ADOLESCENT DEPRESSION: EXPERIENCES AND MEANINGS OF BEING PARENTED AND PARENTING

By

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entitled Adolescent Depression: Experiences of Being Parented and Parenting

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STATEMENT BY AUTHOR

This dissertation has been submitted in partial fulfillment of requirements for an advanced degree at the University of Arizona and is deposited in the University Library to be made to borrowers under rules of the Library.

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DEDICATION

This dissertation is dedicated to all of the families who face mental illness and carry on. May we find ways to ease your suffering.

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ABSTRACT

Major depression affects up to 40% of U.S. adolescents in mild to severe forms, compromising emotional, academic, and relational functioning, including that of interacting with parents. The purpose of this study was to explore the parent-adolescent relationship during an episode of depression in order to elucidate the adolescent experience of being parented and the parental experience as it contributes to the context of the adolescent. Research questions included: 1) What are the depressed adolescent's meanings and experiences of being parented? 2) How do the meanings and experiences of parenting contribute to the context of the lifeworld of the depressed adolescent?

An adapted Colaizzian (1978) method was used to phenomenologically analyze interview data from 6 adolescents and 5 parents. Findings for adolescents supported an essential pattern of *Dysphoric Tension Between Moving Away and Moving Toward*, including themes of *Feeling Devalued within the Relationship* and *Renegotiating the Relationship*. Parent findings supported the essential pattern of *Tension Between Pulling Closer and Letting Go*, with 4 themes including *Losing the Familiar, At the Nexus of Action, Composing Life with the Stranger*, and *Crisis Management Within*. The adolescent and parent findings were compared for differences and commonalities to assist in understanding the context provided by the parents. Findings were used to refine the investigator's previous model of adolescent depression.

CHAPTER ONE

Introduction and Statement of the Problem

The experience of major depression is not solely a personal event. Depression is a devastating disorder that affects the individual as well as those closest to him or her. When the sufferer is an adolescent, the family is intimately involved with all aspects of the experience from onset to recovery and beyond (Farmer, 2002). Parents in particular, may experience a bewildering array of emotions including guilt, anger, and confusion over unprecedented emotional and behavioral changes while the adolescent feels an equally painful and confusing loss of connection to his or her parents.

Statement of Purpose

The purpose of this study is to explore the parent-adolescent relationship during the experience of major depression from two viewpoints: the adolescent experience of being parented while depressed and the parental experience of parenting a depressed adolescent. Currently, information from these two perspectives is scant and no nursing research on this topic was found. This project is a continuation of research attempting to formulate and refine a qualitatively generated model of adolescent depression with the goal of initiating a program of research to test the model. The eventual goal is to better understand the precipitating, potentiating, and compensatory factors in adolescent-onset depression in order to provide effective nursing care. This chapter presents an overview of the proposed study to explore the relationship between the depressed adolescent and his or her parents, including discussions of the problem, significance, research questions,

and the conceptual frameworks that will underlie the proposed research.

Research Questions

Two research questions for this dissertation research are:

1) What are the depressed adolescent's meanings and experiences of being parented?

2) How do the meanings and experiences of parenting contribute to the context of the lifeworld of the depressed adolescent?

The results from these two questions will be used to inform and refine the investigator's previously derived model of adolescent depression.

Statement of the Problem

Adolescence and Depression

Adolescence has been described as a time of transition from childhood to adulthood that is shaped by the individual's social context (Graber & Brooks-Gunn, 1996). Developmental researchers agree that profound intraindividual changes occur in physiological, cognitive, and emotional functioning, yet have not always agreed on interpersonal changes, specifically the evolution of the parent-adolescent relationship. Prominent in early developmental literature was the emphasis on adolescence as a time of growing disengagement from the family, leading to autonomy while later theorists have proposed that relationships with parents are transformed, not ended, with increased independence co-existing with continued warmth and closeness (Larson, Richards, Moneta, Holmbeck, & Duckett, 1996; Young, Lynam, Valach, Novak, Brierton, & Christopher, 2001). While the majority of teenagers reach adulthood with minimal or transitory conflict (Golombek & Marton, 1992; Offer, Ostrov, Howard, & Atkinson,

1990), changes in communication patterns and decreasing time spent in the company of family members raise concerns for many parents (Riesch et al, 2000). For parents of those adolescents who become depressed, the line between normal and abnormal behavior may become blurred as the two parties encounter increasing problems in even the simplest of communications. Additionally depressed adolescents are more likely to have parents with psychiatric diagnoses, contributing to chronically problematic relationships (Hammen, 1999).

The experience of parenting a depressed child and its counterpart, the experience of being parented while depressed, are complex phenomena under-explored by all disciplines, including nursing. Although numerous studies have addressed family variables in association with depression, most have been descriptive and cross-sectional in design and have focused on characteristics of families with depressed adolescents (Hamilton, Asarnow, & Tompson, 1999; Reinherz, Giaconia, Pakiz, Silverman, Frost, & Lefkowitz, 1993; Tamplin, Goodyer, & Herbert, 1998). Most have painted a bleak picture, with parents more likely to have psychiatric diagnoses, substance abuse problems, or harsh, critical parenting styles than parents of nondepressed adolescents (Hamilton et al.; Shiner & Marmorstein, 1998). Although these studies were not designed to establish causality, many hold an implicit assumption that depressed adolescents come from dysfunctional homes. While useful, these studies have resulted in lists of variables and correlates that fail to elucidate the dynamic, reciprocal nature of the parent-adolescent relationship. The few longitudinal studies that have examined both parents and adolescents with psychological distress (e.g. Ge, Conger, Lorenz, Shanahan,

& Elder, 1995), have noted a reciprocal pattern of influences, with adolescents being both products and producers of parental variables. In addition, most depressed adolescents do not come from dysfunctional homes nor do dysfunctional homes consistently produce depressed offspring (Klein, Lewinsohn, Seeley, & Rohde, 2001; Puig-Antich et al, 1993; Tamplin et al, 1998). It is clear that the parent- depressed adolescent relationship is complex and in need of a deeper understanding, which this study attempts, in part, to provide.

Current Conceptualizations of Depression

Major depression is an affective disorder whose hallmark is a negative or sad mood occurring for an extended period of time. The disorder is episodic and recurrent, with at least partial recovery between episodes (Birmaher, Ryan, & Williamson, 1996b). Although depression can, and does, occur at nearly any point in the human lifespan, it is particularly devastating when the first onset is in childhood or adolescence. Early onset depression is thought to be a more serious form of the disorder and indicative of poorer prognosis (Hammen & Brennan, 2001).

Major depression is a heavily researched, profusely discussed topic in the literature that remains difficult to pin down due to a multitude of methods employed to measure, define, and explore it. Angold (1988), in his review of adolescent depression research, found a variety of conceptualizations of depression including a fluctuation of normal mood, a trait, a syndrome, a disorder, a disease, and a handicap. A depressed mood may be part of a number of medical and psychiatric disorders, or may not be part of any disorder (Cantwell, 1990). Petersen, Compas, Brooks-Gunn, Stemmler, Ey, and

Grant (1993) identified three research traditions that have added unique approaches and assumptions to the study of depression, resulting in different conceptualizations and difficulty comparing across traditions. Depressed mood or emotions have been interests for developmental researchers concerned with emotional development. Depressed mood is typically measured through adolescent self-reports of emotions and often co-occurs with other negative moods such as fear or anger. Depressive syndromes, constellations of behaviors and emotions that statistically occur together, have been the interest of psychologists concerned with quantitative deviations from normal behavior, without implying any cause for the associated symptoms. Clinical depression has been the province of those who have seen distressed and impaired patients in clinical settings. The study of clinical depression is based on the disease, or medical, model, which assumes that an identifiable syndrome of associated symptoms exists due to a pathological cause (Hammen & Compas, 1994; Petersen et al, 1993). The disease model has generated the primary diagnostic model used to identify major depression in individuals, the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (APA, 1994).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) lists criteria for identifying two types of unipolar depressive disorders, major depression and dysthymia (American Psychiatric Association, 1994). Major depression consists of experiencing at least five of the following symptoms nearly every day for a two week period or longer: depressed mood, diminished interest or pleasure in almost all activities, significant change in weight or appetite, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or guilt, diminished ability to

concentrate, and recurrent thoughts of death or suicide. Dysthymia is a chronic disturbance involving a depressed mood for at least one year in adolescents, with two of the following symptoms present more days than not: change in appetite, insomnia or hypersomnia, fatigue, low self-esteem, poor concentration and feelings of hopelessness. Dysthymia and depression can be diagnosed in the same individual with depressive episodes superimposed on chronic dysthymia (APA, 1994). Not all patients exhibit these symptoms, a situation especially true of children and adolescents. The DSM-IV criteria were based on adult manifestations of depression, a core psychopathology thought to be consistent across the lifespan (Myers & Troutman, 1993). While many researchers agree that adolescents and adults experience some of the same symptoms, there are notable differences (Birmaher et al, 1996b). Adolescents may present with aggressive behaviors, feelings of boredom, or conduct disorders (APA, 1994; Hammen & Compas, 1994). Hammen and Compas report that 80% of a community sample of adolescents reported that anger was a common emotion when depressed.

While diagnosing major depression in clinical settings by experienced clinicians is usually not difficult, depression as a construct in research is vague and complicated by different diagnostic perspectives (Hammen & Compas, 1994). The depression-as-disease tradition has brought forth a categorical approach to the study of depression, wherein a list of symptoms, such as the DSM-IV criteria (APA, 1994), is used to place a patient in a category. Variations of these symptoms or additional symptoms not included on the list are ignored or considered to be artifacts. In contrast, the depressive syndrome approach is dimensional, assuming that individuals will have some of the same symptoms but will

differ on degree of intensity. The syndrome approach considers additional symptoms as covariates, not artifacts, an important distinction in the study of early lifespan depression where comorbidities are high (Hammen & Compas, 1994). For example, use of the Child Behavior Checklist, a syndrome-based instrument, has shown that depressive symptoms, anxious symptoms, and externalizing behaviors co-occur frequently in clinical samples even though not all of these symptoms are subsumed under the depression label (Achenbach, 1991; Hammen & Compas). Both approaches are evident in the depression literature and this writer will endeavor to differentiate among symptoms, syndromes, and disorders as the discussion proceeds.

As with many psychiatric disorders, specific causes of depression are unknown, although several theoretical views offer explanations. Historically, the psychoanalytic theorists, such as Freud, felt that depression was hatred turned inward in an attempt to hurt an internalized object, most likely a parent. Freud acknowledged that loss in the interpersonal realm was related to depression (Freud, 1985). Although, Freud is the only theorist to address anger, a common experience for depressed adolescents, he was largely responsible for a pervasive belief that depression was non-existent in children and adolescents due to immature superegos. The superego, or conscience, was thought to be necessary for an individual to experience depression (Kotsopoulos, 1989; McCartney, 1992; Nolen-Hoeksema, 1986). Later, Bowlby's theory of attachment, partially based on psychoanalytic thought, also informed the study of depression through an emphasis on a "…psychobiologically based need for relatedness…" (Hammen, 1999, p.25). Early, secure relationships between a child and caregiver are thought to provide a protective

function that lasts throughout childhood and influences adult relationships (Egeland, Carlson, & Sroufe, 1993). This view will be explored further below.

Theoretical Perspectives

Currently, two theoretical perspectives receive the most emphasis in the literature. First, the cognitive theories, and most notably those of Beck and Seligman, focus on the distorted thinking of the depressed individual. Beck's theory (Kovacs and Beck, 1978) posits that negative thoughts about the self and others result in loss of self-esteem and a negative view of the future and outside world while Seligman's theory proposes that depression can result when individuals feel that they have no control over life situations, that is, they hold internal, stable, and global attributions regarding negative events (Abramson, Seligman, & Teasdale, 1978; Schwartz, Kaslow, Seeley, & Lewinsohn, 2000). Research has provided support for these theories in children and adolescents. Cole and Turner (1993) found that cognitive thinking errors, such as blaming oneself for all problems, and attributional style played a significant role in depression in 356 participants. Schwartz and colleagues found that maladaptive attributional styles were associated with current depressive symptoms in adolescents and were predictive of future depressive symptoms. The cognitive theories have led to successful treatment; however Coyne (1976) criticized these approaches for ignoring the very real rejection that depressed people experience. Feeling unlovable is not solely distorted thinking. In addition, Weissman and colleagues (Weissman & Klerman, 1977) noted that the contexts of women's lives and the nature of impairments in relationships played large roles in

depression, yet the cognitive approaches do not readily explain the greater incidence of depression in women.

The second area of emphasis in current research, biological factors, concerns such areas as genetics, neurodevelopment, and molecular biology. Biological approaches to depression research appear to be at the forefront of research efforts prompting W.K.Mohr and B.D.Mohr (2001) to call for a new conceptual model of psychiatric-mental health nursing care. Although an in-depth review of biological factors is outside the scope of this dissertation, a few salient points deserve mention. In a review of genetic studies Birmaher et al (1996b) reported that genetic factors likely account for at least 50% of the variance in the occurrence of mood disorders. Sullivan, Neale, and Kendler (2000) found similar results in a meta-analysis of family studies and concluded, "…its familiality mostly or entirely results from genetic influences." (p.1552). Studies showing the blunting of growth hormone release in depressed children have shown promise for identifying sufferers before, during, and after depressive episodes (Birmaher et al). Yet, sleep abnormalities do not consistently appear in depressed adolescents and the dexamethasone suppression test of cortisol secretion, a useful test in adults, failed to discriminate among depressed children and controls in several studies (Birmaher et al) Although efforts continue to focus on possible neurochemistry abnormalities, no causative factors have been identified nor have consistent biological markers been identified. Evidence of dysregulation has thus far been inconsistent and inconclusive in early lifespan depression (Birmaher et al, 1996a).

Less emphasized, but more important for the study of the experience of depression in families are the interpersonal theories of depression. Coyne (1976) countered the cognitive theory-based concept of distorted thinking by proposing that depressed individuals were not mistaken in their thinking; they were actually accurate interpreters of interactions with those around them. Coyne was intentionally noncommittal about the origins of depressive behavior, stating that an individual only needed to display depressive behavior in order to set in motion a chain of interactions. According to Coyne, the depressed person seeks reassurance from others, which is provided verbally but is accompanied by nonverbally transmitted reluctance and negativity. The depressed individual perceives the incongruence between the words and nonverbal actions, feels more insecure, and displays more depressive symptoms and more reassurance seeking which others provide with increasing frustration. This leads to a cycle that is extremely difficult to change. Joiner, Coyne, & Blalock (1999) admit that this conceptualization was "…vague and underdeveloped…" (p.5), but served the purpose of challenging cognitive theorists' assumptions of depression due to distorted thinking.

In sum, it is likely that each of these areas of exploration have a useful role to play in elucidating the underlying processes of depression. Many researchers adhere to diathesis-stress models in which an underlying vulnerability is triggered by life events perceived as stressors (Hammen, 1997). In this case biological factors, cognitive dysfunction, and interpersonal events are all involved in the onset of depression.

Brief Review of Assessment and Treatment of Depression in Adolescents

Nurses in settings such as clinics or schools may often be the first health care professionals to see or suspect depression. Appearance, including facial expression and style of dress, may be initial clues (Sadler, 1991). Presenting problems may be events other than depression, such as aggressive acts or substance abuse. Careful interviews are required, with information coming from the adolescent, parents, and the school if appropriate. In addition to assessing current problems and their history, Sadler (1991) stresses direct questioning about suicidal thoughts, plans, and attempts. Adolescents who are at risk for harming themselves or others, or who are exhibiting psychotic symptoms, will require emergency services.

Treatment for depression most often consists of psychotherapy and/or medications. Individual psychotherapy involves cognitive-behavioral approaches, interpersonal therapy, family therapy, or nonspecific therapy. Cognitive-behavioral therapy, which targets distorted thinking and strategies for changing depressogenic behaviors, has been shown to be effective both in the treatment of current depression and in the prevention of future episodes (Clarke, Hawkins, Murphy, Sheeber, Lewinsohn, & Seeley, 1995; Hammen, Rudolph, Weisz, Rao, & Burge, 1999; Kolko, Brent, Baugher, Bridge, & Birmaher, 2000). Likewise, interpersonal therapy, which targets interpersonal aspects of depression, has been modified for adolescents from its adult roots and been shown effective (Moreau, Mufson, Weissman, & Klerman, 1991; Santor & Kusumakar, 2001). Family therapy may also be effective for issues of family conflict and parent-adolescent relationship problems, although cognitive-behavioral therapy has also been

shown effective for some family dysfunction (Chiariello & Orvaschel, 1995; Kolko et al). Psychopharmacologic agents have not been as successful for treating early lifespan depression as they have for adults. To date, only fluoxetine (Prozac), a selective serotonin reuptake inhibitor (SSRI), has shown some effectiveness beyond placebos (Hammen et al; Mohr, 1998; Mueller & Orvaschel, 1997).

Two concerns have been voiced regarding the treatment of depression in adolescents. First, in epidemiological studies, such as that of Wu et al (1999), internalizing problems, including depression are under-identified and under-referred when compared to externalizing, or disruptive, disorders, and therefore are severe before they receive attention. Second, current treatments have all been extrapolated from successful adult therapies, which assume mature cognitive and physiological processes (Hammen et al,1999). Hammen and colleagues state that most treatment offered currently fails to consider developmental concerns, social and academic functional impairment, and ongoing stressful home environments that adolescents are generally powerless to change. One potential promising solution for these problems is the implementation of school-based health clinics (SBHCs). Wu and colleagues report that SBHCs provided mental health services that were more widely used by underserved populations as opposed to traditional mental health care settings. In addition to access, SBHCs provide opportunities for early intervention, linkage to services, longitudinal research, and a variety of programs that address social skills, substance abuse, and conflict resolution, for example, in addition to psychotherapy (Adelson,1999; Merry, McDowell, Wild, Bir, & Cunliffe, 2004).

Significance

Prevalence

For adolescents, depression is a devastating disorder with potentially crippling consequences during a period of development in which critical life choices are at the forefront. Although measurement methods vary, the prevalence for major depressive disorder in adolescents is generally reported to be between 0.4% and 8.3% with mild to moderate depression affecting 10 to 40% among all adolescents in the United States (Birmaher et al, 1996a; Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993; Myers & Troutman, 1993;Puskar, Tusaie-Mumford, Sereika, & Lamb, 1999). To date, only one large scale epidemiological study of adolescent psychopathology has been completed, the Oregon Adolescent Depression Project, which found a point prevalence of 2.9% and a lifetime prevalence of 20.4 to 25.3% for unipolar depression in a large random sample of high school students (Lewinsohn, Hops, et al). Sixty-two percent of adolescents reported current symptoms of depression in a study of rural Pennsylvania high school students (Puskar, Tusaie-Mumford, et al) while one out of five Australian youths in a large (N=2032) study reported depressed mood upon diagnostic interview (Patton, Coffey, Posterino, Carlin, & Wolfe, 2000). Several studies, including the NIMH Collaborative Program on the Psychobiology of Depression, concur that the rates of childhood and adolescent depression continue to rise each year, with more recent birth cohorts experiencing a higher rate and earlier onset of the disorder (Birmaher et al.; Brage, 1995; Cantwell, 1990; Lewinsohn, Hops, et al; Lewinsohn, Rohde, Seeley, & Fischer, 1993; Myers & Troutman). Early onset depression is salient in that it portends a more serious

form of the disorder, with more recurrences and higher morbidity (Giaconia, Reinherz, Silverman, Pakiz, Frost, & Cohen, 1994). Most researchers agree that while rates for childhood depression are low (under 3%), a sudden rise in diagnosed cases occurs in early adolescence, around the ages of thirteen to fourteen. Depression accounts for approximately 40% to 50% of adolescent psychiatric admissions, making it the most frequent diagnosis for adolescent inpatients (Chabra, Chavez, Harris & Shah, 1999). Early to middle adolescents have the second highest rate of depression among all age groups; only the eighteen to twenty-four year old group has higher rates (Brage; Golombek & Kutcher, 1990; Myers & Troutman; Nolen-Hoeksema, 1986). Adolescents themselves consistently rank mental health issues, including symptoms of depression, high on lists of health concerns (Millstein, 1993).

Risk Factors Associated with Depression

Depression has been linked with poor academic performance, dropping out of school, increased sexual promiscuity, substance abuse, conduct disorders, suicide, and incidents of school violence (Knox, King, Hanna, Logan, & Ghaziudden, 2000; Kutcher & Marton, 1989; Pullen, Modrcin-McCarthy, & Graf, 2000; Sadler, 1991). The suicide rate for adolescents has quadrupled since 1950, accounting for 12% of the total mortality in this age group (Birmaher et al, 1996b). Depression has been shown to compromise functioning of the adolescent within family and school settings, contributing to poor relationships with parents, siblings, and teachers (Birmaher et al, 1996a). Depression has been associated with substance use and may precede the onset of alcohol and substance abuse by four to five years, allowing a window of opportunity for intervention (Birmaher

et al, 1996b; Cicchetti & Toth, 1998).

The time course of the consequences is not limited with approximately 70% of children and adolescents experiencing recurrence within five years as well as sustaining an increased risk of becoming adults with psychiatric difficulites (Kovacs, 1996). Three out of four depressed teens in the Oregon Adolescent Depression Project experienced psychiatric disorders again by their 24th birthdays (Lewinsohn, Rohde, Seeley, Klein, & Gotlib, 2000). In a follow-up study of adolescents with depression, respondents reported a higher frequency of impairments in work, social, and family functioning ten to fifteen years later as compared to a control group (Weissman et al, 1999). In addition, higher rates of both medical and psychiatric hospitalizations were observed in those with adolescent-onset depression. One of the most powerful predictors of depression in children and adolescents is the presence of a depressed parent (Hammen, 1999). Thus untreated adolescents become depressed parents who pass the legacy of depression to their children. The loss to affected individuals not only becomes society's loss in broken homes but in dollars as well. The estimated economic cost of depression is approximately $43 billion per year including direct and indirect costs, making it one of the ten most costly illnesses in the United States (Hirschfeld et al, 1997). In light of these consequences, a greater understanding of the disorder as it occurs in the context of the family will serve as a foundation for earlier, more thorough treatment.

Unfortunately, 70 to 80% of depressed adolescents are not receiving the treatment they need due to factors such as lack of assessment skills by health care providers, declining public expenditures on mental health care, and poor private coverage of mental

disorders (Bearinger, Wildey, Gephart, & Blum, 1992; Cicchetti & Toth, 1998; Gearon, 2000; Hirschfeld et al, 1997). Two large-scale nationwide studies noted that lack of privacy, insurance, and someone to take them were major reasons for missed care among adolescents (Ford, Bearman, & Moody, 1999; Klein, Wilson, McNulty, Kapphahn, & Collins, 1999). Minority youth appear to be particularly underserved. A California study of health care system usage for mental illness in adolescents showed lower use patterns for minority adolescents, concluding that minority youth are probably referred more often to the juvenile or social welfare system rather than to the mental health system (Chabra et al, 1999).

Nurses encounter depressed adolescents in many settings, including schools, emergency departments, outpatient clinics, and pediatric units. In their survey of nursing competencies in adolescent health, Bearinger and colleagues (Bearinger et al,1992) found that 44% of nurses felt they lacked the skills, including assessment skills, with which to care for depressed adolescents. Similarly, Hirschfeld and colleagues (1997) listed deficits in provider attitudes, beliefs, knowledge, and skills in regard to assessment, diagnosis, and treatment as reasons for the undertreatment of depressive disorders. In light of the pervasive and persistent negative consequences of major depression, it is imperative for nurses to strengthen their knowledge base in order to understand and treat this devastating disorder.

Lack of Research-Based Knowledge

The study of early life-span depression is fairly new endeavor. Only since the 1970s have researchers recognized the existence of the disorder in children and

adolescents and begun to build a knowledge base. Important and informative as this work has been, a crucial assumption underlying these efforts has been that depression as a disorder shows continuity across developmental stages. That is, the symptoms characteristic of adults are the same symptoms one would expect to find in adolescent sufferers (Cicchetti & Toth, 1998). The DSM-IV (APA, 1994) contains a list of symptoms based on adult research, yet it has been used as a basis for research on children as well as adults. Indeed some symptoms, such as sadness and social isolation, are seen across the lifespan, yet our understanding has suffered from lack of attention to the discontinuities across ages, for example, the conduct problems and impulsivity seen in particularly in young males (Gjerde, 1995). In addition, self-understanding and the complex self-schemata that underlie adult depression are not in the repertoire of adolescent abilities (Cicchetti & Schneider-Rosen, 1986). Most psychological theories regarding onset and maintenance of depression are based on adult functioning, yet are applied without refinement to early lifespan depression (Mueller & Orvaschel, 1997). The development of models based on adolescent experiences of depression seems a logical step in advancing knowledge of this disorder.

While knowledge from which to guide care for adolescents seems incomplete, parents have been virtually ignored by research efforts. Most studies concerning parents of depressed adolescents focus only on characteristics of the parents that are associated with the disorder. Thus studies have noted higher rates of affective disorders, substance abuse, and stressful life events in parents, mostly mothers, of depressed adolescents (Ciccetti & Toth, 1998; Downey & Coyne, 1990; Hammen, 1999; Klein, Clark, Dansky,

& Margolis, 1988; Shiner & Marmorstein, 1998; Su, Hoffman, Gerstein, & Johnson, 1997). Several studies have also examined the parent-adolescent relationship, again focusing on the parent-to-child transmission of negative affect, noting poor communication skills and diminished affection for the adolescents (Cicchetti & Toth, 1998; Martin & Waite, 1994; Puig-Antich et al., 1993; Tulloch, Blizzard, & Pinkus, 1997). The missing piece remains the parental point of view in living with a depressed adolescent, which this study helped to elucidate. Only one study was found that concerned living with depressed family members. Badger (1996), in a study of individuals living with a depressed spouse or child, highlighted the ongoing exhaustive process of life at home. Families felt the need to be protective and vigilant on behalf of the depressed member, to use coercive strategies to elicit potential change, to assume the tasks normally handled by the depressed individual, and to find socially acceptable explanations to give to friends, coworkers, and relatives (Badger). Only two of the depressed individuals in Badger's study were adolescents, while the rest were adults, therefore the relational impact of living with depressed adolescents remain to be further explored. Discordant relationships between parents and depressed adolescents appear to be salient in the disorder and underexplored in the literature.

Preliminary Research

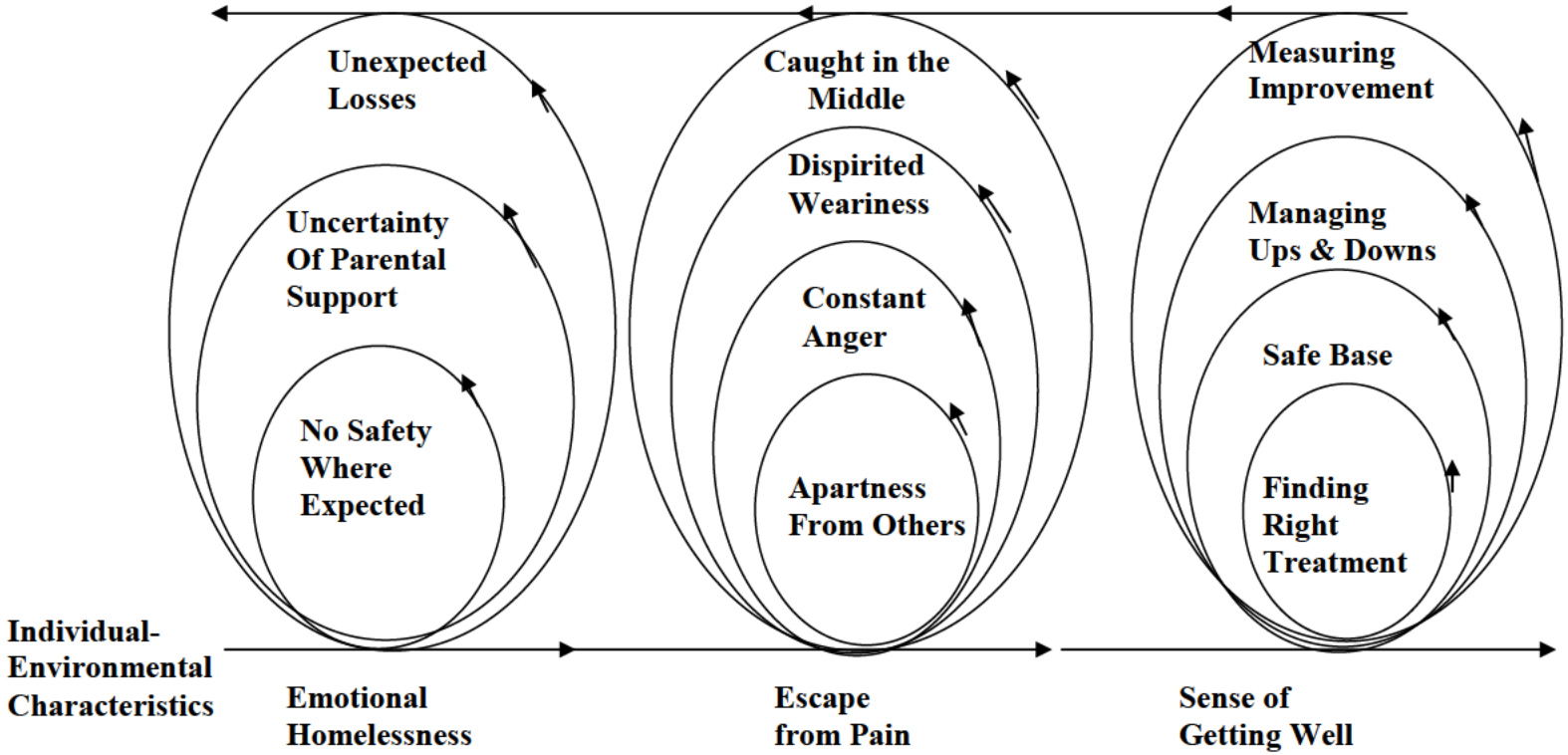
Preliminary work by this writer (Farmer, 2002) included a phenomenologic study of depressed adolescents, wherein they described the experience of being depressed. Several of the resulting themes and theme categories both highlighted the salience of the parent-adolescent relationship in depression and the need for further exploration.

Emotional homelessness was a phrase used in two categories to represent the sense of aloneness and the lack of a safe base that these adolescents experienced when discussing their home lives. Conflictual relationships with parents were characteristic of these participants' narratives. The essential structure of the experience of being depressed was used to construct a preliminary meaning-based model of depression as experienced by adolescents (See Figure 1). Yet in talking to parents during the consenting process, it was clear that they were genuinely concerned for their children's health and were baffled at what had become of earlier good relationships. Parents felt a mix of guilt, isolation, and lack of knowledge regarding how to best help their children. Because this preliminary work was not designed to ascertain dyadic characteristics or multiple points of view and because the parent-adolescent relationship begged for clarification, the next step in a program of research on depression was thought to be to explore parenting of depressed adolescents in addition to the adolescent experience of being parented.

Conceptual Orientation

Nursing occupies an enviable position as a discipline that simultaneously upholds a tradition of rigorous scientific endeavor with a mandate to put this body of knowledge to practical use. Research within the discipline must therefore be guided by philosophical principles consistent with this position. Personal philosophical beliefs will now be discussed in order to clarify the approach to this study and to serve as a statement of this author's perspective on research and major depression. The conceptual framework and methodological background will then be discussed.

Figure 1: Emerging Model of Depression in Adolescents



Neomodernist Philosophy

This author holds what is best described as a neomodernist philosophy of nursing (Reed, 1995; 2006). This position posits that some underlying truths exist in the domain of nursing, yet perceptions are many and varied and are often viewed as powerful truths by their holders. These perceptions are known only as one relates to the world by being in the world and are constructed by humans in concert with their surroundings. Meanings may be culturally shared or individually held. The experts are those who have experienced the phenomenon of interest and share meanings and experiences revealed through narratives and descriptions. The element of time is also inherent in this philosophy, which expresses a developmental-contextual worldview that ever-changing humans are embedded in ever-changing contexts. The neomodernist view also espouses that there are many ways of knowing and therefore multiple approaches to understanding a phenomenon. Exploring the life-world of humans is necessary, as is exploring underlying truths.

In the study of depression, for example, phenomenologic methods are useful to understand the disorder from the perspective of the 'expert' who suffers it, as are empirical-analytic methods to 'stand outside' the phenomenon in order to address concerns such as prevalence of depression and effective treatments. Methods are tools to be used in the pursuit of practical knowledge. Their philosophical roots must be honored yet must be subsumed by a larger philosophy of that includes and values many ways of knowing and a variety of perspectives.

Pattern Recognition

One such overarching view is that of pattern recognition (Newman, 2002). Newman proposes that "…pattern constitutes the unitary grasp of knowledge that the discipline seeks." (p. 2). By focusing on pattern as the overarching narrative of nursing knowledge, previous knowledge and ways of knowing are included as processes in development of knowledge of the whole. Research within Newman's attention to pattern would then include identification and description of patterns, associations among patterns, measuring patterns, and interventions that change patterns. For the proposed study, the pattern we label as depression is the phenomenon of interest, with a focus on identification and description of this pattern as it manifests in the adolescent in the context of the parent-adolescent relationship.

Newman (2002) discusses mutual processing as a means to pattern recognition, as the nurse-researcher interacts with the client-participant. She states,

> The dialogue between nurse-researcher and client-participant became focused on the meaningfulness of events in the client's life. Meaning in a person's life is not only critical but also a way of identifying pattern. A pattern possesses meaning. As meaning is discovered, the pattern becomes apparent [and vice versa] (p. 4).

Thus, to identify the pattern of depression in an individual's life would be to dialogue with the individual to identify the meaning of the experiences in his/her life. Because this study involved both depressed individuals in the context of those who parent them, it was proposed that both will have made meaning about their respective experiences.

Furthermore, the parent and adolescent will have mutually processed events in the depression pattern through communications with one another which may provide data to better understand the pattern of the context.

Under Newman's (2002) attention to pattern, this author will use a narrower conceptual framework to organize and focus knowledge building efforts (Meleis, 1997). The conceptual foundation for this study derives from a nursing-based synthesis of phenomenology and a developmental psychopathological framework (Cicchetti & Toth, 1998; Munhall, 1994).

Phenomenology

Phenomenology is a term that applies to a group of related philosophies as well as approaches to knowledge seeking and methods with which to proceed (Ray, 1994). Phenomenology is concerned with human experience as it is lived, with an ultimate pursuit of understanding what it is to be human (Munhall, 1994; Omery, 1983). One can gain a clearer sense of the nature and meaning of a given experience through hearing from those who have had the experience. Since parent-adolescent relationships during depression have not been explored from a qualitative, interpretive perspective, a phenomenological conceptual orientation was selected in order to understand this experience and produce new insights.

