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Combined Individual Cognitive Behavior Therapy and Parent Training for Childhood Depression: 2-3-Year Follow-Up

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Abstract

Fourteen children with significant depressive symptoms from an open clinical trial of Primary and Secondary Control Enhancement Training augmented with Caregiver–Child Relationship Enhancement Training, participated in a 2-3-year follow-up assessment. The results suggested that the significant decreases in depressive symptoms observed at post-treatment were maintained at 2-3-year follow-up. Mothers’ reports of significant improvement of child psychosocial functioning were also maintained, providing social validation of the effects. Pre-treatment child-rated mother-child relations predicted depressive symptoms at 2-3-year follow-up. These long-term data support the use of the combined intervention and suggest the need for further research on caregiver involvement in treatment.

Keywords

childhood; depression; cognitive behavior therapy; parent training; family

Depressive disorders are among the most prevalent and impairing pediatric conditions (AACAP, 2007) and constitute a major public health concern, requiring effective interventions. Cognitive behavioral treatment (CBT) is the most frequently evaluated and best-supported psychosocial treatment for children with depression (Weisz, McCarty, & Valeri, 2006), particularly when compared to inactive controls (De Cuyper, Timbremont, Braet, De Backer, & Wullaert, 2004; Stark, Reynolds, & Kaslow, 1987; Weisz, Thurber, Sweeney, Proffitt, & LeGagnoux, 1997). However, despite the empirical support for CBT, a recent meta-analysis (Weisz et al., 2006) suggested that the benefits for children with depression are relatively modest and short-lived, with an effect size of 0.34 for therapy compared to inactive controls and a small effect size of 0.24 against active controls. In addition, there is heterogeneity in response such that even therapies that work for most children in a trial fail to produce recovery for significant percentages of children (e.g., 36%; Asarnow, Scott, & Mintz, 2002).

Recommendations for improving efficacy of treatments have included the addition of new methods (Weisz et al., 2006), one of which is increased inclusion of caregivers (Sander & McCarty, 2005), while focusing on targeting difficulties in caregiver–child relations that characterize families of children with depression. Several researchers have piloted protocols that included caregivers in the treatments (e.g., Asarnow et al., 2002; Eckshtain & Gaynor, 2009; Tompson et al., 2007). Results suggest that including caregivers is associated with

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positive treatment outcomes, including reduction in depressive symptoms and maintenance of results in short-term follow-ups (e.g., one-month).

When evaluating treatment effects, a successful treatment should not only document remission of depressive symptoms at treatment completion and shortly thereafter, but should demonstrate maintenance at longer follow-up time points. In their meta-analysis, Weisz and colleagues (2006) found that more than one third of the studies reviewed did not include follow-up assessments and that only five studies included follow-up at one year or beyond. When examining the lasting effects of therapy, they found that the effects proved durable only in short-term follow-ups while effects at follow-ups of one year or longer showed no lasting effects. There is therefore a need for studies that document maintenance of results at longer follow-up assessments. Moreover, all studies that provided long-term follow-up data were conducted with adolescents, suggesting a great need for examination of lasting effects with children.

Eckshtain & Gaynor (2011) conducted an open clinical trial assessing the feasibility and efficacy of combining individual CBT with parent training for children with depression. The parent training targeted caregiver and family deficits identified in research on families of children with depression, including quality time spent together, communication, problem solving, and mood and behavior management. Data were collected at pre-, mid-, and post-treatment and at 1- and 6-month follow-ups. The results demonstrated significant decreases in depressive symptoms that were maintained over 1- and 6-month follow-ups. Benchmarked against the literature, the combination equaled CBT in other studies and was superior to control conditions. Maternal caregiver and teacher report of child functioning significantly improved, providing social validation of treatment effects. Maternal caregiver report of child–caregiver relations significantly improved; however, children did not report improvements in their relations with their maternal or paternal caregivers at post-treatment or follow-up assessments. The positive treatment effects on depressive symptoms and psychosocial functioning provide support for a combined intervention of individual CBT with parent training for children with depression. Unlike other findings where child reports show better outcomes than caregiver reports (Weisz et al., 2006), changes were noted by all informants – children, caregivers, and teachers. One of the main limitations is that the follow-up results focused only on short-term effects without assessing long-lasting effects.

