

Cognitive-Behavioural Family Therapy of the Adolescent Depression (A Case Study)

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Abstract

Depression, which is one of the most common psychological disorders, has attracted special attention from many psychotherapists. In recent years, different treatment methods have been used for depression syndrome. According to the research findings, the family has an important role in creating, maintaining and treating depression; also, research findings have demonstrated that cognitive-behavioural therapy (CBT) is one of the effective methods for treating depression disorders. Therefore, in this study, family therapy based on cognitive-behavioural methods was proposed as an effective treatment method for depression.

Purpose: The main purpose of this work was to explore effect of family therapy on treating depression disorders. **Method:** Method of the present research was case study and the data were obtained by clinical interview and psychological tests. In this study, a severely depressed participant (17 years old) was treated by CBT family therapy. **Results:** The results demonstrated effectiveness of these methods in treating depression. **Discussion:** Consistency and inconsistency of the results were also discussed at the end. One of the limitations of the present research was lack of a control group. Effect of other variables on the dependent variable can be controlled using a control group, which can increase research validity.

Key Words: Family Therapy, Cognitive-Behavioural Therapy, Depression, Adolescents

Kognitiv-Verhaltensfamilientherapie einer Jugenddepression (einer Fallstudie)

Zusammenfassung: Depression, die eine der meist verbreitetsten psychologischen Störungen ist, hat besondere Aufmerksamkeit von vielen Psychotherapeuten angezogen. In letzten Jahren sind verschiedene Behandlungsmethoden für das Depressionssyndrom verwendet worden. Entsprechend den Forschungsbefunden hat die Familie eine wichtige Rolle beim Schaffen, der Aufrechterhaltung und bei der Behandlung der Depression; auch haben Forschungsbefunde gezeigt, dass Kognitiv-Verhaltenstherapie (CBT) eine der wirksamen Methoden ist, Depressionsstörungen zu behandeln. Deshalb wird in dieser Studie eine Familientherapie, basiert auf Kognitiv-Verhaltensmethoden als eine wirksame Behandlungsmethode für Depression vorgeschlagen.

Zweck: Der Hauptzweck dieser Arbeit war, die Wirkung der Familientherapie bei der Behandlung von Depressionsstörungen zu untersuchen. Methode: Die Methode für den

vorliegenden Fall war die Fallstudie, und die Daten wurden von klinischem Interview und psychologischen Tests ermittelt. In dieser Studie wurde ein schwerwiegend deprimierten Teilnehmer (17 Jahre alt) wurde durch CBT Familientherapie behandelt. Ergebnisse: Die Ergebnisse demonstrieren die Wirksamkeit von diesen Methoden beim Behandeln der Depression. Diskussion: Konsistenz und Inkonsistenzen der Ergebnisse werden auch am Ende erörtert. Eine der Begrenzungen der gegenwärtigen Forschung war der Mangel an einer Kontrollgruppe. Die Wirkung von anderen Variablen auf die abhängige Variable kann mit Hilfe einer Kontrollgruppe kontrolliert werden, was die Forschungsgültigkeit steigern kann.

Schlüsselwörter: Familientherapie, kognitiv-Verhaltenstherapie, Depression, Jugendliche

La thérapie familiale cognitivo-comportementale de la dépression de l'adolescent (un cas d'étude)

Résumé: La dépression, un des désordres psychologiques le plus répandu, attire une attention spéciale de beaucoup de psychothérapeutes. Dans les années récentes, des méthodes de traitements différents ont été utilisées pour le syndrome dépressif. Selon les résultats de recherches, la famille a un rôle important dans la création, le maintien et le traitement de la dépression; aussi, des résultats de recherche ont démontré que la thérapie cognitive-comportementale (TCC) est une des méthodes efficaces pour traiter les désordres de la dépression. Ainsi, dans cette étude, la thérapie familiale basée sur les méthodes cognitivo-comportementales a été proposée comme méthode de traitement efficace pour la dépression.

Objectif: L'objectif principal de ce travail était d'explorer l'effet de la thérapie familiale sur le traitement des désordres de dépression. **Méthode:** La méthode utilisée était l'étude de cas, et les informations étaient obtenues par des entretiens cliniques et des testes psychologiques. Dans cette étude, un participant sévèrement dépressif (âgé de 17 ans) a été traité par TCC en thérapie familiale. **Résultats:** Les résultats ont démontré l'efficacité de ces méthodes dans le traitement de la dépression. **Discussion:** La régularité et l'irrégularité des résultats ont aussi été discutées à la fin. Une des limitations de la présente recherche était l'absence d'un groupe de contrôle. L'effet d'autres variables sur la variable dépendante peut être contrôlé en utilisant un groupe de contrôle, ce qui pourrait augmenter la validité des recherches.

Mots clés: Thérapie familiale, Thérapie cognitivo-comportementale, Dépression, Adolescents

Когнитивно-бихевиоральная семейная терапия депрессии у подростков. Представление случая.

Резюме: Депрессия, одно из наиболее распространенных психологических заболеваний, привлекает особое внимание многих психотерапевтов. Для лечения депрессивного синдрома в последние годы используются различные методы. Согласно исследованиям особую роль в создании, поддержании и лечении депрессии играет семья. Было также обнаружено, что одним из эффективных методов лечения депрессии является когнитивно-бихевиоральная терапия (КБТ). Поэтому в данной статье для эффективной работы с депрессией предлагается подход семейной терапии, основанной на использовании когнитивно-бихевиоральных методов.