The majority of depression research has fallen within the empirical-analytic paradigm conducted through use of traditional science methods (Munhall, 1994). The traditional approaches assume that sets of facts are available, separate from and external to individual experience, for objective study. The goal of the researcher within this

tradition is to discover these objective patterns while recognizing the subjectivity of the research process. Although the results from these depression studies have been extremely useful, it is to the advantage of the discipline of nursing to examine the phenomenon from the perspective of more than one paradigm. Several conceptual models of nursing, including those of Parse, Rogers, Newman, and Paterson and Zderad promote the belief that the individual is more than a system of facts (Newman, 2002; O'Connor, 1993; Parse, 1992; Rogers, 1990) and that systems of objective facts alone are not adequate for total care of individuals. If the individual is viewed holistically as a complex being in interaction with a complex environment, then knowledge and understanding of the meaning of individuals' experiences must come from more than one research approach.

When little is known about a particular phenomenon, or when a researcher feels that existing knowledge may be biased, Field and Morse (1985) suggest use of a qualitative approach to conduct nursing research. Qualitative approaches and methods are a means of exploration and description of lesser-known phenomena, ways to uncover new insights and understanding while placing no controls on the phenomenon being studied (Anderson, 1991; Crist & Tanner, 2003; Field & Morse; Munhall, 1994). Qualitative approaches, including phenomenology, assume that reality is socially constructed and grounded in historical and social contexts. When the researcher seeks qualitative data on the lived experience of people, the primary approach is that of phenomenology.

Developmental Psychopathology Framework

In addition to phenomenology, the framework of developmental psychopathology guides this study. The following description of the framework also serves as an a priori statement by the researcher of beliefs about depression. Developmental psychopathology is a growing body of knowledge as well as a theoretical foundation for approaching knowledge development in the area of developmental influences on and interactions with psychological disorders. Cicchetti and Toth (1998) state that the field of developmental psychopathology seeks to "…unify, within a life-span framework, the many contributions to the study of high-risk and disordered individuals emanating from multiple fields of inquiry" (p. 482). The focus of the developmental psychopathological approach is the exploration and elucidation of developmental processes that lead to unique combinations of pathological and nonpathological functioning. It is assumed that individuals move between pathological and nonpathological functioning and that disorders are not discreet categories, but rather, varying degrees and combinations of behavioral, emotional, and cognitive patterns.

Developmental psychopathology is a relatively new approach to integrating knowledge from many disciplines, whose main proponents have been psychologists L.Alan Sroufe, Michael Rutter, and Dante Cicchetti (Carr & Schellenbach, 1993; Cicchetti & Toth, 1998: Sroufe & Rutter, 1984). The approach has roots in many theoretical perspectives including attachment theory, contextual theories, and lifespan theories. Over the past two decades the framework has been refined and current assumptions held include:

1) Behavior can only be understood in context. Meaning is gained not from isolated behaviors but in patterns of behaviors in specific situations. Maladaptive and adaptive are terms that take on different meanings dependent on context and time. Identical behaviors may indicate disorder in one individual and not another. Crying on parting from parents, for example, may be seen as normal response for a three-year-old male, but not for a fifteen-year-old male. Context includes not only the immediate environment but larger social phenomena such as cultural norms, as well.

2) Development is transactional in nature, involving embedded levels of processes from the genetic to the historical and sociocultural. Development is the result of the continual interaction among levels. Events at each level may be both products and producers of changes at other levels.

3) Equifinality and multifinality are evident in developmental outcomes. The concept of equifinality refers to two or more pathways that have similar outcomes. For example, two adolescents may have had very different family and school situations yet both suffer from major depression. In contrast, multifinality refers to similar pathways that result in different outcomes. For example some children of depressed, single mothers become depressed themselves as adolescents, while others do not. Many research efforts in developmental psychology are aimed toward elucidating the reasons for different outcomes.

4) Because development involves increasing complexity and hierarchical integration, pathological or maladaptive patterns may become increasingly complex and ingrained in everyday functioning, resulting in poorer prognoses as the individual ages.

With major depression, for example, it is felt that early intervention is more effective than intervening in adulthood, after an individual has experienced more than one episode of the disorder (Cicchetti & Toth, 1998). However, skills, like maladaptive patterns, may have become more advanced and useful as well, providing a base from which to intervene.

The developmental psychopathological approach provides a logical perspective for this dissertation research. Without a developmental focus to disordered behavior as it manifests in a given age group, knowledge building becomes focused on lists of symptoms and associations among them, rather than focused on linking past and present, individual and contextual events. This approach also values the importance of situational and historical context. As stated earlier, it is this writer's belief that the pattern we identify as depression is not solely an individual event, but rather a complex phenomenon involving embedded levels from the genetic to the cultural. The understanding of this disorder must go beyond the individual viewpoint to include families, peers, and social contexts. This view of depression also values the constellation of adaptive, maladaptive, potentiating, and compensatory efforts that are inherent in any human effort to cope with life events. Persons with diagnoses of depression function normally in many respects and present opportunities for building on strengths while defying research efforts to fit them into tidy diagnostic categories.

The developmental psychopathological view is consistent with many of the philosophical tenets of the discipline of nursing. Nursing has traditionally recognized the complexity of human phenomena, valuing the processes, contexts, and patterns so

intertwined with human health (Meleis, 1997; Munhall, 1994, Parse, 2001). Many nurse scientists have recognized the futility of the sick/well dichotomy (e.g. Moch, Patterson & Zderad), a construct that is not representative of the realities of human functioning (Moch, 1998; O'Connor, 1993). Within any 'disorder' are numerous examples of resilient functioning, including inherent abilities for healing (Reed, 2000). Finally, a developmental perspective is consistent with several conceptual frameworks, notably those of Parse and Rogers (Parse, 1992; Rogers, 1990).

Summary of Chapter

This chapter has explored the foundations for the proposed study. Included were a discussion of the nature of the problem, a statement of purpose, and the research questions for this study. The significance of the proposed study lies in its potential to further elucidate the nature of the experience of adolescent depression in the context of the parent-adolescent relationship. Under the overarching view of Newman's pattern recognition, this study will be guided by a nursing-based synthesis of the tenets of the phenomenological approach and the developmental psychopathological framework.

CHAPTER TWO

Review of the Literature

Chapter 2 will present an overview of literature pertinent to this study. Included will be a review of major depression and individual functioning in adolescents, general parent-adolescent developmental issues, family factors in depression, and family member's experiences with depressed loved ones.

Developmental Psychopathological Approach to a Review of the Literature

Consistent with the conceptual orientation of this study - a nursing synthesis inclusive of a developmental psychopathology framework- major depression will be explored from the viewpoint of multiple, interacting levels. Cicchetti and Toth (1998) suggest a transactional approach among four levels: ontogenic development (factors within the person that affect development such as genes and neurodevelopmental processes), the microsystem (immediate, family environment), the exosystem (community, school factors), and the macrosystem (societal and cultural factors). Furthermore, the authors state, "In accord with a transactional approach, ongoing transactions of risk and protective processes within and among each level of the ecology are conceived as contributing to the emergence and development of a depressotypic organization and to the onset and recurrence of depressive disorders" (p.227). Because this proposal is focused on the experiences of parenting and being parented during depressive illness in the adolescent, the reviewed literature will primarily concern the levels of individual psychological functioning (ontological development) and family functioning (microsystem) with the recognition that the boundaries among these

interacting levels are artificial (Cicchetti & Toth). The review begins with a discussion of family issues in adolescent depression (microsystem).

Parent Experience of Living with a Depressed Child

The literature regarding parent experience of living with a depressed adolescent is sparse. Although many studies have addressed individual factors in adolescent depression, no studies were found that specifically address the parent experience of living with a depressed adolescent. A few shed some light on the experience and provide a start for the proposed study. Angold, Messer, Stangl, Farmer, Costello, & Burns (1998) looked at perceived parental burden and mental health service use in parents of 1015 nine, eleven, and thirteen year old children. Approximately 10% of parents in this community sample had children with one or more psychiatric symptoms, including symptoms of depression. As the level of symptoms increased, so did the parent-reported burden. While depression and anxiety were among the less burdensome symptoms, the presence of perceived burden by parents of any symptom was associated with a five-fold increase in mental health service usage (Angold et al). Mohr (2000) studied the perspectives of parents whose children had been hospitalized for psychiatric care. Themes emerging from interview data included parents' feelings of exclusion from assessment and treatment planning, painful isolation from their children, feelings of being marginalized or "…abnormalized…" feelings of powerlessness, and bewilderment (p.604). Mohr concluded health care providers need to partner with parents in the care of their children and provide support for parents in the parenting role. This study indicates that parents of depressed adolescents in the proposed research study may have negative

feelings about their children's' care as well as feelings of powerlessness and guilt.

More pertinent to the parent experience is a grounded theory study by Badger (1996), who interviewed family members on the experience of living with a depressed family member. Although most were spouses, two participants were parents of depressed children. Badger termed the resulting basic social process Family Transformations, consisting of a series of three stages. The first was *Acknowledging the strangers within*, wherein family members observed the detrimental changes in their loved ones while searching for reasons, solutions, and socially acceptable explanations. Family members questioned whether they had any role in causing the depression. The second stage, *Fighting the battle,* dealt with interactions with the depressed person and negotiating the mental health care system. Families felt the need to be protective and vigilant on behalf of the depressed member, yet used coercive strategies to elicit potential change in them. Protective strategies included affirming affection, suggesting alternative activities to increase pleasure, reducing conflict through withholding upsetting information and avoiding expressed emotions, seeking support from others, and maintaining vigilance regarding the depressed members' safety. Coercive strategies involved avoiding interaction with the depressed member, demanding change, threatening the relationship, and managing treatment. *Gaining a new perspective* was the third and final stage. In this stage, family members focused one's self-preservation to regain a sense of self, and refocusing on other relationships with extended family and friends. *Redesigning the relationship* was a process by which family members reconnected with the depressed person by showing love and concern, yet maintaining an emotional distance. Family

members became hopeful yet remained cautious (Badger).

This study elucidated many interesting strategies and processes common to any family member living with a depressed loved one (Badger, 1996). As such, it has informed the proposed research through the identification of potential responses of parents of depressed adolescents. Because the study did not solely focus on parents, however, it revealed themes common to all types of family members. It may not have identified processes or themes unique to parents alone. The proposed research will attempt to focus more closely on these parental experiences.

Overview of Research on Parent-Adolescent Functioning

Depression in adolescents cannot be understood without examining the family context, most notably the relationship between parents and adolescents. As with individual functioning in depression, most studies of depression in families have focused on characteristics of family structure and functioning without exploring the dynamic, interactive nature of family processes. Although useful, these studies have presented an incomplete picture and have focused largely on risk factors and consequences. Furthermore, mental health clinicians have not always viewed parents positively. Psychiatric disorders in children continue to be viewed as the result of faulty parenting (Mohr, 2000), a unidirectional perspective that assumes children have been passive participants.

The developmental psychopathological framework offers a broader, more balanced approach to the study of depression in families. Families, like other levels in the transactional model, present both risks and support for the individuals functioning

within them (Cicchetti & Toth, 1998; Galambos & Ehrenberg, 1997). For example, Hammen (1999) lists the presence of maternal depression to be one of the strongest risks for depression in her children while, conversely, Resnick, Harris, and Blum (1993) note that the perception of family connectedness was one the most powerful protective factors against disturbed behaviors in a study of over 36,000 Minnesota teens. The developmental psychopathological framework also emphasizes the interaction among levels, in this case, the individual and the family. Adolescents are still highly dependent on parents and the environment they provide, being relatively helpless to effect meaningful change or to leave difficult situations (Hammen et al, 2000). Yet adolescents have matured enough to participate in decision-making, to voice opinions, and to choose, sometimes unwisely, how they will handle problems within themselves or their families. The parent-adolescent relationship occupies a unique position as mediator among risks and opportunities within the family and is worthy of further exploration in connection to depression (Galambos & Ehrenberg, 1997). Parent-adolescent and family functioning when the adolescent is depressed will now be discussed, including a brief overview of nondepressed functioning, theoretical perspectives on depression transmission, and a review of pertinent studies.

Families and adolescents: Independence and connectedness

As stated earlier, depression occurs in the context of normal development for adolescents, making a brief discussion of nondepressed family functioning pertinent. Despite physical maturation and increasing societal privileges, adolescents continue to be dependent on, and a vital part of, their families. Although early theorists stressed family

upheavals and intense struggles (Freud, 1969), current thought emphasizes increasing psychological independence coupled with continued connectedness for adolescents and their families (Feinberg, Howe, Reiss, & Hetherington, 2000; Grotevant & Cooper, 1986; Larson et al., 1996; Youniss & Ketterlinus, 1987).

Psychological independence often involves conflict. Riesch et al. (2000) noted that conflict is pervasive in families, with a general increase in conflictual interactions beginning in early adolescence followed by a gradual decrease through the remainder of adolescence. Parents and their children typically quarrel twice per week during the adolescent years (Riesch et al). In a survey of 163 families, it was noted that disagreements usually focused on everyday topics such as grades, homework, household chores, or fighting with siblings, and were generally not highly emotionally charged. Unlike media portrayals, arguments rarely involved serious or sensitive topics such as substance use or sexual activities. While peers were more influential in day-to-day decisions about music or clothes, adolescents reported relying on parents for assistance and advice on deeper issues such as religious beliefs and educational plans (Riesch et al).

Continued connectedness between parents and adolescents was evident in a study by Larson et al (1996), who used an experiential sampling method to longitudinally track the nature of interactions of teens from ages ten to eighteen with their family members. Over these years a large linear decline in time spent by adolescents with their families in general was noted yet parent-adolescent dyad time did not significantly decrease. Adolescents continued to spend a similar amount of time with mothers or fathers alone, often in conversation (Larson et al). The decline was accounted for by less time with the

family as a whole and less with certain subgroups (i.e. siblings). Even youths who reported more conflicts with parents did not spend less time with them. The authors concluded that adolescent disengagement from family life was not driven by intrafamilial factors but more likely by pulls from outside the family, such as friends or jobs, during which stability of one-on-one time with parents was maintained (Larson et al).

The construct of parenting style has received much attention in the literature and deserves mention in connection with adolescent problem behaviors and depression. Baumrind (1991) identified six types of parenting styles in families with adolescents (four in families of young children) based on the dimensional concepts of parental demandingness and responsiveness. Parents who were moderate to high on demandingness (control) and high on responsiveness (warmth) had adolescents with the best outcomes, for example, high levels of competence, optimism, motivation, social responsibility, self-regulation, and self-esteem (i.e. authoritative parenting). Homes characterized by less control and/or warmth were associated with varying degrees of problems in the adolescents including internalizing (depressive and anxious) symptoms, externalizing (delinquency) symptoms, and substance abuse (Baumrind). Some researchers have criticized these findings, noting that these results do not typify minority, poor, or single-parent families where a more autocratic parenting style (high control, low warmth) has been associated with better outcomes in young children (Radziszewska, Richardson, Dent, & Flay, 1996). However, studies of adolescents have not consistently shown the same findings. Radziszewska et al (1996) surveyed 3993 fifteen year old Caucasian, Hispanic, African-American, and Asian students on parenting style and

outcome measures such as depressive symptoms, smoking, and academic achievement. Adolescents from authoritative families had the best outcomes across ethnic and sociodemographic subgroups (Radziszewska et al). Parenting styles and depression will be discussed further below.

For most families, parent-adolescent communication appears to be most constructive when there is a happy medium between parental over-control and underinvolvement. For example, Palmer & Hollin (2001) found that more mature levels of moral reasoning in adolescents were associated with lower levels of parental involvement. Higher levels of involvement, attachment, and supervision were hypothesized to lead to enmeshment of parents and adolescents and subsequent rebellion. Likewise, clinging and controlling parents in the Riesch et al (2000) study had more conflicts with their teenaged children. In two narrative-based studies of adolescent decision-making, parents' voices were more likely to be internalized and used in decision-making in adolescents who endorsed having authoritative parents (Mackey, Arnold, & Pratt, 2001). Eccles, Lord, Roeser, Barber, and Jozefowicz (1997) found that parents who are able to adjust to adolescents' needs for increased autonomous decision-making and self-direction with little conflict provide better adolescent-family fit. They suggest that parents need to find opportunities for adolescent involvement in decision-making in order to increase self-esteem and self-reliance (Eccles et al).

Parental monitoring is another construct of interest when examining adolescent outcomes. Galambos & Ehrenberg (1997) state, "…Monitoring refers to the parent's knowledge of what the adolescent is doing, where the adolescent is, and with whom he or

she is doing it." (p. 144). Monitoring helps to regulate the adolescent's behavioral autonomy, with less effective monitoring being associated with poorer school performance and more delinquent activities (Galambos & Ehrenberg). High levels of parental monitoring have been associated with a reduction in health risk behaviors (substance abuse, truancy, violent behaviors) in African-American children and adolescents both cross-sectionally and longitudinally in two studies (Li, Feigelman, & Stanton, 2000; Li, Stanton, & Feigelman, 2000). Females and younger children received more stringent monitoring.

Theoretical Perspectives on Depression and Families

Like other psychiatric disorders, depression is associated with impaired interpersonal functioning, profoundly altering day-to-day family life. Interpersonal difficulties have been viewed as concomitants of depression, consequences of depression and causal factors of the disorder (Hammen, 1997). The experience of depression is therefore not easily separated from family functioning, especially when the sufferer is an adolescent. There is no doubt that depression aggregates within families. Analysis of family data from the Oregon Adolescent Depression Project revealed that rates of mood disorders, particularly depression and dysthmia, were significantly elevated in relatives of depressed adolescents (Klein et al, 2001). Depression also showed a high degree of specificity of transmission, that is, depressed adolescents had relatives with depression and not other disorders, such as anxiety or disruptive behaviors.

Genetic factors, as discussed earlier, receive much attention in the literature, with some researchers stating that genetics account for the majority of the variance in the

occurrence of mood disorders (Birmaher et al, 1996a; Sullivan et al, 2000). Yet this viewpoint does not address the fact that most adolescents with depression *do not* have parents with major depression (Klein et al, 2001). Although genes may play a role in vulnerability to depression, other factors work to bring about its manifestation.

Several theoretical perspectives, listed by Hammen (1997), address the onset of depression in a family member, usually a child. Cognitive theory and social learning theory concepts have been linked with familial transmission of depression. Skills and cognitive styles, learned from parents through observation and direct reinforcement, may lead to negative attributional styles and poorer self-concepts (Hammen). The psychodynamic perspective, derived from Freudian thought, compares depression to bereavement. Perceived loss of a loved one, especially a parent, can produce sadness typical of mourning. Unlike grief, however, depression includes anger turned inward, resulting in guilt and self-deprecation (Hammen).

Closely related to, and partially derived from, the psychodynamic approaches, is attachment theory. Attachment theory is primarily the product of the work of John Bowlby, who stated that the human is preadapted from birth to interact with and respond to a caregiver (Bretherton, 1992). Attachment, defined as "…an enduring affectional bond to a specific figure or figures" (p. 281), is a transactional pattern of behaviors guided by genes but sensitive to environmental influences that serve to keep caretakers in close proximity to their young (Ainsworth, 1989; Bretherton). This attachment, or bond, is thought to be necessary for healthy development (Hammen, 1997). As a child develops, the theory proposes that he or she will form internal working relational models

of the self and the caregiver that will encode interaction patterns as templates for future interactions (Bretherton). If the caregiver has provided responsible and loving care, the child has a secure base from which to explore and form relationships due to a positive view of the self and others (Haines, Metalsky, Cardamone, and Joiner, 1999; Hammen). Although not all tenets of the theory have been well received by developmental psychologists, attachment theory has provided a solid starting point from which to explore parent-child relationships (Bretherton; Harris, 1995), a view with which this author concurs.

The importance of attachment theory for the study of depression was revealed through the work of Ainsworth (1989), who noted that sensitively mothered infants had secure, satisfying attachments to their mothers, while insensitively mothered infants had relationships characterized by avoidance or ambivalence (Bretherton, 1992). A secure attachment appears to be important in socioemotional development, influencing future emotional functioning. According to the theory, these insecurely attached children were thought to perceive the world as unpredictable and threatening, resulting in feelings of incompetence and helplessness. Furthermore, these children were hypothesized to interpret the insecure bonds as personal failures, leading to guilt and self-deprecation (Armsden, McCauley, Greenberg, Burke, & Mitchell, 1990).

Studies appear to support the connection between insecure attachment and depression symptoms. For example Armsden et al. (1990) compared four groups of children and adolescents on levels of parental attachment: currently depressed children and adolescents, those with a recent history of depression, those with nonmood disorders,

and those with mothers with physical illnesses. The depressed group had the lowest scores on parental attachment. Those who reported feeling most hopeless had the most insecure attachments. The authors linked cognitive theory concepts to attachment theory, concluding that "…the associations found among security of parent attachment, attributional style, and presence of depressive disorders are consistent with a conceptual model linking insecure attachment with the manifestation of depression through the promotion of depressogenic cognitive schemata." (Armsden et al, p.694). Similarly, Kenny, Moilanen, Lomax & Brabeck (1993) found that less secure attachments reported by a portion of a sample of eighth graders were associated with depressive symptoms, but that the view of self, a cognitive concept, mediated the relationship.

Kobak, Sudler, & Gamble (1991) noted that adolescents who scored lower on self-reported attachment to parents also reported higher levels of depressive symptomatology. Olsson, Nordstrom, Arinell, and von Knorring (1999) differentiated between adolescents with a single episode of depression versus those with comorbid dysthmia. Single episode sufferers did not report low levels of attachment whereas dysthmics did. Maltreated children report similar levels of negative attributional styles and depressive symptoms (Haines et al, 1999). Similarly, Cicchetti and Toth (1998) reviewed several studies involving effects of parenting that is either not attentive to or not in synchrony with the needs of the young child, concluding that later depression is likely associated with these early experiences. Longitudinal studies support the relative stability of attachment types, implying that insecure early attachments have life-long effects, including how the child goes on to parent his or her own children (Ainsworth,

1989; Bretherton, 1992). The results of this writer's preliminary studies resonate with the tenets of attachment theory (Farmer, 1997; Farmer, 2002). The emotional homelessness of the depressed adolescents resembles insecure attachment or a loss of attachment or connectedness, making this theoretical perspective a useful choice when exploring the parent-adolescent relationship during depression.

The Microsystem: Families with Depressed Adolescents

The bulk of research on depression in the family context has been conducted via one of two approaches, the 'bottom-up studies', in which the sample of interest is depressed adolescents who then are a source of information on their families, and the 'top-down studies', which have mainly involved depressed mothers and their children (Birmaher et al, 1996b). A few studies of each kind have discussed the reciprocal processes within families over time. Both approaches have informed the study of depression in adolescents and will be explored below.

General family functioning. Assessments of general family functioning when a member suffers from depression have revealed the profound difficulties confront families. Family functioning is often assessed via the Family Assessment Device (FAD), a tool that contains items surveying six dimensions of functioning: problem solving, communication, roles, affective responsiveness, affective involvement, and behavior control. In most studies using the FAD, families with a depressed child display more severe and consistent psychopathology on all scales than in families with bipolar disorder, adjustment disorder, schizophrenia, and alcoholism (Chiariello & Orvaschel, 1995).

Shiner and Marmorstein (1998) sought family functioning data on three types of families: those with a depressed adolescent, those with a depressed adolescent and a depressed mother, and families with no mental illness. While families with a depressed adolescent showed poorer functioning, depressed adolescents who also had depressed mothers reported the worst functioning. Poor functioning was not time-limited but went on to encompass times when no family member met the depression criteria any longer. Interestingly, fathers in all three groups reported better family functioning than their wives and children. No significant differences were found among the three groups in father-reported functioning. The authors emphasized the importance of considering maternal depression when studying depression in adolescents (Shiner & Marmorstein). Maternal depression will be discussed further below.

Tamplin et al (1998) examined functioning in families with a depressed adolescent with a more fine-grained approach resulting in more optimistic findings. Families with depressed adolescents were compared on the FAD with a community control sample of families with no mental illnesses. Within families, strong mother/father agreement on functioning was obtained on the scales, while adolescents generally reported family problems as more severe. Fifty-six percent of families with depressed adolescents were functioning below the FAD cutoff for healthy functioning. Parents of depressed adolescents generally functioned worse than control parents but that did not imply that both parents suffered. In many cases, one parent continued to function within a healthy range. Poor mental health of the mother was an important predictor of family dysfunction, but no causality was implied. If the depressed adolescent also had a

diagnosis of oppositional defiant disorder, family functioning was worse than with depression alone (Tamplin et al).

However, the authors point out that 44% of families with a depressed adolescent functioned within the healthy range on the FAD whereas 29% of control families were in the unhealthy range, an indication of great overlap in functioning. Problem solving was a special area of strength for families with depressed adolescents, with the family mean for the depression group occurring within the healthy FAD range. Problem solving capabilities appear to remain intact even when other areas are weak (Tamplin et al, 1998).

Loss of a loved one. Loss of a loved one by death or relocation has been linked with depression in some studies. Brown, Harris, & Bifulco (1986) studied 139 women who had suffered a loss of a parent in childhood. Death of the mother resulted in a 23% prevalence rate of depression in adulthood while separation from the mother yielded a 21% rate. Although these rates are not much higher than the average lifetime prevalence rate for women, depression was more likely in those individuals who had experienced a diminished quality of care after the loss (Brown et al). Death of the father in this study appeared to be unrelated to depression in the offspring. Reinherz et al (1993), in a longitudinal study of families of depressed adolescents, noted that gender of the adolescent was pertinent, in that death of a parent elevated the risk of depression for girls but not for boys. Depression may be linked to other losses as well. Golombek & Kutcher (1990) noted that loss of a girlfriend or boyfriend might be linked to depression onset while Sadler (1991) lists disfiguring accidents and life-threatening illness as loss events. Depression related to the loss of a loved one may involve the attachment process

through loss of an important attachment figure (Kaslow, Deering, & Racusin, 1994).

Some studies dispute the negative outcomes of parental death. Heinzer (1995) noted that while parental death was a risk factor for mental health problems in adolescents in retrospective studies, her sample of 62 adolescents who had lost a parent prior to age fourteen generally reported positive perceptions of their health and well being. Girls reported better functioning if the surviving parent was the mother (Heinzer). Lewinsohn et al (1994) found no evidence that parental death was associated with depression in the Oregon Adolescent Depression Project, claiming that earlier studies had mainly surveyed clinical samples as opposed to community samples.

Family structure. A few studies have addressed family structure in relationship to depressive disorders and symptoms. Reinherz et al (1993), in a longitudinal study of predominately Caucasian working class families, noted that being born to older parents (mothers over 30, fathers over 35) carried a higher risk of depression for adolescent children. Being the third child or later in the birth order was also associated with higher rates of depression, as was having three or more siblings. Patten, Gillin, Farkas, Gilpin, Berry, & Pierce (1997), surveying depressive symptoms in 5531 California youths, noted no significant differences across family structures, including two-parent, single mother, single father, and no parent (i.e. step-parent, grandmother) homes. Rather the key issue was whether the adolescent identified the resident adult as supportive. Depressive symptoms increased in both males and females when they resided with parents described as nonsupportive. Girls were particularly vulnerable if they lived in a household with a nonsupportive single father. The authors caution, however, that depressed youths may be

more likely to feel unsupported despite parental attempts (Patten et al, 1997).

Divorce and marital conflict. Divorce and conflict have been associated with maladjustment in offspring in many studies over the last two decades (Cole & McPherson, 1993; Kaslow et al, 1994; Kelly, 2000; Shiner & Marmorstein, 1998). About 50 to 70% of the entire youth psychiatric population is made up of children of divorce (Nolen-Hoeksema, 1986). Depressed youth are more likely to come from families of divorce than nondepressed adolescents (Shiner & Mamorstein). Divorce may cause sudden changes in family structure and functioning, with loss of the presence of a parent and other family members in the home, increased conflicts among members, and changes in employment and income levels for the parents (Kelly; Nolen-Hoeksema).

Recent research has more thoroughly probed the myriad factors subsumed within the construct of divorce. Kelly (2000), in her review of research on conflicted marriages and divorce conducted in the 1990s, noted the importance of separating the constructs of divorce and marital conflict. Divorce per se does not appear to influence child adjustment; rather, it is the nature of the conflict between the parents that is associated with negative outcomes. Prior to divorce, marital conflict is an important predictor of future behavioral and academic problems in the offspring. Approximately 50% of the problems seen in children and adolescents post-divorce were present pre-divorce while marriages were intact but conflictual (Kelly). High levels of conflict, for example, spousal abuse and frequent intense arguments, are associated with future psychiatric disorders, including depression in the children. Johnson, LaVoie, and Mahoney (2001) found that adolescents who reported perceptions of intense conflict between parents also

were likely to report social and personal difficulties in later adolescence. Kelly notes that marital violence has a potent independent effect beyond conflict and is more often associated with child maltreatment as well. While high intensity, overt hostility has been associated with both internalizing and externalizing disorders, covert hostility is more associated with anxiety and depression in the offspring.

Although causative relationships have not been established, psychiatric symptoms in children and adolescents may be due to many factors. Grych & Fincham (1993) note that conflicts may increase worry, shame, and feelings of helplessness especially as conflicts become more intense. Arguing parents may model poor relational skills. Mothers in conflicted marriages are less likely to be warm and empathetic, are more rejecting and erratic, and use guilt and anxiety-inducing disciplinary techniques more often than mothers in stable marriages (Kelly, 2000). Fathers may spend less time with their children, due to limited visitation and noncustodial status, and are more likely to withdraw from daily parenting duties. Additionally, conflict may cause detrimental physiological changes in observing children and adolescents (Kelly). Buchanan, Maccoby, & Dornbush (1991) attributed post-divorce adjustment difficulties, including depressive symptoms, in 522 ten to eighteen year olds to a feeling of being "…caught between parents…" (p. 1008). Divorced parents who continued to have hostile, uncooperative relationships with one another were more likely to have children with problems (Buchanan et al).

Kelly (2000), however, stresses that the majority of children of divorce fall within the average range of adjustment on many standardized measure, with a great overlap

among divorced and never-divorced families. Buffering and protective factors may include a warm relationship with at least one parent and the presence of supportive siblings and peers. Reinherz et al (1993) did not find separation or divorce were significant risks for depression in adolescents in their longitudinal study, but remarriage carried an increased risk of depression in adolescent males only.

Three basic models of transmission of negative emotions in conflicted marriages have been posited to account for effects on children. The first is the marital model where a direct relationship is hypothesized, from marital discord to problems in the offspring (Cole & MacPherson, 1993) while the second model places parent-adolescent problems as a mediator between marital conflict and adolescent problems. A third model was formulated by Downey and Coyne (1990) in which marital discord is related to depression in the offspring through parental depression. Cole and MacPherson found support for the second model in a study of 107 adolescents and their parents. Higher conflict and lower cohesion between a parent and adolescent mediated the relationships between marital troubles and depressive symptoms in the adolescents. Interestingly, the father-adolescent conflicted relationship was more strongly related to depressive symptoms than a troubled mother-adolescent relationship. If both were problematic, the presence of the father-adolescent problems beyond the mother-adolescent problems was associated with an increased severity of the adolescent's symptoms. The third model (Downey & Coyne) has also received support and will be discussed below under parental depression.

Family conflict. Families of depressed adolescents are generally characterized by

conflict than those of nondepressed adolescents. Conflictual interactions may occur between parent and adolescent, between parents, or among several family members. Adolescents reporting higher levels of depressive symptoms are more likely to report increased numbers of arguments with parents (Puskar, Tusaie-Mumford, et al, 1999). Depressed teens have also reported perceiving the family as a whole as less friendly than nondepressed adolescents, listing the family setting as the place of greatest discomfort in their daily lives (Larson, Rafaelli, Richards, Ham, & Jewell, 1990). Martin & Waite (1994) state that family discord, including parent-adolescent conflict, is frequently seen in clinical settings. In the Oregon Adolescent Depression Project, conflict with parents was predictive of future depression in adolescents (Lewinsohn et al, 1994). Stress, including conflictual relationships, characterized depressed adolescents before, during, and after episodes of depression.

Parent-adolescent problems also appear to be the mode of transmission of pressures from outside the family. Conger, Ge, Elder, Lorenz, Simons (1994) conducted a longitudinal study of rural Iowa families subjected to a depressed economy. Economic pressure was indirectly related to adolescent internalizing and externalizing symptoms through parent-adolescent conflict. Marital difficulties were also associated with the economic downturn and, again, were related to adolescent symptoms through a parental hostility variable (Conger et al).

Family cohesion and bonding. Cohesion refers to the degree of emotional bonding and feelings of closeness that family members have toward one another (Johnson et al, 2001; Su et al, 1997). Family cohesion is usually measured with the Family

Adaptability and Cohesion Evaluation Scales (FACES). Several studies have focused on cohesion or bonding in association with depression and other problems in adolescent family members. Lower levels of cohesion seen across adolescent years have been correlated with increases in depression and maladjustment (Johnson et al). Su et al, in their study of families with parents and/or adolescents diagnosed with depression or substance abuse, found that depressed adolescents and their parents both reported lower levels of family cohesion. Cohesion was also found to be an important mediator between stressful life events, such as the sequelae of living with a depressed or substance abusing parent, and depression in the adolescents. In families with parental affective disorders, female adolescents were more likely to report lower cohesion than males in similar types of families, perhaps suggesting that girls are more sensitive to, or impacted by, family difficulties and stresses (Su et al). Resnick et al. (1993) note that cohesion was a protective factor against depression in their study of Minnesota adolescents. Low cohesion also appears to be a strong predictor for future depression (Garrison, Jackson, Marstellar, McKeown, & Addy, 1990; Kaslow et al, 1994).

Family warmth and supportiveness. Warmth and supportiveness are related concepts often used interchangeably and without definition by researchers. They appear to refer to the physical and emotional availability and the support of family members for one another. Like cohesion, warmth and supportiveness are related to attachment between parent and child (Kaslow et al, 1994). Warm relationships with parents are one means of buffering the effects of external stresses on adolescents (Petersen, Sarigiani, and Kennedy, 1991) while lack of warmth or supportiveness is often associated with problem

behaviors.

Reinherz et al (1993), in their longitudinal study, found that girls who were third or later in the family birth order reported less closeness to and less supportiveness from parents. The authors noted that these girls had a poorer perception of their role with the family than girls from smaller families and were more likely to report depressive symptoms. Lack of a family confidant was strongly associated with self-harm in a study of 52 Australian youth who sought emergency care (Tulloch et al, 1997). Poor adolescent-parent communication in general was associated with depressive symptoms and low family cohesion (Tulloch et al). Suicidal ideation, along with depression, was an outcome measure in another Australian study measuring parental affection and level of parental psychological control (Martin & Waite, 1994).

