Family-Based Interpersonal Psychotherapy: An Intervention for Preadolescent Depression

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Family-based interpersonal psychotherapy (FB-IPT) is an evidence-based psychosocial intervention for depression in preadolescents (ages 8–12 years). Adapted from interpersonal psychotherapy for adolescents with depression and modified for younger children, this therapy includes structured dyadic sessions with preadolescents and their parents, guidance for parents in supporting their children and decreasing negative parent-child interactions, and a focus on preadolescents' comorbid anxiety and peer relationships. This article reviews the conceptual foundations and risk factors related to preadolescent depression and the rationale for focusing on improving preadolescents' interpersonal relationships to decrease depressive symptoms and risk for depression during adolescence. The structure and goals for the initial, middle, and termination phases of FB-IPT are described, as well as the specific communication and problem-solving strategies presented to preadolescents and parents. Last, research on the efficacy of FB-IPT is summarized, as are future directions for implementing this promising psychosocial intervention for preadolescent depression in community settings.

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Depression among preadolescents (ages 8–12 years) has historically been underdiagnosed and undertreated (1). However, troubling increases in suicide rates and mental health service utilization in this age group have propelled a renewed focus on depression among preadolescents. Although suicide rates increased for all age groups between 2007 and 2015, the Centers for Disease Control and Prevention has estimated a twofold increase in the number of suicides among children ages 10–14 years (2). Several studies have also determined a significant increase in the number of children and adolescents presenting to emergency departments (EDs) for suicide ideation and attempts (3). Interestingly, during that period, the median age for ED visits for suicidal ideation or attempts was 13, and 43% of these visits were for children younger than age 11. Although most of these visits did not result in hospitalization (97.9%), these trends indicate the need for efficacious outpatient services for preadolescent children evidencing suicidality and suggest that more at-risk young children are presenting with psychiatric distress to EDs of nonpediatric hospitals. For these reasons, the American Academy of Pediatrics has recommended routine screening for depression and suicidality among children ages 12 and older, and in all youths manifesting depression risk factors (4).

Effective intervention for youths with depression could decrease the burden of illness during preadolescence, a sensitive period of social and neural development, when children are first experiencing the biological and social transitions that accompany puberty. However, research and development of empirically supported psychosocial treatments for childhood depressive disorders has lagged behind epidemiological and longitudinal studies of childhood and preadolescent depression. Although indicated as first-line interventions, effective and developmentally informed psychosocial treatments are lacking for children with depression. Despite well-established support for the efficacy of cognitive-behavioral therapy (CBT) over the no-treatment control condition among community samples of preadolescents with depressive symptoms (5), the few studies comparing CBT to active control treatments have found no differences between CBT and relaxation training (6) or CBT and supportive, nondirected therapy (7, 8) in reducing children's depressive symptoms.

The equivocal findings of these studies have highlighted the necessity of involving parents in treatments for children with depression. Because children are usually embedded in a family context and dependent upon their parents for nurturance, support, and assistance (9), parental involvement in treatment for childhood depression meets a critical developmental concern. Depressive disorders do, of course, run in families. Family-based interventions may provide an opportunity to reduce risk factors associated with depression in

children, namely high levels of family conflict, low levels of family cohesiveness (10, 11), and maladaptive parent-child communication and problem solving (12, 13). Children with depression also experience problems in peer relationships (14–16) and behave in ways that may increase their experience of negative interpersonal events (17–19). Even after their symptoms remit, preadolescents who have had depression remain at risk for interpersonal impairment, because they continue to experience significantly more difficulties in relationships with parents and peers than do preadolescents who have not been depressed (20–22).