Цель: Основной целью данной работы является исследование влияния семейной терапии на работу с депрессиями. **Метод:** Исследовался конкретный случай терапии и результаты, полученные в клиническом интервью и психологических тестах. Семнадцатилетний клиент с тяжелой формой депрессии проходил

когнитивно-бихевиоральную семейную терапию. **Результаты:** Результаты показали эффективность использования данных методов в лечении депрессии. **Обсуждение:** В конце статьи обсуждаются согласованность и противоречивость результатов. Одним из ограничений исследования явилось отсутствие контрольной группы. Влияние на независимые переменные других факторов может регулироваться благодаря использованию контрольной группы, что существенно повышает надежность исследования.

Ключевые слова: семейная терапия, когнитивно-бихевиоральная терапия, депрессия, подростки

Introduction

Many depressed people have problems in thinking, concentrating or decision making. They may be easily distracted or have memory problems. In most cases, there may be thoughts about death and suicide or intention of suicide. Range of these thoughts varies from thinking of suicide to committing it. Frequency, intensity and fatality of these thoughts also fluctuate (DSM-IV, 2000)

About 1% of children show a pattern of depression and this rate is fairly constant until early adolescence; however, the prevalence of depression then increases considerably, and from 14 to adulthood, the prevalence of depression reaches 15% (Hakin, et al., 1998; Lewinsohn, et al, 1998; Nelson & Israel, 2000).

Different theories have been raised for explaining reasons for depression. Some therapeutic methods have been also created on the basis of these available theories. Depression has been studied from biological, psychoanalytical and cognitive-behavioral points of views and in systemic theories. Family interaction patterns are one of the variables which seems to interfere with the occurrence and maintenance of depression. In most cases, when one of the spouses is depressed, he/she behaves distressfully and the other spouse responds to this behaviour with more care, so that this relationship gradually turns into a repetitive pattern, and the depressed spouse is not be able to perform his/her duties at home or at work, and is unable to resolve family problems. This issue leads to dispute among family members and increases stress in the family (Asarnow, Jaycox & Tompson, 2001).

In recent decades, family therapy has received great attention due to its important role in occurrence and maintenance of mental disorders. The main infra-structural beliefs of family therapy are that human problems are more interpersonal than intrapersonal. For this reason, intervention approaches should be used for solving these problems, which improve interpersonal relationships. The family is the most effective environmental factor for cognitive growth and child development; and many childhood problems have been caused by their families (Combrink-Graham, 1989). Accordingly, clinical specialists and researchers have considered studying the family as an interactional system. Considering the role of family in the formation and maintenance of mental disorders, family therapy has also been considered a therapeutic strategy for settling psychological disorders. The studies conducted have shown that individual therapies are not capable of providing efficient solutions for problems of both parents and children and those who are successfully treated on the basis of individual therapeutic approaches have demonstrated adverse symptoms once they have returned back to the problematic family. Carr (2000) believed that there are six important components in the process of family therapy:

1. **Functional skills:** The first step in family therapy is to identify the skills required for compatibility in school, house, society and other environments.

2. **Training:** This is one of the principles of family therapy. Functional skills should be taught using structured training methods. While training, family members begin to recognize their adaptive and non-adaptive behaviours and correct the non-adaptive ones through proper training.
3. **Reinforcement:** Designing reinforcement plans, along with training programs, helps in learning, maintaining and generalizing the training. When family members perform the tasks assigned by the therapist at home, in school or at other places, it is necessary to give them scores or points in order to reinforce the more desirable behaviours and minimise some of the non-adaptive behaviours, replacing them with more adaptive ones.
4. **Self-command:** When a child or teenager is interested in establishing a relationship with family members, self-command methods of training help him/her in becoming adapted to house regulations, settling disputes with other family members, and accepting responsibility for his/her actions.
5. **Family counselling:** During the therapy process, family members solve some of their (more intractable) problems by using a counsellor to improve family communications, both inside and outside the family.
6. **Generalization to community:** The last component, which is considered in family therapy, is the generalization of the taught skills into other social environments, such as school and the workplace (Stevens, 2001).

Different studies have emphasized the importance of interactive and attributive family patterns. For this reason, the family has a very important role in the therapy process. According to Mccavley, et al. (1993), there is a relationship between depression in children and adolescents and the stress in their families. In other words, the more the stress in the family, the more the likelihood of depression among the children and adolescents, and the less their social efficiency.

The study by Asarnow, et al. (1993) showed that, after being discharged from hospital, the depressed children who live in families with frequent crises and disputes show less improvement than those who have families without such crises. According to Kazdin and Weisz (1998), the disorders of children and adolescents should be cured within the family setting because the person is more effective in the family system; similar to the way in which the family plays a role in the occurrence and maintenance of the disorder. Therefore, application of family therapy strategies decreases the probability of depression among other family members. On the other hand, depression in children and adolescents is mostly accompanied by other psychological disorders, such as anxiety and conduct disorder, which adds to the importance of the issue and considerations of the therapy process. Family-based therapies increase the ability of family members in solving different problems, by improving family functioning and increasing the adaptive skills of family members. Most psychological interventions that are done to cure depression of children and adolescents are based on cognitive-behavioural approaches. Cognitive aspects of this treatment include confrontation, training and correction of non-adaptive cognitions. The behavioural aspects focus on some goals, such as increasing enjoyable experiences, increasing social skills, improving social relations, settling disputes, and increasing problem-solving skills (Hardman, et al., 1999).