Adolescents who reported parents as low on affection and high on psychological control (i.e. parents who used guilt-induction and intrusiveness as control strategies), doubled their risk of suicidal thoughts, experienced a three-fold increase in risk for self-harm behaviors, and experienced a five-fold increase in risk for depression as compared to adolescents who reported other combinations of affection and/or control. Puig-Antich et al. (1993) noted significant impairments in both mother-adolescent and father-adolescent relationships when the adolescents were depressed as compared to those who did not suffer from the disorder. Depressed adolescents reported less sharing of thoughts and feelings, decreased levels of communication, and increased tension with their mothers. Father-adolescent relationships shared these same traits but also included decreased warmth and increased antagonism. Depressed adolescents were less likely to

confide in their fathers than nondepressed adolescents (Puig-Antich et al).

Longitudinal studies have found associations among relationship variables and depressive symptoms as well. In a prospective study of 388 rural Iowa adolescents and their families, Ge, Best, Conger, and Simons (1996) explored parenting behaviors and the occurrence/co-occurrence of depression and conduct disorder. Parental warmth toward adolescents in seventh grade predicted low levels of depressive symptoms at tenth grade. Gradations of both maternal and paternal warmth and hostility levels were associated with problematic adolescent outcomes. The highest levels of warmth were associated with lack of psychiatric diagnoses, lower levels with a diagnoses of either depression or conduct disorder, and the lowest levels with co-occurrence of both disorders. Hostility levels had the opposite associations (Ge, Best, et al). Holohan, Moos, & Bonin (1999) also note that family supportiveness has been associated with lower levels of depression in longitudinal community samples.

As with many correlates of depression, family relationship variables are not always in direct relationships with depression outcomes. Olsson et al (1999), in a study of Swedish adolescents, noted the importance of differentiating among those with a single episode of depression and those with comorbid diagnoses. Single episode sufferers did not differ from healthy controls on measures of family climate, interaction, and attachment. However, dysthmic adolescents, whether or not they were currently suffering from acute episodes of major depression, had more negative family climates and reported less satisfying social interactions. Major depression combined with conduct disorder was associated with the poorest quality of social interaction, the most negative

family climates, and "…inadequate support from attachment persons." (Olsson et al, p. 234). Frank, Poorman, Van Egeren, & Field (1997) identified two types of perceived parental relationships with depressed adolescents in a study of adolescent inpatients. Some depressed adolescents scored high on a measure alienation from parents, experiencing them as rejecting. These adolescents also reported higher levels of self-criticism as part of their depression experience. Other adolescents, scoring low on alienation, perceived unusually close and dependent relationships with parents and had more interpersonal worries as part of their illnesses. After model testing, the authors concluded that the parental relationship per se was not the salient issue, but rather the nature of the cognitions of the adolescents about their relationships that accounted for the most variance in depression scores (Frank et al)

Only a few studies discuss depression and sibling relationships. Puig-Antich et al (1993) found that depressed adolescents have more antagonistic relationships and more frequent fights with their siblings than do nondepressed adolescents in a cross-sectional study. Sibling-parent relationships also affected depressive symptoms in adolescent participants in a study of differential treatment by parents (Feinberg, Neiderhiser, Simmens, Reiss, & Hetherington, 2000). A "sibling barricade" effect was noted, in which the parental treatment of one child resulted in a paradoxical response in another in some sibling pairs (Feinberg, Neiderhiser, et al, p. 1611). Warmth shown to one member of a sibling pair was associated with increased depressive symptoms in the other. The authors postulated that parents might show more warmth to the nondepressed child in an unconscious attempt to salvage him or her, while investing less in the depressed child.

Alternatively, siblings may wish to de-identify with one another through behaving differently.

Parenting style. Radziszewska et al (1996) studied the effects of parenting style, based on Baumrind's (1991) four styles, on adolescent depressive symptoms, smoking and academic performance in 3993 San Diego ninth graders. According to Baumrind, authoritative parents (moderate control and high warmth) tend to use explanations and reasoning as part of decision-making conversations with their adolescents while autocratic parents (high control and low warmth) make decisions unilaterally. Permissive parents (high warmth, low control) do not exercise much decision-making power while unengaged parents exhibit neither warmth nor control. Radziszewska et alfound that depressive symptoms were lowest in adolescents whose parents exercised a moderate amount of parental control (authoritarian). The adolescents at the high and low ends of the parental control spectrum had higher depression scores, with the unengaged parent group reporting the highest scores. Within the unengaged group, Asian females and African-American males fared the worst. Overall, the authoritarian parenting style was associated with the best adolescent outcomes across ethnic and socioeconomic groups (Radziszewska et al).

Parental depression. The 'top-down' studies mentioned at the outset of this section mainly have to do with the effect of a depressed parent on his or her children. Depressed mothers have been most frequently studied, perhaps because they are more likely to be the custodial parents.

One of the most consistently influential risk factors in early lifespan depression

research is the presence of depression in the mother (Hammen, 1999). Hammen & Brennan state, "…half or more of the child and adolescent offspring of depressed women experience depressive disorders, as well as other conditions." (2001, p. 284). Downey & Coyne (1990) note that children of depressed parents have rates of affective disorders three times higher than children in control groups. Dissent exists regarding whether maternal depression per se is associated with disordered offspring or if the stress of any parental illness might be associated with childhood problems. Downey & Coyne posit that the characteristics of children of depressed mothers are similar to those of children with parents with other psychiatric and medical illnesses. Conversely, Klein et al (1988), in a study of adolescent children of parents with either depression or chronic medical illnesses and control parents, found higher levels of psychopathology and mental health service usage in the depressed group, which included a range of affective and nonaffective disorders in the adolescents. In additional to depression, children of depressed parents are at risk for numerous other health problems, including perinatal complications, cognitive impairments, academic problems, and other physical conditions (Cummings & Davies, 1999; Downey & Coyne; Petersen et al., 1993).

Depression in adolescents in general is associated with functional and interpersonal impairment, but if depressed adolescents have also lived with depressed mothers impairments may be worse. Chiariello & Orvaschel (1995) note that children of depressed mothers exhibit social inhibitions and increased behavioral problems. Hammen & Brennan (2001) compared depressed adolescents with and without depressed mothers on interpersonal functioning, concluding that the offspring of depressed mothers

had fewer friends and social activities, more insecure attachments to others, higher rates of interpersonal conflict events, poorer self-concepts, and higher rates of comorbid disorders, specifically dysthymia. Daughters in particular experienced more life stresses, partially resulting from inappropriate choices. These group differences were noted whether or not the adolescents currently met the criteria for a depressive episode, an indication that interpersonal problems were pervasive and ongoing. Shiner & Marmorstein (1998) noted poorer family functioning, including more parental conflict, in a similar population.

Several mechanisms have been proposed and explored regarding the transmission of parental depression to the children, including genetic influences, marital discord, stress generation, parental behaviors and skills, and insecure attachment. Studies of genetic influences have produced mixed results. A family study of depression by Sullivan et al. (2000) showed evidence of a strong genetic component to familial depression while adoption studies, reviewed by Downey & Coyne (1990) are equivocal. Marital discord, discussed earlier, may be related to both parental depression and adolescent depression in that the parent-adolescent relationship may be the mediator in the relationship between marital distress and adolescent depression (Downey & Coyne, 1990). Although some studies have supported this association, the relationship is likely more complicated, since evidence has been found for a variety of direct, indirect, and reciprocal relationships among marital discord, parental depression, childhood depression, and conduct problem variables (Downey & Coyne).

Davis, Sheeber, Hops, & Tildesley, (2000) examined specific interaction patterns

between fourteen to eighteen year old adolescents and their parents in a longitudinal study of the effects of parental interactions on adolescent depression outcomes. Each parent dyad and their adolescent conversed about a problem while researchers observed the adolescent responses to parental depressive behaviors (whining, dysphoria, self-denigration). Gender effects were prominent, with the strongest found for female adolescents who witnessed fathers expressing depressive behavior. The girls displayed facilitative behaviors towards their mothers (apologies, empathy, caring affect), taking on a peacekeeping role, while suffering the greatest increase in depressive symptoms over time. Another group of increasingly depressed girls were those who attempted to suppress their fathers' aggressive responses toward mothers who had exhibited depressed behaviors. Male youths, in general, responded with aggression to any parental aggressive or depressive behaviors, but those who had increased depressive symptoms were those boys who had witnessed mothers' depressive behaviors toward fathers. In sum, modeling of conversational patterns and the eliciting of responses from adolescent children may be one mechanism by which marital distress is transmitted to offspring (Davis et al).

Somewhat related to this line of research are the stress generation theories. Perhaps it is not the maternal depressive behaviors that are directly related to adolescent depression, as it is the context of impaired maternal functioning. Children of depressed mothers often endure chronically stressful family contexts. Depressed mothers are more likely to have fights and disagreements with others, including partners, children, friends, and coworkers, along with tendencies to partner with men with psychiatric diagnoses thereby providing fathers, stepfathers, and boyfriends who add to rather than buffer stress

(Hammen, 1999). Hammen notes that these behaviors and tendencies continue both during and between episodes of depression, with some events precipitating new episodes. Su et al. (1997) noted gender differences in their study of adolescents living with substance abusing or depressed parents. Female offspring appeared to be much more vulnerable to interpersonal stress and stressful life events than males. Holahan et al (1999) noted that family stressors accounted for higher levels of dysfunction in children beyond the effects of just the presence of a depressed parent.

Of great interest are studies that have explored the behaviors and interpersonal skills of depressed parents. Depressed individuals in general show evidence of dysfunctional interactions with others, including strangers, friends, marital partners, or children (Hops, 1995). In their review of the parental depression literature, Downey & Coyne (1990) listed several characteristics of depressed mothers as compared to nondepressed mothers, including speaking less often, responding slowly, higher levels of hostility and irritability, viewing their parenting roles less positively, rejecting their children, and perceiving themselves to be less competent. Parenting difficulties may begin when the child is in infancy, where an unstable environment and negative parental affect may disrupt brain development and physiologic self-regulation (Cicchetti & Toth, 1998). Depressed mothers are more likely to withdraw from disciplinary situations or to be overly controlling and punitive with their children (Downey & Coyne; Kaslow et al., 1994). Depressed adolescents with depressed mothers report poorer family functioning that control group adolescents or those with nondepressed mothers (Shiner & Marmorstein, 1998). In short, being a parent while suffering emotional pain is a difficult

task.

These dysfunctional mother-child relationships resemble the insecure attachments discussed earlier and several researchers have posited them to underlie the parental depression-child depression link (Chiariello & Orvaschel, 1995; Cicchetti & Toth, 1998; Cummings & Davies, 1999; Hammen, 1997; Kobak et al, 1991). Depressed mothers are less likely to provide appropriate parental care, nurturance, or support (Chiariello & Orvaschel). Children and adolescents who perceive that their parents are not available physically or emotionally may form distorted internal working models of both themselves and their parents (Kobak et al). If depressed mothers are less available and more hostile, the attachment with the child may be insecure and render the child vulnerable to depression (Hammen). Building on attachment theory, Cummings & Davies have advanced an emotional security hypothesis in which family-wide influences increase vulnerability to depression and other psychiatric disorders through threats to emotional security. Maternal depression, marital functioning, parent-child relationships, individual parent and child characteristics, and developmental factors reciprocally interact to produce depressive outcomes in children (Cummings & Davies). Attachment theory principles are combined with interpersonal concepts in this model.

Few studies have addressed the role of fathers in depression in adolescents, and those that have, have produced mixed results. Some studies of depressed fathers have indicated that paternal depression may be a strong predictor of depression in adolescents but others have implicated maternal depression as more important (Kaslow et al, 1994). Thomas & Forehand (1991) found that paternal depression was significantly correlated

with depressive symptoms in sons more so than daughters, whose depressive and anxious symptoms were more highly correlated with maternal depression status. Phares & Compas (1992) found that paternal support was a protective factor for adolescents whose mothers suffered from psychiatric disorders. Martin & Waite (1994), in their study of adolescent suicide attempters, found that a paternal care variable contributed the most variance to adolescent scores on depression, suicidal thoughts, and self-harm measures. Yet Shiner & Marmorstein (1998) found no significant effects on family environment among fathers of depressed adolescents who also had wives with no illnesses, depression, or medical illnesses. The roles of fathers, whether depressed or not, are clearly in need of further exploration in regard to adolescent depression.

Despite the negative picture that parental depression presents, it is worthy to note that not all adolescents of depressed parents become depressed. These resilient adolescents have several characteristics in common including, a good understanding of themselves and their parents, the ability to distance themselves from parental disorders, and the presence of others inside and outside of the family with whom they formed close, warm, relationships (Chiariello & Orvaschel, 1995). Strong family cohesion in the face of parental disorder also plays a mediating role between stress and adolescent health (Su et al, 1997). Another factor is the considerable variability in parenting skills displayed by depressed women. Kaslow et al. (1994) state that a significant percentage of depressed women appear warm and involved with their children, despite suffering from distressing symptoms.

Parent-adolescent reciprocity and interaction. Reciprocity, which refers to the

mutual influences that parents and adolescents have on one another's emotions and behaviors, is a relatively new construct in the study of family psychopathology (Neiderhiser, Reiss, Hetherington, & Plomin, 1999). Problems in children and adolescents have been approached in past research from a unidirectional perspective, that is, problems in the children were thought to be due to influences from parent behaviors or flawed parenting. Much of the previously discussed research continues to fall within this category. More recent, ecologically influenced research has focused on dynamic relationships between parents and children, in which characteristics of one member are simultaneously products and producers of characteristics in the other (Ge et al, 1995; Neiderhiser et al). Although several theories regarding these interactional processes between a depressed individual and others have been developed, one of the best known is that of Coyne (1976). Coyne proposed that depression in an individual might be developed and maintained by transactions involving that individual and others close to him or her, such as family members. The depressed individual seeks reassurance from others, which they provide verbally but with nonverbal reluctance and negativity. The depressed person accurately perceives this incongruence, feels more insecure, and then displays more depressive symptoms in order to obtain more reassurance, producing higher levels of frustration in others (Coyne). Rejection is likely, which among adults, may mean severing friendships or divorce. Yet a depressed adolescent is not likely to be 'divorced' from the family, therefore negative interactions may continue and become ingrained.

In a review of the literature, Slesnick and Waldron (1997) found that families with

a depressed member have generally reported more severe and consistent communication impairments than families of schizophrenics, bipolar individuals, and alcoholics. Unclear messages and incongruent content and affect have characterized these interactions. In parent-child studies, children with depression or comorbid depression and conduct disorder have generally displayed negative affect during problem-solving tasks. Mothers have reacted more negatively to children's behaviors, even if positive, and showed more aversive behavior toward their children than mothers of nondepressed children (Slesnick & Waldron).

Reciprocity has been explored in studies involving brief conversational interactions. Joiner and Barnett (1994) tested hypotheses derived from Coyne's theory with male five to fourteen year old psychiatric inpatients. The participants responded to examples of common interpersonal stories by providing descriptions of likely thoughts, feelings, and behaviors of the story characters. Depressive symptoms or over-reliance on others were, in part, related to high scores on a rejection instrument. Hamilton et al (1999) compared interactional patterns among parent-child dyads in which the child had a diagnosis of depression, a schizophrenic spectrum disorder, or no psychiatric diagnosis. During ten-minute conflict resolution tasks, depressed children and adolescents were more likely to use guilt-induction statements toward parents than schizophrenic or control children ("You always leave me alone!"). Similar to the schizophrenic children, depressed children and adolescents used harsh criticism toward parents. However, parents used similar statements, especially guilt-induction, toward their depressed children as well. In general, the depressed children tended to produce high levels of

globally negative behavior during the interactions (i.e. disagreements). The authors underscored the importance of reciprocity in family studies of depressed adolescents and children, stating that the results are "…supportive of the position that child and parent exert reciprocal influences with the transactional context." (Hamilton et al, p.473). Guilt-induction, in particular may be a hallmark of depressed functioning in interactions.

Applying Coyne's interpersonal approach to depression, Slesnick and Waldron (1997) performed sequential analyses of problem-solving interactions between parents and their depressed adolescent children and a control group. Parents and adolescents identified family problem areas and chose a topic about which to have a ten-minute resolution-oriented conversation. The researchers coded the conversations for both affect and content. Depressed adolescents engaged in interactions characterized by depressive content and affective behavior as compared to control adolescents. Depressive content appeared to suppress aversive responses (disapproval, disagreement) by parents in both depressed and nondepressed adolescents. Although depressed adolescents did not differ from controls in the amount of aversive content toward parents, parents of depressed adolescents had higher rates of voicing aversive content *while* displaying positive affect. Depressed adolescents do perceive their families as more hostile, perhaps accurately, than do nondepressed adolescents, and their families report chronic frustration (Slesnick & Waldron). The authors stress the importance of a family approach to the study of adolescent depression in both conceptualization and treatment.

Sheeber, Hops, Andrews, Alpert, and Davis (1998) further built upon the Slesnick and Waldron (1997) study in a longitudinal study of 494 families, 86 of which contained

a depressed adolescent, from the Oregon Adolescent Depression Project. After observing parents and adolescents in discussions about relevant family issues, analyses revealed that mothers of depressed adolescents were more likely to respond with a problem-solving or facilitative (approving, caring, positive) response to depressive communications (negative affect, complaints, self-derogation) by their children than control mothers. Fathers of depressed adolescents more often withdrew from the depressive communications; depressive statements appeared to suppress both aggressive responses and problem-solving behaviors by fathers. The authors hypothesize that depressive responses may be reinforced by these parental responses. Adolescents may achieve a respite from paternal aggression and may elicit maternal sympathy (Sheeber et al, 1998). Interestingly, follow-up at one year revealed that family communication patterns remained fairly stable, despite changes in depression status in the adolescents.

Two longitudinal studies also observed communication patterns over time. Ge et al (1995) hypothesized that mutual influences were responsible for psychological distress in parents and adolescents. Observing 368 Midwestern seventh graders from two-parent families, the researchers collected three waves of data, one year apart for their cross-lagged effect model. Psychological distress was reciprocally related across three years in that distress in one family member operated as a source for distress in others. Depressed mood was relatively stable across the time span. Gender differences were evident in that mothers' and sons' distress were most highly correlated during early adolescence and that of fathers and daughters was more strongly related during mid-adolescence, perhaps a paternal reaction to emerging sexuality in daughters (Ge et al, 1995). Neiderhiser et al

(1999) proposed a genetic component to the bi-directional processes in family psychopathology wherein genetic factors might be responsible for individual characteristics as well as response patterns in interactions. Using a cross-lagged, genetic model to guide the study of conflict and adolescent adjustment, 395 families were assessed twice, three years apart. Depressive symptoms at Time 1 correlated with maternal- and paternal-adolescent conflict at Time 2 and appeared to have significant genetic influences (Neiderhiser et al).

In summary, depressive symptoms in adolescents are highly intertwined with interactions with parents. The importance of reciprocity when studying families with depressed adolescents has implications in both assessment and treatment. Depressed adolescents may manifest excessive emotional dependence, poor communication skills, and negative and aggressive behaviors while families may exhibit harsh, critical behaviors, may withdraw, or may place less value on interacting with their adolescents (Chiariello & Orvaschel, 1995), with no causal mechanisms implicated. The fact that negative communications continue despite resolution of depressive symptoms implies that parent-adolescent interactions may be an important focus for intervention efforts and in future prognoses.

Summary of Family Functioning

Several family variables appear to play a role in depression in adolescents. On average, families with depressed adolescents are more conflicted, less cohesive, more highly stressed, less supportive, and are likely to contain a depressed parent as well. Interactions between parent and depressed adolescent are likely to be characterized by

guilt-induction, hostility, self-derogation, and, at times, sympathy. Even after the adolescent no longer meets the criteria for a depressive disorder, communications may continue their dysfunctional patterns. Family functioning appears to be an important source of both risks for depression and strengths in preventing and recovering from it. However family functioning may be best understood when individual functioning during depressive episodes is added.

Individual Processes and Functioning: Depressed Adolescents

The passage from childhood to adulthood is shaped by social context (Graber & Brooks-Gunn, 1996). In Western cultures this means that the entry into adolescence does not coincide with adult status, but rather is the beginning of an extended period of transitions. The most obvious transition is that of puberty and physical maturation but other changes are taking place as well (Petersen, Leffert, Graham, Alwin, & Ding, 1997). Cognitive abilities shift from the more concrete thought patterns of childhood to the more abstract capacities of adulthood. Decision making abilities quickly approach those of adults (Beyth-Marom & Fischhoff, 1997). Shifts in friendships characterize this period, evolving from activity-based groups to relationship-based close friendships, including romantic involvements (Brown, Dolcini, & Leventhal, 1997). Both societal expectations and privileges increase with adult-like appearance and the ability to drive or hold a job. Relationships with family members evolve as well and will be discussed below.

The importance of a developmental period within the study of depression lies in its status as context for the disorder. Although some depressive symptoms in adolescents may be isomorphic to those experienced in other periods in the lifespan, adolescence as a

developmental period is intertwined with the experience of the disorder (Cicchetti & Toth, 1998). The transitions of adolescence underlie and give a unique flavor to depression in this age group. Cicchetti and Toth state,

> Whether depression occurs is affected not only by the presence or absence of specific vulnerability or protective factors. Rather, the interplay that occurs between these factors and current and previous levels of adaptation as well as the developmental period during which risk factors are experienced also are vital contributors to depressive outcomes (p. 226).

The discussion now turns to a review of symptoms and functioning during adolescent depression.

Subjective experiences. The hallmark of depressive disorders, and most pertinent to a phenomenological study, is a dysphoric mood. Persistent sadness, loss of interest and pleasure in usual activities, fatigue, and feelings of hopelessness and worthlessness characterize those with depression (APA, 1994; Brage, 1995; Larson et al, 1990; Myers & Troutman, 1993). Larson et al, in a study of ten to fifteen year old Chicago youths, found that less positive affect, less psychological investment in activities, and lower energy levels characterized depressed participants. In a study of Australian high school students using diagnostic interviews, five items most clearly separated depressed participants from nondepressed: loss of interest or pleasure, decreased energy/fatigue, sleep disturbances, suicidal ideation, and diminished concentration (Patton et al, 2000). Self-reproach, guilt, psychomotor agitation or retardation, and appetite disturbance with weight change showed the clearest increases as the severity of the episode increased

(Patton et al). Angold and Worthman (1993) note that adolescents are more likely to experience hypersomnia, guilt, somatic complaints, low self-esteem and hallucinations when compared to adults. Aggression and anger appear to be linked with depression in adolescents. Unlike adults, adolescents may express depressive feelings as an "…unhappy restlessness…" which includes boredom, anger, aggressive outbursts, and decreased frustration tolerance (Golombek & Kutcher, 1990, p.450). Chiariello & Orvaschel (1995) adolescents exhibit more mood lability, irritable mood, negativistic and defiant attitude in adolescence. Knox et al (2000) investigated prevalence and characteristics of aggressive behavior in 74 adolescents diagnosed with major depression. Nearly one fourth of the sample "…demonstrated significant, persistent aggression across settings, and a substantial majority demonstrated such aggression in at least one setting." (Knox et al, p.615-616). Girls exhibited as much aggression as boys, which the authors attributed to the general increase in physical aggression in females in recent years. The authors speculate that aggression and depression are the result of a general dysregulation that predisposes adolescents to both experiences (Knox et al).

Withdrawal/social isolation. Often the first sign of depression in adolescents is an apparent withdrawal from family members and friends. Apathy and loss of interest in social activities evolve into a pattern of aloneness. In a descriptive study of depressed adolescents and their families, Puig-Antich et al (1993) found that depressed adolescents displayed decreased social competence, more shyness, and poorer social skills, and had fewer friends than nondepressed adolescents. Larson et al (1990) conducted a study of Chicago youths in which adolescents carried pagers so that the researchers could signal

them several times daily (experiential sampling method). Upon being signaled, the participants were asked to record their present activities, thoughts, and mood states. Those who were depressed had more negative social feeling states, spent less time in public and more time alone in their rooms, perceived others as less friendly, and participated less in sports (Larson et al). Depressed males spent much less time with friends than depressed females, even though both males and females reported social isolation. Loneliness was also more salient for males in a study of lower and middle-class Midwestern United States adolescents (Brage, Meredith, & Woodward, 1993). Males reported more loneliness, and loneliness was significantly correlated with depression. Olsson et al (1999) in a study of Swedish youth, found that severity of depression affected social interaction. Those adolescents with a single episode of major depression did not differ from the control group in measures of social interaction but participants with dysthymia, with or without superimposed depression, interacted less often. The lowest levels of interaction were seen in adolescents with major depression and conduct disorder combined (Olsson et al).

Social isolation appears to involve both a withdrawal from others and rejection by others. Reinherz et al (1993) noted that adolescents who perceived themselves as unpopular had higher depression scores while Larson et al. (1990) noted that depressed adolescents thought as much about friends during a typical day as nondepressed adolescents, yet depressed males, in particular, spent much less time with friends. The authors concluded that while depressed individuals desired friends, peers did not wish to interact with depressed males (Larson et al). Depressed adolescents report higher

incidences of teasing and rejection by peers (Cole, 1990; Haines et al, 1999; Lewinsohn et al, 1994; Puig-Antich et al, 1993). Haines and colleagues, in a review of attributional style and depression in children and adolescents, acknowledged that being a target of rejection and aggression put victims at risk for depression, however, they added that attributional style (a cognitive concept) was a mediator in the relationship. Depressive symptoms were most likely to occur if victimized adolescents perceive the rejection as directly due to personal flaws. Depressed youths also appear to hold a more hostile attributional bias toward others in social interactions, similar to that of aggressive adolescents (Haines et al). Bennett and Bates (1995) report similar findings in their study of eleven to thirteen year olds. Perceived peer rejection was related to depressive symptoms six months later. The authors highlighted the need for social skills training as part of both treatment and prevention of depression (Bennett & Bates).

Suicidality. Suicidal ideation is another hallmark of depression. Death may be desired as a way to give up in the face of seemingly impossible obstacles and to escape emotional pain (APA, 1994). Rates of suicide attempts and completions have been rising since the 1960s, making suicide the third leading cause of death among fifteen to twenty-four year olds (Lewinsohn, Rohde, Seeley, & Baldwin, 2001). Gender differences are apparent in adolescence, with females making more attempts than males until approximately age twenty, when the rates for females fall to those of males (Lewinsohn et al). Males, however, have higher rates of completion (Angold & Worthman, 1993). Suicide attempts within major depressive episodes have been correlated with impulsive behavior, personality disturbances, substance abuse, and conduct disorder (Kutcher &

Marton, 1989). Suicidal ideation and attempts in adolescence predicted later attempts in early adulthood in the Oregon Adolescent Depression Project as did negative cognitions, poor coping skills, and early-onset depression, although other predictors of later attempts varied by gender (Lewinsohn et al). For females, low self-esteem, excessive emotional reliance on others, and low family support were more predictive while depressotypic attributional style and low support from friends were more predictive for males (Lewinsohn et al). Of all adolescent psychiatric disorders surveyed in this large, epidemiological study, major depression was the only disorder that predicted future suicide attempts. Weissman et al (1999) report that risk of suicide after an episode of depression increases five-fold throughout the lifespan.

Substance use. Use of alcohol, tobacco, and illegal substances are frequently associated with major depression (Brage, 1995; Cicchetti & Toth, 1998; Pullen et al, 2000; Rao et al, 1999). Stowell (1991) found that 72% of a sample of depressed adolescents abused alcohol while 64% reported marijuana use. Covey & Tam (1990) found that smoking and depression were strongly correlated with a positive relationship between depression scale scores and actual number of cigarettes smoked per day. Cicchetti & Toth describe a temporal pattern of depression onset in early adolescence followed by onset of substance use approximately four years later. Pullen et al also noted an age-related pattern in their descriptive study of correlates of depression. Cigarette smoking and alcohol use were uncommon in depressed twelve to fourteen year olds while fifteen and sixteen year olds reported much higher usage, perhaps due to the means to procure the items. Furthermore, depressed users were significantly more depressed than

nonusers with depression (Pullen et al). Neuroendocrine processes may play some role in determining differentiating depressed users and depressed nonusers. In a longitudinal study of depressed adolescents, substance use disorder was more likely to occur in depressed adolescents who had anxiety traits and elevated cortisol secretion prior to sleep onset as compared to depressed nonusers (Rao et al). Substance use is thought to be an attempt to self-medicate against depressive symptoms as well as a way to attract attention and peer approval (Brage; Sadler, 1991). Although risk for substance use is generally higher for all adolescents than at other stages, *substance use* progresses to *substance use disorder* more rapidly in depressed teens (Rao et al). Unfortunately, beyond depression, substance use is associated with encounters with the law and motor vehicle accidents that involve severe injuries and fatalities (Sadler). Additionally, Rao et al (1999) found more impairment in adaptive functioning in depressed substance abusers as measured by global functioning scales and increased use of psychiatric services. Alcohol and cigarette use appear to continue into adulthood (Lewinsohn, Rohde, Klein, & Seeley, 1999).

Academic functioning. A fall in academic performance may be associated with major depression (c.f. Reinherz et al, 1993). Puig-Antich et al (1993) noted that school performance suffered for depressed adolescents, with an increase in behavioral problems and declining grades. Depressed adolescents in the study also received more teacher complaints and were more likely to report not liking their teachers (Puig-Antich et al). Concentration difficulties, fatigue, and chronic absenteeism have been listed as factors in performance (Farmer, 1997; Golombek & Kutcher, 1990; Haines et al, 1999; Sadler, 1991). Depressed adolescents, in general, complete less schooling and are less likely to

attend college, a situation with lasting consequences on employment and educational opportunities (Kutcher & Marton, 1989; Klein et al, 2001; Weissman et al, 1999).

Gender. One of the most striking features of depression is the preponderance of female sufferers. While a review of studies of childhood depression show a nearly equal number of affected males and females, studies of adolescents almost consistently find more depressed females than males in a nearly 2:1 ratio, a situation that continues through adulthood (APA, 1994; Lewinsohn, Hops, et al, 1993; Pullen et al, 2000; Puskar, Tusaie-Mumford et al, 1999; Reinherz et al, 1993; Ruble, Gruelich, Pomerantz, & Gochberg, 1993; Stapley & Haviland, 1989). Early maturing females appear to be particularly vulnerable to psychological distress (Ge, Conger, & Elder, 1996). Gender differences do not appear to be due to reporting biases (Hankin & Abramson, 1999). Reinherz et al (1993) state that females are three times more likely than males to be diagnosed with major depression by the age of eighteen.

Several theories as to the reason for a gender difference have been posited and examined. Biological processes, including genetic contributions have received research attention. Although genetic factors have considerable influence on the vulnerability to depression, no studies have yet directly examined genetic influences on gender differences. Heritability studies suggest that genetic factors operate equally in males and females (Hankin & Abramson, 1999). Angold & Worthman (1993) reviewed and critiqued the body of literature regarding the biological processes of puberty and onset of depression. Pubertal processes appear to be logical considerations in the rising rates of female sufferers around the ages of thirteen to fourteen, yet studies addressing pubertal

timing, status, rate, and hormonal levels have been largely inconclusive. Rather than excluding maturational processes as instrumental in depression, the authors note that they have not been adequately explored (Angold & Worthman). Researchers have tended to rely on external signs of puberty or upon estrogen and testosterone levels, none of which have correlated consistently with depressive symptoms. Angold and Worthman call for exploration of underlying neuroendocrine processes, such as luteinizing hormone and luteinizing hormone releasing hormone (LH, LHRL) levels, that initiate puberty around the ages of nine or ten.

Psychosocial processes appear to provide a more fruitful set of possible explanations for gender differences. Petersen et al (1991) list three theories that have been explored. The first is response style theory, formulated by Nolen-Hoeksema and colleagues (Nolen-Hoeksema et al, 1999). Females are thought to have a lower sense of mastery than males and to use ruminative coping styles rather than problem-solving approaches when confronted with stressful events. Although based on adult experiences of depression, the theory has received empirical support and may be applicable to adolescents (Nolen-Hoeksema et al; Petersen et al). In contrast, other cognitive theories, discussed earlier, propose that thinking errors and dysfunctional beliefs play roles in depression onset, yet studies have not supported different thinking styles for males and females (Hankin & Abramson, 1999).

Second, gender role intensification theory proposes that adolescence produces an acceleration of identification with traditional gender roles (Hankin & Abramson, 1999; Petersen et al, 1991). Some aspects of the stereotypical female role may predispose girls

to depression unlike those of the male role. For example, body shape after onset of puberty may be dissatisfying to girls who perceive societal pressures to be thin whereas the increased size and muscular strength for pubertal males are sources of pride. Hankin and Abramson caution that physical appearance issues may be more salient for Caucasian females, who generally make up the bulk of study participants. African-American females generally report less dissatisfaction with post-puberty appearance (Hankin & Abramson).

Finally, stressful life events have been theorized to play a role in gender differences. The stress-coping theory posits that females have more stressful experiences than males. For example, Whiffen & Clark (1997) found that female depression sufferers were more likely to have experienced childhood sexual abuse than males. Petersen et al (1991) noted that girls experienced simultaneous puberty onset and school change (from elementary to middle school) more often than males. Females appear to be influenced to a greater extent than males by family problems, such as parental mental illness (Su et al, 1997), reporting these events as more stressful than males.

Petersen et al (1991) tested these theories in a longitudinal study of adolescents from sixth through twelfth grades. Little depression was evident in sixth graders but by twelfth grade, females clearly experienced more depressed affect and poorer emotional tone than males. Girls also reported more stressful events, including the above mentioned school change as well as family conflict and divorce. The authors concluded that results supported the response style theory and the stressful life events theory, but not

gender intensification (Petersen et al). The stress-coping theory was also supported by the results of Su et al (1997)

Measurement issues may cloud the 2:1 female to male ratio, however. In the1980s, Kandel & Davies (1982) investigated mood scores of more than 8000 adolescents in their large-scale study of depression. Although females had higher depression scores, the researchers noted that males exhibited more behavioral problems, leading to a hypothesis of gender differences in expression. When depressed and conduct disordered adolescents were considered together, the male to female ratio was equal (Kandel & Davies). Craighead (1991), in a study of adolescents with depression, anxiety, and/or conduct disorder, found that females were more likely to be anxious and depressed while males had conduct problems in addition to depression. Yet dual-diagnosis females received a depression diagnosis while dual-diagnosis males received a primary diagnosis of conduct disorder.