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Family-based interpersonal psychotherapy (FB-IPT) (23) is conceptually rooted in an interpersonal model of depression (24, 25) and in developmental research on the antecedents of depression in youths. FB-IPT focuses on improving two domains of interpersonal impairment in preadolescents with depression, parent-child conflict and difficulty in peer relationships, to decrease preadolescents' depressive symptoms. FB-IPT focuses on improving communication and problem-solving skills in the parent-child relationship, the primary context for children's social and emotional development (26), as a means to improve the quality of the parent-child relationship and to promote effective interpersonal behavior with peers. Adapted from IPT for adolescents with depression (IPT-A) (25), FB-IPT includes several developmental modifications for 8–12-year-olds: increased parental involvement and structured dyadic sessions with preadolescents and parents (to teach and role-play communication and problem-solving skills), an expanded limited sick role (to direct parental expectations for the performance of preadolescents with depression across contexts), parenting strategies for decreasing conflict, increased focus on the effect of anxiety on peer relationships (to increase frequency of initiating interactions with peers), and use of effective communication and interpersonal problem-solving skills with peers. The aims of this article are to describe the conceptual model of FB-IPT, outline the structure and content of its three phases, describe the strategies used with children and parents during each phase, review the growing evidence base for the treatment's efficacy, and discuss future directions for research and implementation.

FB-IPT

Initial Phase

The initial phase of FB-IPT consists of five sessions, each divided to allow for individual meetings with the preadolescent and therapist (20 minutes) and either parent-child dyadic meetings with the therapist or individual meetings with the therapist and at least one of the preteen's parents (20 minutes). Session 1 starts with the parent and child together to review symptoms, establish a plan to monitor any suicidality and keep the child safe, and update the therapist about events and developments that have occurred since the initial assessment. The therapist outlines the rationale of FB-IPT while providing psychoeducation about depression. Because the preadolescents commonly feel better after the initial evaluation, with the relief and support that often result from revealing their symptoms to parents and clinicians, the treatment may be framed as an opportunity to learn more about specific triggers for depression and ways to cope with stressors during the transition into adolescence.

Sessions 2–4 begin with the therapist conducting a short check-in with the parent and preadolescent to identify the agenda for the session. The remaining time in these sessions is divided between individual meetings with the preadolescent and individual meetings with the parent. In meetings with the preadolescent, the FB-IPT therapist introduces the mood thermometer, a visual mood rating scale (scored from 1 to 10) with three pictorial anchors of faces (emojis) indicating euthymic (rated as 1), neutral (rated as 5), and dysthymic (rated as 10) moods, and helps the child use this tool to identify and link fluctuations in mood to interpersonal events. The mood thermometer is used during each session, particularly during the initial check-in with the preadolescent and parent. During such check-ins, FB-IPT therapists ask preteens and their parents to reflect on the preteen's average mood for the week as well as times when the preteen's mood was at the lowest and highest. Therapists reserve individual meetings with preadolescents for following up on symptoms, particularly suicidality, and engaging in safety planning. During session 2, the primary task for the preadolescent is to construct a closeness circle, a visual mapping of the child's interpersonal relationships. The closeness circle is a set of four concentric circles with the preadolescent's name written in the center circle. The therapist works with the preteen to identify and write the names of family and friends on stickers and place them within a set of concentric circles that orbit the preteen's name. The distance of each sticker from the circle containing the preteen's name represents the perceived closeness and support provided by each person. The closeness circle provides direction for completing the interpersonal inventory in sessions 3 and 4, an in-depth discussion of important relationships in the preadolescent's life and of how these relationships have influenced or may be influenced by the preteen's depression. Typically, preadolescents' interpersonal inventories focus heavily on their relationships with parents and siblings. Peer relationships on the interpersonal inventory are important to survey to determine whether the preteen has established age-appropriate friendships that can provide social opportunities and support

at school and to determine whether peer conflict and/or bullying are contributing to the depressive symptoms. Compared with adolescents, preteens typically have sparser interpersonal networks, and their discussion of relationships can be less detailed and complex. The process of completing the interpersonal inventory informs the final task of the initial phase of FB-IPT: identifying the interpersonal problem area (grief, role transitions, role disputes, or interpersonal deficits) that will provide the context for interpersonal skill building and increasing positive experiences in relationships that will form the focus of the middle phase of treatment.

