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Children and Families: Health and Wellness
A Family Systems Approach to Addressing Depression in Children

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Abstract

Children of all ages and around the globe can experience depressive symptoms. However, certain symptoms of depression can be expressed in distinct ways from depression in adulthood. While many individualistic approaches are utilized to treat depression in childhood, family systems modalities can be utilized with effectiveness since family factors can contribute to depressive symptoms (Ghandour et al., 2019). Family systems theories often examine and address the interactions between family members and the context in which the interactions occur. Specifically, structural family therapy has been demonstrated to be effective in reducing childhood depression symptomology (Jiménez et al., 2019). Structural family therapy focuses on boundaries, hierarchies, and subsystems within a cultural context. The purpose of this literature review is to propose that structural family therapy is appropriate for addressing depression in childhood. Additional discussion includes structural family therapy being appropriate for various cultures around the globe.

Major depressive disorder is a common mental disorder affecting children of all ages (James et al., 2018) and becomes higher in prevalence for children who have entered puberty (Costello et al., 2006). Mental health problems in childhood, such as depression, have been shown to have a more negative effect (e.g., a reduction in work resulting in a lower SES outcome) in the person's adult life when compared to the effect of physical health issues (Delaney & Smith, 2012). Furthermore, depressive disorders were found to be one of the leading causes for disability in 2017 (James et al., 2018). Individuals who experienced depressive symptoms at an early onset typically had poorer quality of life, more depressive episodes, greater medical psychiatric comorbidity, more suicide attempts, and more significant symptoms severity than those with later ages of onset of major depressive disorder (Zisook et al., 2007). Given the research

demonstrating the negative effect that early onset of depression has on an individual, it is imperative to consider interventions.

Family systems therapy has been demonstrated to be an effective approach for addressing depression in childhood (Jiménez et al., 2019; Tompson et al., 2017; Trowell et al., 2007). Due to the reliance of children on their caregivers, it is prudent to involve the family in addressing mental health concerns (Steinberg, 2001). While many approaches operate from an individualist approach (see Bernaras et al., 2019), consideration of the family is significant since children with a primary caregiver who rated their own mental health as fair or poor in mental or emotional health had an increased rate of depression at 13% (Ghandour et al., 2019). The purpose of this literature review is to propose structural family therapy as an effective modality for treating children with depressive symptoms.

Theories and Treatment of Depression

Theoretical models posit various causation for depression (Bernaras et al., 2019). Biological and psychological are two main perspectives regarding etiology. Biological theories have postulations, such as alterations in brain structure (Whittle et al., 2014), genetic factors (Scourfield et al., 2003), and noradrenaline deficits (Narbona, 2014). Psychological perspectives explain depression through theories, such as attachment theory (Bigelow et al., 2013), behavioral models (Skinner, 1953), cognitive models (Beck, 1987), and interpersonal theory (Markowitz & Weissman, 1995). While many theories focus on psychopathology in an individual context, it is important to consider systemic theories.

Watson (2012) defined family systems theory as a framework for understanding human functioning that focuses on interactions between family members and between the family and the context in which it is embedded. Family systems theory posits reciprocal causal explanations as opposed to linear (Robbins et al., 1998). To understand depressive symptoms from a child, family systems approaches would explore the interactions and context for such behavior. Interactions and context for depressive symptoms can first be assessed within the family environment. Tompson et al. (2017) found that family environment characteristics can be a predictor of recovery among depressed children. A study comparing the effects of family-focused treatment for childhood depression (FFT-CD) and individual supportive psychotherapy for children, who were 7 to 14 years of age diagnosed with depressive disorders, demonstrated that children had better outcomes with FFT-CD (Tompson et al., 2017b). Additional studies have shown an effectiveness in utilizing family systems theories for addressing depression in childhood (Asarnow et al., 2020; Luby et al., 2021). Specifically, one of the most prominent family therapies is structural family therapy (Sexton et al., 2003) developed by Minuchin (1967), which has been demonstrated to address depression in childhood (Jiménez et al., 2019; Weaver et al., 2013).

Depression in Childhood

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association [APA], 2013) is often used to determine if a person meets the criteria for a depressive disorder. Several diagnoses are possible for a person exhibiting depressive

symptoms: persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, single depressive episode, recurrent depressive disorder, persistent mood (affective) disorder, and other mood (affective) disorders.

For a person to be diagnosed with major depressive disorder, several criteria must be met nearly every day for a minimum of two consecutive weeks. Possible criteria include a depressed mood, diminished interest in most activities, significant weight loss, insomnia or hypersomnia, feelings of worthlessness diminished ability to concentrate, and recurrent thoughts of death or suicide. Consideration for children includes the understanding that children can “mask” depressed moods with irritable moods and acting out and not meeting expected weight gain rather than a significant loss in weight (APA, 2013).