Concerned with gender differences in the experience of depression, Baron and colleagues evaluated response differences in males and females on the Beck Depression Inventory (BDI) and the Reynolds Adolescent Depression Scale (RADS) in a series of studies on Canadian adolescents (Baron & Campbell, 1993; Baron & Joly, 1988; Baron & Perron, 1986; Campbell, Byrne, & Baron, 1992). Despite controlling for demographic and living condition variables, females consistently scored higher than males throughout adolescence, but discriminant function analyses revealed a consistent pattern of items characteristic of females: loss of appetite, fatigue, weight loss, sad mood, and suicidal ideation on the BDI; and crying, sad mood, stomachaches, and self-deprecation on the

RADS. Males showed a pattern characterized by irritability, work inhibition, social withdrawal, and sleep disturbances (Baron & Campbell; Baron & Joly; Campbell, Byrne et al). Similarly, Stapley and Haviland (1989), proposed gender differences in depression to be an extension of non-depressed adolescent emotional functioning and explored emotional experiences in a middle class community sample of students. After measuring frequency, intensity, duration, and context of ten emotions, the researchers found that shyness, shame, guilt, sadness, and self-hostility were more frequent emotional experiences for females while males experienced contempt more frequently. The gender-based differences in the depressive experience may arise from the pre- existing differences in emotional functioning and self-image (Offer et al, 1990; Stapley & Haviland, 1989). Interestingly, loneliness presents an interesting paradox; while loneliness and depression are correlated, girls report more depression but boys report more loneliness (Brage et al, 1993; Koenig, Isaacs, & Schwartz, 1994). Koenig et al, in a study of 397 urban high school students noted that the depression scores of males tended to be low or high while females had more moderate scores. Among boys, all levels of depression appeared to be associated with loneliness whereas girls with mild to moderate levels still reported spending time with friends.

Unfortunately, outcomes may be affected by lack of understanding of male expression of depression. Gjerde (1995) and colleagues examined depressive symptoms in a community-based sample (N=99) of 23 year olds who had been followed longitudinally for twenty years through repeated collections of behavioral, cognitive, and interpersonal data. Males who were diagnosed as depressed at age 23 had exhibited a

core of symptoms, observable from childhood on, which included an antagonistic personal style, impulsivity, and conduct problems. Gjerde labeled this pattern "allocentric" (p. 1278). Depressed adult females did not differ from their nondepressed counterparts in personal style until post-puberty when they were characterized as introspective, self-focused, and behaviorally less active, the "autocentric mode" (p.1278). Not only did depression manifest differently in males and females, but males had exhibited troubling symptoms not typical of DSM-IV depression for a long period of time before finally meeting the criteria as adults. A valuable window of opportunity for treatment had been lost.

In summary, while many factors play into the gender differences seen in depression, the way in which depression has been defined may have led to a favoring of female responses in depression scales and diagnostic criteria. The more typically male patterns of emotions and behaviors may lead to more frequent diagnoses of disruptive disorders and treatment that may be inappropriate or incomplete.

Age. Age appears to be correlated with depression and depressive symptoms, with older adolescents reporting higher levels of symptoms (Brage et al, 1993; Larson et al, 1990; Puskar, Tusaie-Mumford et al, 1999). In addition, Puskar, Tusaie-Mumford et al noted that eleventh and twelfth graders were more likely to endorse a desire to self-inflict injury and Brage et al found that older adolescents in their sample reported more loneliness. Part of this age-related change may be due to the maturation of cognitive abilities, which may broaden both emotional experiences and the languaging skills with which to report emotions. Two studies reported that younger adolescents' abilities to

report affective states were questionable (Larson et al; Patton et al, 2000). Another possibility is that the likelihood of experiencing stressful events increases with age (Petersen et al, 1991). Additionally, it is possible that older adolescents report symptoms that are more consistent with the adult-based criteria used to diagnose the disorder, thus aiding recognition of depression by researchers and clinicians (Patton et al).

Comorbid disorders. Another hallmark of early lifespan depression is the high rate of comorbidity, the occurrence of other mental disorders either concurrently or sequentially with depression. Rates of comorbidity in adolescents have been reported as ranging from 42% to 85% for one additional diagnosis (Birhamer et al., 1996b; Cicchetti & Toth, 1998; Myers & Troutman, 1993; Rohde, Lewinsohn, & Seeley, 1991). Up to 50% of depressed adolescents have two or more co-morbid diagnoses (Birmaher et al). The most frequent comorbid disorders are the anxiety disorders, dysthmia, disruptive disorders (i.e. conduct disorder), and substance abuse (Birmaher et al; Myers & Troutman). Conduct disorder, involving such behaviors as physical aggression, stealing, vandalism, and running away from home are present in up to 37% of depressed individuals. Prepubertal boys are particularly likely to exhibit these problems although, as age increases, the number of girls with the diagnosis also increases (Kutcher & Marton, 1989; Myers & Troutman). Similar to academic decline, a chronic pattern may be set if the adolescent enters the juvenile justice system rather than receiving mental health care. Other disorders that are associated with depression include obesity, anorexia nervosa, bulimia, and symptoms of personality disorders, most often borderline and avoidant types (Attie, Brooks-Gunn, & Petersen, 1990; Brage, 1995; Kutcher & Marton;

Sadler, 1991). Somatic complaints, such as headaches and abdominal pain, are more common in younger sufferers (Sadler). Additionally, depression may be seen with the attention disorders, Tourette syndrome, and physical illnesses and disabilities (APA, 1994; Kutcher & Marton). Major depression is more likely to occur after the onset of another psychiatric disorder, however conduct disorder and dysthmia may also persist after remission from depression. (Birmaher et al; Cicchetti & Toth; Lewinsohn et al, 1999). Anxiety, in particular, appears to be a forerunner of major depression in children and adolescents whereas substance abuse begins after depression onset (Cicchetti & Toth; Reinherz et al, 1993).

Comorbidity is an important concept in the study of depression for two reasons. First, comorbid diagnoses generally predict poorer functioning and outcomes. Lewinsohn, Rohde, & Seeley (1995) examined outcomes of 1507 adolescents, aged fourteen to eighteen, with 'pure' depression and depression combined with anxiety, substance use, or disruptive disorders. Those teens with comorbid depression had significantly more difficulties in the academic setting, higher use of mental health services, and had attempted suicide more often. Anxiety disorders had the largest impact on general functioning while substance use had the least (Lewinsohn et al). The presence of comorbidities enhances the risk of recurrent depression and lengthens its duration into the adult years (Birmaher et al, 1996b).

The second reason is that the issue of comorbidity is controversial, calling into question the validity of the construct of depression as currently defined (Harrington, 2000). Hammen & Compas (1994) assert that a valid understanding of early lifespan

depression has been hindered by the assumption that children manifest depression like adults and that additional symptoms, such as anxiety or conduct problems, are considered secondary phenomena or separate disorders. Nearly 80% of adolescents suffer from comorbid disorders, indicating that premature drawing of boundaries may have led to a narrow definition of depression as well as assessment tools that vary in what items are included. For example, anger is listed as the most typical emotional experience for depressed adolescents in clinical settings (Hammen & Compas), yet anger appears in neither the CES-D nor the CDI scales, both of which are frequently used in research Kovacs, 1981; Radloff, 1977). The DSM-IV diagnostic criteria emphasize the number and type of adult symptoms one may experience while applying another label to extra symptoms (1994). Yet if two 'disorders' are highly comorbid, such as anxiety and depression, perhaps only one label is necessary (Lewinsohn et al, 1995). For example, Gerhardt, Compas, Conner, & Achenbach (1999), in a study of anxious and depressive symptoms on the Child Behavior Checklist, felt that adolescents with 'pure' major depression actually appeared to be a subset of a larger group with both types of symptoms. The salient issue is that treatment modes may have been influenced by a narrow definition of depression. A treatment designed for and tested with 'pure' depressives may not be effective in the clinical setting if other disorders are present. Kovacs (1996) suggests that further investigation is needed to determine if a different diagnostic system might result in treatment emphasis on comorbid disorders as well.

Attributional style. Attributional style, a construct receiving much attention in the depression literature, refers to a pattern of cognitions involving how one views the self in

relation to life events (Schwartz et al, 2000; Haines et al, 1999). Attributions, reasons assigned to the occurrence of events by individuals, may be stable or unstable, global or specific, and internal or external. Attributional style as a construct evolved from the learned helplessness model of depression (Abramson et al, 1978). Many studies have documented a relationship between negative attributional style and depressive symptoms in adults and children (Haines et al; Nolen-Hoeksema, Girgus, & Seligman, 1992; Turner & Cole, 1994). Depressed individuals are more likely to view negative events as due to factors within themselves (internal) that are pervasive (global), and unchanging (stable) whereas positive events are associated with external, unstable, and specific causes (Schwartz et al). Maladaptive styles are not only associated with concurrent depressive symptoms but may predict future depression. Although adolescents in general experienced shifts in attributional style over a one-year period in the Oregon Adolescent Depression Project, those with highly maladaptive styles were likely to continue this pattern (Schwartz et al). Those with maladaptive styles were more likely to experience psychological distress one year later. Optimism, a related concept, was inversely related to depression scores in a study of midwestern adolescents (Puskar, Sereika, Lamb, Tusaie-Mumford, & McGuiness, 1999). Optimistic teens, who were primarily influenced by their parents' attributional styles, were more likely to achieve goals, experience less depression, and use problem-focused coping strategies. Haines et al, in exploring the origins of attributional style, posit that early relationships with parents, peers, and teachers may influence children and that early depression episodes may leave a 'scar' on cognitive processes, firmly entrenching negative attributional styles.

School-related risk factors. The shift from elementary to middle or junior high school has been implicated in the onset of depression (Eccles, Lord, & Buchanan, 1996; Eccles et al, 1997; Petersen et al, 1991). Eccles and colleagues have conducted a large scale, longitudinal study of school environmental effects on Michigan adolescents' academic achievement, beliefs, and affective reactions (Eccles et al, 1996; Eccles et al, 1997). Some early adolescents experienced drops in motivation and self-esteem and increases in anxiety, depressive symptoms, and school disengagement concurrent with the shift from elementary school to junior high/middle school. The authors posit that the junior high environment emphasizes increased teacher control, decreased personal and positive student-teacher relationships, increased public evaluation of work, and increased competitive grading as compared to elementary or Kindergarten-8th grade schools. Students who experience difficulties in shifting to the larger, more impersonal schools continue to have psychological and academic problems through high school (Eccles et al, 1997).

Natural Course and Risk and Protective Factors

In adolescence, depressive episodes last from two weeks to eighteen months with an average length of eight to nine months, a more rapid recovery than with adults. Within one year, 80% of those who have experienced depression will no longer meet the criteria for the disorder. Length of illness is related to severity of the episode, age of onset, and whether psychotic features were present (Myers & Troutman, 1993; Strober, 1985). Twenty percent of those with an initial diagnosis of unipolar depression will be rediagnosed at a later age with bipolar illness (Strober). As stated earlier, the recurrence

rate of major depression is high and the chance for future mental health problems is high (Cicchetti & Toth, 1998). Future problems are more likely in those whose depressive episodes were longer in duration and who had multiple episodes, suicide attempts, greater stress and conflict in interpersonal relationships, substance use, traits of borderline or antisocial personality disorders, a depressogenic cognitive style, and a family history of depression (Lewinsohn et al, 2000).

Yet there are protective factors against depression as well, a key concept within the developmental psychopathological framework. Puskar, Tusaie-Mumford, et al (1999) list male gender, enrollment in an academic program (not remedial or vocational), living with parents, participating on a sports team, and low levels of life stressors as protective factors against the onset of major depression. Although some protective factors are unalterable, others may provide clues to prevention and treatment of the disorder.

Preliminary Research: The Experience of Being a Depressed Adolescent

An earlier phenomenologic study of the essential structure of the lived experience of being a depressed adolescent was completed as a Masters thesis (Farmer, 1997). In-depth interviews with three adolescents resulted in twelve theme categories from which a preliminary essential structure of the experience was formulated. At a later date, two additional interviews were conducted to improve data saturation. Through further analyses, theme categories were reduced to eight and the essential structure was refined (Farmer, 2002).

Several findings were of interest to the proposed study. Participants, aged fourteen to seventeen, felt a disconnectedness with others, including parents,

encompassed by a theme category termed *Emotional homelessness* (Farmer, 2002). The participants felt an unexpected lack of comfort and safety at home. In addition, all expressed anger at parents coupled with the recognition of dependence upon them. Parental conflict or divorce was a prominent topic for some, but anger was a central topic in all the interviews, the symptom by which the participants measured the waxing and waning of their illnesses and the changes in relationships with their parents.

A visual model of the findings was developed to better capture the richness of the data and to illustrate the temporal and processual features of the experience of depression (See Figure 1)(Hunter, Lusandi, Zucker, Jacelon, & Chandler, 2002). The model was the result of individual work and discussion with faculty members. The model and essential structure of the depression experience were presented to two different university departmental forums and at an international conference, resulting in a wide range of feedback from a variety of disciplines.

In brief, the model depicts the depression process as based on descriptions of those who had the experience. The onset of depression is thought to reside in some combination of individual and environmental characteristics, not explored in this preliminary work. The sets of ovals represent rough divisions of timing and co-occurrence of certain phenomena. Hierarchy is not to be inferred from the arrangement of the ovals, which reflect an arrangement of somewhat simultaneous events. The arrows represent direction of flow through the model. The adolescent may move among the processes and may revisit previous experiences. The top arrow returns to previous phases, representing the high recurrence rate of depression. The initial phase represents

the long-standing issues that adolescents discussed. At some point the adolescents recognized that they did not feel safe where they expected to feel it: home. This was due to abuse or a sense that they were not valued. Uncertainty of parental support included statements about not feeling that they could truly converse with their parents and uncertainty that their parents were 'there' for them. Some had suffered visible losses through divorce or a sibling leaving home

At some point the adolescents began to feel a pervasive sense of what was termed 'emotional homelessness', a situation that may have gone on for years prior to actual diagnosis. The second phase consists of the more acute processes and events that are generally recognized and labeled as depression. This phase included a sense of apartness from others, unrelenting anger toward parents, teachers, peers, and others, a sense of dispirited weariness, and feelings of being caught in the middle of disagreements among parents or stepparents. Escape from pain included spending more time away from home as well as suicide attempts. The more dramatic attempts served as mechanisms for entry into treatment. The third phase consisted of the treatment experience and included finding a treatment that felt right and provided a safe base, ways of measuring improvement in themselves and in relationships with others, and desire to make meaning from the experience. It is expected that adolescent data from the proposed study will reflect some of these same themes, but will expand the parent relationship information in particular and provide other refinements in the model.

Summary of Individual Functioning

In describing a depressed adolescent, Lewinsohn et al. (1994) list the following correlates from the Oregon Adolescent Depression Project: a history of current and past psychopathology (depression, substance abuse, anxiety), problem behaviors (i.e. conduct problems), physical symptoms or illness, suicide attempts, depressogenic cognitive style (pessimism; global, stable attributions for failure), negative body image, excessive emotional dependence on others, self-consciousness, less effective coping mechanisms, low support from family and friends, and cigarette smoking. Many processes within the individual interact to produce this pattern of emotions, thoughts, and behaviors we label as depression, including genetic factors, neurochemical processes, cognitive processes, and responses to stressful events. These processes occur within the context of normal adolescent development, creating a life-stage unique experience of the disorder. Depression affects all facets of an adolescent's life, leaving him or her with a life-long risk for future health problems. Yet knowledge of the disorder and of protective factors within individual functioning can serve as a basis for providing appropriate and effective treatment.

Summary of Chapter

This chapter has explored the literature pertinent to the proposed study of the adolescent experience of being parented while depressed and the experience of parenting a depressed adolescent. Using a developmental psychopathological framework, individual and microsystem influences and processes were explored in relationship to depression. Family processes included loss, family structure, divorce, marital and family conflicts,

cohesion and warmth, parenting style, parental depression, and reciprocity of interactions. Several theoretical perspectives were discussed, most notably attachment theory. Individual adolescent processes discussed included subjective experiences, social isolation, suicidality, substance use, academic functioning, gender, age, comorbidity, and school-related factors. Preliminary studies by this investigator were discussed.

CHAPTER THREE

Methodology

This chapter begins with further discussion of phenomenology as an approach and a research method. The study's research design and methods, including discussions of sample, settings, and data collection, analysis, and management follow. Also included are considerations of ethical issues and strategies for achieving trustworthiness of the results.

Origins of Phenomenological Approaches

As stated in Chapter 1, phenomenology served as one the philosophical approaches guiding this study. Phenomenological methods were employed in the design of this study.

Phenomenology began as a philosophical approach to knowledge and reality, and its beginning is most often attributed to Edmund Husserl (1859-1938), a German mathematician turned philosopher (Crotty, 1996; Cohen & Omery, 1994; Ray, 1994; Lopez & Willis, 2004; Munhall, 1994; Omery, 1983). Frustrated with what he felt was a lack of clarity in scientific endeavors, he sought principles on which to establish a secure base for human knowledge, principles on which all future science could be built (Crotty; Lopez & Willis). Husserl was concerned with the essence of things; the universal core of what defines an experience once cultural and theoretical knowledge, everyday beliefs, and nonessential attributes are stripped away (Cohen & Omery; Crotty; Lopez & Willis; Ray). Transcendental phenomenology, as Husserl's approach was termed, is epistemological in nature and concerned with what is truth (Cohen & Omery). For

Husserl, phenomenology as method was an individual, self-reflective process aimed at reduction, or purification of the phenomenon of interest by means of bracketing out what was not pertinent (Cohen & Omery; Lopez & Willis). Husserl's associates and students established the Munich Phenomenological Circle, considered to be the beginning of the phenomenological movement (Crotty).

One of Husserl's students was Martin Heidegger (1889-1976), who rejected Husserl's transcendental approach to pursue a more ontological endeavor, that of the meaning of being itself (Crotty, 1996). Humans, because of their abilities to understand and communicate through language, were felt to be the means to explore 'being' in general. Heidegger was concerned with what he called *Being*, a term meaning an authentic, largely unrealized existence that is obscured by everyday life in the world (Cohen & Omery, 1994; Crotty; Lopez & Willis, 2004). He used the term *Dasein* to mean people who comprehend their presence in the world. Heidegger saw *Dasein* as individuals thrown into a world in which they were not always free to choose their paths and in which they were aware of their own mortality. Phenomenology, for Heidegger, was a way to look past the everyday struggles and concerns to see the larger meaning of *Being*.

Heidegger employed a hermeneutic method to interpret meanings underlying everyday events in his endeavor to understand the meaning of *Being* itself (Cohen & Omery, 1994). Unlike Husserl, Heidegger believed that human presuppositions and conceptualizations regarding the events of interest could not be eliminated, or bracketed, and they make intelligibility and meaning possible. Investigated phenomena possess

meaning because of the contexts humans supply. Meaning of an event is revealed through language as a way of *Being*. Hermeneutics is a means to systematically deal with everyday interpretations to find new, underlying interpretations, resulting in a deeper understanding of the event (Lopez & Willis, 2004; Ray, 1994).

Some of the existentialist philosophers, most notably Sartre, Merleau-Ponty, and Ricoeur, embraced the tenets of phenomenological thought, blended them with existentialist tenets, and provided another variation on the phenomenological theme. Rather than emphasize consciousness like Husserl, the existentialists were concerned with the bodily presence, or embodiment, of humans in the world (Crotty, 1996). Humans are in the world as bodies and interdependent with the world. Phenomenologic perception is not a discovery of meanings, but a dialogue between humans and the phenomenon of interest that brings meaning to both; no meanings lie in wait (Crotty).

Although European in origin, phenomenological thought was readily accepted by American philosophers and psychologists, who professed to follow Husserlian, Heideggerian, or some combination of these approaches (Cohen & Omery, 1994; Koch, 1995). The approaches came into nursing research via those scholars who had studied phenomenological methods in the social sciences (Morse 1991). Phenomenology was suitable for a person-centered discipline in which problems often could not be researched with traditional methods.

Common Tenets of Phenomenology. Phenomenology, at present, includes a variety of approaches and methods, but several unifying characteristics exist:

1) A search for reality as presented to human consciousness and awareness.

Reality and consciousness are inseparable. Reality exists only within consciousness. Phenomenology is a means to examine the nature of objects or experiences within the milieu of human consciousness (Crotty, 1996). Heidegger described this as Being-in-the-World.

2) Intentionality. Closely associated with reality and human consciousness is the concept of intentionality. Husserl used the term to mean that human consciousness is always a consciousness of something. It is always related to objects, thoughts, or experiences (Crotty, 1996). Unlike current definitions and usage of the word, "…intentionality is the radical interdependence of subject and world" as opposed to a purposeful action (Crotty, p.38). It refers to reaching inward, an in-tending, to describe the idea that knowledge of a phenomenon dwells within the knower, not outside as a separate object. Crotty states that phenomenologists remove themselves from the positivist subjectivity-objectivity spectrum by holding this belief as subject and object as one.

3) Consciousness and immediate experience. Phenomenological researchers believe that the best way to explore and understand phenomena are within the consciousness of humans who have experienced the phenomena first hand (Crotty, 1996).

4) Methods to identify, elucidate, and interpret human phenomena. Many methods exist for doing phenomenological research, including descriptive (Husserlian) and interpretive (Heideggerian) methods, as well as combinations of these (Cohen & Omery, 1994). Husserl believed it to be a solitary pursuit while others focused on texts and lived experiences (Crotty, 1996). The data consist of statements made by the

participants that are then examined for meanings and patterns. There are various strategies for the analysis of phenomenological data put forth by different schools of phenomenology (i.e. van Manen, Giorgi, Colaizzi) (Colaizzi, 1978; Koch, 1995; Munhall, 1994: Omery, 1983). All involve some way to identify significant statements within the raw data, those pertinent to the phenomenon of interest, and organize them according to themes. The researcher does not reach conclusions but, instead, aims for a comprehensive description and interpreting of the experience as it is lived by the participants (Anderson, 1991; Munhall). Common to all is the elucidating of an object or event within human experience while uncovering preconceived notions, prejudgements, and beliefs about the phenomenon. The focus on the phenomenon is what separates phenomenology from other qualitative research approaches (Crotty).

Phenomenological Methods and the Integrated Method for this Study. For this study, an adapted method will be used, incorporating elements from Colaizzi (1978) in order to attend to the patterns of parent-adolescent experiences and lifeworlds in depression. The approach is inductive and exploratory; the researcher clarifies and records his or her own beliefs about the phenomenon before asking participants to describe what it is like to have a given experience. Benner, Tanner, and Chesla (1996) have stated that "…the way that humans are engaged in their world is set up and bounded by what matters to them" (p. 352). This study will aim to identify what these concerns are and to uncover and describe why they matter. Depression is a complex, personal and interpersonal phenomenon that involves events, stories, thoughts, and emotions. It is

important to identify patterns in these narratives in order to understand both the elements of the personal experience and the meaning of these elements to the sufferer.

In the preliminary studies, this writer used the method put forth by Colaizzi (1978). Themes were grouped into clusters with related meanings, and then into categories according to related underlying commonalities. From the analysis of those data, an essential structure was formulated of the lived experience of the phenomenon of depression. This approach provided a description of elements of the experience, one of which was the importance of finding meaning in being depressed and recovering from it, yet did not fully tap the interpretations of this event by the participants.

For the current study, the methods included both description of the experience and interpreting meanings in the narratives of parents and adolescents. The aim was two-fold. The first aim was "…to understand the situation within the practical lived world of the participant, with all of its constraints, realities, and possibilities" (Benner et al, 1996, p. 362-363). This was accomplished through entering a dialogue with the narratives provided by the participants to understand their concerns. The second aim was to then move outside of the context of the narratives to identify structures in the data and involves a deliberate stepping away from the lived world in order to ascertain themes and obtain a comprehensive description.

Although little attention in the literature in the past has been paid to theory or model development from phenomenological data, meaning-based models are becoming more prevalent in nursing research (Haase, Heiney, Ruccione, & Stutzer, 2000; Morse, Hupcey, Penrod, & Mitchum, 2002). The power of qualitatively derived models lies in

the closeness to real experience and the innovative yet practical approach to organizing findings. Phenomenologically based models allow the reader to experience recognition of a phenomenon within the self or in others (Morse, 1997). By combining the phenomenological results with an extensive literature review, linkages to other concepts can be formulated along with identification of antecedents and consequences, thus strengthening the resulting model (Morse). In the previous study, the researcher completed the phenomenological interviews and data analysis, developed a preliminary model of adolescent depression, and conducted an extensive literature review on depression to strengthen and extend this model. The model is an attempt on the part of the investigator to visually describe complex conceptual relationships. The focus on parent and adolescent narratives allows for multiple perspectives and the elaboration of these elements within the existing model, which may then pave the way for further testing and the development of adolescent-based instruments.

Overview of Design and Methods

The two research questions for this study included:

1) What are the meanings and experiences of being parented, for the depressed adolescent?

2) How do the meanings and experiences of parenting contribute to the context of the lifeworld of the depressed adolescent?

Questions 1 and 2 required a phenomenological design. The phenomenologic approach focuses on the phenomenon of interest as lived by the individuals themselves, with the assumption that this experience is valuable (Benner et al, 1996; Crist & Tanner,

2003; Field & Morse, 1985; Lopez & Willis, 2004; Munhall, 1994). The phenomenological approach was appropriate due to the lack of understanding pertaining to the personal perspective on being parented while depressed and to parenting a depressed adolescent, the need to attend to the dynamic, interactive nature of the lifeworld of depression, the addition of another research perspective on the study of depression, and the value of the meaning of events in the lives of individuals. Question 2 required additional steps to compare the patterns of the adolescent concerns and the parent concerns.

Phenomenological Method for Questions 1 and 2

Although Questions 1 and 2 shared the phenomenological approach and involved the same dyads of adolescents and parents, there were differences in certain aspects of the procedures. Sample and method of questioning will be discussed separately for Question 1 and Question 2, followed by a combined discussion on data collection, management, and analysis.

Samples

Sample for Question 1. For the adolescents, a purposive sample of eight to twelve was sought for this study, with seven being recruited and retained. A purposive sample is one selected by the researcher according to the needs of the study (Morse, 1991). Purposive sampling involves the conscious selection of those participants who are experts in the phenomenon of interest, by virtue of having lived the experience (Burns & Grove, 1993). In addition to having had the experience, the participants were able to reflect on and provide narratives about depression, were willing to share their experiences as

completely as possible, and had the patience and time to sit for an uninterrupted period of time (Crist & Tanner, 2003; Morse, 1991). Redundancy refers to the repetition of themes that occurred as more participants were interviewed (Crist & Tanner). Most phenomenological studies surveyed have used samples of seven to sixteen participants, although a few have sampled larger numbers (Dumas, 1999; Haase, 1987; Haase & Rostad, 1994; Phipps, 1993; Talseth, Gilje, & Norberg, 2001). Sample adequacy was achieved after the first six adolescent participants, when the researcher noted redundancy in interview content.

All participants met the inclusion criteria for adolescents for Question 1. All adolescent participants:

1) Were aged thirteen to eighteen.

2) Met the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for Major Depression.

3) Were in treatment with a mental health care professional for major depression.

4) Lacked concomitant symptoms or conditions that interfered with processing or expressing thoughts, feelings, and ideas, including such conditions as thought disorders, developmental delays, current psychotic symptoms, or speech disorders as confirmed by the adolescents' health care providers.

5) Spoke English.

6) Were personally interested in participating in the study.

7) Had parental consent to participate.

Phenomenologic methods are constrained by their reliance on language-based meanings. Participants needed to be able and willing to engage in verbal interchanges in order to contribute to answering the research question. In addition to having had the necessary experience, the participants were personally willing to share their perspectives (Morse, 1991). Single, in-depth interviews have been commonly and successfully used with adolescents (Deatrick & Faux, 1991). The investigator's past experience with adolescent participants was that they were willing and articulate interviewees who freely discussed their experiences (Farmer, 1997; Farmer, 2002). This continued to be the case with this study, with the exception or one participant, who appeared angry during his interview.

Sample for Question 2. The parent sample consisted of parents adolescents described above. All participants:

1) Were parents of thirteen to eighteen year old adolescents who were currently in treatment for major depression.

2) Were custodial parents of the depressed adolescents (living with them at least 50% of the time, either full or joint custody).

3) Lacked conditions that interfered with processing or expressing thoughts, feelings, or ideas such as thought disorders or psychotic symptoms as confirmed by the providers from whom the dyads were sought, with confirmation by the investigator at the consenting process.

4) Spoke English.

5) Consented to participate.

Some parents were suffering from psychiatric disorders of their own, most notably depression. This did not exclude them from study participation since they still had perspectives on parenting to share. In no case did the disorder interfere with the parent's ability to express thoughts and emotions. The investigator decided not to interview one parent after the adolescent and the therapist described behaviors that may have posed a risk to safety. In that instance, the adolescent was eighteen, consented for herself, and was interviewed. Custody was salient, in that noncustodial parents, if not present for day to day activities of their adolescents, were thought to be lacking in the intimate and intense parenting experiences that custodial parents had. Noncustodial parents were not interviewed. Redundancy was again achieved after the fourth or fifth participant was interviewed.

Data-Generating Statements

Data-generating statement for Question 1. In phenomenology, detailed narratives of an experience are elicited through broad, data-generating questions or statements (Haase, 1987). For Question 1, the following data-generating statement was used with adolescents:

> Please tell me what it is like for you to be parented while depressed. I am very interested in what it is like for you with your parents during this time, including your thoughts, feelings, and actions, as if you were telling me your story.

Data-generating Statement for Question 2. The data-generating statement for parents of depressed adolescents was: "Please tell me what it is like for you to parent

your depressed teenager, including your thoughts, feelings, and actions, as if you were telling me your story."

Data Collection Procedures

After obtaining institutional review board approval (See Appendix D), letters with information about the study were given to selected mental health care providers in the Tucson community who see adolescents in their practices. The informational letter (See Appendix A) described the study and contained contact information for the researcher. The providers presented the letters to potential participants, who gave permission for the investigator to make telephone contact with them. The investigator ascertained that the appropriate inclusion criteria were met, explained the nature of the study, obtained parental consent, and then spoke with adolescents to obtain their assent. Data-generating statements were distributed.

The investigator arranged for interviews at times and places chosen by the participants, with privacy and comfort being primary (Field & Morse, 1985). The individuals chose to meet in their homes, except for one adolescent who chose to be interviewed in a private corner of a restaurant patio. Brief demographic data was obtained, including information on diagnoses, length of illness, treatment modes, and familial positions of those who live in the home (i.e. father, mother, stepsister, etc.). Each member of the parent and adolescent dyad were interviewed separately and privately from one another.

The audiotaped interviews began with the appropriate data-generating statement. As participants related their narratives, general prompts were given to elicit further

comments as needed, such as: "Tell me more about…" or "What was that like for you?" (Seidman, 1991; Snow, Zurcher, & Sjoberg, 1982). Participants were encouraged to continue until they felt that they had completed the narratives. Field notes were written after each interview on such topics as physical appearance, emotional state, nonverbal communications, and anything that the investigator felt might clarify the verbal transcripts later (Field & Morse, 1985). Since an individual's affect and manner of dress are greatly influenced by mood disorders, field notes were thought to provide valuable information on current mental functioning. Interpretive data collection can include repeated interviews (Siedman; Crist & Tanner, 2003), but only one interview per participant was completed for this study. Research questions did evolve during the interview process with early participants that influenced foci in later interviews. For example, one adolescent voiced distress at being caught between conflicting requests by his divorced parents, which led to increased investigator awareness of this issue in later participant interviews and data analysis.

Human Subjects Protections

Research with vulnerable populations, such as minors with psychiatric disorders, has traditionally been more challenging in terms of subject protection than that with adults or mentally healthy children. Children are not able to volunteer for, or refuse, participation in studies by themselves and are therefore subject to potential exploitation by those with the ability to grant permission. Even though carefully scrutinized by institutional review boards, research on minors may be met with suspicion by parents (Frame & Strauss, 1987; Weinberger, Tublin, Ford, & Feldman, 1990).

Several concerns need to be addressed in research with minors who have psychiatric disorders. First, the minor's ability to understand the nature of the study, including risks and benefits of participation, must be considered. Mental incompetence, while applicable to some psychiatrically ill individuals, must not be assumed in all (Bentley, 1991; Murray, 2000). Informed consent/assent is possible, and many researchers of psychiatric phenomena have encountered few problems (Kimmel, 1996). In previous research by the investigator, depressed minors fully understood the research process as well as the assent/consent process and confidentiality (Farmer, 1997). Second, coercion is of great concern with minors. Kimmel cautions researchers of the overlapping nature of enticement and coercion. Parents of minors with psychiatric disorders may be more willing to engage in research in hopes of alleviating symptoms, thus encouraging their children to participate. Minors are often curious about research, especially that which includes the extra time and attention that an in-depth interview provides (Farmer; Kimmel). Money, especially larger amounts, may also serve as an initial enticement (Kimmel). The third issue is that of confidentiality. Adolescents may reveal information about their mental status, illegal activities, and abusive situations that has the potential to harm them legally and academically. Steps must be taken to both protect their privacy and provide safety.

Researchers who work with adult participants share some concerns with those involved with minors. Although the participants in this study will be considered to be capable, consenting adults, they may be subject to issues of coercion as well. Privacy regarding revelations of illegal or abusive activities will also need to be considered.

To safeguard the participants in this study, the investigator completed all required procedures of the University of Arizona Human Subjects Protection Program for consent and assent forms, recruitment letters, and supporting documentation meet committee guidelines for safe, legal, and noncoercive procedures. The investigator discussed the steps of the study separately with adults and adolescents, encouraging questions, and thoroughly reviewing the consent/assent process (Kimmel, 1996). Participants were offered twenty dollars and they were advised that they could withdraw at any time. A Certificate of Confidentiality was obtained from the Department of Health and Human Services, National Institute for Alcoholism and Alcohol Abuse that provided authority for the investigator to withhold identifying characteristics that may incriminate individuals who discuss illegal activities (See Appendix C). This certificate was explained to participants but they were cautioned that revelations regarding abuse, neglect, and danger to self or others could necessitate reporting to proper individuals.

All other aspects of the interviews were confidential both to outside sources and between the parent and adolescent. Confidentiality was further ensured by data management procedures. Interview audiotapes were designated with number codes only. A transcriptionist assisted the investigator in transcribing the de-identified tapes. She signed a statement that she would keep interview data confidential (see Appendix F). Names, including those of participants, siblings, friends, schools, and small communities, were not included in transcripts. All tapes and written materials were stored in a locked location in the researcher's home and will be kept for secondary analyses in the future. The only people with access to the transcripts were the researcher and members of the

dissertation committee. Consent and assent forms were kept in a locked facility at the College of Nursing.

Contingency Planning

Interviews may be stressful events when topics involve parenting issues and mental illness. In particular, the investigator considered procedures for dealing with emotional distress, suicidal ideation, and threats to others, including the investigator. Emotional distress, had it arisen, would have been managed with pausing the interview and allowing time for individual comfort measures (May, 1991). No emotional distress occurred during the interviews, except for occasional tears on the part of one parent. When asked whether she wished to stop the interview, she stated she wished to continue. The investigator debriefed participants post-interview to provide closure (May). To the investigator's knowledge, none of the participants required follow-up with therapists due to severe distress. Because the study involved depression, discussions of suicidality occurred in some of the interviews. Revelations about past suicidal thoughts or attempts were treated as interview data. Current ideation, had it occurred, would have been reported to the participant's therapist and the participant would have been assisted in obtaining urgent care.