Parent meetings during the initial phase provide opportunities to further assess family relationships and circumstances that may be contributing to the preadolescent's depression as well as any parental behavior or responses to the preadolescent's depressive symptoms that may be increasing conflict and decreasing support in the parent-child relationship. Often parents struggle to understand their children's irritability and demotivation as aspects of depression rather than as "moodiness" or "having a bad attitude." During this early stage of treatment, the FB-IPT therapist establishes good working relationships with the parents, who serve as primary support persons for their preteen, guides the parents in accessing services (e.g., medication evaluations, school accommodations, emergency care in case of increased suicidality), and shapes their responses in parent-child interactions to decrease negative interactions and increase the preteen's perceived support. Therapists use individual meetings with parents in sessions 2–4 to expand upon the limited sick role, which serves as a framework for setting expectations about the preteen's routine and performance given the depression, and to provide continued psychoeducation about preadolescent depression. Therapists also share with parents a set of "parent tips," or strategies that are consistent with the limited sick role. Many of the strategies involve reminders for parents to increase their empathy and support for preadolescents who are struggling with depression and amotivation (e.g., "Consider the intention, not the outcome") and to balance that support with clear expectations for their preteen's participation in routines and social activities despite not feeling his or her best (e.g., "Be kind and firm"). The therapists use the parent tips to address the most challenging behavior identified by the parents and to collaborate with the parents to find ways to decrease arguments, resume school routines, schedule daily check-ins to talk about problematic issues at home (e.g., "Strike while the iron's cold"), and increase the number of positive parent-child interactions. Parent meetings also provide an opportunity for the therapist to get a better sense of changes in the parent-preteen relationship that may have preceded the depressive episode and to gain an understanding of the parents' own experiences with depression. A history of depression in parents is one of the most robust predictors of depression in children and adolescents, with a parental history of at least two episodes of major depressive disorder placing youths at the highest risk for developing depression (27). FB-IPT therapists address self-care with all parents (e.g., "Put on your oxygen mask first") as they support their preadolescents in recovering from depression; self-care is especially important for parents with a history of depression or untreated depression. Although FB-IPT therapists refrain from acting as parents' therapists, they use their relationship with the parents to inquire about parents' willingness to initiate their own psychotherapy and may facilitate referrals for parents' individual treatment.

In session 5 of the initial phase, the therapist presents a case formulation of the preadolescent's depression and works with the parent-child dyad to identify one of four problem areas that will frame the middle phase of treatment. FB-IPT uses the same four problem areas outlined in IPT for adults and adolescents, with expanded context to reflect grief, transitions, and disputes that may affect the family system rather than the preadolescent only. For example, grief may be the identified problem area if a preadolescent's depression is related to decreased emotional availability or depression of a parent who is dealing with bereavement and loss. The problem area of role transitions captures potentially stressful developmental transitions that typically occur among 8–12-year-olds, such as pubertal onset, change in schools, increased academic demands, shifting friend groups, and increased online communication with peers. The problem area of interpersonal deficits continues to encompass themes of social isolation and loneliness that are related to skill deficits that may precede the preteen's depression but also includes increased focus on the comorbid anxiety that manifests as social avoidance. The therapist meets with the parent-child dyad together and presents a narrative of the preadolescent's depression, summarizing changes or difficulties that may have negatively affected his or her relationships and encouraging feedback from the preadolescent and parent about the identified problem area. Once consensus has been reached, the therapist meets individually with the preadolescent to process the formulation and begin setting goals for the middle phase of FB-IPT.