Clark, et al. (1999) tested the effect of cognitive-behavioural therapy on the treatment of a group of adolescents with major depression. The studied group was trained in 16 sessions to become more adapted to depression. At the end of the therapy period, this group was compared with the control group which had not been trained at all. The results showed that improvement rate of the experiment group (60.8%) was significantly higher than that of the

control group. This difference continued for (at least) 4 months after ending the treatment.

Brent, et al. (1997) compared the relative efficiency of cognitive-behavioural therapy, family therapy, and non-directive supportive therapy. The results demonstrated that, after 16 sessions of therapy, the improvement rate was 60% in the adolescents who were cured by cognitive-behavioural therapy, 34.4% in the non-directive supportive therapy, and only 29% in family therapy.

Therefore, if family therapy is applied alongside cognitive-behavioural therapy, it can play a major role in the improvement of disorders among children and adolescents, in general, and in the depression of children and adolescents, in particular.

In order to fulfill the goals of family therapy, first, there should be empathy between the therapist and the family. All the family members should know that the goal of therapy is to support the family and it should be ensured that they have the opportunity for decision-making in the ways of reaching their goals (Kraus, et al., 2001). According to Gulliman (2002), the methods which are applied in family therapy vary from one case to another. These methods are selected and applied considering the various different needs, specifications and malfunctions of the families concerned.

Review of the Related Literature

Considering the role and importance of the family, family members can be trained to change incorrect, insensitive and maladaptive behaviours in children and adolescents. Families can be helped to establish healthy emotional relations using models of strengthening correct behaviour and sensible thoughts. Children with depressed parents are more susceptible to depression and other psychological disorders than other children. The risk of these children suffering from mood disorders is four times higher than that of the children who live with normal parents (Beardslee, et al., 1998).

Asarnow, Jaycox and Tompson (2001) studied the effect of family therapy with an emphasis on cognitive-behavioural approach among depressed children. In this study, family members were taught basic skills and they were trained in the nature of depression, problem-solving skills, and the effects on solving problems of the family and improvement in the ways of relationships between family members. The results of this research showed a significant difference between the experimental group and the control group (which did not receive any therapy); the difference was in terms of the improvement in depression symptoms: in the experimental group, the depression syndrome was significantly decreased. Matakas, et al. (1999) studied the effect of the family in major depressive periods of hospitalized patients. In this research, 47 participants aged between 20-64 years old, who were suffering from major depression were studied. The participants were classified into two groups. The first group did not communicate with their families during the treatment, while the second group communicated with them. Depression rates of the participants was measured on a weekly basis using five scales. It is necessary to note that none of the families in the two groups were trained. After three weeks, there was a significant difference between the two groups in terms of improvement of depressive symptoms. The group that communicated with their families improved more quickly. These results indicate the important role of the family and the necessity of family therapy for the treatment of depression.

Asarnow and Scott (1999) applied a combination of cognitive-behavioural therapy and family therapy for some depressed students in the fourth to sixth grades. They treated these children in 9 group sessions the work being based on cognitive-behavioural therapy. In the therapeutic sessions, the main training skills and their applications were emphasized. Family

training was done aiming at the generalization of these skills into other environments in which the children were present (for example, school and society). After the families and children were separately trained, some sessions were allocated to training all the other family members, such as the person suffering from depression. The results of this research demonstrated that depression symptoms in children who were treated by family therapy and cognitive-behavioural approaches significantly reduced, in comparison with the control group, which was not treated at all.

Fristad, et al. (1998) studied the effects of family training on the improvement of mood disorders. In this research, families and participants were trained in ways of recognizing mood disorders, its intermediate effective factors, intrapersonal factors, importance of social skills and also the effect of stress on mood disorders. Also, in the training sessions, the participants were trained within the framework of cognitive-behavioral approach in terms of adaptation ways to problems, problem solving and replacement of sensible thought with insensible one. At the end of training sessions, the participants and family members reported improvement of clinical syndrome and positive changes in interpersonal interactions.

Brent, et al. (1998) studied the effects of family training on the treatment of depression among the youth. They 'trained' families of a group of depressed youths about the nature of depression, attitudes to depression, and its treatment. 98% of the people who participated in these classes thought that such a training was useful and led to improved family relations.

Wissman, et al. (1997) studied two groups of parents and their children in a 10-year longitudinal study. The studied people were divided into two groups: one group, in which parents did not have any psychological disorder, and another group, in which at least one of the parents suffered from a major depression disorder. The results of this study showed that children with depressed parents had more depression syndromes, in comparison with the other group, especially before the age of puberty.

Beardslee, et al. (1997) treated 37 children, 8-14 year olds, with the parents suffering from mood disorders. They divided them into two groups: one group was treated using family therapy and mental-training interventions, and the other group was treated only using task therapies. The first group, which was trained in methods using family therapy with mental-training interventions, recognized the disorders of their parents and had better social and educational functions; also, compared with the second group, their educational and social functions increased as well.