The onset of major depressive disorder can occur at any age, but there are higher prospects for symptoms occurring with puberty (APA, 2013). Children, aged 3-17, have a prevalence rate of 3.2% for depression and nearly 80% had received treatment for depressive symptoms (Ghandour et al., 2019). Boys, 10 years or younger, are more likely to be diagnosed with depression than girls. However, by early adolescence, teenage girls are 1.5-3 times more likely to be diagnosed with depression (APA, 2013). Researchers using self-report measures, such as the Children’s Depression Scale (Lang & Tisher, 1978) and the Children’s Depression Inventory (Kovacs, 1992), have found children experiencing high depressive symptomology at 4.2% in Spain (Bernaras-Iturrioz et al., 2013), 6.2% in Finland (Almqvist et al., 1999), and 10% in Australia (McCabe et al., 2011).

Structural Family Therapy

Salvador Minuchin began working in family therapy as a child psychiatrist. Minuchin and colleagues at the Wiltwyck School for Boys were challenged by the ineffectiveness of utilizing an individualistic approach for juvenile delinquents. He then began to recognize that his clients’ behaviors were not simply an action but a reaction. Through trial and error, he and his colleagues taught themselves family therapy. By 1965 Minuchin was the professor of psychiatry at the University of Pennsylvania and the director of both the Children’s Hospital of Philadelphia’s Department of Psychiatry and the Philadelphia Child Guidance Clinic. He continued to insist that all child psychiatry is family psychiatry and that human behavior, including psychopathology, must be understood within the context in which it occurs (Sexton et al., 2003). The most predominant context is human context. Human context involves systems of rules that regulate behaviors and reciprocal processes. Subsequently, actions in one part of the system influence another part of the system. Therefore, all family members are encouraged to be included in the therapy sessions (Minuchin, 1974). In the 1970s, Minuchin and his colleagues developed structural family therapy, which became one of the most influential family systems approaches and resulted in family therapy being accepted into mainstream psychiatry (Sexton et al., 2003).

Therapists utilizing structural family therapy map family structure to address presenting problems. Important concepts of structural family therapy include boundaries, hierarchies, and subsystems. Minuchin postulated that restructuring to realign the hierarchies and boundaries would resolve family issues (Gerhart, 2018). Boundaries are defined as rules for psychological

and physical distance between members of the family. Boundaries determine the degree and management of distance, closeness, hierarchy, and family roles (Minuchin & Fishman, 1981). Boundaries typically are organic rather than static. Three types of boundaries are considered: clear boundaries; enmeshment and diffuse boundaries; and disengagement and rigid boundaries (Gerhart, 2018). Clear boundaries allow each person to develop and maintain a sense of identity and differentiation with simultaneously allowing for close emotional contact. A therapist can see results of clear boundaries by a person balancing distance and closeness by the customs of their culture. Enmeshment and diffuse boundaries do not allow for a sense of identity and differentiation due to an overt sense of connection and mutuality. A therapist can make such an assessment by observing family members interrupting one another, mind reading, insisting on high levels of protectiveness, and/or feeling threatened at disagreement or difference.

Additionally, a therapist will note if a family reports problems in one or more members and likely about complaints about the family interaction to assess for enmeshed relationships and diffuse boundaries (Gerhart, 2018). Disengagement and rigid boundaries often lead to autonomy and independence without emotional connection, which typically results in emotional and sometimes physical isolation. A therapist can make such an assessment by observing family members lacking in reaction or repercussions to problems, significant freedom for most members, few expressions or demands for loyalty and commitment, and engaging in parallel actions instead of reciprocal interactions. For any assessment of boundaries, a therapist must view the family within the context of culture (Gerhart, 2018).

Minuchin (1974) defined a family as a system consisting of multiple subsystems. The three important subsystems assessed are couple, parent, and child/sibling. Minuchin made two assessments concerning subsystems: discerning if there is a distinction between the parent and couple subsystem and a clear boundary between the parent and child/sibling subsystems. If a family presents an issue concerning a child, the therapist will first make an assessment concerning the parental hierarchy to determine the intervention. Three forms of parental hierarchy include effective, insufficient, and excessive. Effective parental hierarchies are evidenced by parents setting boundaries while concurrently maintaining emotional connection to the child. Insufficient hierarchies are evidenced by a permissive parenting style of not effectively managing the child's behavior and enmeshed boundaries. Excessive parental hierarchies are evidenced by strict rules and severe consequences resulting in rigid boundaries between the parents and child (Gerhart, 2018).

Diagnosis

Structural family therapists diagnose based on the working hypothesis that is developed from the observations and experiences due to joining the family (Minuchin, 1974). This differs drastically from a psychiatric diagnosis that often gathers data about or from the client and assigns a label to the symptoms described. A family diagnosis includes the therapist's accommodation to the family to develop a therapeutic alliance following the assessment. Typically, a family identifies one member of the family (i.e., "identified client"). Families typically exhibit tendencies to focus attention on the identified client and on the past and express a desire for change to occur with the identified client rather than on focusing on the preferred transactional patterns in the present day. The therapist will broaden the focus to include the family's interactions as a contributing factor

to the problem situation. To assess these interactions, the therapist will assess six areas: preferred transactional patterns, the system's flexibility and capacity for restructuring, resonance, life context, developmental stage, and the identified client's symptoms as used to maintain the family's preferred transactional patterns. Unlike psychiatric diagnoses that are often static, family therapists' diagnoses are often evolving. The evolving diagnoses are related to context and provide ongoing therapeutic interventions. Therefore, the "[d]iagnosis and therapy become inseparable" (Minuchin, 1974, p. 131).