Middle Phase

The middle phase of FB-IPT consists of six sessions (sessions 6–11) and focuses on using the identified problem area to guide preadolescents and their parents in implementing communication and problem-solving skills to reduce the disruptions in interpersonal relationships that have contributed to the preadolescent's depressive symptoms. Although the problem areas differ in focus, their resolution often involves an overlapping set of strategies, such as assisting the preadolescent to emotionally process his or her experience related to the problem area, communicate his or her needs more effectively, handle interpersonal conflict through negotiation and problem solving, and initiate new relationships with peers. Sessions in the middle phase of FB-IPT are divided between individual meetings with the preadolescent and dyadic meetings with the preadolescent and parent. Individual meetings with the preadolescent consist of teaching and

rehearsing interpersonal skills related to the identified problem area. Therapists engage in role-playing each skill with the preadolescent during individual meetings and then structure role-playing between the child and parent to rehearse during dyadic meetings. The goal of dyadic meetings with parents is to help them understand the interpersonal strategies so they can model and help their child practice and implement each skill at home or with peers.

Individual meetings with preadolescents during the middle phase focus on deconstructing daily interpersonal events that are related to the problem area and teaching the preadolescent to implement different communication and problem-solving strategies to improve the outcomes of these interactions. Therapists begin sessions by checking in about situations that were associated with the preteen's experience of dysthymic mood. Consistent with the communication analysis technique used in IPT for adults and adolescents, FB-IPT therapists help to construct a depression circle, a visual flowchart of how communication between the preadolescent and another person happened in a situation, using frequent prompts to help the preadolescent recall the specific exchanges in the interaction (e.g., "What did you say next? What words did you use? How did your father respond? What did he say? Were those the exact words he used?"). After mapping the depression circle, therapists work with preadolescents to assess patterns of problematic communication and to identify ways of improving their interactions with family members and peers. A set of "tween tips" outline specific communication skills and problem-solving strategies that can be introduced and rehearsed with preadolescents. Many of the tween tips involve strategies for directly communicating feelings, needs, and preferences in ways that are nonblaming (e.g., "Make an 'I feel' statement"). For preadolescents who mostly express irritation and anger in their relationships, therapists encourage voicing "softer" feelings, such as concern, disappointment, and hurt, with those they trust. Preadolescents are also coached to use strategies that promote better outcomes when addressing an issue that could lead to a conflict with a family member or friend. Making an appointment to talk instead of bringing up an issue when the other person is distracted or busy can help a conversation be more productive (e.g., "Use good timing"). Verbalizing an understanding of the others' perspective when there is a conflict with a family member or friend (e.g., "Give to get") can also promote a shared understanding and avoid a negative interaction. In addition to decision analysis, a strategy used in IPT for adults and adolescents, therapists work with preadolescents to compromise (e.g., "Meet in the middle") and/or negotiate resolutions to disputes that address the needs of both parties (e.g., "Let's make a deal"). During middle-phase sessions, therapists typically introduce the tween tips individually so that the child can build on each tip sequentially and choose the tips that appear to be the most relevant and potentially helpful to the preteen's problem area. With preadolescents who experience social isolation or withdrawal due to social anxiety, therapists rehearse and plan "interpersonal experiments" that involve initiating interactions with peers.

After identifying a skill, the therapist discusses how the skill could be applied to the situation documented in the depression circle and engages the preteen in role-playing to use the new skill. Role-playing is an essential component in FB-IPT because it helps the preadolescent practice a new communication skill, problem-solving technique, or strategy for initiating social interactions with peers. The therapist explains how role-playing works (e.g., "We will practice talking to each other like two characters in a television show or movie or play") and helps the preadolescent create a script using the new communication or problem-solving skill. The therapist begins the role-playing by demonstrating how to use the new skill, allowing the preteen an opportunity to model the tone and timing of the delivery while responding in a way he or she thinks the other person will react. This practice provides opportunities to revise the script, anticipate negative responses, and create a plan for taking a break from the conversation. The preadolescent and therapist then switch roles so the preteen can practice using the skill and replying to different responses given by the therapist.