Barrett, Dadds & Rapee (1996) compared three groups of depressed children with each other. The first group used cognitive-behavioural therapy method, the second group used a combination of cognitive-behavioural therapy and family therapy methods, and the third one, as the control group, did not receive any therapy. They found that 57% of the children in the first group, 84% in the second group and only 26% in the control group made improvements.

King and Kirschenbaum (1990) studied a group of children (n=135), who were kindergarteners to the fourth grade children. These children received a higher score than the cut-off score in the screening questionnaire of mood disorders. The participants were divided into two groups; the first group included the children who received social skills and family therapy training. Parents and teachers of the second group were counselled. This research finding demonstrated that the combined therapy of the first group was more effective in depression reduction than the method in the second group.

Lewinsohn, et al., (1990) studied 14-18 year old adolescents (n=59), who had major depression. The studied adolescents were divided to three groups; the first group received cognitive-behavioural therapy. In the second group, the adolescents received therapy, along

with their families; and the third group did not receive any therapy. The results of this research showed that both the first two groups of adolescents improved more than the third group in terms of depression criteria, and there was a significant difference between them. The second group improved more than the first one in terms of depression syndrome and anxiety.

Based on the results of the present research, it seems that family therapy is effective in the treatment in depression with an emphasis on cognitive-behavioural methods. Since no research has been done in Iran using this method, an adolescent participant received a trial of combined cognitive-behavioural skills therapy, with an emphasis on the family.

Research Methodology

The participant was a 17-year girl in the third grade of high school. She was the second child in the family, and both of her parents held a Bachelor's degree. She had one 23-year old sister, who was diagnosed as suffering from a major depression disorder based on clinical interview, DSM-V diagnostic criteria, diagnosis of a psychologist and psychological tests. Results of the Beck Depression Inventory, SCL-90-R, and the short form of the Minnesota Multiphasic Personality Inventory (MMPI), indicated major depression in the participant. After determining the type of disorder, she was treated using the methods available in family therapy approaches and cognitive-behavioural therapy techniques. The condition of the participant was followed up for one year after the treatment.

Family therapy includes different therapeutic methods which are designed to help family members solve their psychological problems. Family therapy includes four stages of (1) planning, (2) assessment, (3) treatment and (4) reviewing (Carr, 2000). All the methods and techniques of cognitive-behavioural therapy emphasize the role of cognitive and behavioural processes in the formation and maintenance of psychological disorders and the application of experimental methods, based on cognitivism and behaviourism to control and treat disorders (Zarb, 1992 (trans. by Khodayarifard & Abedini, 2003). In the present research, the following techniques were used, after diagnosing the participants' disorder:

1. **Problem solving method:** One of the techniques, which were used in cognitive-behavioural approaches is the problem-solving method. The general goal of training problem solving is to train and help people gain insight into their abilities. Using this method, the person can utilize his/her abilities to deal with routine problems. Problem solving method includes five stages as follows:
 - a. In the first stage, the person is helped to consider problems as one part of their routine life and control him/herself against problems, shocks and emotions.
 - b. In the second stage, the person understands the problem and defines it operationally.
 - c. In the third stage, the person is asked to raise all innovative solutions, which help him/her solve the problem. In this stage, no judgment is made about the provided solutions.
 - d. In the fourth stage, the person assesses every solution separately and then selects the most practical and suitable one.
 - e. In the fifth stage, the person applies the selected solution effectively (D'Zurilla & Goldfried, 1971, quoted from Kendall, 2000).

In this research, the psychotherapist asked the family to raise one of their problems during a session, in the presence of other family members. Then, the therapist trained the family members to apply the problem-solving method.

2. **Self-monitoring:** With this method, the participant is asked to record his/her thoughts using a self-reporting table. In order to prepare this table, the participant should first note the week-days and related dates, and then record nonsensical thoughts, and then the

duration and hours spent on dealing with them. The participant is gradually helped to identify his/her cognitive distortions and replace them with more sensible thoughts.

3. **Positive thinking or recognizing strengths:** In this method, the participant is encouraged to increase self-respect and promote self-esteem by recognizing his/her positive and good experiences and finding their roles. This technique can be executed individually and in the family and includes the following stages:
 - a. In the first stage, the participant is asked to mention his/her strengths.
 - b. In the second stage and in some sessions, the participant is asked to mention at least 10 to 15 good experiences for which he/she feels happy and is proud of.
 - c. In the third stage, the participant is asked to refer to the reliable strengths used in these pleasant experiences.
 - d. In the fourth stage, the participant is asked to define his/her strengths in terms of priority and select five to eight abilities which are called reliable strengths.
 - e. In the last stage, the participant is asked to present some pieces of evidence and criteria which indicate that his/her most valuable and valid strengths are reliable (Khodayarifard, 2000).
4. **Relaxation:** This is a skill, which can be easily learnt. It can decrease stress and anxiety and help people to reduce internal stresses. With this method, the participant is asked to sit on a comfortable chair or lie down on the ground and put small pillows below his/her knees, loosen his/her tights and belt, breathe slowly and regularly for some seconds and say "calm down" with each time of breathing. Then, he/she should concentrate on different parts of his/her body and loosen muscles of that part while breathing. He/she should start with his/her toes and then gradually concentrate on other parts of his/her body to reach face muscles. After concentration on each body part, the person should take a deep breath and release it slowly (Benson, 1985).

