low cognitive vulnerability.

Children's development of negative cognitive style influenced not only by direct learning from parental inferential feedback about negative events in the child's life, but also by indirect learning from parents through negative parenting practices. Young [12] hypothesizes that maladaptive schemas could be the result of inadequate parenting or ongoing aversive experiences within the family environment such as repeated criticism or rejection. Parental rejection and restrictive control in childhood predicted subsequent self-criticism in adolescence [13]. Children's self-worth, inferential styles, and attitudes are influenced by the quality of their relationships with their parents [14, 15]. Children who are raised by parents characterized by low warmth [16] and/or high criticism [17, 18] tend to develop more depressogenic cognitive styles than other children. Parents who impose rigid or perfectionistic standards on their children may influence their children to adopt those same standards in themselves, resulting in the formulation of dysfunctional attitudes [17, 19].

Findings from previously mentioned studies had proposed various potential treatment implications, with special recommendation for greater inclusion of caregivers in the treatment of depressed children [20-22]. Cognitive-behavioral therapy (CBT) has been evaluated by several studies as the best-supported psychosocial intervention for treatment of Major Depressive Disorder depression (MDD) in children and adolescents [23-26]. Recently, many studies supported that the efficacy of CBT can be enhanced by including adjunctive sessions for positive parenting practices to individual CBT sessions [27-32]. Results suggest that including parents is associated with positive treatment outcomes, regarding reduction in depressive symptoms and maintenance of results in short-term follow-ups.

There are many family-focused interventions for childhood MDD that target parenting practices, but few interventions address parental psychopathology. In this study, I proposed an approach addressing psychopathology in parents as well as children through providing cognitive behavioral therapy for both children and their parents, separately, in treatment of childhood MDD. I hypothesized that modifying negative cognitive styles of parents will in turn replace their negative inferential feedbacks with positive and supportive ones, hence parents can model healthy adaptive cognitive styles to their children, helping them to overcome depression. This study's objective is to evaluate effectiveness of this approach.

2. Methods

2.1. Participants

Children and their parents were recruited from child psychiatry out-patient clinic, Abbassia psychiatric hospital. Children were evaluated by specialized child psychiatrists through psychiatric clinical interview based on Diagnostic and statistical manual of mental disorders, 5th edition. (DSM-5) published by American Psychiatric Association [33]. DSM-5 diagnoses were made based on information derived from the parents about the child and from the child about him/herself.

The inclusion criteria were that the child's age was between 8 and 12 years, the child met DSM-5 criteria for MDD, and that child and his/her parents are willing to participate in treatment. Exclusion criteria were receiving another psychosocial treatment for depression during the 3-month intervention phase, and having primary symptoms of a non-depressive disorders that suggested a need for alternative services, such as severe conduct disorder, schizophrenia-spectrum and other psychotic disorders, intellectual disability. Another exclusion criterion was reporting of acute suicidality, meaning suicidal ideation with a plan and level of intent that made the child a high-risk case.

Children who were taking antidepressant medications were eligible if they continued to meet inclusion criteria and had been on the same medication and dose for at least 3 months prior to entering the study and throughout the 3-month intervention phase. Twenty children and their parents were evaluated for participation in this study. Six children did not meet diagnostic criteria for MDD and were referred to other treatment interventions. Five children presented with intellectual disability and also were referred to other treatment interventions. Two families dropped out before the start of treatment. Thus, seven children and their parents participated in this study, none of them expressed an interest to discontinue participation during the course of the treatment.

The children's age ranged from 9 to 11 years old (M = 10.1; SD = 0.9), most of them were males (85.7%). Three children were taking antidepressant medication, but they met the requirement of fulfilling criteria of MDD and were using the same medication and dose for at least 3 months prior to enrollment and throughout their participation. Most of parents participating in treatment were mothers (77.8%), see Table 1.