Data Analysis

Data analysis involved procedures with roots in both Heideggerian and Husserlian traditions of phenomenology to both interpret meanings in the narratives of parents and adolescents and to move outside of the context to identify structures in the data (Benner et al, 1996; Crist & Tanner, 2003; Colaizzi, 1978). Data from the adolescent interviews

and parent interviews were analyzed separately but with the following steps in common. Initially, the researcher recorded her conceptualizations and beliefs about depression, parenting, and being parented, most of which are discussed in Chapter 1. While Husserlian approaches recommend 'bracketing' of these preconceptions, it was recognized that the researcher was inextricably situated in the world and that bracketing was not feasible. Instead, assumptions were documented, shared with the committee, updated, and referred to during analysis in order to recognize their influence during the interpretive process (Crist & Tanner; Guba & Lincoln, 1989; Hycner, 1985; Lopez & Willis, 2004; Packer & Addison, 1989). For example, as the data were being analyzed, it was recognized that the investigator had a bias toward linear temporal arrangements of themes. When this was observed by the dissertation chair, the investigator re-examined data with awareness that themes may represent simultaneous events in the lifeworlds of the participants.

Analysis included the following steps, most closely approaching those of Colaizzi (1978) with the recognition that the process was not linear:

1) Listening to interview audiotapes and reading transcripts in entirety was undertaken to promote a sense of meaning in context;

2) Discussing of transcripts of early interviews with committee members to evaluate the investigator's technique, and to identify topics that were unclear, incomplete, or merited further exploration in subsequent interviews.

3) Identification of meanings, themes, and concerns within the data were noted and recorded in an interpretive writing process involving summaries of salient points within

each narrative transcript. Below is an abbreviated example of a summary from an adolescent participant, Dan:

The most prominent central concern identified in Dan's interview was injustice. He was sent to a residential treatment facility against his wishes and felt that his mother did not believe him when he said that he was not that ill. Dan stated, "I had to pay a little too much for these couple of minor things. I didn't need that to be worked on. I think I grew a little angrier the more I had to play my role to get out of there." Escape was another prominent theme: "I guess at my worst would be with my dad. I used the computer as a distraction to my depression." Unworthiness or rejection was indicated by statements such as, " 'Mom, you ignore me on weekends, you ignored me for a certain purpose of something else, I don't know'". Like other participants, loss was another concern: "My sister and mom moved out at the same time…(brother) hasn't been there for years….Then (dad) got diagnosed with cancer, pretty bad."

Gratefulness was identified within the interview through statements such as, "She was willing to dish out as much money as it takes, as much time away from anything else it takes, and that's great." Dan expressed statements that indicated stronger abilities to see his parents as a mix of strengths and weaknesses, recognition of their humanness: "…it's better now. Her job takes a lot of stress on her." Other central concerns for Dan included coming to terms with acceptance of all that had happened to him and learning how to balance his relationships with his divorced parents.

4) Identifying exemplars and paradigm cases within the data. Crist and Tanner (2003) state that exemplars, "…are salient excerpts that characterize specific common themes or

meanings across informants" while paradigm cases "…are vibrant stories that are particularly compelling…" to which the researcher returns repeatedly (p.204). Paradigm cases exemplify a pattern in the data that may make recognition of said pattern easier in other interviews. Colaizzi's method (1978) does not use the terms 'exemplar' or 'paradigm case', but uses 'significant statement' and 'theme' to identify salient concerns in the data.

For example, this example from a parent participant characterized the common theme of *Monitoring the Emotional and Situational Impact on Family*:

> It's hard for her older sister especially because she's always been her older sister. They go to church functions and things like that. She [older sister] sees how people treat Felicia and she just wants to be the silent one, you know. One half wants to rescue Felicia and the other half wants to disappear.

An example of a paradigm case comes from another parent participant. This example is particularly compelling in that the sheer joy of laughter is profound for this mother:

> One of the first times he's laughed… I'll never forget that. I don't know how long it was after he started his medication. He actually laughed. And I realized in that moment how long it had been. And it really blew me away. I mean, it really blew me away. I thought, oh my gosh, this poor boy has been so unhappy for so long and it just becomes such a way of life that you don't even comprehend how it used to be. Until you have one little thing back that you remember, oh my gosh! And when was the

> last time he actually laughed and was joyous about something and… That was a significant moment. I remember that was a significant moment.

5) Conceptualization and coding of salient concerns and meanings within the data. Benner et al (1996) call this process naming whereas Colaizzi (1978) refers to the extraction of significant statements or phrases that concern the phenomenon of interest and appear to express a single meaning. As interpretation of interview data continues, central concerns, exemplars, and paradigm cases aid in the process of naming, which is the use of words or phrases to categorize and code the information. Naming is a fluid process with changes being made as interviewing and analysis continues (Crist & Tanner, 2003). *Anger* was a name that was applied early in the analysis process to verbally aggressive statements made by adolescents, such as, "I would hit things, punch things, out of rage." As the process continued, the investigator and the committee members recognized that the name *Anger over injustice* seemed to be a more appropriate label from the viewpoint of the lifeworlds of the adolescents. A purely Husserlian analytic process would have resulted in single significant statements for which underlying meanings would have been formulated. A theme with the name *Expressions of anger* would have been compiled, containing statements with similar meanings (Colaizzi).

6) Organization of meanings and concerns into a pattern or structure that shows a pattern or relationship among these elements by virtue of their containing underlying fundamental meanings across participant interviews. Exemplars and paradigm cases were read multiple times to further understand the connections among them. The pattern for each group of participants underwent numerous reorganizations as new meanings

came into focus. The findings reported in Chapter 4 represent one, but not the only, interpretation of the data. This interpretation was deemed the most useful and representative of the data at this point.

9) Integration of themes into an essential pattern of the adolescent experience of being parented while depressed and of the contextual elements of the experience of parenting a depressed adolescent. Whereas an exhaustive description, according to Colaizzi (1978), represents "…the investigated phenomenon in as unequivocal a statement of identification of its fundamental structure as possible" (p.59), the interpretive summary in Heiddegarian-derived analysis represents an in-depth and comprehensive summary of emerging interpretations including meanings, concerns, and themes, that occurs simultaneous to final interviews (Benneret al, 1996; Crist & Tanner, 2003). Similarities are evident within these approaches in that both are a synthesis of data with a final goal of focusing on the phenomenon of interest itself, rather than on the participants' descriptions of it (Crotty, 1996).

Additional Steps for Question 2

Question 2 concerns the contribution of the parental lifeworld to the adolescent meanings and experiences of the adolescents. Only one study was found that incorporated a method for comparing narratives from two groups on a similar phenomenon. Phipps (1993) used the comparison of data from members of husband-wife dyads in a study on gender differences in the experience of infertility. For this Husserlian-based comparison, Phipps completed phenomenological interviews with husbands and wives separately. After separate data analyses, she compared resulting

theme categories, theme clusters, and themes. While she found that the same categories were common to both genders, differences in meaning existed at the level of themes and theme clusters (Phipps). The process used in this study resembled that of the Phipps study in some respects. The parent and adolescent data were analyzed separately, via the steps discussed above, then compared across meanings, themes, and concerns for both convergent and divergent elements, bearing in mind that the parent data was conceptualized as contextual to the adolescent data. It was expected that there would be a greater number of differences at all levels of meaning than with the Phipps study because the parent-adolescent relationship involved different levels of responsibility, authority, stress, and maturity between the two members in comparison to marital couples. For example, an interpretation of selected parent data as voicing the theme of *Uncomfortably Watching Aloneness* is contrasted with the adolescent theme, *Escaping the pain of connections*. However, commonalities were found in salient events or similar emotions. For example, the adolescent theme '*Awareness of Reaching a Crossroads*' shares similarities with the parent theme, *Functioning During Shock of Sudden Clarity*. The goal was not to determine which dyad member had a more valid narrative, but to consider them as two perspectives on the parented-parenting process during a life-altering phenomenon. Areas of emphasis, differences in themes, and inter-relationships among concerns and meanings will be noted in Chapter 4. The parent summary, as described above in Step 9, stood alone as an essential pattern, as well as serving as a context for the adolescent pattern.

Data Management

Data management was assisted by use of the Microsoft Word program for recording and linking transcript themes and excerpts and recording summaries. Interview transcripts were given a label such as 'Mother #1'. Excerpts were labeled in the same way.

Trustworthiness

Rigor has been an important yet disputed area of concern in qualitative research. While some investigators have advocated the adoption of positivist criteria, others have rejected these criteria in attempts to redefine such concepts as validity from an interpretivist point of view (Angen, 2000). Criteria for methodological rigor have been set forth by several authors including Packer & Addison (1989) and Guba & Lincoln (1989), and have often been used in qualitative studies to enhance trustworthiness.

Packer & Addison (1989) emphasize the interpretive process of uncovering as being the location for evaluation. They state, "Interpretation is the working out of possibilities that have become apparent in a preliminary, dim understanding of events…" and, as such, "…are not undisciplined guesses and do not shoot beyond the evidence in a speculative way" (p. 277). A good interpretation is one that has instead answered the practical concerns that originally motivated the inquiry. Packer and Addison offer four approaches to evaluating interpretive research, discussed below. Suggestions from other authors are incorporated.

Coherence. Coherence refers to the plausibility or intelligibility of the interpretations. A plausible coherent interpretation should incorporate strategies to

consider both confirming and disconfirming evidence. Steps must be taken to ensure careful and attentive data collection and analysis to produce what Munhall calls the "unaltered faithful telling of experiences by people" (1994, p. 84). Prolonged engagement, one such step, implies immersing oneself in the data gathering process in a way that allows for in-depth exploration of the phenomenon within its context (Guba & Lincoln, 1989). Rapport with participants is enhanced by prolonged engagement. Because the phenomenologic approach requires one or more in-depth interviews, prolonged engagement takes on a different quality than that of methods involving longer-term contact, such as ethnography. In this study, engagement started with the first telephone contact with the parent or adolescent and included explanations, assurance of confidentiality, and proper phenomenologic technique. Phenomenological interviews are designed to be in-depth and as long as necessary for the participants to describe their experiences. The investigator respected the participants' views and closely attended to their responses in order to encourage in-depth sharing and good rapport. The presentation of the self as socially desirable is a concern, especially with adolescents. However as participants become more comfortable in the interview, the social desirability issue becomes less problematic (Brink, 1991). In this study as in preliminary work, the investigator found that adolescents relaxed quickly, becoming frank and open about their experiences (Farmer, 2002).

Progressive subjectivity. This term refers to the depth to which the researcher is involved in the phenomenon of interest and can recognize her or his thoughts and opinions versus those of the study participants (Guba & Lincoln, 1989). Researchers

need to balance subjectivity with awareness of personal opinions and suppositions, such that careful creativity combined with privileging the participants' experiences in the interpretation of meanings is possible. For this study, the investigator recorded opinions on depression and philosophical views before data collection began and periodically reviewed them throughout the data analysis process. Adherence to the data analytic steps was carried out and the data gradually shaped into the final interpretations without veering into groundless conclusions. The investigator maintained a careful audit process that documented: 1) the investigator's shifts in conceptualizations, beliefs, opinions about the phenomenon, 2) the accuracy of the transcriptions from audiotapes, and 3) the use of steps for data analysis. Readers need enough information to be able to follow the investigator's decision-making logic, to judge the worth of the arguments, and to arrive at similar conclusions to the investigator (Angen, 2000; Guba & Lincoln). Angen and Munhall (1994) stress the importance of coherence and comprehensibility of the results. Others must be able to make sense of the results in order to judge trustworthiness and to ultimately achieve an 'aha' experience. The investigator worked with the dissertation committee to establish a process of audits and debriefings (Guba & Lincoln).

External evidence. External evidence is the seeking of outside confirmation that the interpretation indeed corresponds to that of the individuals who provided it (Packer & Addison, 1989). Performing member checks is the process of returning to those who provided interviews with in order to seek feedback on evolving interpretations or to receive confirmation on the final product (Guba & Lincoln, 1989: Packer & Addison). Holding the belief that the investigator's interpretations need to be compared with the

'truth' as presented by participants presents troublesome issues for the investigator. For example, participants described experiences with a psychiatric disorder that, by definition, has cognitive and emotional components that shift with recovery. Both adults and adolescents may have shifted their perspectives as the disorder has waxed and waned, so that the interpretations based on data from an earlier time may not fit current thinking or may not be recalled (Angen, 2000; Packer & Addison). Additionally, participants may attempt to validate their own views in the final product, as opposed to providing thoughtful feedback to the investigator (Appleton & King, 1997). Appleton and King suggest seeking out nonparticipants who are at similar points in their experiences of the phenomenon to those of the original interviewees as well as doing member checks. Participants may be useful in correcting errors, getting additional information, and providing opinions whereas nonparticipants may be more valuable in validating interpretations (Appleton & King). For this study, the investigator sought feedback from nonparticipants with personal experiences similar to those of the participants, as well as experts, such as therapists.

Consensus. According to Packer and Addison (1989), consensus refers to interpretations that make sense to others as well as being communicable. Others should be able to see that the interpretation follows from the data. One useful process was peer debriefing, the investigator's engagement with non-involved colleagues for the purpose of elucidating bias and for the opportunity to dialogue about tentative interpretations of the data. The investigator communicated with committee members by e-mail, telephone, and in person. Packer and Addison, and Angen (2000) caution that colleagues will not

have the same level of involvement in the data as the investigator, and therefore may have alternative interpretations. However this was not the experience of this investigator. Sharing the de-identified data formally in a poster session and informally in discussion with colleagues resulted in clarification of interpretations.

Practical implications. Packer & Addison (1989) state that interpretations can be evaluated on their degree of use in the context of the original concern, their assistance in understanding a phenomenon, their emancipation of participants, and their implications for practice. Research in human health needs to be useful, paving the way for practical answers to health concerns. The investigator must faithfully provide a construction that awakens understanding and creative thought in readers, empowering them to take action to improve the lot of those who suffer, what Angen (2000) calls generative promise. Therefore the onus is on the researcher to make visible those whose voices need to be heard, to "…provide as complete a data base as humanly possible…" so that others may have enough information to apply the results as they see fit (Guba & Lincoln, 1989, p. 242). Johnson (1997) states that in phenomenology the researcher needs to open new possibilities that move the reader to understand the phenomenon more fully. To answer these challenges, the investigator obtained thick descriptions and Chapter 4 contains liberal use of quotes such that readers may judge the usefulness of the results (Guba & Lincoln).

Additional criteria. Guba and Lincoln (1989) and Angen (2000) provide additional criteria for qualitative research. Angen refers to ethical validation criteria while Guba & Lincoln provide intrinsic criteria. Beneficence (Angen) and fairness

(Guba & Lincoln) refer to care for the human condition and the respect for all voices in the research process. Ray (1994) states that credibility is circular: starting with the interviewees, going through the researcher, and returning to the readers so that all may understand the experience. In essence, the researcher needs to combine respect, beneficence, and ethical standards with an adherence to methodological soundness. The investigator endeavored to present an interpretation worthy of these criteria that can potentially improve the care for families with depressed adolescents.

Summary of Chapter

Chapter 3 has included the methods for the proposed study. Questions 1 and 2 used a phenomenologic method based on Husserlian and interpretive traditions, and compared parent and adolescent experiences. Question 2 involved using parent and adolescent interpretations to explore convergent and divergent themes in an attempt to better understand how the parent experiences contribute to the adolescents' context.

CHAPTER FOUR

Presentation of Findings

This chapter will discuss the findings of the study as organized by research question. Profiles of the participants are provided first, followed by adolescent interview results, and finally parent contextual results.

Profiles of the Participants

In order to understand the lifeworld of the participants, the interviews were conducted simultaneously with observations of vocal intonations, gestures, and the activities going on around the participants in their settings. A brief set of profiles is included below in order to provide background for the interview results. Pseudonyms are used for all participants and any individuals named in the interviews. Alphabetical pairs of names were used for organizational purposes.

Dyad 1

Alex is a 15-year-old Caucasian male who lives with his 31-year-old divorced mother, Allison. At the time of the first interview Allison and Alex were living in a small but tidy urban apartment. By the second meeting, they had lost the apartment due to financial difficulties and were living temporarily in the small crowded home of her stepfather and his extended family. Alex's father is not involved in parenting.

Alex was dressed casually for his interview and appeared younger than his stated age. In addition to major depression, he was receiving care for attentional and learning disorders and is in a self-contained special educational classroom at a local school. He appeared distressed and angry at times during the interview. Eye contact was poor.

Allison works as a bus driver but has been on a medical leave due to a variety of health problems. She was well-groomed and dressed casually in a sweatsuit, but appeared drowsy for her interview, which she stated was due to her medication regimen and her diagnosis of depression. Speech was somewhat slow and she appeared to have difficulty attending to some of the questions. However, she was cooperative and appeared to be concerned about her son's well-being.

Dyad 2

Beto is a 16-year-old male living with his mother, Barbara, a Caucasian, divorced mother of three children who is employed in an administrative capacity in a healthcare related business. She and Beto, her 16-year-old middle son, live in a small rural community. Beto's older sister had left home to attend a university while Beto's younger brother still lived with him and their mother. Although Barbara and her ex-husband shared custody of the children, Beto had been living almost solely with his mother for the past year. Beto's father is of Mexican-American descent and Beto self-identifies as "Mexican". Beto was between his sophomore and junior years of high school at the time of the interview and was working part-time.

At the time of the interviews, Beto had been receiving medication and psychotherapy for approximately five months and was experiencing improvement in mood and daily functioning. Both Barbara and Beto were dressed casually for their interviews. Both appeared comfortable discussing their experiences and were insightful and articulate.

Modified Dyad 3

Carla was an 18-year-old Mexican-American female who had just graduated from high school at the time of her interview. She had just left her father's home after an argument, having lived with him and a half-brother for two years, and was temporarily staying at the home of her maternal grandparents. Carla's father is a member of a large prominent and wealthy family in the urban area where she lives but she stated that the family never accepted her as a member.

Carla was interviewed after work on a secluded restaurant patio. She was dressed in casual business clothes, was well-groomed, made good eye contact, and was animated and articulate. Because of the recent relational difficulties and reports by both Carla and her therapist regarding the father's alcohol use and angry outbursts, this researcher did not interview him. Carla was able to complete high school with honors, obtain a full scholarship to college, and work part-time while recovering.

Dyad 4

Dan, aged 17, was the youngest child of Denise, a 50-year-old Caucasian, divorced mother of three. Dan and his sister lived at home with their mother but visited their father on weekends. Dan had a history of attentional and learning disorders and, although reportedly academically gifted, had struggled with school since his elementary years. A series of charter schools had not rendered improvement. According to Denise, all three of her children had suffered from depressive symptoms in their teen years. Denise was employed part-time as a surgical nurse and in a sales position for medical

equipment. She was also completing courses toward a master's degree at a local university.

At the time of the interviews, Dan was home again, working with a tutoring service, had just obtained a driver's license, and was continuing with psychotherapy locally. Denise and Dan were both interviewed in their home in an affluent suburban neighborhood. Both were dressed casually and made appropriate eye contact. Denise was very articulate, knowledgeable, and open, needing little in the way of prompts. Dan exhibited a slightly cynical and humorous style of communicating but was insightful and open.

At the time of the interviews, Dan was home again, working with a tutoring service, had just obtained a driver's license, and was continuing with psychotherapy locally. Denise and Dan were both interviewed in their home in an affluent suburban neighborhood. Both were dressed casually and made appropriate eye contact. Denise was very articulate, knowledgeable, and open, needing little in the way of prompts. Dan exhibited a slightly cynical and humorous style of communicating but was insightful and open.

Dyad 5

Eva is an 18-year-old Mexican-American female who had begun her senior year of high school at the time of the interviews. Eva had a history of depression (possibly bipolar), substance use, and police arrests. Eliana, her mother, was a 37-year-old married health office employee at a nearby school. Eva's father and a 6-year-old sister also lived in the home, located in a mobile home park in a rural setting, which Eliana claimed was a

"meth neighborhood". However, their home was well-kept and was located next to Eliana's parents' home.

At the time of the interviews Eva and Eliana reportedly maintained a guarded relationship with one another. Eva had discontinued her medication four months earlier and felt "fine." She was committed to finishing her senior year and was reportedly using alcohol only intermittently. She self-identifies as lesbian but continues the process of discovering how this impacts her self-concept. Eliana remained very concerned about her daughter's well being and her possible sexual preferences. Eva was dressed casually in black and wearing facial piercings for her interview. Eliana was also casually dressed and well groomed. Both made appropriate eye contact and were open and articulate. Eliana was openly tearful during her interview.

Dyad 6

Felicia was a 16-year-old Caucasian female currently attending a self-paced charter school. She is the second child of Fran, a married mother of four children who works in a therapeutic horseback riding business. Felicia has a long history of difficulty with an attention disorder and mood dysregulation. Although Fran states that Felicia has been diagnosed with bipolar disorder, Felicia claims to have "always felt down." Felicia has been involved in counseling and has taken medications for the past two years.

Fran reported that her four children have each struggled with behavioral disorders including attention deficit disorder, depression, and bipolar disorder. The most severe problems have occurred with the youngest, a 12-year-old girl, who has been hospitalized for suicidal ideation in the past. Felicia, by comparison, is thought to be "easy".

Felicia's most significant issues are with social skills. Both Fran and Felicia state that family relationships are generally warm and close. Both described the importance of their religious beliefs in remaining strong. The family lives in a middle-class, suburban neighborhood.

The interviews took place at home. Felicia exhibited a dramatic style of dress, wearing black clothes and anime' jewelry (based on Japanese animation), while Fran was dressed casually. Both Fran and Felicia made appropriate eye contact and were very open, articulate, and knowledgeable.

Results of Research Question 1: What Are the Meanings and Experiences of Being Parented?

In analysis of the interviews with adolescent participants, the essential pattern was that of *Dysphoric Tension Between Moving Away and Moving Toward.* Although normal development does involve the process of forging new relationships with parents, the scope and magnitude of the relational issues seemed larger for depressed adolescents. Therefore the term 'dysphoric' was included, meaning a state of irritable, anxious unhappiness. Moving away, or disconnecting could be global or specific to certain issues.

Two major themes emerged from the data: 1) Feeling devalued within the relationship, and 2) Renegotiating the relationship. Each contained several specific theme clusters within. Although a temporal relationship could be assumed for some participants, the researcher felt that the participants lived each of these themes simultaneously. Emphasis may have been greater in one theme than another for a given

participant. Some specific relational issues fell into one theme more so than the other. For example, one participant discussed more openness with her mother on school issues but little on issues of substance use and intimate relationships. Each theme is discussed below, with excerpts from adolescent interviews presented to illustrate each theme.

Theme 1: Feeling Devalued Within the Relationship.

Feeling devalued encompassed feelings of loss of importance in the lives of others either through intentional or unintentional events. This theme was suggested by the sub-themes of *Mourning Lost Connections, Escaping from Pain, Shame of Failing Self and Others, Holding Together during Uncertainty of Parental Support and Care,* and *Anger Over Injustice.*

Mourning lost connections. All adolescent participants had experienced losses of contact with personally important individuals in their lives. In some cases, losses involved parents themselves. Approximately three years prior to the interview, Dan's mother, Denise, abruptly left her husband and three children after years of being unhappy in her marriage. Denise likened it to "putting on my oxygen mask first" so that she could then end the marriage and return to her parenting role. Shortly thereafter, the oldest son moved out and Dan's sister left to live with Denise, who had moved in with a male companion. Dan and his father were the only family members left.

> Dan: Like, she [Mother] just walked, never good. And she did. It was like, three months later because she tried to take it as temporary. I'm like, "Are you going to move in again?" and she says, "I don't think so". I said, "All right. Any particular reason why you left in the first place?" It

> wasn't until a lot later, like this last year, I guess, that I really learned, you know, why.

Some losses were due to death, divorce, romantic breakups, and parental behaviors the adolescents perceived to be unsupportive or uncaring. Yet the adolescents played roles in isolating themselves from others, including parents, as represented below in *Escaping from pain.* Some took active measures to mentally escape their situations. Losses of others in the lives of the adolescents, however, seemed to impact the day-to-day interactions with parents, for example, boyfriends, girlfriends, and members of the extended family. As the teen tried to cope with losses, behaviors emerged that became the source of friction.

> Felicia: And then I had two friends that were guys and one that was sort of kind of a friend and the rest liked to pick on me. I couldn't stand up for myself, cause I've always been picked on since whenever. Anyways, I stopped going to school and that's why I didn't pass, because I didn't want to go, because I just hated it.

Barbara and Beto shared a complicated history that was pertinent to Beto's onset of depression. Barbara and her husband divorced approximately 10 years ago and Barbara engaged in a long-term live-in relationship with a woman. Beto's father lived with a girlfriend for 6 years, who functioned much like a stepmother to Beto and his siblings. When Beto was not at his father's house, he was often with his paternal grandparents and the extended family. Beto reportedly functioned well until a series of personal losses occurred. In short succession, his mother's relationship dissolved, his

sister left for college, his father's girlfriend moved out, and his paternal grandfather, his "Tata", was diagnosed with terminal cancer. Beto's father began using alcohol and reportedly came to rely on Beto for emotional support. Beto moved in full-time with his mother. His school performance declined, he began using illicit substances, and he voiced a desire to kill himself. Cutting his wrist was the event that brought him into psychiatric care.

> Beto: I was trying to stay strong, I was just trying to hold up everything. Just trying to, like, keeping my brother all right, and my dad… I think about six months. That was horrible. My step mom leaving. Just for months. For about six months. It was just miserable. I was just trying to hold on.

A parent who did not live up to the image of what the adolescent expected was also interpreted as a loss. Until age 16, Carla had lived with her mother and two half-sisters. Carla's father had left the family early in her life and she had no contact with him other than occasional gifts and phone calls. As Carla entered her teen years, her relationship with her mother deteriorated and she went to live with her father. Neither was reportedly prepared for this arrangement and Carla's two years with him were contentious. During Carla's senior year at school, a rejection by a boyfriend compounded her grief and she exhibited signs and symptoms of depression.

> Carla: I wish it would have been different in some ways, I just don't see how that would have been possible. I wish we connected more as a family and did more family things. Cause then on the weekends, when

> weekends would come around, he [Father] had his own like business thing, so he would be other cities in Arizona doing appraisals and such. So he wouldn't even be in town.

Escaping from pain. In addition to losses, adolescents themselves played a role in distancing themselves from others, including their parents. In some cases adolescents appeared to be creating space for themselves as a respite from their parents.

> Felicia: I think the biggest issue is, with my parents, is that I stay in my room most of the time. My room is my little hole. In there I can immerse myself, myself in other things to keep myself distracted from the real world. And that's, I guess, my coping technique.

Another example of escape is that of deliberately setting limits with parents to avoid interactions. During her high school years, Eva became emotionally distant from her family and Eliana suspected use of alcohol and illicit substances. Eva refused to comply with substance abuse treatment and both Eva and Eliana reported that their relationship became very hostile. Eva became involved in an intimate relationship with a female classmate but due to shame, kept the nature of the relationship secret.

> Eva: Like I said when you're angry, you say, "Get away from me. I don't want you, I don't need you right now. With all my family issues, leave me alone, don't try to help me. I just need to be away, I don't need to be here." That just develops a hate for them, and I was like, they don't understand you. The more and more I tell them, the more and more they grab on to you. They don't understand you.

Illicit substances and alcohol use were used by two participants in an effort to numb or escape from painful realities:

> Eva: There was a lot of fighting, not physical, but a lot of yelling, a lot of hate. It was tough. Especially when you get to that point too with your parents, you know home is your comfort zone, and you can't be comfortable at home if it leads you to look for other ways out, other escapes. That led me to alcohol and drugs. I think I could have gotten better a lot faster or I could have not gotten to the point I've gotten in if it wasn't so difficult. If it wasn't for the parents, and then alcohol involvement, just stopped caring.

Dan attempted to bury his grief deep within and distract himself through sleeping or playing online computer games.

> Dan: Numbing it out. Is what I used the term for. Numbing everything out. Completely numb. Yeah, I think it can happen to me. Big impact. To a certain extent, yes. I think I had that. But, I never at one point had no feeling at all. It just didn't feel like that. It just felt like I didn't want to have feelings. Kind of, rather than not having any at all. I think it could have escalated to that completely, but it never got to a point of suicide attempt or anything like that. I think it was lucky.

In sum, adolescents sought to lessen pain by means available to them. Computer activities and illicit substances could serve the same purpose of providing a refuge and relief from emotional pain.

Shame of failing self and others. The participants were frequently aware that they were behaving in ways that were not congruent with what their parents expected or what they expected of themselves. Several expressed guilt or remorse for their activities, setting up a cycle of increasing emotional pain necessitating increased desire to escape. Beto felt guilty about hiding his illicit drug activities from his mother.

> Beto: I don't know why I started to stress you know and to see my mom worrying about me as much as she did. So I felt bad about that, because I thought I was messing up everybody's lives. My mom was really sad. I thought she was more depressed than I was, just watching me. I didn't know what to do. I thought everything everybody felt was because of me, because I was not right… I would feel better to make everybody else feel better. Just put me down.

The symptoms of depression were also a source of guilt as well.

> Felicia: She'll, like, start crying and then she'll go to her room. But all the stress… It makes me feel horrible. I try to be helpful around the house, I try to be good, I try to not fight with my siblings. And it's hard. Especially when I'm in one of my down moods and I just want them to leave me alone.

Holding together during uncertainty of parental support and care. Participants felt that they were in some way not important to their parents, that their needs or wants were peripheral in their parents' minds. At one extreme were statements that indicated that basic needs were not being met.

Carla: There was really no need for like cooking dinner or part of all that, so the fridge was cruddy and it didn't have very much food in it. So I pretty much provided myself with meals and then towards the end he didn't really like, in the beginning he bought me like all my hygienic stuff, like shampoo and all that. And then once I got the job and I started like making money, then he expected me to buy my own stuff. If ever I didn't have it and I would ask him for it, he would be like, okay how much is this gonna cost me?

Beto: Going through that bad time, I was with my stepmom, my dad used to come home drunk every night. Crying. I had never seen my dad cry before. He used to cry all the time. Blame me for a lot of things. You know when you get drunk, you get drunk. It was just harder and harder on me. I was trying to stay strong, I was just trying to hold up everything.

For other participants, this theme was evident in statements that indicated less attention from parents than they would have liked. Situations such as jobs, divorces, or illness kept parents from attending to their children as much as the adolescents would have wished. One example came from Alex, whose mother worked long hours while struggling wih her own medical and psychiatric illnesses. Alex appeared to feel secondary in his mother's life:

Alex: I'm really only with my mom on Saturdays and Sundays and that's it. I have more time to spend with my grammy and grandpa because she

> has to work. That's the only time I get to see her. But we haven't been going any anywhere or nothing.

Dan's father became depressed and mourned openly after Denise had left the family, reportedly relying on Dan for emotional support. Dan's school attendance dropped, he began staying up all night and sleeping all day, and was visibly depressed when he visited his mother. Despite Denise's efforts to encourage Dan and his father to get psychotherapy, Dan's father did not make appointments. A diagnosis of prostate cancer plunged Dan's father into deeper depression and Dan was "not functioning at all" when Denise picked him up for a visit.

> Dan: [discussing visits from with his mother, who had left the family] "Mom, can we do something after?" I don't want to go to that restaurant every time, just say good-bye afterwards. "Mom, can we see a movie afterwards? Can we do something afterwards?" No, no, no. and it was always no. I kind of grew a little angry after that. "Mom, you ignore me on weekends, you ignored me for a certain purpose of something else, I don't know."

After Carla's breakup with her boyfriend and onset of depressive symptoms, her father was supportive in finding a therapist but would only pay for five visits. The therapist agreed to see Carla at no cost after that but her narrative indicates that she tries to rationalize her father's limited support.

> Carla: He [father] was usually fine, unless he was depressed about something. He does have his own moods and feelings, he was sad. But I would say he was like 35% of the time, he was irritable and angry, and most of the time he was pretty okay. He just kind of did his own thing. When we all kind of lived our own lives and just met up at home in the evenings to go to bed.

These excerpts illustrate how the adolescents began to consider their parents as unreliable emotionally. Yet these youths continued maintain a hope or belief that better connections were possible.

Participants also spoke about situations where they knew that their parents did not approve of their choices in everyday matters such as clothing or friends. While some statements reflected differences in personal preferences, others indicated that the adolescent felt hurt or insulted by a lack of broader understanding on the part of a parent. Although, highly intelligent, Felicia has had few close friends and has experienced teasing and ostracizing in school settings. She herself stated that she has unique interests and does not enjoy the company of her peers. However rejection remains painful and has resulted in poor school attendance and several changes in schools. She spends much of her free time online in chat rooms. Yet Felicia feels hurt by her mother's comments on her dramatic clothing choices.

> Felicia: Then she says, maybe you should dress nicer or something or wear something in style or whatever, but she doesn't really understand that when you do that they just think that you're trying to fit in and they

> make fun of you more. Another thing she doesn't understand is I like dressing how I dress, it's comfortable and for sixteen years I've been raised around boys so I don't really do the girly thing.

Anger over injustice. The participants felt powerless in decision-making processes with their parents on a number of issues. Parents' reactions to symptoms of depression often included limitations on privileges previously enjoyed. While some conflicts involved common activities like haircuts or clothing choices, other conflicts arose from treatment decisions parents had made. Anger was apparent in many of the discussions of these issues. A few months prior to the interviews Denise and Dan's therapist felt that Dan was not making significant progress in therapy. Inpatient residential treatment was selected as the best option for Dan. He felt angry but he complied.

> Dan: It was like it was about third or fourth month here to March, April, I don't remember, went up on May 5th, a little before that, maybe a week or so before it was put into play, really. At the time we seemed to be getting better with outpatient with [psychologist]. But it still didn't seem to be going much anywhere. And this is the kind of thing for me to get back on track before next year at school. Like, "Mom, this is not right, this is not right." "What else are we going to do? What else are we going to do now?" [mom asks]. I just drew a blank, I'm like, hey, if I'm joining up and I didn't have any other better suggestions. Even when I went up there I'm like, "Mom this is too, too extreme, way too extreme." We're talking

about people who been on meth, haven't had a day sober in their life for four years, like try to stab their parents, kind of thing. It was a little much!

Even though Dan eventually came to value some of the skills he learned in residential treatment, anger toward his mother regarding her decision to send him there was obvious during his interview: "I hated it and family values haven't changed about that now for now."