Findings of the Research

In this research, an adolescent participant was studied and treated over a course of 71 sessions, once per week. Ms. F.T. declared in the first session that, *"I have been experiencing severe continuous headaches for 2 years. Medical examinations showed that my headaches are not physical. I sleep with difficulty; I think about suicide; and I think that, if I die, it would be more convenient. I tremble and I am moody and nervous. My parents do not pay much attention to me; both of them pay more attention to my elder sister. They are very nervous and try to solve their problems with quarrelling. I have had an educational dropout in two recent years."*

Her mother also declared that her husband was a very angry person; and there have been verbal, and even physical, conflicts between her and her husband. She said that her daughter was in love with their neighbour's son when she was 15. Then, when he was conscripted to military service, her daughter found that he was not a good boy and he tried to abuse her. A similar event occurred last year. Her father paid much more attention to their elder daughter and said that the younger one was not listening to anyone. She has been nervous and suspicious of her parents. She had had an educational dropout and was not satisfied with her physical status.

Diagnostic Measures: Beck Depression Inventory, MMPI test and SCL-90- R test were used to diagnose the type of disorder in addition to clinical interviews considering DSM-IV diagnostic criteria of depression. Results of the MMPI test showed depression (Figure 1), and also indicated dissatisfaction with physical status, a level of high inhibitions, problems with expression of interests, expecting others' support, lack of insights into her problems,

paranoid thoughts, suspicion and severe pessimism, inflexibility, feeling of worthlessness, tendency to masochism, fear, anxiety and seclusion.

Results of the Beck Depression Inventory (long and short forms) indicated severe depression in the participant. The participant attained a score of 43 in the long form, and 16 in the short one (see Table 1). Her IQ was estimated to be 118 with the rank of 85% using Raven test, indicating an excellent IQ level.

Some variables such as depression, anxiety, hostility, fear of diseases, etc. were assessed using SCL-90-R questionnaire. In all the cases, her score was higher than the normal limit (the results are given in Table 2). Clinical interview based on DSM-V criteria showed that the participant saw the environment bothersome and unsuitable and had severe depression; emotional relations were very strained in the family; she thought her father was very rough; she needed support, dependency progress and was hopeless, frustrated and apprehensive of future. It is necessary to note that two psychiatrists confirmed the above diagnoses.

Before treatment and after treatment

Long test score	43	2
Short test score	16	0

Table 1: Results of Beck Depression Test before and after the treatment

Therapeutic Sessions: In therapeutic sessions, first of all, the results of the performed tests were interpreted and explained for the participant, and then she authenticated these results. In a session in which her parents were present, the results of the performed tests were interpreted for them. In family therapy sessions, the role of family in the depression of people was mentioned and some strategies were presented for reducing stress in the family.

The family members were trained in terms of problem-solving methods, optimism and its effect on behaviour. In these sessions, the family members were asked to increase emotional relations in family, complete forms about strength points, talk about adopting different methods for solving family problems, and to provide a tranquil environment in the family in their own turn.

Moreover, the parents were trained to accept the participant (not to scold her) and try to talk with her. In one of the individual sessions, the therapist explained about relaxation and its role in establishing tranquility; trained them to be relaxed and asked them to perform it every day for 20 to 30 min and also to go to swimming pool twice or three times a week.

In the family sessions, the father talked about admission into university and the family's expectations from her. Her mother cried continuously because she herself was influenced by depression and obsession, and also needed treatment. The participant believed that, because her elder sister was admitted in an accredited university, others expected the same thing of her, which resulted in her anxiety and educational drop-out. In the next session, which was held with the participant individually, her weaknesses, strengths, potential reasons for moodiness and depression along with her cognitive distortions were analyzed. Moreover, there was a conversation about her tendency to aggressiveness and she declared that her aggressiveness was the result of suffering from depression and that her parents were suspicious of her because, whenever she came in, they stopped talking, and wanted to prove that she was always wrong. Whenever she talked with them, they only said that she was blameworthy. It was noticed that family members often scolded each other while confronting them with their problems and her mother had incompatible behaviours due to her own depression and obsession.

In the next session, in which all the family members were present, the role of stress (such as repetitive fault-finding and its effect on depression) was raised and the parents were asked to hold family sessions for solving their problems and being trained in new behaviours. The participant's sister was recommended to have a closer relationship with her, and to provide her with opportunities to talk about her problems. In the next family session, problem-solving methods were repeated to the family by raising a problem and studying its different solutions. They were also instructed how to control their anger, not to find fault with others, and to observe its effects on family relationships and their mental problems.

In one of the individual sessions, the participant declared that she had been well two or three weeks ago and had successfully passed her examinations; but, she was moody more recently and did not like to study. In this session, the educational role of methods of self-command was introduced to help to reduce psychological disorders and the participant was recommended to go swimming, body-building and movies whenever she was moody. In the same session, the participant again talked about her nervous and obsessed mother and said that she was scolding her very often. She also talked about bad family relations. In the next family, all the family members confirmed reduced depression of the participant and correction of their relations. In this session, optimism was taught to the family members and the therapist asked them to fill out the form of strengths. This form was discussed in all family sessions. In one of the individual sessions, the participant said that she was much better but she was sometimes worried about losing her family members. On this basis, she was instructed to replace sensible thoughts with insensible ones and she was asked to record all these thoughts and talk about them in the next session.