The purpose of the current study was to provide initial data on the long-term effects of the combined CBT and parent training treatment conducted by Eckshtain & Gaynor (2011). Analyses focused on three areas. The primary focus was the extent to which depressive symptoms and psychosocial functioning maintained improvement 2–3 years after treatment completion. A second point of emphasis was the status of caregiver–child relations 2–3 years after treatment completion. Finally, associations between pre- and post-treatment variables and depressive symptoms 2–3 years after treatment completion were examined. In light of the previously reported positive findings from the short-term follow-up assessments, the primary hypothesis was that the positive changes in depressive symptoms and psychosocial functioning would be maintained 2–3 years after treatment completion. Given the contradicting reports of caregiver and child regarding their relations and the recognized lack of agreement between caregiver and child reports of symptoms and experiences documented in previous studies (see Achenbach, McConaughy, & Howell, 1987; DeLos Reyes & Kazdin, 2005; Eckshtain & Gaynor, 2009), it was hypothesized that both will maintain the report of relations from post-treatment. Specifically, maternal caregivers would continue reporting positive relations with their children compared to pre-treatment assessment and the children would report similar relations to those reported at pre-treatment assessment. Based on the considerable literature documenting the importance of family context and caregiver–child interactions for the maintenance of childhood depression, it was hypothesized that report of poor caregiver–child relations at pre- and post-treatment would be related to higher levels of child depressive symptoms 2–3 years later.

METHOD

Participants

Participants were 14 children and their caregivers who completed an open clinical trial of individual CBT and parent training (Eckshtain & Gaynor, 2011). When participating in the open trial, all the children were in elementary or middle school in a semi-rural community. They were referred to the study by school professionals if they scored 11 or higher on the Children's Depression Inventory (CDI; Kovacs, 1992). Inclusion criteria for the open trial included a score of 11 or higher on a second CDI given at the pre-treatment assessment (approximately 2 weeks later), having a caregiver who agreed to participate, and if receiving psychiatric medication, a stable dose for at least two months at enrollment. Exclusion criteria included symptoms of a non-depressive disorder as the primary problem or report of acute suicidality. Fifteen children completed the treatment and pre-, mid-, and post-treatment assessments. Fourteen children completed one- and six-month follow-up assessments (one child was lost due to maternal hospitalization for health reasons) and all participated in the current study.

When enrolled in the open trial, the average age of the children was 10.27 (*SD* = 2.02) years. The sample included 10 females and 5 males, 13 (86.7%) of which were Caucasian and two (13.3%) were multi-racial. In four cases both caregivers participated in the treatment with the child, in one case only the paternal caregiver participated, and in 10 cases only the maternal caregiver. Prior to their participation in the open trial, 12 (80%) had received psychotherapy and seven (46.7%) were prescribed psychiatric medications, which included stimulants, antidepressants, a mood stabilizer, and an antipsychotic (for further information, see Eckshtain & Gaynor, 2011). The 14 participants in the long-term follow-up sample had an average age of 13.0 (*SD* = 2.08) and included 9 females and 5 males, 12 of whom were Caucasian and 2 multi-racial. Long-term follow-up data were obtained from all 14 children and 13 of the children's caregivers (13 maternal caregivers and in two of these cases also paternal caregivers).

Procedure

Following a protocol approval by the Human Subjects Institutional Review Board at Western Michigan University, caregivers for the 14 children were contacted via telephone by the first author (who had also served as the therapist for all of the children in the open trial) and were invited to participate in the current study. Following verbal consent, a package containing consent and assent forms (for the caregiver and child, respectively) and questionnaires was mailed to the families. The caregivers were requested to sign the consent forms (on behalf of the child and for their own participation) and complete self-report inventories. The children were requested to sign the assent form and complete self-report inventories. The caregiver and child materials were placed in separate envelopes and then into a larger self-addressed envelope and mailed back to the researchers. All the fourteen children and at least one caregiver who had completed the original open trial (including the two mid-range follow-up assessments) participated in the current study. When data from 2 caregivers were available, the data from the primary caregiver (the caregiver who spent the most time with the child, which in both cases was the maternal caregiver) were used in the analyses.