In relation to treating presenting concerns, structural family therapists identify three possible relationships between the family system and the symptom (e.g., depression): ineffectual challenger, "shaper," or "beneficiary." Families who are ineffectual challengers of a symptom are considered passive and even enabling. The family fails to challenge the symptomatic member to maintain a highly enmeshed or disengaged structure. Families who are "shapers" of symptoms typically mold the person's experience and behaviors, such as a child who is triangulated into the couple subsystem conflict. Families who act as a "beneficiary" utilize the symptom to maintain the family structure (Gerhart, 2018). For example, a depressed child provides the parents with a way to unite and/or distract them from their marital issues. Such assessments in family structure then lead to the use of intervention.

Interventions

Structural family therapists utilize such interventions as enactments, systematic reframing, boundary making, and challenging the family's certainty and worldview (Gerhart, 2018). Enactments are considered a distinctive intervention within structural family therapy, in which the therapist encourages the family to reenact an interaction or conflict as opposed to talking about them in session. Systemic reframing involves the therapist acknowledging that all behavior is reciprocal, such as a pursuer/distancer pattern. This removes the blame from one person and distributes it evenly. Boundary making is a type of enactment that addresses rigid or diffuse boundaries allowing for an interruption of interaction patterns. Therapists challenge family's certainty about unproductive assumptions and worldviews by overt questioning. Examples of assumptions that are challenges are "The kids' needs come first," and "It's better to keep peace than start conflict." Additional interventions include intensity and crisis induction, unbalancing, expanding family truths and realities, making compliments, and shaping competence (Gerhart, 2018).

Modern Society Implications

In modern society it can be appropriately questioned whether a theoretical framework from the 1960s is relevant in modern society. McAdams et al. (2016) assessed the relevance of structural family therapy with three indicators: frequency of relevant publications, contemporary significance of client issues and treatment in publications, and an indication of ongoing assessment and refinement of the clinical process and outcome in publications. Per this assessment, publications have remained steady at an average rate of more than three publications a year. Additionally, structural family therapy has been utilized in recent years for a plethora of client issues and in different treatment settings. For instance, publications demonstrate application of the model to address bullying (Butler & Platt, 2008), parental alienation syndrome

(Gottlieb, 2013), adolescent eating disorders (Loeb & LeGrange, 2009), and bipolar disorder (Miklowitz, 2012). Furthermore, the model has been utilized in public schools (Gerrard, 2008), school-family-community collaboration efforts (Messina et al., 2015), and children's residential treatment centers (McLendon et al., 2012). McAdams et al. also found that between 2000 and 2015, five process and four outcome research studies focused on structural family therapy. Such evidence demonstrates the clinical relevance for structural family therapy in modern society.

Diversity Considerations

Structural family therapy has a history of engagement in multicultural settings and with diverse clients (Corey, 2013). The model was developed by working with people from a low socioeconomic status unlike many theoretical approaches that were based upon work with the middle-class population (Minuchin, 1967). Gerhart (2018) acknowledged that Minuchin and proponents of structural family therapy were from immigrant and diverse backgrounds and, therefore, acknowledged strengths in diverse families. Structural family therapy's greatest strength regarding diversity is that family structure is consistently assessed in the context of setting and culture (Epstein et al., 2012). Furthermore, boundaries and hierarchies are restructured and reinforced in the context of cultural values (Epstein et al., 2012). Given that Pedersen (2001) called multiculturalism the "fourth force in counseling," it is important to acknowledge how structural family therapy is appropriate across cultures. Epstein et al. (2012) stated that structural family therapy is an appropriate modality for Chinese families due to assessment occurring with a cultural lens, family hierarchy being a central tenet, and the therapist operating as an expert. Immigrant families with first generation Asian Americans experiencing differing acculturation issues that could result in conflict among family members could benefit from structural therapy as its principles are compatible with Asian American values (Kim, 2003). Santisteban and Mena (2009) developed Culturally Informed and Flexible Family-Based Treatment for Adolescents with structural family therapy as the foundation. Additional modifications of structural family therapy have demonstrated effective in reducing drug use with Hispanic youth and an improvement in family functioning with African American families (Robbins et al., 2008). Gerhart (2018) reported minimal research specifically being conducted regarding gay, lesbian, bisexual, and transgender couples and families utilizing structural family therapy; however, Minuchin (1996) described utilizing this approach with a gay couple. Additionally, Coates and Sullivan (2005) have reported applying tenets of the model with same sex parents. Due to the cultural consideration, structural family therapy can be appropriate for addressing childhood issues cross culturally.

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