In the next family session, the family members were asked to write their 10 to 15 good memoirs. In the next session which was held individually, the strengths written by the participant for the family members were investigated. She declared that she did not accept her mother and did not find any strengths in her. Thus, improvement of relations between the participant and her mother was emphasized based on the problem solving method and skill learning. Moreover, some strategies were presented for reducing obsession in the mother. For example, she was asked to record bathing duration and its times and then reduce it gradually. In addition, they were recommended not to condemn each other when they face problems because this method would lead to depression in the family members. The following family sessions were divided into two parts. In the first part, the problems and issues which caused disorder in the family relations were raised and their solutions were presented. In the second part, optimism was implemented and the family talked about their strengths and good memories with each other. Every session, the forms of the strengths of the family members and the forms of replacing sensible thoughts were studied. In addition, the mother's obsessive actions (such as long-term bathing and washing) were gradually reduced. In the sessions which were arranged with the participant alone and with her sister, there was an attempt to reinforce their emotional relations and remove suspicions of the participant about her sister by discussion, by problem-solving methods and by talking about cognitive distortions. Their relationship was turning into a closer one, gradually; they were talking and going out with each other. In addition, the therapist recommended the participant to fill her time with computer work, English and sports classes, all of which increased her self-esteem. After 58 therapeutic sessions, the participant declared her readiness for participation in the preparatory classes for university entrance examination. She also declared that her self-confidence had increased and she had changed her attitude toward her face; she thought that many people loved her, in contrast to the past.

During an individual session, her father declared that his wife’s obsession was improving, and his daughter was becoming well; she was going to classes for her entrance exam and she was studying more enthusiastically. He said that his anger was reduced to a great extent and he was trying to solve the problems in tranquility. After the end of the treatment period, Beck tests, MMPI and SCL-90-R were administered for the participant again. MMPI result (Figure 1) indicated that the participant was normal in terms of all factors. Result of Beck Depression Test indicated lack of depression. In SCL-90-R test, almost all the rates were normal (Figure 2).

In order to follow the treatment trend for one year, one session was held with the participant herself or with her family every month. Her condition was very good and she had no problems; the obsession with her mother was cured; and the anger rate of her father was reduced; and the family were solving their problems through discussion, and the emotional relations of the family members were improved. In addition, she had participated in the university entrance exam and she was majoring in English Language in one of the accredited universities of Tehran.

Discussion and Conclusion

The results of the present research showed that family therapy, using cognitive-behavioral techniques such as problem solving, relaxation, family positivism and self-monitoring could be very effective in the treatment of depression. As was observed, the studied participant suffered from major depression and the psychotherapist’s suggestions had improved family relations, changed thinking patterns among family members, and had cured the participant using family therapy and increasing the participation of family members.

On the basis of clinical interviews, it was specified that some factors such as cognitive distortions, negative attitude toward the self, lack of self-regulation and environmental pressures were among the factors which helped the growth of depression in the participant. In addition, insufficient intrapersonal skills and low activity level of the participant were effective in growth and maintenance of her depression. Therefore, family factors and cognitive factors were considered for the treatment of depression.