Recruitment and enrollment for the open clinical trial lasted over a year. As such, at the time potential participants were contacted regarding providing long-term follow-up data, it was

2–3 years since completion of acute treatment. Because enrollment into the long-term follow-up assessment phase was done at a single time point, the length of time since treatment completion varied across participants. For four participants the long-term assessment was conducted at approximately 2 years post treatment completion, for four participants it was at approximately 2.5 years post treatment completion, and for six participants it was at approximately 3 years post treatment completion.

Treatment

The treatment in the open trial included 23 sessions over a 3–4 month period. The individual CBT was based on the Primary and Secondary Control Enhancement Training (PACSET) manual (Weisz, Moore, & Southam-Gerow, 1999) and included 16, 45-minute sessions. The parent training was based on the Caregiver–Child Relationship Enhancement Training (C–CRET) manual (Eckshtain & Gaynor, 2003) and the PASCET manual (Weisz et al., 1999) and focused on psychoeducation, spending quality time, reinforcing positive mood and behavior, positive communication, empathic listening and support, and problem solving. The parent training included seven, 60-minute sessions, which involved the caregiver alone or the caregiver and the child. All sessions were conducted at the school of the participating child (for further information, see Eckshtain & Gaynor, 2011).

Measures

The *Children's Depression Inventory* (CDI; Kovacs, 1992) is a child-report measure assessing depressive symptoms. The CDI has 27 items with each item consisting of three choices (0, 1, or 2) and higher scores indicating greater severity. In a normative study of the CDI with a sample of 1,252 children ages 8–16, the mean was 9.09 ($SD = 7.04$; Smucker, Craighead, Craighead, & Green, 1986). It has acceptable internal consistency and a 6-week test-retest reliability of .67 (Kovacs, 1992).

The *Strengths and Difficulties Questionnaire* (SDQ; Goodman & Scott, 1999) is a caregiver-report measure of child psychosocial functioning. The SDQ is a 25-item inventory assessing conduct problems, hyperactivity, emotional symptoms, peer problems, and prosocial behavior. The SDQ uses a 3-point scale and scores range from 0–40 and fall into abnormal (16–40), borderline (12–15), or normal (0–11) categories (Bourdon, Goodman, Rae, Simpson, & Koretz, 2005). Reliability ranges from .70 to .85 and internal consistency ranges from .51 to .76 (Goodman & Scott, 1999).

The *Parent–Child Relationship Questionnaire* (PCRQ; Furman, 2001) assesses warmth, closeness, positive disciplinary strategies, parental power assertion, and possessiveness on a 5-point scale from 1 (hardly at all) to 5 (extremely much). Higher totals indicate a better relationship. Children completed the 40-item youth version, while caregivers completed the 57 item version.

Statistical Analysis

Several analytic approaches were taken. First, because the timing of the long-term follow-up data spanned over a period of 2–3 years since acute treatment completion, we assessed differences in the distribution of scores across this one-year period using the nonparametric Kruskal-Wallis test. Finding no differences, these data were combined and considered 2-3-year follow-up data in the analyses. Second, continuous outcome data were analyzed using nonparametric Friedman and Wilcoxon tests. Nonparametric tests do not assume dependent variables are normally distributed and 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. In addition, associations between pre- and post-treatment reports of caregiver–child relations and depression levels on the CDI at 2-3-year follow-up were examined using Pearson correlation coefficient.

RESULTS

Depressive Symptoms and Psychosocial Functioning

Children's Depression Inventory (n=14) and Strengths and Difficulties Questionnaire (N=13)—Follow-up scores on the CDI at 2-3-year follow-up showed no statistically significant difference when compared to the post-treatment scores, $Z = -0.46$, $p=.65$, with no significant trend from post-treatment across the three (1-month, 6-month, and 2–3-year) follow-up assessment periods, $\chi^2=2.07$, $p=.56$ (see Table 1). These data suggest that gains were maintained across the long-term follow-up period.