		Number	**Percentage**
Child gender	Male	6	85.7%
	Female	1	14.3%
Child use of antidepressant medications	No	4	57.1%
	Yes	3	42.9%
Parents participating in the treatment	Mother	7	77.8%
	Father	2	22.2%

Table 1: Characteristics of participants.

2.2. Procedure

Cognitive-behavioral therapy was provided separately to children and their parents in 12 weekly sessions, each lasting one hour, in group therapy format. Parents' sessions were parallel to children sessions, focusing on learning the same cognitive-behavioral therapy skills and techniques taught in the children's groups, aiming to modify negative cognitive styles of parents as well as children.

Parents' sessions' main target was modifying the parents' negative cognitive styles, which would in turn replace their negative inferential feedback with positive and supportive one, hence parents can model healthy adaptive

cognitive styles to their children. This was prepared for by providing psychoeducation about childhood MDD (including symptoms, contributing factors, course, treatment), and supporting the importance of parents' roles as models and change-agents for their children.

Parents also learned to promote their children's generalization of skills by using the same terms and concepts learned in sessions at home, and by encouraging their children to practice these new skills outside of session, parents were aided in applying these skills to their own family interactions. So instead of dependence solely on modifying children's cognitive styles directly, modifying parents' negative cognitive styles related to parents themselves and to their children would reduce parental negative inferential feedback which indirectly would modify children's negative cognitive styles through modeling.

Regarding children's sessions, cognitive-behavioral therapy skills and techniques were designed to match the generally more concrete cognitive level of children, skills were divided into small components that can be mastered in a step-wise fashion. Exercises were presented as "games" initially to make them more engaging to children and to increase the likelihood that these "games" could become their tools for combating depression. To encourage children to complete home assignments token economy was used, also the term "Home assignment" was avoided as many children have negative associations with it, so it was replaced with "Happiness pills". Practice-at-home was a crucial part of treatment and was included weekly, so both children and parents received simplified sessions handouts and home assignments to implement and generalize the usage of cognitive-behavioral therapy strategies within children and parents' daily life. Table 2 demonstrates an overview of the sessions' objectives.

	Children's group	**Parents' group**
Session 1	Introduction and group rules	Introduction, group rules, and orientation to treatment program
Session 2	Psychoeducation about symptoms of depression	Psychoeducation about childhood depression, and parents' roles as models and change-agents for children
Session 3	Identifying different types of feelings and situations that trigger each of them	Identifying different types of feelings and situations that trigger each of them
Session 4	Measuring feelings intensity, and identifying impact of intense negative feelings on daily functioning	Measuring feelings intensity, and identifying impact of intense negative feelings on daily functioning
Session 5	Controlling intense negative feelings by relaxation techniques and self-soothing skills	Controlling intense negative feelings by relaxation techniques and self-soothing skills
Session 6	Identifying differences between thoughts, feelings and behaviors, and the relationship between them	Identifying differences between thoughts, feelings and behaviors, and the relationship between them
Session 7	Identifying different types of thoughts (core	Identifying different types of thoughts (core

	beliefs and automatic thoughts), and training on thoughts monitoring to capture common negative thoughts	beliefs and automatic thoughts), training on thoughts monitoring to capture common negative thoughts, and understanding impact of modeling of parents' cognitive styles and parental inferential feedback on development of their children's core beliefs.
Session 8	Identifying different types of cognitive distortions, and training on thoughts monitoring to capture commonly made cognitive distortions	Identifying different types of cognitive distortions, training on thoughts monitoring to capture commonly made cognitive distortions, and understanding impact of parent's' cognitive distortions on development of their children's cognitive distortions
Session 9	Challenging and testing negative thoughts and replacing them with positive and more balanced thoughts.	Challenging and testing negative thoughts and replacing them with positive and more balanced thoughts, and training on applying these skills to family interactions by using at home the same terms and concepts learned in sessions to promote generalization of skills
Session 10	Enhancing self-esteem	Highlighting impact of positive parenting practices on children's self-esteem
Session 11	Problem-solving skills training	Problem-solving skills training
Session 12	Anti-bullying techniques training, and review of all learned skills	Psychoeducation about strategies for depression relapse prevention

Table 2: Overview of sessions' objectives.