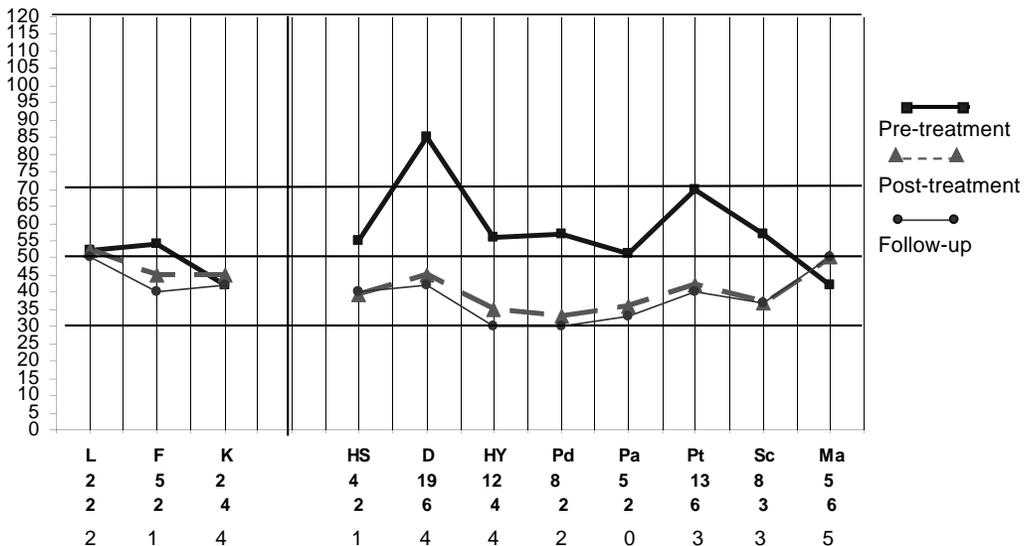


Figure 1: Pre treatment, post-treatment and follow-up results of MMPI

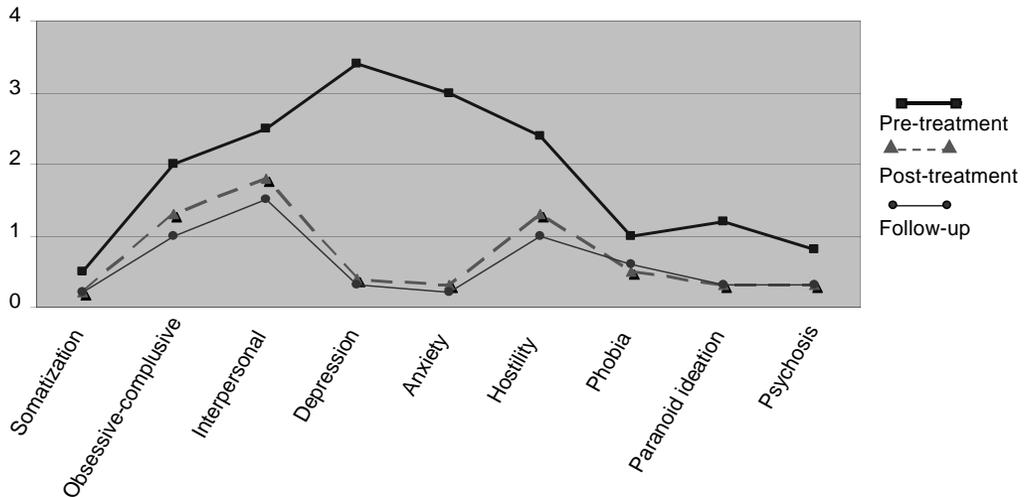


Figure 2: Pre treatment, post treatment and follow up results of SCL-90-R Test

From a cognitive point of view, confrontation, training and correction of non-adaptive recognitions were considered. In behavioural terms, increasing the person's enjoyable skills, increasing their social skills, as well as their conflicts and problem solving skills were considered. In family therapy, the generalization of the trained skills to other environments and improvement of family relations were emphasized.

The findings of this research indicated the effect of combined family therapy method with an emphasis on cognitive-behavioural approach, which was consistent with findings of the studies performed in this field. For example, Asarnow, Jaycox and Tompson (2001) reported positive effects of family therapy, with an emphasis on cognitive-behavioural approaches on the improvement of depression syndrome. In this research training, problem-solving skills and its effect on the improvement of the relationships among family members were emphasized.

Asarnow and Scott (1999) applied effect of a combination of cognitive-behavioural therapy and family therapy on some depressed students in the 4th to 6th grades. They emphasized training basic skills and their generalization to the living environment. Results of this research indicated improvement of depression in children who received cognitive-behavioural therapy and family therapy. Fristad, Gavazzi and Soldano (1998) studied the effect of family on improvement of mood disorders. They trained some effective intermediate factors in mood disorders, intrapersonal factors, importance of social skills, the effect of mental pressures on the occurrence of mood disorders and ways of adapting to problems and problem-solving for the families. At the end of the training sessions, the participant and the family members reported improvements in the clinical syndrome, and positive changes in interpersonal interactions, respectively. In the present research, results of the interview with the participant and her family members after the treatment, and the psychological tests indicated improvements of depression syndrome and changes in interpersonal relations of family members.

Brent et al. (1998) studied the role of family training in the treatment of depression among the youth. They trained families of a group of depressed youths in terms of nature of depression, attitudes toward depression and its treatment. At the end of the training course,

98% of people who participated in these classes considered the training useful, which was consistent with the findings of the present research.

In a longitudinal study by Visman et al. (1997), two groups of parents and their children were compared with each other. The first group included people whose parents did not have any psychological disorders. In the second group, at least one of the parents suffered from a major depression. Results of this study showed that children with depressed parents had more depression than the other group, especially before the maturity of depression syndrome. This study indicated the importance of family in the occurrence of disorders, especially of depression, among children.

One of the limitations of the present research was the lack of a control group. The effect of other variables on the dependent variable can be controlled using a control group, which can increase the validity of the research. Another limitation of this work was that it was a case study. The role of therapeutic methods can be studied with more reliability by using independent variables and a larger sample-size and comparing experimental and control groups, with each other. Accessibility of more participants makes it possible to apply different levels of the independent variable (therapeutic methods) and study changes in the dependent variable (disorder syndrome).

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References

- AMERICAN PSYCHIATRIC ASSOCIATION (DSM-V) (2013). *Diagnostic and Statistical Manual of Mental disorders*. Washington, DC: APA.
- ASARNOW, J.R., JAYCOX, L.H. & TOMPSON, M.C. (2001). Depression in youth: Psychosocial interventions. *Journal of Clinical Child Psychology*, 30, pp. 15-33.
- ASARNOW, J.R. & SCOTT, C. (1999). Combined family education and group Cognitive-Behavior Therapy with preadolescent children: A preliminary study. Manuscript in preparation.
- ASARNOW, J.R., GOLDSTEIN, M.J., TOMPSON, M. & GUTHRIE, D. (1993). One-year outcomes of depressive disorders in child psychiatric inpatients: Evaluation of the prognostic power of a brief measure of expressed emotion. *Journal of Child Psychology and Psychiatry*, 34, pp. 129-137.
- BARRETT, P.M., DADDS, M.R. & RAPEE, R.M. (1996). Family treatment of childhood anxiety: A controlled trial. *Journal of Consulting and Clinical Psychology*, 64, pp. 333-342.
- BARKER, P.H. (1992). *Clinical Interviews with Children and Adolescents*. New York: Guilford Press.
- BEARDSLEE, W.R., VERSAGE, E.M. & GLADSTONE, T.R.G. (1998). Children of affectively ill parents: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, pp. 1134-1147.
- BEARDSLEE, W.R., VERSAGE, E.M., WRIGHT, E.J., SALT, P., ROTHBERG, P.C., DREZNER, K. & GLADSTONE, T.R.G. (1997). Examination of preventive interventions for families with depression: Evidence of change. *Development and Psychopathology*, 9 (1), pp. 109-130.
- BENSON, H. (1985). *Beyond the Relaxation Response*. New York: Berkley Books.