There was no statistically significant change between the post-treatment SDQ scores average and the 2–3-year scores, $Z= -1.09$, $p=.28$. Similarly, there was also no significant trend from post-treatment across the three (1-month, 6-month, and 2–3-year) follow-up assessment periods, $\chi^2=1.89$, $p=.60$ (see Table 1). These data suggest that SDQ changes observed during the treatment interval were maintained.

Caregiver–Child Relationships

Parent–Child Relationship Questionnaire: Maternal caregiver report (N=13)— Maternal caregivers reported significant improvement in their relationships with their children during acute treatment. However, from post-treatment to 2-3-year follow-up maternal caregivers reported a significant worsening of relations, $Z = -2.34$, $p = .02$, which was also apparent when the data from post-treatment across all the follow-up periods (1-month, 6-month, and 2–3-year) were included, $\chi^2=10.95$, $p=.01$ (see Table 1). Of note, however, despite the significant decrease in maternal caregiver–child trend in relationships at 2-3-year follow-up, the relationships were still significantly better than that reported at pre-treatment, $Z= -2.34$, $p=.02$, suggesting some endurance of the improved relations.

Parent–Child Relationship Questionnaire: Child report (N=14)—The children did not report significant changes in their relationships with their maternal caregivers during acute treatment. Likewise, they failed to report significant changes at 2-3-year follow-up compared to post-treatment, $Z= -.83$, $p=.41$. However, at 2-3-year follow-up assessment the means were not different than at pre-treatment, $Z= -.71$, $p=.48$. As with their maternal caregivers, children did not report significant changes in their relationships with their paternal caregivers during acute treatment. However, comparison of the 2-3-year follow-up data with the post-treatment data suggested a significant worsening of relations, $Z= -2.32$, $p=.02$. Again, at 2–3 years the data were no different than pre-treatment, $Z= -1.68$, $p=.09$.

Caregiver–Child Relations as Predictors of Depressive Symptoms at 2-3-Year Follow-Up

While taking into consideration the limitations of having a small sample, results demonstrated a trend showing that children's report of the maternal caregiver–child relationship on the PCRQ at pre-treatment significantly predicted depressive symptoms 2–3 years later, $r = -.59$, $p=.03$, while pre-treatment depressive symptoms on the CDI ($r=.28$, $p=.34$) did not. Not surprisingly given the lack of change on the child-rated PCRQ during treatment, post-treatment report also correlated significantly with depressive symptoms at long-term follow-up, $r= -.59$, $p=.03$. The only other variable to approach significance was the child's report of the paternal caregiver–child relationship at pre-treatment, which trended toward significance in predicting depressive symptoms at 2-3-year follow-up, $r= -.46$, $p=.096$.

DISCUSSION

This study provides preliminary evidence supporting the positive long-term effects of combining individual CBT with parent training for the treatment of childhood depression. The clinically significant changes that occurred in depressive symptoms and psychosocial functioning during the course of treatment (see Eckshtain & Gaynor, 2011) were maintained 2–3 years later. These changes were documented by both a child's self-report (CDI) and a parent report (SDQ). Such long-term effects have not been documented previously in treatment studies for children with depression.

The existing treatment outcome literature for children with depression lacks long-term follow-up results that extend to one year or longer following treatment completion. Available treatment studies that assessed long follow-ups with older adolescents have not been promising. For example, Brent, Kolko, Birmaher, Baughter, & Bridge (1999) found that more than half of the adolescents that participated in their study received additional treatment within the two years following treatment completion. Lewinsohn, Clarke, Seeley, & Rohde (1994) found that approximately one half of those who recovered following treatment, subsequently relapsed. Treatment for depression should focus not only on symptom reduction but also on ways to manage depressive symptoms and prevent relapse and return of symptoms (Kennard, Emslie, Mayes, & Hughs, 2006). Current approaches to target relapse and recurrence of symptoms include booster sessions, continuation of treatment following symptom remission, and development of new treatments that can target processes that contribute to vulnerability to relapse (Simons, Rohde, Kennard, & Robins, 2005). In light of the positive results from the current study, an additional focus might include parent training. Studies have documented the importance of family context and caregiver–child interactions for the development and maintenance of childhood depression (e.g., Sander & McCarty, 2005); therefore, parent training programs should focus on deficits characterizing families of children with depression. As detailed above, C-CRET addresses these deficits.