2.3. Measures

The Arabic version of Parent-rated Mood and Feelings Questionnaire PMFQ [34] was used pre-treatment and post-treatment to evaluate depression symptoms. It is a 34-item questionnaire developed to measure depressive symptoms for children and adolescents aged between 8 and 18 years old [35]. The PMFQ statements asked parents to rate on a 3-point scale (0 = Not true, 1 = Sometimes, and 2 = True) how their child felt or acted in the past two weeks. A cut-off score of 28 has been recommended to produce optimal sensitivity and specificity [34]. Children were also clinically evaluated pre-treatment and post-treatment by specialized child psychiatrists through psychiatric clinical interview based on DSM-5 [33].

2.4. Ethical considerations

This study was approved by the ethics committee of Abbassia psychiatric hospital. Written consent was obtained from parents on behalf of their children and for their own participation after discussing the aim of the study and the treatment provided with them.

2.5. Statistical analysis

Data were summarized using mean and standard deviation in quantitative data, and using frequency (count) and relative frequency (percentage) for categorical data. For comparison of serial measurements before and after treatment within each patient, the nonparametric Wilcoxon signed-rank test was used. Comparisons between absolute change and percent change of PMFQ scores pre- and post-treatment between children using and children non-using antidepressant medications were done using the nonparametric Mann–Whitney U test. These tests do not assume that dependent variables are normally distributed. Additionally, these tests are less vulnerable to the influence of extreme scores because they rely on ranks. These considerations and the small sample size make this a generally conservative approach.

3. Results

At the end of the treatment, all of the children no longer met DSM-5 criteria for Major depressive disorder according to clinical evaluation by specialized child psychiatrists. Figure 1 demonstrates that the pre-treatment PMFQ score (M = 43.1; SD = 10.8) which indicates depressive disorder, decreased at post-treatment (M =8.1; SD =5.6), a score indicating that depressive disorder was unlikely. The change of reported depressive symptoms on PMFQ pre- and post-treatment is shown in Table 3

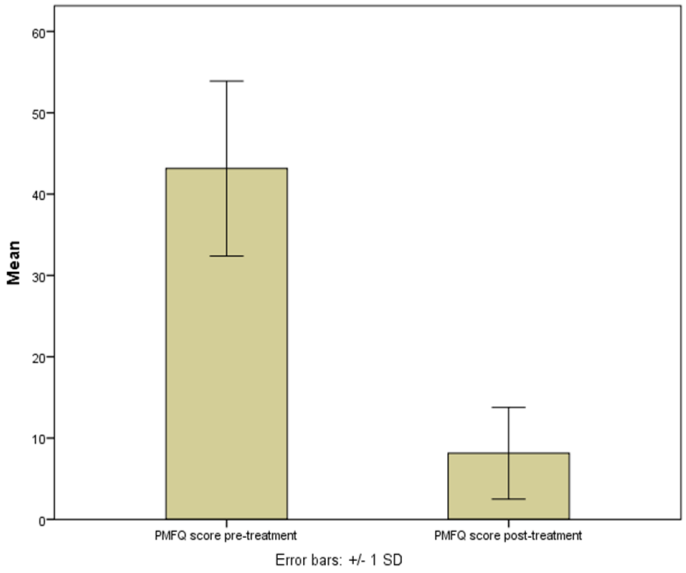

Figure 1: Comparison of pre-treatment and post-treatment mean and standard deviation scores of parent-rated mood and feelings questionnaire PMFQ.