Parents are integrated into middle-phase sessions in dyadic meetings with the therapist and the preadolescent. During dyadic meetings, preadolescents teach their parents about the new skill they have worked on during their individual meeting and provide context for when using the new skill could improve interactions or lead to closer relationships with family members or friends. Preadolescents who wish to share their depression circles with parents can provide specific examples of when the skill could be helpful in diffusing a conflict or resolving a disagreement. The therapist typically helps to structure this discussion, clarifying the skill, engaging the parent as the preteen's practice partner for the upcoming week, and brainstorming with the parent situations in which the skill could be applied with the preadolescent at home. The therapist then role-plays the skill with the parent before having the preadolescent rehearse the new skill with the parent. FB-IPT therapists provide feedback and often discuss with the parent and child how communicating differently improves the emotional tone of the interaction, even if issues remain unresolved and disagreements continue. For preadolescents who struggle with anxiety, parents are enlisted to provide support in implementing "interpersonal experiments" to increase the preteen's social interactions and ability to initiate a conversation or activities with peers, as well as to serve as practice partners for rehearsing approach strategies. For all skills, dyadic practice is encouraged at home, and parents and preadolescents agree on goals for practicing their new skill during the upcoming week.

Termination Phase

The termination phase of FB-IPT (sessions 12–14) consists of three sessions that focus on ending the course of treatment consistent with one of three possible outcomes: the preadolescent has demonstrated significant improvement in depressive symptoms and will end treatment, the preadolescent will continue outpatient therapy for residual symptoms of

BOX 1. Recommendations for family-based interpersonal psychotherapy

- Family-based interpersonal psychotherapy (FB-IPT) is an appropriate intervention for children between ages 8 and 12 who present with a depressive disorder or clinically significant depressive symptoms, including suicidal ideation or attempt.
- FB-IPT specifically addresses preadolescents' depressive symptoms related to bereavement, developmental transitions, family conflict, and difficulties in peer relationships.
- The treatment is effective for depressed preadolescents with comorbid anxiety that may interfere with initiating peer relationships.
- FB-IPT integrates individual meetings with at least one parent into the initial phase of treatment to provide psychoeducation, introduce parenting tips, and set expectations for helping depressed preadolescents maintain daily routines.
- Therapists introduce communication and problem-solving skills to preadolescents and scaffold parent-child role-plays to rehearse these skills in the middle phase of treatment.
- FB-IPT may improve symptoms in depressed preadolescents by increasing their interpersonal competence with parents and peers, allowing for increased support, decreased conflict, and increased confidence in negotiating complex parent and peer relationships.

depression, or the preadolescent requires a higher level of care for continued treatment of major depressive disorder. As with the middle phase, sessions are structured to include a 10-minute check-in with the preadolescent and parent, a 20-minute individual meeting with the preadolescent, and a 20-minute dyadic meeting with the preadolescent and parent. Check-ins during the termination phase continue to involve mood ratings and symptom checks as well as follow-up regarding skill practice at home and with parents during the previous week. Because the depressive symptoms of many preadolescents decrease during treatment, check-ins during the termination phase often include reports of euthymic mood. FB-IPT therapists spend time during individual meetings with preadolescents to explore and link euthymic mood to changes in relationships with family members and peers. Through constructing a wellness circle, a graphic representation of a positive interpersonal event, the therapist and preadolescent can identify ways in which the preteen may be communicating or behaving that are contributing to decreased conflict and shared enjoyment. This process of identifying and explicitly linking skill usage to positive outcomes in social relationships further solidifies the preadolescent's mastery of skills and willingness to implement these strategies outside of sessions. The therapist and preteen reflect on and outline changes in the identified problem area and discuss how the preteen has contributed to resolving problems that coincided with the depression. Individual meetings with preadolescents also focus on psychoeducation about depression recurrence, creating a plan for continuing to monitor symptoms ("early warning signs"), anticipating stressors, and continuing to communicate with parents and friends about any emerging depressive symptoms. Last, the therapist encourages the preteen to explore his or her feelings about ending treatment and saying goodbye to the therapist.