Carla remained perplexed and angry about her father's methods of disciplining her.

> Carla: If he disagreed with me going somewhere, doing something, he would take my phone. Which seems kind of like little, but, your phone is like, you kind of have to have a phone if you get into trouble, whatever. It's your communication with the world. So I would just get really upset and I'm like, "This is like retarded."

The sense of injustice was illustrated by one participant's feelings that her parents had actually contributed to the worsening of her depressive symptoms. After Eva's parents discovered her alcohol and drug use, they refused her requests to go out with friends. Eva saw this as not listening to her expression for a need for more freedom.

> Eva: I don't think parents even know how to help their kids. They're not going to listen to you because they fear your voices. Nothing really at that point when you're in that condition. When you're not doing a good job of taking care of yourself right now so what makes you think I'm going to listen to your advise? So yeah, "Just listen to me." I was screaming for

them to listen to me. They don't want to have it. So yeah, I blame them for not helping me get better faster.

To summarize, Theme 1 was drawn from participants' statements of feeling disconnected from parents, from losses of significant connections, from descriptions of shame, anger, and uncertainty, and injustice. A global feeling of being devalued was thought to be supported by these findings.

Theme 2 Renegotiating a Relationship

The second general grouping of interview data includes statements that indicated a changing of the adolescent perspective on the relationship with a parent. While disconnection appeared to characterize the first grouping of data, a movement toward reconnection characterizes the statements and behaviors of the teens in these data. This theme is supported by the sub-themes of *Awareness of Reaching a Crossroads, Opening the Self to Nurturance, Constructing New Ways of 'Being' Together, Recognizing the Human Imperfection of Parents, and Grateful fo Centrality in Parents' Lives.*

Awareness of reaching a crossroads. Most participants described an event or a period of time where a sense of discomfort with themselves and their behaviors arose. The dissonance of their current lifeworld with the lifeworld in which they wished to exist became apparent. This revelation became a turning point or points from which they began moving toward more harmonious interactions with parents.

Beto describes an event that triggered his awareness of self-destructive behaviors and finally provoked opening up to his mother:

> Beto: I was dating this one girl for about two years and she started getting into drugs. And what happened was I got so upset 'cause that was what I was doing. I didn't want her to do it and I got so mad where I started hurting myself over it. Cutting, and hurting myself. One day I got really messed up on drugs and I was really mad at her. I hurt myself and I didn't realize how bad. Two of my friends looked at me and said, "you need to go to a hospital. Check it out." That's when my mom started finding out. I went to the emergency room. I asked if I needed stitches and they said, "yeah, you'll probably need stitches". So I said "no", I wanted to go so I could find my mom. So that's when my mom found out what was really going on.

At this point, Beto was living the life of and drug dealer and user. He was painfully able to recognize himself in the behaviors of a girlfriend with her self-destructive behaviors and sense of hopelessness. His cutting behavior, although done to deal with pain, was the event that enabled communication with his mother and obtaining help. Beto ceased contact with his drug-related connections.

Another example is Eva's description of losing her intimate partner. Like Beto, Eva's turning point initiated more open communication and self-awareness:

> So then, the other turning point would have had to have been, I lost my girlfriend and, because she knew she couldn't put up with it any more. So she said she couldn't deal with it anymore… It's time to give up, you know. So that was my second turning point, that was my main one. That

made me stop drinking. I'm not drinking until I'm okay. Until I know I can handle it…. I guess getting out of a relationship, you have more time to focus on you, because any relationship, you're worried about making each other happy. When you get out of that you have so much time to like focus on yourself. You're valuable too.

Opening the self to nurturance. Awareness of their circumstances prompted another crucial event for the adolescents, opening themselves to help from others. Parents, relatives, friends, and counselors served as providers of emotional nurturance as well as providers of instrumental support such as arranging care and teaching skills. When his depression was at its worst, Dan moved out of his father's house and in with his mother, quit school temporarily at the suggestion of the therapist, and experienced partial symptomatic improvement.

Dan: Yeah, I guess that's when my depression was at the worse, panic kind of, sort of. I was there, nothing to help me, and I was doing bad in school, and didn't go back that year. I just couldn't get myself out of bed, kind of thing. Mom was like, "Nope, we can't do this anymore. Get your butt up and come live with me." I don't even know what my reaction was, "Okay". It didn't seem to be too big of an issue.

Although Dan was too ill at this point to take an active role in seeking help, he was open to his mother's ministrations. His anger was not in evidence at this time, and he accepted nurturance.

When her girlfriend wanted to end their relationship, Eva ingested an entire wholesale-sized bottle of acetominephen and was discovered by her mother a few hours later. Eva spent two days in a medical intensive care unit and began outpatient psychotherapy and medication. Looking back on this episode, Eva realized the value of nurturance in the form of counseling. Counseling served as the bridge to enhanced closeness with her family.

> Eva: I have never really been able to look back, like step out of my world and see what's going on around me. I was never able to do that. I realize that now after counseling. Like, counseling really helps. They really do, like they're very, very quick on everything. This is what I see going on. And it was like… Especially if you do, like family sessions. Not when we were all together, cause that's really hard to do at first, like they talk to your family, giving them messages, "Well this is how your mom feels." That helped a lot.

Even if the parent was not the primary confidante, opening relationships with others enhanced the relationship with parents.

> Beto: And what mostly brought it out was I met this one kid, who was older, who was almost my sister's age and he considered me as a little brother and started looking out for me at the same time my Tata passed away. I admired him; he was like my big brother. Always wanted to do was the same thing he did. He kept me out of a lot of trouble.

In this example, as in the others, allowing the self to be open to guidance and nurturance became a crucial step on the way to moving closer to parents.

Constructing new ways of 'being' together. As depression lessened and skills increased, interactions with parents and others shifted in nature.

> Dan: I realized that I'm going to have to use this radical acceptance; I can't use it in everything, like <u>every</u> <u>thing</u>. But you just kind of have to lay in peace and you can do something in the situation. There's nothing that I can say, because I tried. So I just let it lie and let it run its course and I learned that's an expense, that's patience to an extent, I could never believe that I have.

> Alex: We yell back and forth. Don't talk to each other. But not really a big deal. All kinds of stuff. But it's OK. We apologize to each other. It's OK.

Rather than continue where pre-depression relationships left off, the adolescents felt as if the relationships were qualitatively different. This did not imply that the relationship was free of discord or even remained intact - disagreements were acknowledged- but rather that communication with parents was a thoughtful, constructed process. In addition, adolescents began to see their parents in more realistic terms, as a mix of strengths and weaknesses.

Recognizing the human imperfection of parents. When depression symptoms were more severe, the participants tended to speak of their parents in more negative terms or they were not able to consider parents as experiencing a range of emotions and

qualities. As depression symptoms abated, relationships improved, and self-awareness increased, the adolescents could see the humanness of their parents, the combination of more or less acceptable traits as opposed to a concrete black and white views.

> Carla: And that happened to be when my graduation happened. So, he showed up for it and then he said, congratulations and gave me a hug, but you know he then like, not that it mattered but, there was no card or anything with congratulations. And he knew how hard I had worked to get what I had gotten. It just like, I don't know, like I don't expect things from people, but I just thought, I'm graduating and you know how much this meant to me. Just recently on Monday he took me shopping and he was like, yeah this is your late graduation gift. We just kind of hung out and had dinner and that was probably the closest we had actually been since it happened... He does have the other side of him that's caring and thoughtful.

Some participants also voiced better understanding of difficulties in the relationships between parents.

> Dan: So when I was going more into the youth thing [residential treatment] and I was up there, it was really hard between those two. Like it wasn't such a good idea, my dad's. And my mom thinking it was a great idea, kind of like, back and forth. Not till I really got back that I really saw, these two are really at ends. These conversations, they weren't too real. Like they're there agreeing and things, at that place, they weren't too

real. Yeah, when I got back like the first night, oh my god, you guys have got to be kidding me!

Dan had not realized the extent of the problems between his parents until his depression had improved enough for family sessions. His earlier discussions had focused more on the possibility that he himself had caused his mother to leave the family. Now he could see the unsuitability of his parents for one another.

These two excerpts illustrate that adolescent 'movement toward' the parent aided an openness to the parent as a human with needs, flaws, and strengths.

Grateful for centrality in parents' lives. As opposed to the feeling of being devalued or insignificant earlier in the depression process, adolescents spoke of feeling more central in parents' day to day lives. Combined with this was gratitude for this position. Some were openly thankful for the interventions of their parents, although not all expressed this level of emotion.

Dan: But, yeah, she's very supportive, I guess. Made a lot of big decisions that hurt her right now. Obviously can tell she did it for me, like when she sent me to [residential treatment] over the summer and she knew it was hard for me. . . But she's still with the decision that it was a good idea and I'm like, I can still respect that even if I don't believe it was. Because I know she did it the one thing, for me. She was willing to dish out as much money as it takes, as much time away from anything else it takes, and that's great. I couldn't ask for anything more.

> Eva: I think one thing that my dad did, that always, even to this day, even when we'd not cuss, even when we just sat, he'd always go to me and hug me, hold me, tell me he really didn't understand what was going on but that he cared and he was there for me.

> Beto: She mainly took me to every counselor's appointment. And then she was there all the way, all the way. More than I thought she really was.

Dan summarized his experience with his mother succinctly: "The ray of light comes into the hole of darkness, thing. It pretty much was that." Although not every adolescent participant felt the level of gratitude that Dan expressed, they appreciated the efforts their parents made and could see that healing, at least in some small way, had been a consideration.

In sum, these two themes, *Feeling Devalued Within the Relationship and Renegotiating the Relationship* support the essential pattern, *Dysphoric Tension Between Moving Away and Moving Toward.* The first theme was supported by narratives that expressed isolation, grief and pain while the second was supported by statements discussing the healing and closeness that occurred as emotions and thoughts were shared.

Results of Question 2 How Do the Meanings and Experiences of Parenting Contribute to the Context of the Lifeworld of the Depressed Adolescent?

The second research question concerned the context that the parents' lifeworld provided for the depressed adolescents. The essential pattern was that of *Tension*

Between Pulling Closer and Letting Go. As parents became aware of the suffering and isolation their children experienced, closeness was actively facilitated by organizing treatment and daily existence. At the same time parents realized that their children were no longer the familiar people of the pre-depression years. Rebuilding closeness was required. In the process, however, parents needed to let go of some of the past patterns of communication and past conceptualizations of their children. Simultaneously, inner growth began as parents reconceptualized themselves. The essential pattern was supported by the themes of *Losing the Familiar, At the Nexus of Action, Composing Life with the Stranger*, and *Crisis Management Within*. The findings are presented as themes of meanings and experiences first. In parentheses a context is named for each theme. These contexts will be discussed farther below as they apply to the environment provided by the parents.

Theme 1 Losing the Familiar (Context of Concern)

Theme 1 involved the events and emotions conveyed in the parent narratives as they realized that their adolescents were not functioning in familiar ways. It was supported by the sub-themes of *Perceiving a Drifting Away* and *The Shock of Sudden Clarity.*

Perceiving a drifting away. Parents described early events that were indicative of a change in the relationship. The changes were not always perceived as depression but as an alteration in the adolescents' way of relating their environments and parents. Parents' emotional responses included confusion and sadness. Some of noted changes involved school performance and personal habits.

Denise: As each year would progress and he wouldn't be able to function that level, he would absorb as much as he could in his own way, but not do the homework, not get the grades and in these schools if you don't get the grades you don't pass the classes. So they put him in the gifted classes that he tested into and he kept dumbing down each semester. This wasn't very good at all for this kid…One of the issues that was very disconcerting, that we had seen before, was that he would stay up all night on the computer doing online gaming. It wasn't that it was terrible violent, it was that it was at the exclusion of all else. And in fact I think it was the trigger, because I really spoke seriously with his dad, some anger about taking over.

Changes in personal relationships outside of family were also disconcerting to parents:

Eliana: I knew that there was something going on and I could tell that it was because of a relationship. I questioned her; I've always been real open with her since she was a little girl. And that's when I knew that there was really something going on because she was shutting me out of her life. She didn't want to talk to me; she didn't want to be close to me any more. I really, like, I was a stranger. So when we started out asking her questions and, my husband and I, trying to get her to open up to us, she would get very angry, very hostile.

Parents were also very aware that losses in the adolescents' lives had personal impact, including grief. Denise knew that Dan's father was depressed and dealing with a diagnosis of prostate cancer, thus impacting Dan's emotional functioning. Barbara also could list a number of losses in her son's life:

> Barbara: You know, he'd been having issues with school, he'd been having an issue with his grandfather had been diagnosed with cancer over the holidays and his dad and his dad's significant other had been a big part of the kid's life for the last five years. They had split up that summer. [Sister] had left to go to college and there were all these changes and losses and apparently this thing with his dad really really affected him. Unfortunately his father had a really difficult time with it and he kinda of unburden himself with his sixteen year old son instead of maybe talking to another adult or what ever. Really Beto came away from that whole thing feeling like it was all his fault, that the whole thing had happened. So he'd had such a hard year and then this.

Yet parental narratives at this point, do not indicate knowledge that intervention was necessary. Serious behavioral changes put the level of adolescent grief and depression into perspective.

The shock of sudden clarity. Parents discussed moments when the declining function they were watching suddenly made sense to them, as if pieces of a puzzle suddenly came together two reveal the larger picture. Some narratives were filled with

the small details that come with a shocking moment, in this case when there was no doubt that their children were ill.

> Eliana: I got the bottle and I looked at it and it was empty, totally empty. I said, "You drank the whole bottle?" She said, "Yeah, I drank the whole bottle"…. So I just automatically got here, picked up the telephone book, called Poison Control and told them what happened. And they asked if she was vomiting and I said, "Yeah." "For how long?" And I told them. They said, "Well, she's vomiting she should be okay but she needs medical care immediately. You're going to promise me that you're gonna take her to emergency room right now." So that's what we did, we took her straight to the ER and right away they admitted her. They started giving her the Mucomyst and she was admitted, I believe it was two days. That's when we just kept talking to her and then she told us that she wanted to end her life. She just couldn't take it anymore, that she just wanted to die. And we're like, why? Why are you feeling this way? I don't understand. And she was like, 'I just don't feel like living.' And that's when they came in and talked to her and they told us that she was suffering from depression, and that's what happened.

Although Dan had been exhibiting depressed behavior, the extreme severity was not evident to Denise until she saw him in the context of his father's home during what was supposed to be a holiday visit.

> Denise: And when I went to get him on the weekend after Christmas it just seemed things culminated, and he was, "Mom" [very low depressed voice]. Couldn't get up at all. I thought I was going to have to call for intervention, I could not get him up. Finally we got him up that day, but I was pretty panicked. He said, "I'm just not going to get up at all." I was very fearful for the long term and I was really really terrified for short term. I didn't know if he was suicidal. He insisted he wasn't, but it was real frightening to have your child to that…. Being in the position of not functioning at all.

Although tragic, these events were key in clarifying the need for treatment. Parents could no longer minimize the emotional suffering their children were living. Parents were propelled into proactivity.

Theme 2 At the Nexus of Action (Context of Action)

Once faced with a serious illness, the parents in this study proceeded to take action. This theme discusses narratives that described the many tasks the parents took on, from case manager duties to monitoring the other family members. The parents who participated in the interviews seemed to take on a large portion of the activities, with the non-participant parents either absent from the home or seemingly not as active. This theme is supported by the sub-themes of *Managing the Complexity of Care, Adjusting School to Fit the Adolescent's Needs, Feeling Unsupported in the Parent Role, Sharing the Burden with Others*, and *Monitoring the Emotional and Situational Impact on Family*.

Managing the complexity of care. Arranging care for the adolescent was a huge and sometimes daunting responsibility. Unless the teen had been seen in the past for another condition, appointments with psychotherapists and psychiatrists were difficult to obtain. Long waiting lists added to the stress of coping with an ill child.

> Barbara: One of the most frustrating parts was trying to get him to see a doctor. I had to go through health plan, a list of doctors…. I was then extremely more stressed, I was freaking out pretty much. I got to get this kid in for some meds, he's just like doing nothing, he's just barely functioning…. I think what really, really blew me away was that I was talking to the receptionist personally at Dr. L's office. Telling her everything I went through. Thought it might help with the situation, bump him up a little bit. And she said, "Why didn't you admit him to a hospital?" I said, "Well we were in emergency room, and he really wasn't a danger to himself." "You could have had him admitted to [hospital] then you would have had meds immediately prescribed. He wouldn't have to be on this waiting list." I was <u>so</u> angry with that, well you should have done this, kind of thing… I kept calling and kept calling.

Treatment decisions took deliberation and time. Medications were not an immediate fix and a trial and error process was needed.

> Barbara: I also knew that, just getting in and seeing somebody and being prescribed something, that doesn't necessarily mean it's going to work. You've got to go through that, 'lets try this for a while, and see if this is

> working', and it's a long process. And I was just like, oh man. You're frustrated, you want things to be better, because things have gone from what you thought was somewhat normal, to completely …. It was just nothing. It was pretty overwhelming for me personally and emotionally. It was very difficult.

Two parents described especially difficult decisions they made that required weighing the risk of intensifying alienation from their children with increasing chances for better health.

> Denise: I made the decision to go with the psychologist who had suggested residential treatment…. Hindsight, I don't know, anyway, essentially took him up there. Probably the hardest thing I ever did was leaving him there, because he didn't want to stay. His dad wasn't interested in going with me there… He [Dan] had a tremendous amount of anger, extreme. He tried to keep inside as much as he could, but a lot locked up inside. And the thought was, to try and cope with, not only with the separation, which was very painful, but perhaps a lot of what his brother went through.

> Eliana [who had called the police when her daughter was using illicit substances]: I work in the health office, so the ladies in the health office were my friends so that's how she got suspended from school and arrested. So that was kind of another way of her having to get even more help and learning more about drugs. She had to go through some drug counseling.

These excerpts illustrate the intensity of intervention and decision-making with which parents contended. These parents moved beyond instincts to shield their children and instead took risks that could enhance long-term functioning.

Adjusting school to fit the adolescent's needs. For parents, school was an especially salient topic. All parents discussed advocating for and carrying out changes in the school day to better meet the declining academic capabilities that depression had wrought.

> Denise: He could not keep his eyes on the work, his definition of himself. So that was another big problem. Just a lot of hurts and pain. So, I took him out of school. I asked [counselor] for suggestions. She said, "He needs to join life. School can come later."

> Allison: At first I had to fight to get him the handicapped program because he has no visible handicaps but once I fought to get him in, he did real well. He just started soaring.

> Fran: Felicia could not handle the stress of being in the regular classroom… Now she's at [a self-paced school]. And there's less time to be social but I still have a hard time getting her there because if anybody makes a snide remark of anything like that she just doesn't want to go back.

Parents seemed to realize that the images they held of their teens as 'typical' students were no longer realistic. The outcome was to take an active role in designing school contexts that fit the needs of their children.

Feeling unsupported in the parent role. Feeling as if they were alone in struggling through parenting depressed children was a frequent theme in the narratives whatever the marital status of the parent participants. The spectrum of nonsupport ranged from spouses and ex-spouses who appeared to hinder the progress of their children to those who seemed to opt out of an active managerial role. Psychiatric diagnoses in spouses/ex-spouses played a role as well.

> Denise: I don't know, his dad was very, very against his going [to residential treatment] and he was pretty clear in all the sessions. We had therapy sessions, one to two times a week, for an hour to three hours on the phone, Dan, his dad. They were very very painful. His dad was very, very against him going up there and it was very clear in the sessions. He didn't support him being up there, he didn't believe in it.

> Barbara: His dad and his dad's significant other had been a big part of the kid's life for the last five years. They had split up that summer. Unfortunately his father had a really difficult time with it and he kinda of unburdened himself with his 16-year-old son instead of maybe talking to another adult or what ever.

Fran: My husband has always kind of stayed out of it. You know, I don't know if it's that he just doesn't want to face things… My husband and I don't fight over it or what we should do or anything. He stays out of it which is good and bad both, because I'm the sole person involved. And my husband also has a mood disorder you know.

Parents also voiced a broader desire for support within the extended family and community.

Denise: No family support, I don't have family alive. His brother and sister, you know, kind of, they try to be there. His [dad's] family wasn't involved at all… I wish - it might have been easier to talk to parents of kids that had been depressed.

Fran: I think the hardest part is I don't have many people to talk to about it because there really aren't any support groups for our kids. There aren't things for teenagers. Everything would be great if Felicia could meet other people like her that understand the things that she goes through, you know, to be able to see and talk to adults who have it and got through it all and are successful and may have some words of wisdom or something because nothing I can say… They'll say to me, "Mom, you truly do not know or understand". And they're right.

These parents recognized the personal burden of being the sole decision-makers. Furthermore, they could not be the sole 'experts', because they had not been through the experience of severe depression.

Sharing the burden with others. Some narratives did include discussions of the importance and benefits of interacting with others who could be of assistance to the parent and adolescent. Family members, friends, co-workers, and school officials were examples.

> Barbara: Ms. S [the high school counselor], she was awesome… She'd been going through the same thing [with her own child], and she looked at me and said, "You know what…" –it was just so awesome, she said, " I can remember when I just happy that she could get out of bed, and that I know exactly what you're going through." With her there and being able to take my side basically, unless other people have either had somebody depressed or mentally ill in their family or have been around it, or had the experienced it themselves, people don't really know what it's like. Having her there and being able to express that, with the other teachers and the principal, and the other counselor in the room, I just really appreciated that.

Unlike the excerpts in the last sub-theme, this parent's narrative expressed the benefits of connecting with an expert; not for her counseling expertise but for her experiences as a parent.

Monitoring the emotional and situational impact on family. For most participants, the depressed adolescent was not the only child in the home. Parents faced

the fallout that the illness had produced in siblings, including less attention and embarrassing moments.

> Fran: It's hard for her older sister especially because she's always been her older sister. They go to church functions and things like that. She [older sister] sees how people treat Felicia and she just wants to be the silent one, you know. One half wants to rescue Felicia and the other half wants to disappear. "I don't know her." It makes things very difficult for them.
>
> Barbara: He doesn't see his Dad hardly at all and that bothers me and I feel bad… That's uncomfortable because that's especially Dad's side of family, especially the family was involved with that for a long time. Your family and your immediate family, those people you're related to are very, very important in that Mexican-American culture. So with him pushing most of that away, you know…
>
> Fran: It's very stressful dealing with your other kids who think it's unfair that because they think I treat that person like, "If I grew up like that, you would never tolerate that from me.' I say, 'You're right. I wouldn't but you're different and I treat all of you differently and this is the situation and this is how I'm handling it and if you don't like it I'm sorry."

Parents expressed guilt over having to expend so much energy on one child at the expense of others. The tendency for the adolescent to isolate him or herself could be

interpreted as disrespect for the extended family, another shameful situation for the parent. Family therapy, with its perceived implication of flawed family functioning, had the potential for producing shame in the parent as well.

In summary, these sub-themes convey the many ways in which the parent is acting on multiple fronts to create an environment that will best support the adolescent, while trying to manage the needs of the family.

Theme 3 Composing Life With the Stranger (Context of Engaging)

As with any life-changing event, shifts must be made in how one relates to others involved. Depression in the adolescents, with behavioral and relational changes being hallmarks of the disorder, necessitated a new approach on the part of parents. The narrative examples which expressed this theme contain discussions of how parents engaged their children in daily interactions. Pre-depression images needed to be left behind while new connections based on current functioning needed to be forged. The sub-themes that supported this theme included *Painfully Standing Firm, Uncomfortably Watching Aloneness, Assisting Teens in Self-Management, Balancing Expectations with Teen's Fragility, Process of Letting Go*, and *Witnessing Healing*. The tension of pulling the teen closer versus knowing when to set boundaries or let go is evident in many excerpts.

Painfully standing firm. Coping with what parents perceived to be extreme behaviors required setting firm boundaries with teens with consequences for violating rules. Because parents knew their adolescents were suffering, refusing to let them make decisions for themselves brought suffering for both parties. Substance abuse counseling

began after Eliana informed the high school of her daughter's alcohol use, resulting in a police arrest.

> Eliana: …when we went to the psychiatrist he gave us a referral to take her to [substance abuse]. So we could get her and she threw a fit, I mean a screaming fit in the truck and – I guess our choice, we could have called the police, we were contemplating that but it was hard as a parent to do that. It was just so hard even though you knew it was the drugs, and we knew what she was going through. It was so hard for a parent to actually turn in your child, you know, to the police, but we did.

> Denise: Children, they have their down sides too. They get what they want. It's hard to be so responsible for kids at sixteen, that are fighting so hard for their autonomy and yet you have to act like you're five. Some of the behavior is his choosing. It's my responsibility to stand firm. Wish I had all the answers…

> Exemplified here are the conflicted feelings of wanting to be on positive terms with the adolescents yet knowing that firmness in setting boundaries was necessary for better long-term health and safety.

Uncomfortably watching aloneness. Watching isolative or socially incongruent behavior was stressful for parents. Some had made efforts to engage their adolescents but with mixed results, and appeared to be coming to terms with letting the teens initiate conversation when ready.

Fran: She talks very loud, very fast. She focuses on just a few general interests. And so…Therefore it's very hard for her to make friends and then she's very, very sensitive. Kids could maybe tease her in a way that you and I wouldn't find hurtful but she's very hurt and very defensive. So the biggest issue for me with her is one, getting her through school. She does not like to do the work, but the major thing is the social and her not having any friends.

Allison: Sometimes it's hard, he gets in moods, he doesn't want to talk, doesn't want to listen, wants to be by himself. He goes to his bedroom and hides out. It's difficult. He just ignores you. He very seldom will talk to you about it. He just kind of sits there and is off on his own. If you come and ask him, "what's wrong?" he doesn't say anything.

Assisting teens in self-mangement. If possible, parents tried to help their children to understand some of the effects of illness and how to lessen emotional pain.

Barbara: And he very much knows when, you know, I'm wigging out about stuff. No matter how calm I'm trying to be, he knows. He just automatically knows and so he picks up on that and then he feels guilty, he feels like it's all his fault, that this stuff is going on. I keep trying in spite of him. "Beto, let me have my stuff and my feelings, don't own it, it's not yours, it's mine." But he has a hard time about it.

Setting of personal boundaries is evident here in an attempt to prevent excess negative emotion on the part of the adolescent. Barbara was aware that her son was prone to take on the emotional climate around him, and she tried to assist him in learning to armor himself.

> Fran: Maybe I'll give her the cue to talk softly. There's times I have to tell her, you know, "Felicia, stop talking" because maybe it's just, I'm talking to another adult or it's not appropriate or whatever, lots of times it's "Felicia, Felicia", trying to get her out of whatever she's focused on doing or talking about.

Teaching social skills was another way of trying to facilitate engagement with the parent and with the world beyond.

Balancing expectations with teen's fragility. Large portions of the narratives were devoted to discussing attempts to find the right balance of expectations for behaviors and activities for the adolescents while considering the fragility induced by the depression. Parents recognized the need for the reduction of stressors but also knew that a lack of expectations for daily life was not in the best interests of their children. A trial and error approach was described, although in the early recovery period even small responsibilities appeared to be overwhelming.

> Barbara: I didn't feel like I could even get even close to saying, "Here are the rules and you're breaking the rules," because, you know, he would just …decomp, you know, and it would just throw him back into, "I'm having a bad day and I just feel like crap and I know I should….and you don't

want me around and you would be better off if I wasn't here" and then he's doing all this other stuff again. I'm just like, oh man… I really didn't want to go down that road but here we are…you want to have some sort of enforcing of rules.

Denise: I just feel overwhelming urge for him to do something. I have to balance that with pushing. Keep going, keep going. He doesn't want to be pushed. He needs to be able to have a say but to be able to balance that with pushing him out into new experiences is where we're having a real hard time now. Not confident even though he's very smart. I don't know. We're still working on that, that's a big piece of the puzzle. It's really not where it needs to be.

Eliana: She was – it's hard to explain – whenever I call her on something she had done wrong, whenever I tried to discipline her in anyway, it would just get to be a total, a big huge fight. It would be a total blow out with the screaming, and the yelling, and the – her rage - you know, she would just go into a rage. That was so hard. And then I with my temper, I'd explode and I'd get mad and then I'd get hurt, because she was just so hurtful in her words. She was so disrespectful. Just so different from what she was in the past. It just wasn't her.

Again, the tension between the desire for harmonious and sheltered relationships and the expectation that the teen step back into life is present in these narrative excerpts.

Process of letting go. Another extensive topic within the parent narratives was the struggle of accepting the teens for who they were post-diagnosis. Recognition of permanent changes in behaviors and attitudes occurred with time but were not necessarily easy to accept. Some parents appeared to struggle with what changes were brought about by the depression experience versus what was due to normal maturation. According to Eliana, Eva had been a "perfect child" until her high school years, being an active participant in sports and music as well as achieving superior grades.

> Eliana: I understand that they want to experiment and that's a part of their life. But it's just hard to let your own child, you know, to accept that for your own child, to let them experiment and let them make mistakes. It's just – it's very hard and I personally don't accept it so that's where I have my struggles with her... I try to listen to her more. I just try to understand her and learn to accept her for who she was. For her sexuality, you know, learning to accept that. Just saying it's okay. That was hard for me. I don't really know a hundred percent if she's totally homosexual, she says she's bisexual. What ever road she walks, I'm okay with it. I need to accept that.

> Denise: His fear that he related to me was that he felt I was disappointed in him, because he wasn't the perfect A student, playing on a perfect

soccer team, and to doing all the things that we wanted. And he says, "I'm not that person, and I never will be. I'm tired of trying." I told him, "I never told you any of those things and I never told you I was disappointed with grades. I just want you in school and moving forward." His feeling was that my constant pushing the exercising and constant pushing the school work meant he couldn't be responsible…I can't let him be that person. But his point to me was, "I am that person." So I backed off.

Fran: I've tried to get her to sit down with me and read [books on social skills] or read them herself or whatever but she's just not interested, so that's hard too because here she has this problem and it really hurts her and she says she wants to do something about it. But yet when it comes down to it she doesn't really want to do it.

Each of these parents conveys letting go of past, idealized images of the teen while attempting to accept who the current personality is. Parents did not find this process pleasant but appeared to be aware of its inevitability.

Witnessing healing. Parents were able to recognize some improvements in mood, behaviors, and communication as therapy progressed.

Barbara: One of the first times he's laughed… I'll never forget that. I don't know how long it was after he started his medication. He actually laughed. And I realized in that moment how long it had been. And it really blew me away. I mean, it really blew me away. I though, oh my

gosh, this poor boy has been so unhappy for so long and it just becomes such a way of life that you don't even comprehend how it used to be. Until you have one little thing back that you remember, oh my gosh! And when was the last time he actually laughed and was joyous about something and… That was a significant moment. I remember that was a significant moment.

Allison: Sometimes they're [the days] are good. We can joke around. We can play around. ….A good day would be.. that he just wants to play by himself, and that, you know, he'll come out and wrestle with me sometimes and , you know, he'll joke around and talk to me. Stuff like that.

Denise: One of the positives that's kind of come out of it, Dan going up there, is that he can turn things around if he feels the need. I think they were able to show him that my reaction to some things a lot or too strong, or too much. They did that a lot of different ways, in fact, one of the key things for both of us.

These were moments of joy in the interviews; sudden recollections of the first post-depression smile or an improvement in academic functioning. A sense of hope is present.

Theme 4 Crisis Management Within (Context of Transcendence)

The tensions of illness and evolving relationships brought inner uncertainty. Parents experienced changes in thoughts and emotions during the time their teens were depressed. Often there were grief and depressive symptoms. Some parents became clinically depressed along with their children. However, all participants discussed positive changes that had occurred within themselves and in the relationship with their teens as well. Sub-themes that supported this theme included *Quietly Suffering Guilt and Grief, Gaining Wisdom*, and *Living with Uncertainty.*

Quietly suffering guilt and grief. Parents suffered personally from the experience of caring for their adolescents. Fatigue and anxiety are additional emotions but are not expressed to the teens or other family members.

> Eliana: Cause I even had to go on medication for a while because I couldn't take it. I couldn't go a day without crying, I couldn't function, I couldn't do my daily duties that I had to do as a mom. Because I just couldn't handle it. So I went on medication for a short while just to get me through the toughest part, especially when she started abusing drugs, started using them. …Because there were days where I didn't want to get out of bed, where I was even feeling lethargic. Should I end it? Is there a reason for me to live? [crying]

> Allison: So I ended up with severe depression myself. And that's been a battle of my own, so it's been hard dealing with that on my own as well

and that's been the biggest trouble this last year is dealing with my own depression.

Fran: But, sometimes I totally just have to disengage. I love spider solitaire and there are times I just have to go sit down and play spider solitaire because I just have to be able to detach myself for a little while. I'm sure it's not good for my health. Sometimes I do get depressed over it. It's been taxing physically and I'm tired a lot.

At one end of the spectrum were parents who had learned to recognize their own stress levels and engage in ways to self-calm while at the other were parents who suffered from suicidal depression.

Gaining Wisdom. In their narratives, parents included discussions that indicated new understanding of themselves and their children. These pearls of wisdom included behaviors they had used as coping skills for themselves, new perspectives on adolescent behaviors, increased knowledge of when to intervene and how, and a recognition some aspects of the experience had become familiar.

Fran: At first that [cutting on self] was scary but then when I understood it a little better, it wasn't… I've never been afraid she was going to kill herself, fortunately, that's … I've been really lucky.

Interviewer: What did you understand about that?

That it was her anger and frustration you know. She needed to… She needed counseling to deal with that and try to help her with ways to deal with that.

> Denise: But, it's kind of like it's [inner pain] in there forever, and you grow a little bit of callus over it, but you think about it, dream about it, turn it in your mind, turn it over, kind of look at it at different angles, and you feel the pain again. In anger, in what ever, and you talk about it, just reduces its ability to make you feel bad. So I talk about it. Because I hurt so I keep talking about it because of that… And so, he still doesn't like that. Doesn't like to think that he's the cause of my pain, but there are a lot of good things, you know, that came out. Can't fix a lot of times, I've said some bad stuff.

> Eliana: It's been – makes you even bitter at times but yet at the same time it makes you sit back and think and realize how important family is or how important life is itself. It's gotten me more closer to God, it's given me more faith. I've learned to put more faith in him because I've learned to know that I can't control everything. That things happen and I just have to cope deal with it and to have faith that you will get through it.

As with witnessing healing, a sense of hope comes with wisdom in the narratives. Coping skills are evolving.

Living with uncertainty. Parents seemed aware that improvement in mood did not imply a problem-free future for their adolescents. Narratives included discussions about the uncertainty of such basic activities as whether the adolescents would complete

school or whether parents could even leave home for the workplace and trust that the teens would remain safe. Always present was the specter of worsening symptoms.