	Pre-treatment			**Post-treatment**		
	Not true	**Sometimes**	**True**	**Not true**	**Sometimes**	**True**
Miserable or unhappy	0 (0%)	0 (0%)	7 (100%)	4 (57.14%)	3 (42.86%)	0 (0%)
Didn't enjoy anything	0 (0%)	0 (0%)	7 (100%)	5 (71.43%)	2 (28.57%)	0 (0%)
Less hungry	3 (42.86%)	0 (0%)	4 (57.14%)	5 (71.43%)	1 (14.29%)	1 (14.29%)
Ate more	6 (85.71%)	0 (0%)	1 (14.29%)	6 (85.71%)	0 (0%)	1 (14.29%)

Tired	2 (28.57%)	0 (0%)	5 (71.43%)	6 (85.71%)	1 (14.29%)	0 (0%)
Moving and walking slowly	4 (57.14%)	1 (14.29%)	2 (28.57%)	7 (100%)	0 (0%)	0 (0%)
Restless	3 (42.86%)	0 (0%)	4 (57.14%)	4 (57.14%)	3 (42.86%)	0 (0%)
No good	0 (0%)	0 (0%)	7 (100%)	5 (71.43%)	2 (28.57%)	0 (0%)
Blamed self	3 (42.86%)	0 (0%)	4 (57.14%)	6 (85.71%)	1 (14.29%)	0 (0%)
Indecisive	5 (71.43%)	0 (0%)	2 (28.57%)	6 (85.71%)	1 (14.29%)	0 (0%)
Irritable	0 (0%)	0 (0%)	7 (100%)	1 (14.29%)	6 (85.71%)	0 (0%)
Talking less	2 (28.57%)	0 (0%)	5 (71.43%)	6 (85.71%)	1 (14.29%)	0 (0%)
Talking slowly	2 (28.57%)	0 (0%)	5 (71.43%)	6 (85.71%)	1 (14.29%)	0 (0%)
Cried a lot	1 (14.29%)	0 (0%)	6 (85.71%)	5 (71.43%)	2 (28.57%)	0 (0%)
No good in future	2 (28.57%)	0 (0%)	5 (71.43%)	5 (71.43%)	2 (28.57%)	0 (0%)
Not worth living	2 (28.57%)	0 (0%)	5 (71.43%)	5 (71.43%)	2 (28.57%)	0 (0%)
Thoughts of death	2 (28.57%)	1 (14.29%)	4 (57.14%)	7 (100%)	0 (0%)	0 (0%)
Better off without	6 (85.71%)	0 (0%)	1 (14.29%)	7 (100%)	0 (0%)	0 (0%)
Suicidal thoughts	4 (57.14%)	0 (0%)	3 (42.86%)	7 (100%)	0 (0%)	0 (0%)
Not see friends	1 (14.29%)	1 (14.29%)	5 (71.43%)	5 (71.43%)	2 (28.57%)	0 (0%)
Poor concentration	3 (42.86%)	0 (0%)	4 (57.14%)	4 (57.14%)	3 (42.86%)	0 (0%)
Bad things happen	3 (42.86%)	0 (0%)	4 (57.14%)	4 (57.14%)	3 (42.86%)	0 (0%)
Hated self	3 (42.86%)	0 (0%)	4 (57.14%)	5 (71.43%)	2 (28.57%)	0 (0%)
Bad person	2 (28.57%)	1 (14.29%)	4 (57.14%)	5 (71.43%)	2 (28.57%)	0 (0%)
Looked ugly	4 (57.14%)	1 (14.29%)	2 (28.57%)	6 (85.71%)	1 (14.29%)	0 (0%)
Worried about aches and pains	5 (71.43%)	0 (0%)	2 (28.57%)	6 (85.71%)	1 (14.29%)	0 (0%)
Lonely	1 (14.29%)	0 (0%)	6 (85.71%)	6 (85.71%)	1 (14.29%)	0 (0%)
Unloved	0 (0%)	1 (14.29%)	6 (85.71%)	4 (57.14%)	3 (42.86%)	0 (0%)
No fun at school	3 (42.86%)	0 (0%)	4 (57.14%)	5 (71.43%)	2 (28.57%)	0 (0%)
Never be as good	1 (14.29%)	2 (28.57%)	4 (57.14%)	4 (57.14%)	3 (42.86%)	0 (0%)
Did everything wrong	1 (14.29%)	1 (14.29%)	5 (71.43%)	5 (71.43%)	2 (28.57%)	0 (0%)
Poor sleep	4 (57.14%)	1 (14.29%)	2 (28.57%)	7 (100%)	0 (0%)	0 (0%)
Slept more	4 (57.14%)	0 (0%)	3 (42.86%)	7 (100%)	0 (0%)	0 (0%)
Not cheered up	0 (0%)	0 (0%)	7 (100%)	7 (100%)	0 (0%)	0 (0%)