Intervention studies for children with depression have often not assessed child functioning from the perspective of the primary caregivers (Weisz et al., 2006). In addition, there are often discrepancies between caregiver and child reports regarding improvement (Achenbach et al., 1987). Given this backdrop, it is significant that not only did results from the self-report measure of depression suggest significant improvement and maintenance of results 2–3 years after treatment has been completed, but so did the caregiver report of psychosocial functioning and emotional symptoms. These findings provide social validation of the long-term effects of the treatment provided.

Child-reported depressive symptoms and caregiver-reported psychosocial functioning were maintained, despite the fact that maternal caregiver–child relations, as reported by maternal caregivers, and paternal caregiver–child relations, as reported by the children, had deteriorated at 2-3-year follow-up assessment. It is possible that maternal caregiver reports are partially the product of heightened conflict related to developmental and environmental changes associated with the teen-age years (as the sample mean is now 13 years old), including balancing demands for increased autonomy with need for support and supervision. Importantly, the deterioration was not complete as maternal caregivers continued to see their relations with the child as improved compared to pre-treatment. Children did not report improved relations with maternal caregivers during acute treatment or at follow-up. In fact, the best predictor of depressive symptoms at 2-3-year follow-up was child-rated maternal caregiver–child relations, which was a better predictor than initial depressive symptoms. These data suggest that even though depressive symptoms improved and were maintained, child's relative rank-order at 2–3 years was highly predicted by pre-treatment maternal caregiver–child relations. This result further suggests the importance of targeting caregiver–child relations even in the face of positive depression change.

The major limitations of the current study include the open clinical trial design and the small sample size. Given the episodic nature of depressive symptoms and the relatively high rates of response to placebos and supportive therapy (Bridge, Birmaher, Iyengar, Barbe, Brent, 2009), the absence of a concurrent control group does not allow to assess whether the maintenance of changes can be conclusively attributed to the treatment. In fact, it is common for groups in clinical trials of psychotherapy for adolescents with depression to converge over the course of extended follow-up periods so that most participants demonstrate recovery (see Birmaher, Arbelaez, & Brent, 2002).

The positive long follow-up results provide evidence for the efficacy and feasibility of combining individual CBT with parent training for the treatment of childhood depression, while simultaneously justifying further research employing more rigorous controls. The current findings need to be replicated in future trials using larger samples with more stringent control conditions and/or an additional treatment comparison group. The deterioration in caregiver–child relations and the predictive validity of caregiver–child relations on future depressive symptoms encourages further research on treatment strategies that can effectively influence these relationships.

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Table 1

Within-treatment means and standard deviations

	Pre-Treatment		Post-Treatment		1-mo. Follow-Up		6-mo. Follow-Up		2-3-yr. Follow-Up	
Measure	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Depressive Symptoms (CDI)	17.73	7.09	6.00	7.94	5.93	8.78	3.64	3.15	6.07	4.34
Psychosocial Functioning (SDQ)	17.93	6.03	7.86	3.10	7.15	3.36	7.31	3.07	6.46	4.39
Caregiver-Child Relations (PCRQ)										
Child re: Mother	146.36	16.71	147.14	21.98	149.15	21.64	153.31	19.84	143.69	20.36
Child re: Father	138.64	16.91	143.86	17.68	141.86	20.86	152.23	20.19	131.46	22.81
Maternal Caregiver	208.29	26.58	233.00	22.27	235.46	22.60	229.62	23.05	222.69	20.22

Note. CDI = Children’s Depression Inventory; SDQ = Strengths and Difficulties Questionnaire; PCRQ = Parent Child Relationship Questionnaire.