> Barbara: But I do worry. I do worry. I don't know what's gonna happen in school. He's doing fine now but he absolutely has no responsibilities except going to work three days a week and doing his chores on Friday. That's it. So it's not a lot.

> Eliana: I just don't want that for her especially with the drugs. She liked it, she admitted, she liked it and that's what scares me… Is she just going to end up being an addict and there's no way of handling that? That's what scares me.

> Fran: I had really hoped that Felicia would go to college because she's so bright but at this point I don't really see that happening because she has a really hard time just being herself. That's she's not interested and so I don't know. Because she's a good worker, I think that she could get a job but then not everybody's nice to you at work. So is she going to be able to keep a job? Um, so there are a lot of concerns with Felicia. I know that from now until she is 18, there is a lot of growth and changing that she will do. And it's just hard to foresee what's going to happen, how that's going to play out.

In summary, the essential pattern of *Tension Between Pulling Closer and Letting Go* was supported by parent narratives expressing holding on to past

functioning until illness was a certainty, followed by finding balance in connecting with their children while letting go. In the process, parents needed to personally integrate the new complexities in their lives.

Comparison of Results of Parent and Adolescent Interviews

The major aim of Research Question 2 was to address how parent experiences and meanings contributed contextually to the lifeworlds of the depressed adolescents. The first step was to identify the themes and concerns of parents, as discussed above. The researcher then felt it was necessary to assess commonalities in themes expressed by adolescents and by parents. It was felt that commonalities would indicate that parent patterns were in synchrony with those of their adolescent children. Synchronous patterns were thought to be indicative of parents who were assessing the emotional needs of their children and thus providing a context supportive of healing and continued development. To accomplish this, a comparison was conducted across major themes and sub-themes within each set of results, parent and adolescent. The discussion content and meanings were compared for 1) degree of agreement on events; 2) degree of parental recognition of adolescent emotions and behaviors; and 3) degree of parent-adolescent reciprocity of emotions and behavior, such as a nurturing-gratitude or anger-standing firm pairing. This category included paradoxical or conflicting couplings of data as well. These could indicate a 'misreading' of adolescent needs and thus delay treatment or hinder development. Table 1 contains a summary of the comparison process. The discussion of the results of this process will be organized by adolescent themes.

Theme 1: Feeling Devalued Within the Relationship

The interpreted meaning in this general theme was that of the adolescents feeling unimportant and peripheral in the lives of parents. The comparison process using sub-themes within this theme illustrates the variety in parent data as context. *Mourning lost connections* contained vivid expressions of the personal devastation caused by loss of family members and friends. Within parent data, losses were discussed but the emotional intensity voiced by the adolescents did not appear to be recognized as clearly by parents. Denise stated, "…but it was more his dad would call me, frustrated because he wasn't going to school…I offered suggestions." Wrong attributions of symptoms were also voiced by parents. Beto stated, "My mom kinda understood. That I was going through that bad time and she figured…mostly because of my Tata, she had no idea how much I missed my step-mom." Barbara: "Then Tata died. It's just been horrible semester…He was in a bad place with the death." In general, most losses in the adolescent lifeworld were not interpreted by parents as emotionally crucial events with life-altering potential. The parental sub-theme, *Feeling unsupported in the parent role* shared some parallels with the adolescents' sub-theme of *Mourning lost connections*, in that feelings of aloneness added to negative emotions.

Shame of failing self and others was another area in which parents' narratives lacked awareness of the emotional intensity their children were feeling. One parent, Barbara, recognized shame in her son but the scope of her understanding was limited in comparison to the rich discussion by her son. Several adolescents voiced their shame at causing emotional distress for the parents through behaviors such as arguing and

involvement with illicit substances, implying that adolescents monitored the parental and familial reactions to their behaviors. In this way adolescent narratives share a parallel to the parent sub-theme of *Monitoring the emotional and situational impact on family*.

The sub-theme of *Holding together during uncertainty of parental support and care* had a paradoxical counterpart in the adult sub-themes. Whereas adolescents had discussed feelings of being peripheral in their parents' lives, parent narratives focus on how central the adolescent was in their lives, how much they worried, and the numerous actions they took, particularly in the post-diagnosis period. Some parents did discuss the lack of support provided by their spouses or ex-spouses, for example alcohol use, depending on the adolescent for emotional support, and disbelief in the symptoms of depression. However, those spouses were either non-custodial parents or not actively involved in day-to-day care, and therefore were not interviewed. In an interesting parallel to their adolescents, parent narratives did yield a sub-theme of *Feeling unsupported in the parenting role*, the feeling of lack of importance or expected assistance during this time of crises.

In contrast to minimal convergence, two sub-themes, *Escaping from pain* and *Anger over injustice*, had matches in parental sub-themes as evidenced by recognition of similar events and responses by both parties. Understanding the underlying emotions may not have occurred. Parents recognized the isolating behaviors as indicated by the content of *Uncomfortably watching aloneness*, but did not have a sense of the meaning of aloneness as an escape from pain. *Anger over injustice* had a counterpart in the parents' *Painfully standing firm* in that a cause-effect or circular communication pattern occurred.

Parents discussed difficult decisions, arguments over those decisions, and the feelings of powerlessness that their children expressed. However, at a higher level, parents saw this as expected and correct behavior for parents with little emphasis on the injustice felt by their children. In another parallel set of narratives, parents quietly suffered guilt and grief as did their isolative children.

Theme 2 Renegotiating a Relationship

Parental themes as context were much more obvious in this adolescent theme. With the onset of crisis events, parents' narratives contained more discussions that indicated similar experiences of events and meanings to that of their adolescents.

Awareness of reaching a crossroads the adolescent sub-theme, exhibited a high degree of congruence with the parental sub-theme of *Shock of sudden clarity*. Both parents and adolescents described similar events and narratives exhibited a high degree of reciprocity of behaviors, for example, Dan stated: "Mom was like, 'Nope, we can't do this anymore. Get your butt up and come live with me.' I don't even know what my reaction was, 'Okay'." Of that same incident, his mother, Denise stated: "I didn't know if he was suicidal. He insisted he wasn't, but it was real frightening to have your child to that…being in the position of not functioning at all. So I took him home with me." *Awareness of reaching a crossroads* shares similarities with the parental sub-theme of *Gaining wisdom.* By recognizing the extremes that their behaviors had taken, adolescents were exhibiting the acquisition of wisdom. Similarly, the adolescent sub-theme of *Opening the self to nurturance* shared salient congruence with the parental sub-themes of *Managing the complexity of care* and *Adjusting school to fit the adolescent needs*. For

parents, the meanings spoke to caring for the numerous needs of the adolescents including emotional, physical, and environmental while their children spoke of not functioning normally and openly accepting this assistance. Eva stated: "I really turned all that tough love, all that, weird things I was getting from people, the negativeness…I really got to see that behind all that was the caring." *Opening the self to nurturance* also shared parallels the parental process of *Sharing the burden with others*. While adolescents revealed their emotions and thoughts to parents and counselors, parents confided in school counselors, their own therapists, and other parents. Parents, unlike adolescents, felt a need for more support than they were receiving.

Constructing new ways of being together was supported contextually by the parental themes of *Assisting teens in self-management*, *Balancing expectations with teen's fragility*, and *Process of letting go*. For example, Eva stated: "But now I'm trying to be better like an adult, you start talking to them, negotiating, compromise." Her mother Eliana stated: "I try to listen to her more. I just try to understand her and learn to accept her for who she was." As stated earlier, the relationships were not necessarily steadily improving but there appeared to be more recognition of the issues between the parents and adolescents, with more open communication. Denise stated: "…it's hard not to be over-reactive when your kids do things you don't like. He's not physically harmed himself by (staying up all night on the computer). It has to be talked about and just kind of, we're doing some learning here and maybe this is social interaction…"

The parental theme of *Witnessing healing* was interpreted as having a high degree of agreement with the adolescent theme of *Recognizing human imperfection of parents*.

Dan stated: "No reason to be angry because she's trying to do as much as she possibly can. You kind of have to pay for that part, I guess I was ready to do that…" His mother stated: "The whole situation hurts me, I don't mind crying, frustration, kind of. Dan has always been okay in sharing but since he came back from treatment, really excellent at that." With healing, closer relationships were evolving to encompass an understanding of each other as individuals with emotions and flaws.

The parental sub-theme of *Quietly suffering guilt and grief* also shared some commonalities in agreement on events and reciprocity of behaviors in relationship to the adolescent theme of *Recognizing human imperfection of parents*. Beto knew that his mother was suffering: "My mom was really sad. I thought she was more depressed than I was, just watching." Barbara stated: "I'm a person too, with feelings and I'd try to explain that to him. 'This is very difficult watching you go through this.'" But as a whole, parent interviews did not include discussions indicating recognition that their children knew of their distress. This supports the earlier finding that parents were generally not aware of the shame and guilt felt by their teens.

The adolescent sub-theme of *Grateful for centrality in parents' lives* shared commonalities with the parental themes of *Managing complexity of care*, *Adjusting school to fit the adolescent needs*, *Assisting teens in self-acceptance and understanding*, and *Balancing expectations with teen's fragility*. The adolescent meanings clearly included gratitude for parental care, even when specific actions produced anger. Yet there was no parental meaning indicating a realization of the gratitude of their children.

Living with uncertainty was unique in that parents were quite concerned about the future health and functioning of their adolescents, yet adolescents did not voice similar concerns. Adolescents viewed their episodes of depression as limited, single events.

Parent Results as Context for the Adolescent Themes

A more general way of conceptualizing the parent findings as contexts for the adolescent meanings and experiences is described below. The contexts are taken from the earlier themes supported in the parent data. Their use will be further discussed in Chapter 5.

Losing the familiar – The context of concern. This theme was interpreted as representing a parental context of concern. Definitive action on behalf of the adolescent has not occurred yet, but unfamiliar behaviors and emotions have heightened parental vigilance. Thus parents are concerned but awaiting more events on which to base actions.

At the nexus of necessary action – The context of action. These results represented the point at which parents began definitive action in the form of managing care, working with schools, and managing the family. The context of concern was still present but the context of action was an addition.

Composing life with the stranger – The context of engaging. This theme best represents a parental context of engaging, of making active attempts to thoughtfully observe the adolescent, to communicate, and to search for signs of lessening symptoms. Parents also began learning how to balance their children's fragility with reasonable expectations. Again, this Context joins those of Concern and Action.

Crisis management within – Context of transcendence. Understanding the self and learning new personal skills were also key in parenting the depressed adolescent.

When comparing the four contexts with the adolescent data a pattern emerges, as seen in Figure 3. The adolescents appear to experience losses including important people in their lives and a perceived loss of parental support well before parents are aware that problems exist. As more unfamiliar behaviors emerge, parents become suspicious or concerned - the 'Context of Concern'- but do not take any actions. It is not until a definitive event for the adolescents occurs such as attempting suicide or ceasing to attend school, that parents are moved into the 'Context of Action'. Once parents have become more fully aware of the nature of their children's illness, and are engaging in actions that support a caring environment, they begin the process of composing life with the strangers – the 'Context of Engaging. Parents begin to reach inward as well, to cope with their own feelings, to develop new skills, and to begin living with the uncertainty of a chronic illness.

Summary of Chapter

This chapter has included a description of the results of the two research questions. Essential patterns were identified, supported by themes and sub-themes. Adolescent and parent data were discussed separately and then compared across participant groups in order to identify convergent and divergent themes and sub-themes. Parent themes were finally described as four general contexts, which were thought to illustrate how the parent patterns of themes and concerns would serve as environments for adolescent healing and development.

CHAPTER FIVE

Discussion and Implications of the Results

This chapter begins with a review of the findings about the depressed adolescent's experience and ascribed meanings of being parented and the parent's experiences of parenting. Links to the literature reviewed in Chapter 2 are discussed in relation to the findings. Study results and literature links are then used to refine the preliminary model developed by the investigator. A brief discussion of the methodological limitations and implications for nursing research and practice are also included.

Conceptual Framework Review and Overview of Results

As stated in Chapter 1, a neomodernist philosophy (Reed, 2006; Reed, 1996) guided the conduct of this study and included beliefs that meanings may be both shared and individually held, that individuals who have experienced a given phenomenon may be considered experts, and that multiple approaches to understanding a phenomenon are valuable. Newman's (2002) pattern recognition and mutual processing served as overarching perspectives to the support the conduct of this study. Furthermore, the tenets of the developmental psychopathology framework (Cicchetti & Toth, 1998) informed the investigator's approach to research and included beliefs that behavior can only be understood in context, that development is transactional among multiple levels, and that development involves increasing complexity and hierarchical integration of patterns. Finally this study was guided by the philosophical and methodological approaches of phenomenology (Benner et al, 1996; Colaizzi, 1978). The method integrated steps from both descriptive and interpretive schools of phenomenology in an adaptation of

Colaizzi's method in order to understand the lived world of the participants and to move outside of these narratives to identify and compare structures within the data. The philosophic tenets of the hermeneutic circle – the movement between text and context, part and whole, adolescent and parent narratives – were employed, providing rich data.

The study resulted in two essential patterns involving the adolescent-parent relationship during an episode of depression in the adolescent. Both the parents and the adolescents had unique and informative perspectives on their experiences and the meanings related to depression.

The essential pattern of the depressed adolescent in the parented context consisted of two major themes, with sub-themes:

Essential Pattern: Dysphoric Tension Between Moving Away and Moving Toward

1) Feeling devalued within the relationship
    a) Mourning lost connections
    b) Escaping from pain
    c) Shame of failing self and others
    d) Holding together during uncertainty of parental support and care
    e) Anger over injustice
2) Renegotiating a relationship
    a) Awareness of reaching a crossroads
    b) Opening the self to nurturance
    c) Recognizing the human imperfection of parents
    d) Grateful for centrality in parents' lives

These themes and sub-themes appeared to be simultaneous phenomena, with movement occurring among them. However study findings supported that meanings and experiences falling within the *Renegotiating a relationship* theme appeared to be associated with lessening of depressive symptoms.

The essential pattern of the parental narratives was *Tension Between Pulling Closer and Letting Go* and consisted of four major themes:

Essential Pattern: Tension Between Pulling Closer and Letting Go

1) Losing the familiar (Context of Concern)
    a) Perceiving a drifting away
    b) The shock of sudden clarity
2) At the nexus of action (Context of Action)
    a) Managing the complexity of care
    b) Adjusting school to fit the adolescents' needs
    c) Feeling unsupported in the parent role
    d) Sharing the burden with others
    e) Monitoring the emotional and situational impact on family
3) Composing life with the stranger (Context of Engaging)
    a) Painfully standing firm
    b) Uncomfortably watching aloneness
    c) Assisting teens in self-management
    d) Balancing expectations with teen's fragility
    e) Process of letting go

f) Witnessing healing

4) Crisis Management Within (Context of Transcendence)

a) Quietly suffering guilt and grief

b) Gaining wisdom

c) Living with uncertainty

Again, some themes appeared to represent simultaneous processes while others were more sequential. In general, sub-themes related to the *Context of concern* preceded those of the *Context of action*, but the *Contexts engaging and transcending* could be lived simultaneously. All overlap as recovery proceeds.

Integrating the Literature with Study Results

Theoretical Perspectives on Depression and Families

The study findings resonate strongly with the psychodynamic approaches, specifically attachment theory (Ainsworth, 1989; Bretherton, 1992; Hammen, 1997). Attachment, the transactional pattern that keeps caretakers in proximity to offspring, is thought to be necessary to normal development. The perceived loss of a loved one, especially a parent, can lead to grief, inwardly directed anger, guilt, and self-deprecation. Like the works of Armsden et al (1990), Kenny et al (1993), (Kaslow, Deering, & Racusin, 1994), Golombek & Kutcher (1990), and Kobak et al (1991), this study lent support for the tenets of attachment theory. The adolescent participants all described losses, real and perceived, of important people in their lives through death, divorce, rejection, and leaving home. Guilt and grief were strong sub-themes. The study findings lend support for, but do not discriminate among, several other theoretical perspectives

regarding the transmission of depression. Genetic transmission may have played a role in that every family in this study contained members with mood and substance abuse disorders, usually first degree relatives (Klein et al, 2001). In support of cognitive and social learning theories, skills and cognitive styles learned from parents and other relatives may have influenced the self-concepts and coping styles evidenced by the adolescent participants (Hammen, 1997).

The study findings generally support the developmental psychopathological approach to understanding adolescent depression (Cicchetti & Toth, 1998; Eccles et al, 1997; Hammen et al, 2000; Larson et al, 1996). Adolescents exhibited a high degree of dependence on and connectedness with parents and the environment they provided, as evidenced by profound symptomatology when these relationships were disrupted. As well, the adolescents in this study were moving toward independent thoughts and desires and a wish to voice opinions as they continued toward adulthood. Unfortunately, choices made by the depressed adolescents in this study were not always conducive to health and well-being. As recovery proceeded, parents expressed the need to 'let go' of their children, allowing them more choice and freedom, and learning to accept them as is. While development was not halted by depression, its trajectory was perhaps altered for these participants. This study supported the interconnections among multiple levels of development from the biological to the sociocultural.

Links to the Literature: Feeling Devalued in the Relationship

The symptoms experienced by the adolescents in this study were consistent with those described in the numerous studies on depression. Persistent sadness, loss of

pleasure in activities, hopelessness, and feelings of worthlessness were symptoms experienced by the adolescent participants (APA, 1994; Brage, 1995; Larson et al, 1990; Myers & Troutman, 1993). Negativistic and defiant behaviors, more characteristic of depression in the adolescent phase of development, were also evident to some degree in the adolescents in this study (Chiarello & Orvaschel, 1995; Knox et al, 2000). The findings of this study also support research which has identified social withdrawal, suicidality, substance use, and comorbid psychiatric conditions as common in depression (Bennett & Bates, 1995; Birmaher et al, 1996b; Cicchetti & Toth, 1998; Larson et al, 1990; Lewinsohn et al, 1999; Pullen et al, 2000).

When comparing across adolescent and parent results, several key points were noted in the study findings and are summarized in Table 1. The most striking finding is that parents appeared to have little awareness or response to the adolescent experiences within the theme of *Feeling devalued within the relationship*. Adolescents were feeling shame and uncertainty of parental support and had experienced losses while parents exhibited little response to these phenomena. Parents appeared to be aware of behavioral changes but did not identify them as necessitating action. The emotional depth experienced by the adolescents went unrecognized. The findings of this study partially support previous research indicating that poorer family functioning and lack of cohesion, and warmth are associated with depression in adolescent offspring (Puig-Antich et al, 1993; Shiner & Marmorstein, 1998; Su et al, 1997; Tulloch et al, 1997). Most of the adolescents lived within family contexts that were characterized by ongoing or new disruptions in relationships or living arrangements. Low warmth and cohesion were

evident within some families, along with mental health disorders in multiple family members. Early in depression, adolescents were likely to feel unsupported. Yet, some parent-adolescent dyads concurred on the experience of having close, supportive elements to their relationships throughout the depressive episode, but especially during recovery. Adolescents did not agree with their parents on many issues, but they were grateful for the help and support they had received while depressed.

Within the theme of *Feeling devalued within the relationship*, study findings did support the dyadic matching of parental sub-theme *Painfully standing firm* while adolescents expressed *Anger over injustice*. Puskar, Tusaie-Mumford, et al, (1999) found that adolescents reporting higher levels of depressive symptoms are more likely to report increased numbers of arguments with parents. Several parent and adolescent participants described anger, arguments, and unresolved conflicts throughout the depressive episode and into recovery, which also support the findings of Lewinsohn et al (1994).

Divorce and marital conflict played a large role in the findings of this study and may have increased the number of arguments among parents and adolescents. Although, marital status had no role in the selection criteria for study participants, four of the parents had experienced highly conflicted divorces. Of the remaining two parents, one had a spouse who was uninvolved in the mental health concerns of the adolescent, and the other had an intact marital situation. The study findings support the association of adolescent depression with marital conflict (Kelly, 2000). Grych & Fincham (1993) note that conflicts may increase worry, shame, and feelings of helplessness in children,

Table 1 Comparison of Adolescent and Parent Themes and Subthemes

Adolescent Themes/Sub-themes	In Parental Sub-themes, Degree of:		
	Agreement on Events	**Recognition of Adolescent Emotions and Behaviors**	**Parent-Adolescent Reciprocity in Behaviors**
Feeling Devalued Within the Relationship			
Mourning Lost Connections	Perceiving drifting away	None	None
Escaping from Pain	1) Perceiving drifting away 2) Uncomfortably watching aloneness	None	Perceiving drifting away
Shame of failing self and others	None	None	None
Holding Together through Uncertainty of Parental Support and Care	None	None	None
Anger over injustice	Painfully standing firm	Painfully standing firm	Painfully standing firm
Renegotiating a Relationship			
Awareness of Reaching A Crossroads	The shock of sudden clarity	The shock of sudden clarity	The shock of sudden clarity
Opening the Self to Nurturance	1) Managing Complexity of Care 2) Adjusting school to fit the adolescent needs	1) Managing Complexity of Care 2) Adjusting school to fit the adolescent needs	1) Managing Complexity of Care 2) Adjusting school to fit the adolescent needs
Constructing New Ways of Being Together	1) Assisting teens in self-management 2) Balancing expectations with teen's fragility 3) Process of letting go	1) Assisting teens in self-management 2) Balancing expectations with teen's fragility 3) Process of letting go	1) Assisting teens in self-management 2) Balancing expectations with teen's fragility 3) Process of letting go
Recognizing Human Imperfection of Parents	1)Witnessing healing 2)Quietly suffering guilt/grief	Witnessing healing	1)Witnessing healing 2) Quietly suffering guilt/grief
Grateful for Centrality in Parents' Lives	1) Managing complexity of care 2) Adjusting school to fit the adolescent needs 3) Assisting teens in self-management 4) Balancing expectations with teen's fragility	None	1) Managing complexity of care 2) Adjusting school to fit the adolescent needs 3) Assisting teens in self-management 4) Balancing expectations with teen's fragility
Parent Sub-themes that had no counterparts in the adolescent results: Living with Uncertainty **Parallel Feelings:Parents and Adolescents**: Feeling unsupported in the parent role; Uncertainty of Support and Care; Sharing the burden with others; Opening the Self to Nurturance; Monitoring the emotional and situational impact on family; Shame of Failing Self and Others; Gaining wisdom; Recognizing the Human Imperfection of Parents			

especially as conflicts become more intense. These emotions were evident in adolescent narratives in this study. Similar to the findings of Grych & Fincham and Cole and McPherson (1993), the adolescents in this study reported less supportive and more conflictual relationships with non-custodial fathers. Concerning the relationship of family structure and depressive symptoms, the study supported the findings of Patten et al (1997) in that 'supportive' was defined by the adolescent; a step-parent or grandparent could provide a loving and warm environment as well as a two-parent home.

Links to the Literature: Renegotiating a relationship

One of the most disabling symptoms for the adolescent participants, and one of the first signals of illness for parents, was academic decline and failure (Klein et al, 2001; Puig-Antich et al, 1993; Weissman et al, 1999). Five out of the six adolescents needed special accommodations at school, alternative school settings, or prolonged absences in order to regain abilities to complete schoolwork. Parental action and engagement in deeper relationships did not begin until the adolescent exhibited behaviors well outside of the 'norm' of functioning, such as school failure or suicide attempts. At this time parents became greatly involved in an array of interventions, from basic care to negotiating the health care system to assisting their children in self-acceptance. Study findings supported a concerted effort to tailor educational needs to fit their adolescents' current levels of functioning and to balance expectations with capabilities.

These efforts resonate with the concept of parental monitoring (Galambos & Ehrenberg, 1997). Several adolescent participants had expressed involvement in illicit activities, unapproved internet activities, leaving home when they wanted, and a general

lack of parental supervision of daily events. Parents discussed lack of control of their children, employment responsibilities, and lack of involvement from the other parent as impediments in monitoring their adolescents. Increased involvement in daily activities of their children may constitute better parental monitoring and thus be linked with decreased depressive symptoms. These findings lend support for the tenet that parental monitoring may be a factor in decreasing illicit activities and enhancing academic performance in depressed adolescents (Galambos & Ehrenberg). Adolescents generally recognized their parents' efforts and felt gratitude, although this was not verbally expressed to parents. Paradoxical findings existed, such as adolescent feelings of being devalued while parents stressed how central their children were in their lives.

Parallel experiences and meanings were evident in examples such as both parents and adolescents expressing the feeling of being unsupported in their current situations. These findings were consistent with those of previous studies concerning living with a depressed family member (Badger, 1996; Mohr, 2000). The parents in the current study expressed feelings of guilt and lack of support as well as frustrations of obtaining suitable mental health care. Several parental sub-themes were highly consistent with the findings of Badger's grounded theory study, especially the stages of A*cknowledging the strangers within* and *Gaining a new perspective*. These stages concerned relations with the diagnosed family member and the personal transformation that came with living with a loved one with depression. The findings of this study were somewhat consistent with Mohr's conclusions regarding parents' feelings of being marginalized and powerless, perhaps because Mohr specifically interviewed parents whose children had been

hospitalized about their experiences with the health care system. Although they felt unsupported, the parents in the current study were generally informed and proactive in their children's health care.

The study findings support the solitary experience of emotions such as grief, pain, guilt, and, to some extent, gratitude on the part of both parents and adolescents. In addition, parents struggled with impairments in mental and physical health, generally without the knowledge of their children. Parents expressed additional burdens of having to monitor the family as a whole while meeting the needs of the depressed adolescent. Finally, parents expressed the uncertainty that now existed for the mental functioning, academic achievement, and future adult functioning of their children. Parents appeared to be more aware of the chronicity that a diagnosis of depression implied than their adolescents, who did not share concern for their future health. Parental uncertainty about the future functioning of their children is, unfortunately, a valid concern. Recurrence rates are high, especially in those adolescents who have attempted suicide, have abused substances, and have had conflict in interpersonal relationships (Cicchetti & Toth, 1998; Lewinsohn et al, 2000).

Finally, although parents in this study were not specifically asked to discuss their own mental health history, four of the six had a history of past or current mood disorders while the other two described extreme stress and anxiety related to current functioning. Many studies discuss the functioning of children of depressed mothers (Chiariello & Orvaschel,1995; Cicchetti & Toth, 1998; Cummings & Davies, 1999; Hammen, 1997; Hammen, 1999; Hammen & Brennan, 2001; Kobak et al, 1991) however these studies

focused on the impact a depressed mother has on her children. Since this study did not take that stance and the accuracy of maternal depression diagnoses is unconfirmed, degree of support of findings cannot be discussed. However similarities in adolescent behaviors can be noted. Social inhibitions or difficulties that could be pervasive were discussed by two participants and concur with the findings of Hammen and Brennan. Adolescents may experience more chaotic living arrangements, such as new intimate partners for parents or moving to other homes (Hammen), which occurred for some participants in this study. Maternal behaviors discussed by other studies included disrupted employment, frequent arguments, and lack of nurturance and basic care (Chiarello & Orvaschel; Hammen) but were not evident in this study. Thomas and Forehand (1991) found that paternal depression was significantly correlated with depressive symptoms, particularly in sons. Two males and one female in this study had fathers with mood disorders and had particularly difficult relationships with them. However, Phares and Compas (1992) found that paternal support was a protective factor for adolescents, which may have applied to one adolescent in this study.

Links to Preliminary work by this Investigator

A phenomenologic study of depressed adolescents, wherein they described the experience of being depressed was complete by this investigator (Farmer, 2002). It is important to note that previous study was not used as an a priori structure with which to organize the findings in the current study. The first study addressed a different research question. Several of the resulting themes and theme categories both highlighted the salience of the parent-adolescent relationship in depression and the need for further

exploration. The essential structure of the experience of being depressed was used to construct a preliminary meaning-based model of depression as experienced by adolescents (See Figure 1). Yet this model was not based on exploration of multiple points of view nor was it used a priori in the current study. However, the current study findings can now be used to refine the model of adolescent depression with more extensive results on dyadic interactions. Furthermore, the model can now be seated within the context that parents provided.

The process of model refinement involved comparisons among the existing model components and the results of Questions 1 and 2. Despite the increasingly frequent derivation of models from phenomenological studies, none of the authors surveyed described methods for the formulation or refinement of the models (Kearney & Griffen, 2001; Schrieber, 1996; Wuest, 2000). In the absence of documented criteria, the investigator used an adaptation of Haase's decision-making process for the combining of qualitative data and existing theory (See Figure 2) (Haase et al, 2000). The 'existing theory' was the original model. New meanings, themes, and concerns were compared for congruence with the existing components in the model. Where sub-themes were congruent with model components, the original model component stood. Congruence was judged by how well the sub-themes and model components represented the same underlying meaning. The current study findings included themes not contained or only partially contained in the model; these were included as new components to better visually represent the depression meanings and experiences. Because the current study

focused more closely on being parented while depressed, most new components represented sub-themes with a relational focus. The new model is depicted in Figure 3.

Meanings and experiences are grouped according to clusters that may occur simultaneously or close proximity in time. Adolescents may spend days to years in a given component. The clusters are organized in a sequential fashion; however the model does not preclude simultaneity, re-experiencing of phenomena, or lack of experiencing individual components.

The starting point is *Genetic/environmental characteristics.* This study was not designed to explore these characteristics, but the literature supports their existence. The first phase, or set of ovals, represents *Feeling devalued within relationships*. During this phase, adolescents experience real and perceived losses. Death, divorce, neglect, abuse, and absence or loved ones are represented here. The adolescents experience the dispirited weariness of grief and loss. The parental *Context of concern* begins in this phase as parents recognize changes in their children.

The second set of ovals, *Emotional homelessness*, represent the set of behaviors and emotions that families, therapists, researchers know to be 'depression'.
Anger, social isolation, shame, and escapes such as suicidal attempts are represented here. The parental *Context of action* becomes prominent here; *most* parents were compelled to assist their children during this phase. It is likely not possible to exist within *Emotional homelessness* indefinitely. Adolescents who exit this phase through severe substance abuse or suicide were obviously not included in this study. At some point the adolescent participants in this and the previous study gained *Awareness of*

reaching a crossroads, the first oval within *Renegotiating a relationship.* A compelling need to move toward connectedness and wellness occurs at this time.

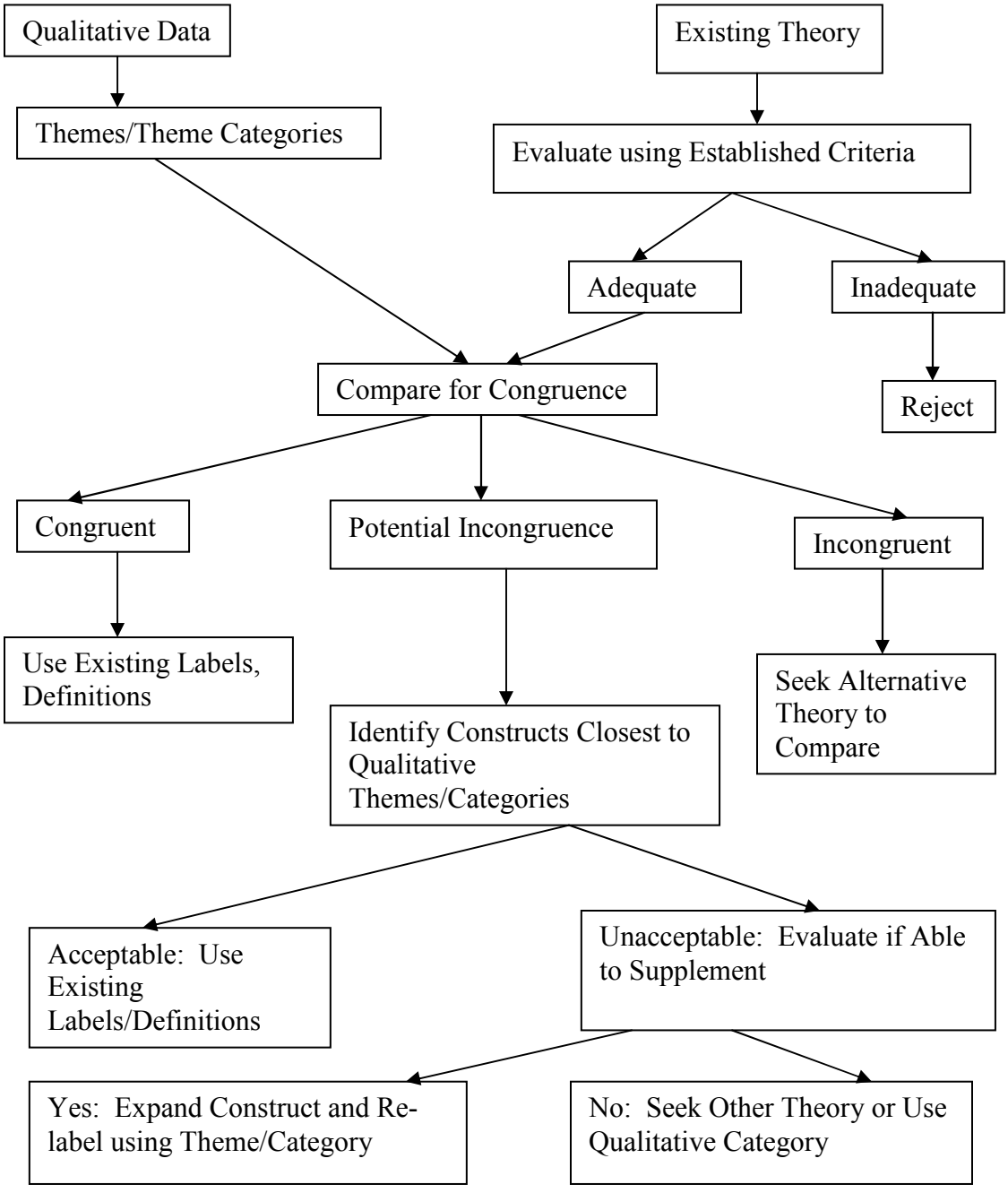
The third set of ovals represents the *Renegotiating a relationship,* connecting with therapists and reconnecting with parents and other loved ones, if possible. A proactive stance on the part of parents and adolescents yields therapeutic and educational interventions that are associated with a decrease in depressive symptoms. Should efforts be fruitful, the adolescents will gain a *Sense of getting well.* For approximately 30% of the adolescents, this will be the only experience with a psychiatric illness (Kovacs, 1996; Lewinsohn, Rohde, Seeley, Klein, & Gotlib, 2000). Realistically, and unfortunately, the return arrows imply reexperiencing of phenomena, but perhaps at a different point in development. The parental *Contexts of engaging and transcendence* begin here but, like other *Contexts* continue beyond the processes that the model represents.

Limitations of the Study

Limitations of this study include, first and foremost, the fact that this is the first study done by this investigator using an adapted phenomenological approach. The novice-level familiarity with the methods may have limited the analytic process in ways that experts would not have experienced. This investigator endeavored to share the analytic process with committee members and colleagues in order to faithfully interpret the data.

