

Low family cohesion was associated with the incidence of major depressive disorder in adolescents

Garrison CZ, Waller JL, Cuffe SP, et al. *Incidence of major depressive disorder and dysthymia in young adolescents.* *J Am Acad Child Adolesc Psychiatry* 1997 Apr;36:458-65.

Objective

To determine the incidence, transitions over 1 year, and risk factors for major depressive disorder (MDD) and dysthymia in adolescents.

Design

3 year cohort analytic study.

Setting

6 public middle and high schools in south east USA.

Participants

247 adolescents who were at a higher risk for MDD or who were selected randomly from students not at risk for MDD. Participants completed at least 2 consecutive evaluations which resulted in 359 observations.

Assessment of risk factors

A self administered questionnaire was used to screen participants and gather data on demographic variables, depression (the Center for Epidemiologic Studies Depression Scale [CES-D]), suicide (3 items added to the CES-D), life changes (a modified version of the Coddington Life Event Schedule for Adolescents), and family environment (Family Adaptation and Cohesion Evaluation Scales). Socioeconomic status was measured using the Hollingshead Two Factor Index of Social Position.

Main outcome measures

Semistructured interviews of the adolescent and of 1 parent were used within 12 months of screening to measure psychiatric disorders (Present Episode version of the Schedule for Affective Disorders and Schizophrenia for School-Age Children) and level of impairment (Children's Global Assessment Scale) in the previous year. 4 diagnostic categories were assigned: MDD with

or without any other disorder, dysthymia with or without any other disorder (except MDD), any disorder other than MDD or dysthymia, and no disorder. [Interviewers were blinded to the screening data.]*

Main results

The weighted 1 year incidence was 3.3% (95% CI 0.0% to 8.9%) for MDD, 3.4% (CI 0.0% to 9.1%) for dysthymia, and 1.0% (CI 0.0% to 2.8%) for any other disorder. Observations that remained in the same category over the next year were 20% for MDD, 3% for dysthymia, and 5% for any other disorder. Univariate logistic regression analyses showed that the incidence of MDD was associated with family cohesion in the previous year and with the total CES-D scores at baseline. In a multivariate analysis, only family cohesion was associated with the incidence of MDD (odds ratio 0.79, 95% CI 0.65 to 0.96); participants with greater family cohesion had a lower risk of developing MDD. For those with MDD at baseline, 10% had any other disorder and 57% had no disorder at follow up. For those with dysthymia at baseline, 19% had any other disorder, 78% had no disorder, and none had MDD at follow up. 26% of observations with any other disorder at baseline had MDD at follow up, and 11% had dysthymia.

Conclusions

The incidence of major depressive disorder in adolescents was associated with less emotional bonding in the family. There were no statistically significant risk factors for the incidence of dysthymia. Most adolescents with major depressive disorder or dysthymia at baseline were free of disorder 1 year later.

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Commentary

The strengths of the study by Garrison *et al* are the use of an epidemiological strategy, a 2 stage design using self reports and subsequent face to face interviews, and the estimate of incidence in a healthy population. This study does what all scientific research should: (1) it clarifies areas of doubt, (2) it addresses conceptual ambiguities, and (3) it raises important questions.

This study reported a substantial incidence rate of depression in young adolescents. The rates of MDD and dysthymia were lower than those of a comparable study of adolescents (5.26%),¹ but this study did not use concurrent parent assessments and the participants were younger.

The results support the growing concern about artificial distinctions between disorders which are virtually homologous

on their symptom entry criteria.² Dysthymia and MDD cannot be considered distinctive when the only classification difference is duration and the presence or absence of perhaps 1 symptom.

The study design was enhanced by the inclusion of some self report measures of recent life events and family functioning. The data should be interpreted with caution as they were collected solely from the adolescents themselves. The finding that perceived family support has aetiological significance supports previous conceptual views that family process, rather than structure, influences the onset of psychopathologies. The authors suggest that the adolescents' appraisal may simply reflect an underlying genetic vulnerability for depression in the family. Future research studies should compare the origins,

natural history, treatment response, and outcomes of familial and non-familial depressive disorders. There may be a case for family preventive strategies based on altering family process, but caution is required as many families report dysfunctional elements without having an index case and only some adolescent depressive subtypes show significant associations with disturbed family functioning.³

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1 Lewinsohn PM, Hops H, Roberts RE, et al. *J Abnorm Psychol* 1993;102:133-44.

2 Caron C, Rutter M. *J Child Psychol Psychiatry* 1991;32:1063-80.

3 Tamplin A, Goodyer I, Herbert J. *J Affect Disord* 1997;48:1-13.