A Parental Program for the Prevention of Depression in Adolescents

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Introduction

The tendency, in the last generation of programs designed to prevent adolescent depression, is to include prevention strategies targeted for the family The Parentaland not only for the adolescents (Gillham et al., 2000, 2007; Lee & Eden, 2009; Horowitz & Garber, 2006; Matos et al., 2015). The Program for the Prevention of Depression in Adolescent-3PDAs, comprises 10 thematic sessions (15 hours of training), and was develpded to: (i) Increase the effectiveness of Mind and Health Program (Program for Prevention of Depression in Adolescents; Arnarson and Craighead, 2009), to prevent the first episode of depression/ dysthymia in adolescents at risk for depression; (ii) Increase the parents comprehensibility about risk and protective factors for adolescent's depression or dysthymia; (iii) Increase the quality of the relationship between parents and adolescents: communication, conflict resolution and problems, emotional validation, acceptance, compassion and social support.

The present study aims to describe the process of planning, implementing and evaluating results of the 3PDA. These preliminary analyzes of the effectiveness of the parental program 3PDA are performed using the results of Children's Depressive Inventory (CDI; Kovacs, 1983; Portuguese version: Marujo, 1994) for adolescents at baseline, post-test and 6 month follow-up.

Methodology

Participants

The sample included 49 subjects, sixteen (16) parents in Experimental Group (3PDA) and thirty three (33) parents in Control Group (PPDA). The selection was carried out from a sample of parents of adolescents, aged 13 to 15, considered as being "at risk" (scores between the 75th and the 90th percentiles on the CDI). It was randomized a group of parents of teenagers who were doing the 3PDA program, to take part in 3PDA. The parents who accepted to participate took part of the EG

Instrument

Children Depression Inventory – CDI (M. Kovacs P. D. D., 1983; Portuguese version: Marujo, 1994). CDI is used to evaluate depressive symptomatology in children and adolescents, aged 7-17.

Table 1. Means and SD for change in tree moments for PPDA and 3PDA

Change	Group	M	SD	F	p
Pre-test/Post-test	PPDA	-3,88	5,52	0,075	,785
	3PDA	-4,38	6,73		
Post-test/Follow up	PPDA	00,85	4,20	4,218	,046
	3PDA	-2,19	6,01		
Pre-test/Follow up	PPDA	-3,15	6,10	3,743	,059
	3PDA	-6,56	5,05		

Results

The analysis of the pre test results revealed no statistically significant differences in the scores of CDI between the experimental and control groups [F (1, 46) = 2.197, p = .14] and between the genders [F (1, 46) = 2,197 p = .145]

The groups did not differ in change between the pre-test and post-test (F (1, 48) = 0.075, p =.785), between the pre-test and the follow up (F (1,48) = 3.743, p = .059).

Nevertheless, between the post-test and follow up the difference was statistically significant (decrease at CDI scores), change is higher in 3PDA regarding the PPDA (cf. Table 1). The Reliable Change Index (RCI) (Jacobson & Truax, 1991) was calculated between CDI moments clarify the direction of change. If we consider the effect of programs at pre-test /follow up of six months, then the 57.5% of PPDA subjects were classified in global improvement, 18.2% in no change and 24.2% in global deterioration. However at 3PDA all subjects were classified in global improvement.

Conclusion

Results suggest that both programs contribute to the decrease of CDI scores, but 3PDA is more effective in maintaining this effect and in its amplification in the medium term. Its possible to conclude that prevention strategies targeted for the family are an important contribute to prevent depression (Gillham et al., 2000, 2007; Lee & Eden, 2009; Horowitz & Garber, 2006; Matos et al., 2015).

References

Arnarson, E. O., & Craighead, W. E. (2011). Prevention of depression among Icelandic adolescents: a 12-month follow-up. *Behaviour Research and Therapy, 49*(3), 170-4. doi: 10.1016/j.brat.2010.12.008

Horowitz, J. L., & Garber, J. (2006). The prevention of depressive symptoms in children and adolescents: a meta-analytic review. Journal of Consulting and Clinical Psychology, 74(3), 401-415.

Kovacs, M. (2006). New steps for research on child and adolescents depression prevention. *American Journal of Preventive Medicine, 31,* S184-S185.

Lee, C., & Eden, V. (2009) Family-based approaches to the prevention of depression in at-risk children and youth. In Essau, C. A. (Ed), *Treatments for adolescent depression: Theory and practice* (pp. 177-214). New York, NY, US: Oxford University Press.Matos, A. P., Marques, C., Oliveira, S.; Pinheiro, M. R., Arnarson, E. O., & Craighead, W. E. (2015). A prevention program of depression in at-risk adolescents: Preliminary results from baseline to follow-up, *9th International Technology, Education and Development Conference, INTED2015* Proceedings, 7770-7779.

Matos, A.P. & Pinheiro, M.R. (2013, junho). Programa parental para a prevenção da depressão nos adolescentes: um contributo para aumentar os fatores de proteção familiar. *Proceedings of the VIII Simpósio Nacional de Investigação em Psicologia,* Aveiro.

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