Dyadic meetings with preadolescents and parents are used to reinforce any success that preadolescents may have had during treatment and in implementing more-effective communication and problem-solving skills. FB-IPT therapists also focus on any positive changes the parents have made that have helped improve their preteen's symptoms or functioning and provide reinforcement for the parents' attempts to support the preteen's efforts and model communication and problem-solving strategies outside of sessions. Parents are also provided psychoeducation about depression recurrence and work with their preteen in establishing a routine for continued monitoring and skill utilization and a plan for seeking care in the future should the depression recur. FB-IPT therapists may revisit the issue of a parent seeking individual treatment for untreated psychological problems and may encourage parents to express their feelings about ending the FB-IPT.

EFFICACY STUDIES

Support for FB-IPT as an efficacious treatment for preadolescents diagnosed as having depression includes an open treatment trial (28), a randomized controlled trial (29), and a small randomized controlled trial among overweight and obese preadolescents with loss-of-control eating (LOC eating) (30). The open treatment trial of FB-IPT (N=20) demonstrated the feasibility and acceptability of FB-IPT as a psychosocial intervention for preadolescents with depression and their parents, as evidenced by high treatment compliance, low attrition rates, and favorable clinical outcomes for preadolescents completing treatment. The trial also demonstrated that preadolescents who received FB-IPT alone were as likely as those receiving combination treatment (selective serotonin reuptake inhibitor and FB-IPT) to have significant reductions in depressive and anxiety symptoms and to experience significant improvement in global functioning. In a follow-up study (31), 42 treatment-seeking preadolescents who met *DSM-IV* criteria for a depressive disorder were randomly assigned to FB-IPT or child-centered therapy (CCT), a supportive and nondirective treatment that closely approximates the standard of care for pediatric depression in community mental health. Preadolescents receiving FB-IPT were more likely to have achieved remission posttreatment than those receiving CCT (66% vs. 31%) and evidenced greater reductions in anxiety symptoms and interpersonal impairment from pre- to posttreatment. A significant indirect effect for decreased social impairment mediated the association between the FB-IPT and the preadolescents' depressive

symptoms posttreatment. This result suggests that reducing social impairment is one mechanism by which FB-IPT may decrease preadolescents' depressive symptoms. Most recently, FB-IPT was tested as an effective intervention for reducing depressive and anxiety symptoms in overweight and/or obese preadolescents with monthly episodes of LOC eating (N=24). Compared with those treated with family-based health education, those randomized to receive FB-IPT demonstrated greater decreases in depressive and anxiety symptoms after a 12-week course of treatment, and the reductions in depressive symptoms were maintained at the 1-year follow-up. Although no differences in weight-related outcomes were found, preadolescents receiving FB-IPT were less likely to endorse LOC eating posttreatment and evidenced greater reductions in disordered-eating attitudes at the 6-month follow-up. Although these preadolescents' depressive and anxiety symptoms did not reach diagnostic levels, the reduction of these comorbid symptoms may be significant in improving their LOC eating as they enter adolescence. Taken together, these findings support FB-IPT as a promising and effective treatment for anxiety and depression in preadolescents.

CONCLUSIONS

Depressive disorders are the leading cause of disability worldwide (32). Effective treatments for depressed preadolescents would be a significant step toward reducing the burden of depression and a possible step toward preventing or delaying depression recurrence in adolescence and early adulthood. FB-IPT is emerging as an efficacious psychosocial intervention for decreasing preadolescents' depression, anxiety, and interpersonal impairment (Box 1). Future studies are necessary to test the effectiveness and transportability of delivering FB-IPT in community settings as well as the longitudinal outcomes of depressed preadolescents treated with FB-IPT.

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