- BRENT, D.A., HOLDER, D., KOLKO, D., BIRMAHER, B., BAUGHER, M., ROTH, C., IYENGARE, S. & JOHNSON, B. (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family and supportive therapy. *Archives of General Psychiatry*, 54, pp. 877-885.
- BRENT, D.A., KOLKO, D., BIRMAHER, B., BAUGHER, M., BRIDGE, J., ROTH, C. & HOLDER, D. (1998). Predictors of treatment efficacy in a clinical trial of three psychosocial treatment for adolescent depression. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32, pp. 770-774.
- COMBRINK-GRAHAM, L. (1989). *Children in family context: perspectives on Treatment*. New York: Guilford Press.
- CARR, A. (2000). *Family Therapy; Concepts, process and practice*. New York: John Wiley & Sons.
- CLARKE, G.N., ROHDE, P., LEWINSOHN, P.M., HOPS, H. & SEELEY, J.R. (1999). Cognitive-behavioral treatment of adolescent depression: Efficacy of acute group treatment and booster sessions. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, pp. 272-279.
- FRISTAD, M.A., GAVAZZI, S.M. & SOLDANO, K.W. (1998). Multi-family psychoeducation groups for childhood mood disorders. A program description and preliminary efficacy data. *Contemporary Family Therapy*, 20, pp. 385-402.
- GULLINAN, D. (2002). *Students with Emotionul and Behavior Disorders*. New Jersey: Pearson Education.
- HAKIN, B.L, ABRAMSON, L.Y., MOFFITT, T.E., SILVA, P.A., MCGEE, R. & ANGELL, K.E. (1998). Development of depression from preadolescence to young adulthood: Emerging gender differences in a 10 year lorgitudinal study. *Journal of Abnormal Psychology*, 107, pp. 123-140.
- HARDMAN, M.L., DREW C.J. & EGAN, M.W. (1999). *Human Exceptionality. USA: Allyn & Bacon .*
- KAZDIN, A.E. & WEISZ, J.R. (1998). Identifying and developing emprically supported child and adolescent treatments. *Journal of Consulting and Clinical Psychology*, 66, pp. 19-36.
- KENDALL, P.C. (2000). *Child & Adolescent Therapy: Cognitive-Behavioral procedures*. New York: Guilford Press.
- KHODAYARIFARD, M. (2000). Application of Positive Thinking in Psychotherapy from Islamic Perspective. *Journal of Psychology & Education*, 5, pp. 141-164.
- KING, C.A. & KIRSCHENBAUM, D.S. (1990). An experimental evaluation of a school- based program for children at-risk: Wisconsin early intervention. *Journal of Community Psychology*, 18, pp. 167-177.
- KRAUS, S., MAXWELL, K. & MCWILLIAM, R.A. (2001). Practice makes perfect: Research books at family-centered practcies in early elementary grades. *Exceptional Parent*, 31 (3), pp. 62-63.
- LEWINSOHN, P.M., ROHDE, P. & SEELEY, J.R. (1998). Major depressive disorder in older adolescents. *Clinical Psychology Review*, 18, pp. 765-794.
- LEWINSON, P.M., CLARKE, E.N., HOPS, H. & ANDREWS, I. (1990). Cognitive-behavioral treatment for depressed adolescent. *Behavior Therapy*, 27, pp. 385-407.
- MATAKAS, F., SCHMITT, V.T., ROHRBACH, E., VOGT-KEMPE, A. & CHURAN, J. (1999). Effect of the family relationship on in-patient treatment of sever major depression: Is family therapy always appropriate? *Family Therapy*, 26 (3), pp. 201-211.
- MCCAVLEY, E., MYERS, K., MITCHELL, J., CALDERON, R., SCHLOREDT, K. & TREDER, R. (1993). Depression in young people: Initial presentation and clinical course. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32, pp. 714-722.
- NELSON, R.W. & ISRAEL, A.C. (2000). *Behavior Disorders of Childhood*. New Jersey: Prentice-Hall.
- STEVENS, P.W. (2001). *Systems Theories*. In: D.C. Lacke, J.E. Myers & E.L. Herr (Eds.), *The Handbook of Counseling*. U.S.A: Sage.
- SHERAS, P.L. (2001). Depression and suicide in adolescence. In: C.E. Walker & M.C. Roberts (Eds.), *Handbook of Clinical Child Psychology (3rd Ed)*, (pp. 657-673). New York: Wiley.
- WISSMAN, M.M., WARNER, V., WICKRAAMARANTE, P., MOREAU, D. & OLFSON, M. (1997). Offspring of Depressed Parents: 10 years later. *Archives of General Psychiatry*, 54, pp. 932-940.