Table 3: Reported depressive symptoms on PMFQ pre and post treatment.

Results of the nonparametric Wilcoxon signed-rank test indicated that participated children demonstrated significant improvement of depression symptomology as evidenced by differences between pre-treatment and post-treatment PMFQ scores (W value = 0, *P*-value = 0.025). See Table 4.

		Minimum	Maximum	Mean	*SD*	*P*-value
PMFQ	Pre-treatment	30	54	43.1	10.8	0.025
	Post-treatment	2	19	8.1	5.6	

PMFQ; Parent-rated mood and feelings questionnaire

Table 4: Pre- and post-treatment PMFQ scores.

The nonparametric Mann–Whitney U test did not demonstrate a statistically significant difference between absolute change (U value = 2, *P*-value > 0.2) and percent change (U value = 6, *P*-value >0.2) between pre- and post-treatment PMFQ scores among children using and children non-using antidepressant medications. See Table 5.

		Number	Mean	*SD*	*P*-value
Absolute change	Children non-using medications	4	40.5	8.0	> 0.2
	Children using medications	3	27.7	9.1	
Percent change	Children non-using medications	4	81.4%	13.7%	> 0.2
	Children using medications	3	80.2%	10.2%	

Table 5: Change between pre-/post-treatment PMFQ scores among children using/non-using medications.

4. Discussion

This pilot study examined the effectiveness of providing cognitive-behavioral group therapy for both children and parents, separately, in treatment of childhood MDD. After participating in this study, all the children no longer met DSM-5 criteria for MDD according to clinical evaluation by specialized child psychiatrists. Results demonstrated statistically significant reductions of depressive symptoms of children as reported by their parents. The results also demonstrated that none of the children had a score indicative of depressive disorder at the end of treatment. However, results did not demonstrate statistically significant difference between improvement of children using and children non-using antidepressant medications. These findings suggested efficacy of this approach and supported the study's hypothesis.

The addition of parents' sessions followed findings from studies linking development of childhood depression to modeling of parents' negative cognitive styles, direct learning from negative parental inferential feedback and indirect learning from negative parenting practices [5-9, 16-17, 19], and recommendations for greater inclusion of parents in the treatment of depressed children [20-22].

This study's approach focused on addressing psychopathology of parents as well as their children through providing cognitive behavioral group therapy for both children and parents in treatment of childhood MDD, hypothesizing that modifying negative cognitive styles of parents will in turn replace their negative inferential feedbacks with positive and supportive ones, hence parents can model healthy adaptive cognitive styles to their children, helping them to

overcome depression. Throughout the course of the treatment none of the participating children nor their parents expressed an interest to discontinue participation which suggest high acceptability of this approach.

The main limitations of this pilot study were small sample size, absence of control group, and lack of follow-up data. This study aimed at providing preliminary data on treatment impact, feasibility, acceptability; a randomized controlled trial using large numbers and long-term follow up is needed to clarify treatment efficacy.

5. Conclusions

In conclusion, the present results of this Pilot study supported the efficacy of providing cognitive behavioral group therapy for both children and their parents, separately, in the treatment of childhood MDD. A randomized controlled trial is needed to further clarify the promise of this study's findings and determine the degree to which this approach is effective regarding long-term improvement and relapse prevention of childhood MDD.

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There are no funding resources.

Conflicts of Interest

There are no conflicts of interest.

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