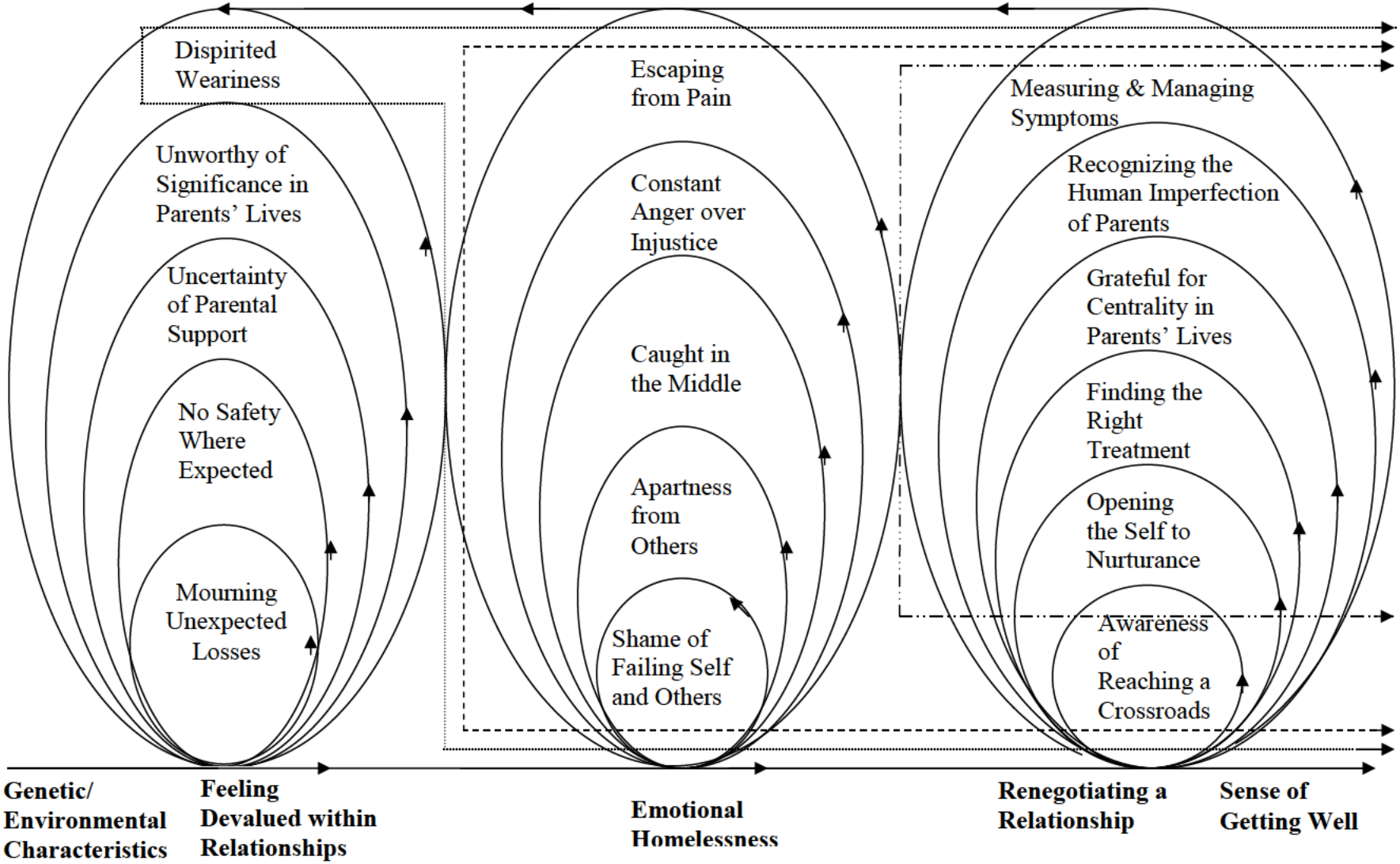
Second, participation was contingent upon being a willing interviewee. The parents in this study were motivated to help their children and had were interested in educating themselves on the nature of depression. Obviously, less involved parents or

Figure 2: Haase's Model for Combining Qualitative Data and Existing Theory

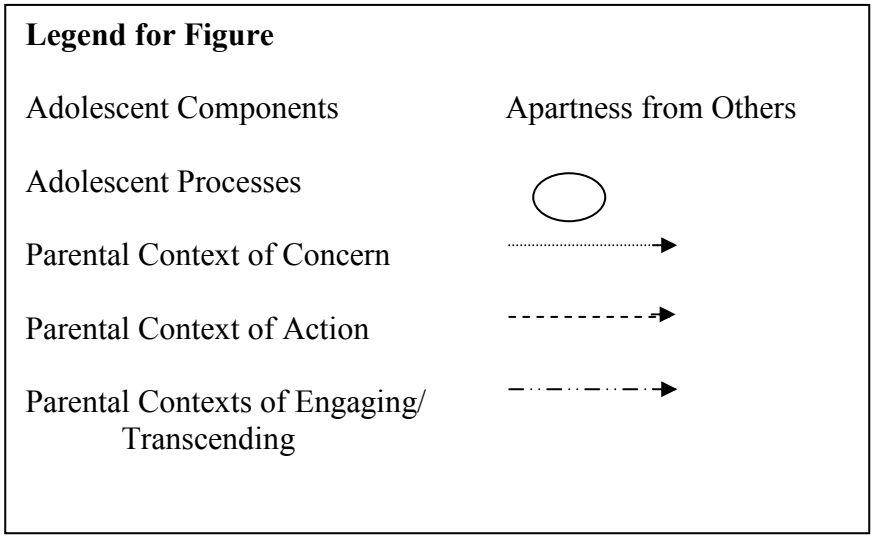


From: "Research triangulation to derive meaning-based quality-of-life theory: Adolescent resilience model and instrument development," by J.E. Haase, S.P.Heiney, K.S. Ruccione, & C. Stutzer, (1999), International Journal of Cancer (Suppl 12), 125-131. Reprinted with permission.

Figure 3: Emerging Model of Adolescent Depression with Dyadic Elements



Legend for Figure



those with significant mental health issues would not have agreed to be contacted. Their viewpoint is missing from these narratives, as is that of adolescents who were severely ill or uninterested in the study. Yet the participants in this study did come from a variety of environments, from poverty to wealth, rural to urban, and moderately ill to recovering.

Memory and emotional state may have played a role in the content expressed in interviews. Depression, by definition, is a disorder that may cloud realistic thinking patterns and emotions. A waxing and waning chronic illness may influence what is salient for participants dependent upon where in the pattern they are at the time of the interviews. An interview on a 'good day' may have produced content quite different from one on a day where symptoms were more extreme. Additionally, participants may have withheld concerns, day-to-day experiences, and meanings due to discomfort, embarrassment, or fear of consequences. The investigator attempted to encourage as much sharing during interviews as possible and the adolescents, in particular, were very frank about events, including sexual encounters and substance use.

The viewpoints of fathers, non-custodial parents, and supportive relatives are missing as well. All of the parent participants were mothers, even though some adolescent participants had close relationships with their fathers. Some of the adolescents had lived with the non-custodial parents in the past, therefore these parents may have had salient thoughts and emotions related to their children. Grandparents were important in the lives of two of the participants, yet this study was not designed to interview these individuals. Future studies should include these viewpoints.

Finally, due to time constraints, only one interview per participant was conducted. Multiple interviews would have been preferred and may have added to the richness of the narratives.

Implications for Nursing

Nursing Theory

The phenomenological approach was successful in obtaining rich narratives from the participants. The use of integrated methods elicited both meanings and lived experiences of being parented and of parenting during an adolescent's episode of depression. While Husserlian and Heiddegerian approaches differ in some respects (Lopez & Willis, 2004), the main tenets support the importance of exploring the life-world of humans. The results of this integrated method provided components for a model of depression in adolescents as members of families and this model can perhaps serve to guide further research and theory development.

The overarching view of pattern recognition (Newman, 2002) can continue to guide further research by this investigator into major depression. Identification and description of patterns, such as the parented-parenting patterns elucidated in this study, are useful as an approach to understanding and making sense of human behavior. Studying patterns can also serve as steps to ascertaining associations among, obtaining measurement of, and ultimately designing interventions that change patterns.

Theory development is desperately needed at all levels concerning depression in adolescents. This study is a beginning.

Clinical Practice

Given the profound negative affects of depression on academic, employment, legal, and interpersonal aspects of life, preventative efforts are imperative. Nurses who work in school, pediatric and family health settings need to educate themselves about risk factors for depression in order to identify those in need of intervention. Knowledge of early signs and symptoms of depression will aid in better identification of the disorder in their patients. Although concerned, parents in this study did not take definitive action until severe depression was evident. Parents and school officials need basic information on depression. Loss of loved ones, contentious parental divorce, poor relationships with peers, and academic difficulties are all potential precursors for the disorder and counseling should be made available before visible signs begin. One of the stunning revelations in this study was that of a lack of available support groups for these participants. Agencies dealing with community mental health could serve this urgent need, preventing further sequelae, uniting parents and adolescents who could help one another, and providing needed education. School-based mental health clinics could provide a centralized system of education, preventative efforts, and early identification for adolescents and parents (Merry et al., 2004). The results of this research, together with previous empirical findings and the emerging theory indicate an approach that may enhance recover and prevent relapse. It is an approach that recognizes the parent-child relationship, the significance of patterns of behaviors, the developmental potential inherent in psychopathology, and the multiple levels of systems affected by adolescent depression.

Further Research

As with many research efforts, this study generated more questions than it answered. Among the directions for future research are:

1) What role do fathers play in the onset and management of depression in their children? No fathers agreed to be interviewed, or met the study criteria. Current research is largely devoid of information on fathers and mental illness in their children.

2) What role do siblings play in adolescent depression? Given that they witness similar events in family life and that they may receive less parental attention, might they be at additional risk?

3) How do parents perceive 'abnormal' behavior in their teenage children? Parents assumed that some depressive symptoms were normal for adolescents. At what point did they become concerned? How can parents support normal development while intervening in abnormal behaviors?

4) What is the potential role of the internet in depression and recovery? Internet activities were used by participants as a means of escape in this study as well as a source of social interaction. Would online support groups be effective in recovery efforts?

5) What do parents need in terms of support and education? Severe illness in their children was devastating to the parents in this study.

6) What interventions work best for youth? Adult interventions cannot be extrapolated to fit individuals in a different developmental stage. Adolescents have a 'culture' of their own and interventions need to be in context.

Hopefully, this study will serve as a beginning to researching ways to promote better mental health to this vulnerable group of parents and teens.

Conclusions

Depression affects all facets of an adolescent's life, leaving him or her with a life-long risk for future health problems. Depressive symptoms in adolescents are highly intertwined with parental interactions. Knowledge of the disorder and of protective factors within individual functioning must be combined with knowledge of the parental context in order for the provision of optimal care.

Summary

This chapter included discussions of conceptual overview and findings, links to theory and literature, limitations of the study, and implications for nursing. Findings were used to refine the investigator's previous model of adolescent depression. Several potential research directions were discussed.

APPENDIX A

LETTER TO PROSPECTIVE SUBJECTS

ADOLESCENT DEPRESSION: EXPERIENCES OF PARENTING AND BEING PARENTED

Dear Parent and /or Adolescent,

My name is Terri and I am a nurse researcher from the University of Arizona, College of Nursing. I am interested in studying what it is like to live with depression in your family. I am looking for teenagers, ages 13 to 18, who have depression and parents who live with a depressed teenager to voluntarily participate in the above-titled research study. You are eligible to participate because you are a teenager in treatment for depression or are the parent of one.

If you agree to participate, the study will involve one to three interviews for each of you, for which you will be paid. The interviews will be held at a place and time convenient for you. For teenagers, I will ask about what it is like for you with your parents during this time that you have been depressed. If you are a parent, I will ask what it is like to parent your depressed teenager at this time. Parents and teenagers from the same family will be interviewed separately. You can share whatever you feel is important for me to know and what you tell me will be kept confidential.

My goal is to help find better ways to assist families who have depressed teenagers, and I would greatly appreciate your help! Please sign this form if you are interested. I would like the opportunity to discuss the study and answer any questions. I hope you will participate!

Thank you,

Terri J. Farmer, MS, RN, PhD Candidate
Principal Investigator
University of Arizona, College of Nursing

I am interested in this study. I understand that my provider will give my phone number(s) to Terri Farmer, who will contact me. NO MEDICAL RECORDS will be involved in this study.

Name: _____

Phone numbers: _____

_____

APPENDIX B

LETTER TO PROSPECTIVE PROVIDERS

ADOLESCENT DEPRESSION: EXPERIENCES OF PARENTING AND BEING PARENTED

Dear Provider,

Thank you for agreeing to help me recruit participants for my dissertation research. My study involves depressed adolescents and their parents. It is an open-ended, low-pressure interview study basically asking about the day-to-day parent-adolescent relationship when the adolescent is depressed. No therapy is involved. Interview data is confidential, even from future subpoenas (Certificate of Confidentiality on file from the Department of Health and Human Services) and participants will receive a small payment. Your role would be to hand the enclosed recruitment letter to patients who meet the criteria listed below. If they are interested in being contacted, they can sign the form and list telephone numbers and I will call them to discuss whether they wish to participate or not. I will answer any questions and make arrangements for the consenting process and interviews.

CRITERIA FOR INCLUSION

FOR ADOLESCENTS:

1) Must be 13 to 18 years of age
2) Must be under your care for major depression
3) No comorbid thought disorders or developmental delays (OK if they have other diagnoses
   such as ADHD, anxiety, OCD)
4) Must read and speak English

FOR PARENTS:

1) Must have a 13 to 18 year old adolescent under your care for depression
2) Adolescent must reside with said parent at least 50% of time
3) Must read and speak English

WHEN YOU HAVE A SIGNED FORM, EITHER FAX IT TO ME AT 529-4625 OR CALL ME AND I WILL PICK IT UP (HOME 529-4625, CELL 405-0106).

Please contact me if you have any questions. I truly appreciate your willingness to help!

Thank you!

Terri Farmer, MS, RN, PhD. Candidate
University or Arizona College of Nursing

APPENDIX C

HUMAN SUBJECTS APPROVAL

Human Subjects Protection Program
http://www.irb.arizona.edu

THE UNIVERSITY OF
ARIZONA.
TUCSON ARIZONA

1350 N. Vine Avenue
P.O. Box 245137
Tucson, AZ 85724-5137
(520) 626-6721

6 March 2003

Terri Farmer, Ph.D. Candidate
Advisor: Pamela Reed, Ph.D., R.N.
Nursing
PO Box 210203

RE: **BSC #02-55** ADOLESCENT DEPRESSION: EXPERIENCES OF PARENTING AND BEING PARENTED

Dear Ms. Farmer:

We received your 14 January 2003 and 27 February 2003 letters and accompanying revised consenting documents and updated Project Approval Form for the above referenced project. All of the conditions as set out in our 7 October 2002 letter to you have been addressed and the consenting documents have been revised accordingly. Therefore approval for this subjects-at-risk project is granted and the enclosed date-stamped consenting documents reflect an **expiration date of 7 October 2003.** ***Note: Certificate of Confidentiality must be obtained and submitted prior to subject accrual.***

The Human Subjects Committee (Institutional Review Board) of the University of Arizona has a current assurance of compliance, number FWA00004218, which is on file with the Department of Health and Human Services and covers this activity.

Approval is granted with the understanding that no further changes or additions will be made either to the procedures followed or to the consent form(s) used (copies of which we have on file) without the knowledge and approval of the Human Subjects Committee and your College or Departmental Review Committee. Any research related physical or psychological harm to any subject must also be reported to each committee.

A university policy requires that all signed subject consent forms be kept in a permanent file in an area designated for that purpose by the Department Head or comparable authority. This will assure their accessibility in the event that university officials require the information and the principal investigator is unavailable for some reason.

Sincerely yours,

Theodore J. Glattke, Ph.D
Chair
Social and Behavioral Sciences Human Subjects Committee

TJG:tl
cc: Departmental/College Review Committee

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES

JUN 30 2003

National Institutes of Health
National Institute on Alcohol Abuse & Alcoholism
6000 Executive Boulevard
Willco Building, Room 409
Bethesda, Maryland 20892

Pamela Reed, Ph.D., RN, and Ms. Terri Farmer
University of Arizona Health Sciences Center
PO Box 210203
1305 N. Martin St.
Tucson, AZ 85721-0203

Dear Dr. Reed and Ms. Farmer:

Enclosed is the Confidentiality Certificate protecting the identity of research subjects in your project entitled, "Adolescent Depression: Experiences of Parenting and Being Parented." Please note that the Certificate expires on October 7, 2004.

Please be sure that the consent form given to research participants accurately states the intended uses of personally identifiable information (including matters subject to reporting) and the confidentiality protections, including the protection provided by the Certificate of Confidentiality with its limits and exceptions.

If you determine that the research project will not be completed by the expiration date, October 7, 2004, you must submit a written request for an extension of the Certificate three months prior to the expiration date. If you make any changes to the protocol for this study, you should contact me regarding modification of this Certificate. Any requests for modifications of this Certificate must include the reason for the request, documentation of the most recent IRB approval, and the expected date for completion of the research project.

Please advise me of any situation in which the certificate is employed to resist disclosure of information in legal proceedings. Should attorneys for the project wish to discuss the use of the certificate, they may contact the Office of the NIH Legal Advisor, National Institutes of Health, at (301) 496-6043.

Correspondence should be sent to Dorita Sewell, Ph.D., Confidentiality Certificate Coordinator, Office of Scientific Affairs, National Institute on Alcohol Abuse and Alcoholism/NIH, Willco Building, Suite 409, 6000 Executive Boulevard, Rockville, MD 20852; 301-443-2890, Fax 301-480-1726; dsewell@mail.nih.gov.

Sincerely,

Dorita Sewell, Ph.D.
Confidentiality Certificate Coordinator

Enclosure
cc: Linda Phillips, Ph.D., RN
Office of Nursing Research

CONFIDENTIALITY CERTIFICATE

Number: AA-46-03

Issued to

University of Arizona Health Sciences Center

conducting research known as

Adolescent Depression: Experiences of Parenting and Being Parented

In accordance with the provisions of section 301(d) of the Public Health Service Act 42 U.S.C. 241(d), this Certificate is issued in response to the request of the Principal Investigator, Pamela Reed, Ph.D., RN, and Ms. Terri Farmer, to protect the privacy of research subjects by withholding their identities from all persons not connected with this research. Dr. Reed and Ms. Farmer is primarily responsible for the conduct of this research, which is supported by private funding.

Under the authority vested in the Secretary of Health and Human Services by section 301(d), all persons who:

1. are enrolled in, employed by, or associated with the University of Arizona Health Sciences Center and its contractors or cooperating agencies and

2. have in the course of their employment or association access to information that would identify individuals who are the subjects of the research pertaining to the project known as "Adolescent Depression: Experiences of Parenting and Being Parented,"

are hereby authorized to protect the privacy of the individuals who are the subjects of that research by withholding their names and other identifying characteristics from all persons not connected with the conduct of that research.

The purpose of this doctoral dissertation study is to explore parent and adolescent experiences and ascribed meanings during adolescents' depressive episodes. Data will be collected from adolescents and parents. The study will focus on adolescent experiences of parenting and of being parented, and adolescent and parental experiences of the depressive episode.

A Certificate of Confidentiality is needed because potentially illegal or sensitive use of addictive substances and other sensitive information will be collected during the course of the study. The certificate will help researchers avoid involuntary disclosure that could expose subjects or their families to adverse economic, legal, psychological and social consequences.

Measures to be taken to protect confidentiality include confidentiality training for research staff, restricted access to study records, use of codes instead of recognizable names, publication only of grouped data, and other steps to protect privacy.

This research begins on May 1, 2003, and is expected to end on October 7, 2004.

As provided in section 301 (d) of the Public Health Service Act 42 U.S.C. 241(d):

"Persons so authorized to protect the privacy of such individuals may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings to identify such individuals."

This Certificate does not protect you from being compelled to make disclosures that: (1) have been consented to in writing by the research subject or the subject's legally authorized representative; (2) are required by the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or regulations issued under that Act; or (3) have been requested from a research project funded by NIH or DHHS by authorized representatives of those agencies for the purpose of audit or program review.

This Certificate does not represent an endorsement of the research project by the Department of Health and Human Services. This Certificate is now in effect and will expire on October 7, 2004. The protection afforded by this Confidentiality Certificate is permanent with respect to subjects who participate in the research during the time the Certificate is in effect.

June 18, 2003
Date

Mary C. Dufour, M.D., M.P.H.
Deputy Director
National Institute on Alcohol Abuse and Alcoholism

APPENDIX D

SUBJECT CONSENT FORMS

THE UNIVERSITY OF ARIZONA COLLEGE OF NURSING
SUBJECT CONSENT FORM
ADOLESCENT DEPRESSION: EXPERIENCES OF PARENTING AND BEING PARENTED
(For parents)

I AM BEING ASKED TO READ THE FOLLOWING MATERIAL TO ENSURE THAT I AM INFORMED OF THE NATURE OF THIS RESEARCH STUDY AND OF HOW I WILL PARTICIPATE IN IT, IF I CONSENT TO DO SO. SIGNING THIS FORM WILL INDICATE THAT I HAVE BEEN SO INFORMED AND THAT I GIVE MY CONSENT. FEDERAL REGULATIONS REQUIRE WRITTEN INFORMED CONSENT PRIOR TO PARTICIPATION IN THIS RESEARCH STUDY SO THAT I CAN KNOW THE NATURE AND RISKS OF MY PARTICIPATION AND CAN DECIDE TO PARTICIPATE OR NOT PARTICIPATE IN A FREE AND INFORMED MANNER.

PURPOSE
I am being invited to voluntarily consent to my participation in the above-titled research project. The purpose of this project is to explore the parent-adolescent relationship by ascertaining the experiences of parenting/being parented during the adolescent's episode of major depression.

SELECTION CRITERIA
I am being invited to participate because my adolescent has a diagnosis of major depression, is currently undergoing outpatient treatment, is between 13 and 18 years of age, and is able and willing to participate. Furthermore, I am a custodial parent of this adolescent and am willing to participate. Approximately 5 to 10 parent-adolescent pairs will be enrolled in this study.

PROCEDURE(S)
If I agree to participate, I will be asked to participate in one to three audiotaped interviews during which I will be asked to respond to one broad question. I will be asked to describe what it is like to parent my depressed adolescent. The first interview will last approximately one hour. One or two additional one hour interviews may be scheduled as needed to further explore these questions. In the interviews, I will be encouraged to express my thoughts freely. Each interview will be in a quiet, private location at my home. I may stop the interview at any time.

RISKS
Few risks are associated with this study. Reflecting on unpleasant memories related to depression may result in feelings of anxiety, sadness, or anger, but I understand that the interview process will be as supportive as possible. Should problems arise, the investigator, Terri Farmer MS, RN, will assist me contacting appropriate help. There is also the risk that information I give could be disclosed to outsiders. Please see information about our Certificate of Confidentiality under "Confidentiality".

BENEFITS
There are no known benefits to participation in this study.

CONFIDENTIALITY
Principal investigator, Terri Farmer, MS, RN, and authorized personnel may have access to my data. A number will be assigned to my audiotapes and transcripts. My name or identifying information will not appear on any report or publication of this data. **A Certificate of Confidentiality** has been approved by the Department of Health and Human Services (DHHS). This does not mean that DHHS approves or disapproves of this study. This certificate will protect the investigator from being forced to release any research data in which I am identified, even under a court order or subpoena. The investigator, however, may report cases of child abuse and, should I reveal that I am thinking of harming others, or myself, the investigator may report this information to the appropriate authorities in an attempt to get help.

PARTICIPATION COSTS AND SUBJECT COMPENSATION
There are no monetary costs for participation, however cost in time will be approximately one hour per interview. I will not be compensated for my participation.

LIABILITY
Side effects or harm are possible in any research program despite the use of high standards of care and could occur through no fault of mine or that of the investigator involved. Known side effects have been described in this consent form. However, unforeseeable harm also may occur and require care. I do not give up any of my legal rights by signing this form. In the event that I require or am billed for medical care that I feel has been caused by the research, I should contact the principal investigator Terri Farmer, MS, RN, PhD Candidate at (520) 405-0106. If I have questions concerning my rights as a research subject, I may call the Human Subjects Committee office at (520) 626-6721.

AUTHORIZATION
BEFORE GIVING MY CONSENT BY SIGNING THIS FORM, THE METHODS, INCONVENIENCES, RISKS, AND BENEFITS HAVE BEEN EXPLAINED TO ME AND MY QUESTIONS HAVE BEEN ANSWERED. I MAY ASK QUESTIONS AT ANY TIME AND I AM FREE TO WITHDRAW FROM THE PROJECT AT ANY TIME WITHOUT CAUSING BAD FEELINGS OR AFFECTING MY CARE. MY PARTICIPATION IN THIS PROJECT MAY BE ENDED BY THE INVESTIGATOR FOR REASONS THAT WOULD BE EXPLAINED. NEW INFORMATION DEVELOPED DURING THE COURSE OF THIS STUDY, WHICH MAY AFFECT MY WILLINGNESS TO CONTINUE IN THIS RESEARCH PROJECT, WILL BE GIVEN TO ME AS IT BECOMES AVAILABLE. THIS CONSENT FORM WILL BE FILED IN AN AREA DESIGNATED BY THE HUMAN SUBJECTS COMMITTEE WITH ACCESS RESTRICTED TO THE PRINCIPAL INVESTIGATOR, TERRI J.FARMER MS, RN OR AUTHORIZED REPRESENTATIVE OF THE COLLEGE OF NURSING. I DO NOT GIVE UP ANY OF MY LEGAL RIGHTS BY SIGNING THIS FORM. A COPY OF THIS SIGNED CONSENT FORM WILL BE GIVEN TO ME.

_____ _____
Subject's Signature Date

INVESTIGATOR'S AFFIDAVIT

I have carefully explained to the subject the nature of the above project. I hereby certify that to the best of my knowledge the person who is signing this consent form understands clearly the nature, demands, benefits, and risks involved in his/her participation and his/her signature is legally valid. A medical problem or language or educational barrier has not precluded this understanding.

_____ _____

Signature of Investigator Date

THE UNIVERSITY OF ARIZONA COLLEGE OF NURSING
SUBJECT CONSENT FORM
ADOLESCENT DEPRESSION: EXPERIENCES OF PARENTING AND BEING PARENTED
(For age 18)

I AM BEING ASKED TO READ THE FOLLOWING MATERIAL TO ENSURE THAT I AM INFORMED OF THE NATURE OF THIS RESEARCH STUDY AND OF HOW I WILL PARTICIPATE IN IT, IF I CONSENT TO DO SO. SIGNING THIS FORM WILL INDICATE THAT I HAVE BEEN SO INFORMED AND THAT I GIVE MY CONSENT. FEDERAL REGULATIONS REQUIRE WRITTEN INFORMED CONSENT PRIOR TO PARTICIPATION IN THIS RESEARCH STUDY SO THAT I CAN KNOW THE NATURE AND RISKS OF MY PARTICIPATION AND CAN DECIDE TO PARTICIPATE OR NOT PARTICIPATE IN A FREE AND INFORMED MANNER.

PURPOSE
I am being invited to voluntarily consent to my participation in the above-titled research project. The purpose of this project is to explore the parent-adolescent relationship by ascertaining the experiences of parenting/being parented during the adolescent's episode of major depression.

SELECTION CRITERIA
I am being invited to participate because I have a diagnosis of major depression, I am currently undergoing outpatient treatment, I am between 13 and 18 years of age, and am able and willing to participate. Furthermore, I have a custodial parent enrolled in this study. Approximately 5 to 10 parent-adolescent pairs will be enrolled in this study.

PROCEDURE(S)
If I agree to participate, I will be asked to participate in one to three audiotaped interviews during which I will be asked to respond to one broad question. I will be asked to describe what it is like to be parented during the time that I have been depressed. The first interview will last approximately one hour. One or two additional one-hour interviews may be scheduled as needed to further explore these questions. In the interviews, I will be encouraged to express my thoughts freely. Each interview will be in a quiet, private location at my home. I may stop the interview at any time.

RISKS
Few risks are associated with this study. Reflecting on unpleasant memories related to depression may result in feelings of anxiety, sadness, or anger, but I understand that the interview process will be as supportive as possible. Should problems arise, the investigator, Terri Farmer MS, RN, will assist me contacting appropriate help. There is also the risk that information I give could be disclosed to outsiders. Please see information about our Certificate of Confidentiality under "Confidentiality".

BENEFITS
There are no known benefits to participation in this study.

CONFIDENTIALITY
Principal investigator, Terri Farmer, MS, RN, and authorized personnel may have access to my data. A number will be assigned to my audiotapes and transcripts. My name or identifying information will not appear on any report or publication of this data. **A Certificate of Confidentiality** has been approved by the Department of Health and Human Services (DHHS). This does not mean that DHHS approves or disapproves of this study. This certificate will protect the investigator from being forced to release any research data in which I am identified, even under a court order or subpoena. The investigator, however, may report cases of child abuse and, should I reveal that I am thinking of harming others or myself, the investigator may report this information to the appropriate authorities in an attempt to get help.

PARTICIPATION COSTS AND SUBJECT COMPENSATION
There are no monetary costs for participation, however cost in time will be approximately one hour per interview. I will be compensated $10.00 for my participation.

LIABILITY
Side effects or harm are possible in any research program despite the use of high standards of care and could occur through no fault of mine or that of the investigator involved. Known side effects have been described in this consent form. However, unforeseeable harm also may occur and require care. I do not give up any of my legal rights by signing this form. In the event that I require or am billed for medical care that I feel has been caused by the research, I should contact the principal investigator Terri Farmer, MS, RN, PhD Candidate at (520) 405-0106. If I have questions concerning my rights as a research subject, I may call the Human Subjects Committee office at (520) 626-6721.

AUTHORIZATION
BEFORE GIVING MY CONSENT BY SIGNING THIS FORM, THE METHODS, INCONVENIENCES, RISKS, AND BENEFITS HAVE BEEN EXPLAINED TO ME AND MY QUESTIONS HAVE BEEN ANSWERED. I MAY ASK QUESTIONS AT ANY TIME AND I AM FREE TO WITHDRAW FROM THE PROJECT AT ANY TIME WITHOUT CAUSING BAD FEELINGS OR AFFECTING MY CARE. MY PARTICIPATION IN THIS PROJECT MAY BE ENDED BY THE INVESTIGATOR FOR REASONS THAT WOULD BE EXPLAINED. NEW INFORMATION DEVELOPED DURING THE COURSE OF THIS STUDY, WHICH MAY AFFECT MY WILLINGNESS TO CONTINUE IN THIS RESEARCH PROJECT, WILL BE GIVEN TO ME AS IT BECOMES AVAILABLE. THIS CONSENT FORM WILL BE FILED IN AN AREA DESIGNATED BY THE HUMAN SUBJECTS COMMITTEE WITH ACCESS RESTRICTED TO THE PRINCIPAL INVESTIGATOR, TERRI J.FARMER MS, RN OR AUTHORIZED REPRESENTATIVE OF THE COLLEGE OF NURSING. I DO NOT GIVE UP ANY OF MY LEGAL RIGHTS BY SIGNING THIS FORM. A COPY OF THIS SIGNED CONSENT FORM WILL BE GIVEN TO ME.

_____ _____
Subject's Signature Date

INVESTIGATOR'S AFFIDAVIT

I have carefully explained to the subject the nature of the above project. I hereby certify that to the best of my knowledge the person who is signing this consent form understands clearly the nature, demands, benefits, and risks involved in his/her participation and his/her signature is legally valid. A medical problem or language or educational barrier has not precluded this understanding.

_____ _____

Signature of Investigator Date

1/2000

ASSENT FORM FOR THE STUDY OF THE EXPERIENCES OF PARENTING AND BEING PARENTED DURING AN EPISODE OF ADOLESCENT DEPRESSION

I agree to voluntarily participate in a study that involves interviewing adolescents currently undergoing outpatient treatment for depression and their parents. The purpose of this study is to describe the everyday experiences and meanings associated with being parented while I am depressed.

I will meet with Terri Farmer, MS, RN at a convenient time for me at my home for one to three one-hour interview sessions. I will talk about what it is like to be parented during my episode of depression. The interview will be audiotaped and then transcribed. Terri Farmer and authorized personnel may have access to my interview data. A number will be assigned to my interview audiotape and transcripts. My name or other identifying information (names, schools, friends) will not appear on any report of publication of this data. I may refuse to answer any questions I wish and/or my participation at any time.

A **Certificate of Confidentiality** has been approved by the Department of Health and Human Services (DHHS). This does not mean that DHHS approves or disapproves of this study. This certificate will protect the investigator from being forced to release any research data in which I am identified even under a court order or subpoena. The investigator, however, may report cases of child abuse and should I reveal that I am thinking of harming others or myself the investigator may report this information to the appropriate authorities in order that I get help.

Risks related to my involvement in this study may include unpleasant memories related to depression or feelings of sadness or anger, but the interview process will be as supportive as possible. If I am feeling stressed or sad when I am done telling about my experiences, Terri Farmer MS, RN will assist me in getting help. There are no known benefits to participation in this study. I will be paid a total of $10.00 for my time at the end of my interviews.

I can ask questions at any time and I may withdraw from the study at any time without causing any bad feelings. Whether or not I participate in this study, my treatment will not be affected.

_____ _____

Participant's Signature Date

_____ _____

Terri J. Farmer, MS, RN Date
Principal Investigator
University of Arizona College of Nursing

APPENDIX E

DEMOGRAPHIC DATA FORM

DEMOGRAPHIC DATA FORM

ADOLESCENT DEPRESSION: THE EXPERIENCES OF PARENTING AND BEING PARENTED

Dates of Interviews:
_____

Adolescent: Age ____ Sex ____ Grade___ Location of Interviews_____

Parent: Age ____ Sex ____ Location of Interviews _____

Length of time with this parent_____

Who lives at home: (familial positions)

_____ _____

_____ _____

_____ _____

DSM-IV Diagnoses:
_____

Length of illness: _____ Length of treatment: _____

Types of treatment: _____

Significant developmental/health history:

Field notes:

APPENDIX F

STATEMENT OF CONFIDENTIALITY

Adolescent Depression: Experiences of Parenting and Being Parented

Confidentiality Statement

I agree to keep in the strictest confidence all information about the individuals taking part in this research project. I will not discuss the identity of participants or any information that the women provide as a part of this study with anyone who is not a member of the research team.

I also agree to keep secure audiotapes and written materials pertaining to this study. I understand that failure to comply with these standards for maintaining confidentiality will result in my dismissal from the research project.

Signature of Interviewer Date

Signature of Principal Investigator Date

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