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Cognitive-Behavioral Depression Treatment for Mothers of Children With Attention-Deficit/Hyperactivity Disorder

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An adaptation of the Coping With Depression Course (CWDC) was evaluated in mothers of children with attention-deficit/hyperactivity disorder (ADHD), a population at risk for depression. Mothers were randomly assigned to receive the CWDC either immediately following an intensive summer treatment program targeting their child's behavior or after a wait-list period. Measures of maternal functioning, cognitions about child behavior, parent-child and marital relationship quality, child behavior, and ADHD-related family impairment were obtained at pretreatment, posttreatment, and 5-month follow-up. The CWDC resulted in improvements in maternal depressive symptoms, maternal self-esteem, child-related cognitions, and family impairment at posttreatment compared to a wait-list control group that were maintained at follow-up. Findings suggest that the CWDC is a promising intervention for mothers of children with ADHD, particularly those with current depressive symptomatology.

Attention-deficit/hyperactivity disorder (ADHD) is characterized by developmentally inappropriate levels of inattention, hyperactivity, and impulsivity that are first apparent prior to age 7 and associated with functional impairment in the home, school, and social settings. Given these difficulties, impaired parent-child interactions are a hallmark of the disorder (Johnston & Mash, 2001). Moreover, parents of children with ADHD experience relatively more parenting stress, depression, and marital distress, and lower levels of parenting self-esteem, relative to parents of nonproblem children (for reviews, see Fischer, 1990; Johnston & Mash, 2001). For example, approximately 40% of mothers of children with ADHD have a history of major depressive disorder (MDD; Chronis, Lahey, Pelham, Kipp, Baumann, & Lee, 2003). Furthermore, regardless of depression status, parents of children with ADHD make more negative attributions for their children's misbehavior, particularly their oppositional and aggressive behaviors, than parents of children without behavior problems (Johnston & Freeman, 1997). These negative attributions likely contribute to negative parenting behavior, such as harsh/inconsistent discipline and uninvolvement (Johnston & Patenaude, 1994; Johnston, Patenaude, & Inman, 1992). For example, parents of children with ADHD may fail to focus on positive behaviors that occur in the context of ADHD or oppositional/aggressive behaviors (Freeman, Johnston, & Barth, 1997). They may also withdraw from attempts to manage their children due to beliefs that certain behaviors are beyond their control. Importantly, these parental cognitions may negatively impact parenting, which may then exacerbate child behavior problems, creating a reciprocal pattern of negative interactions in these families (Cummings & Davies, 1999; Lang, Pelham, & Atkeson, 1999; Patterson, 1982; Pelham et al., 1997; see reviews by Beardslee et al., 1983; Cummings & Davies, 1994; Downey & Coyne, 1990).

Three evidence-based treatments for ADHD have been identified: behavior modification (including behavioral parent training and classroom behavioral interventions), stimulant medication, and combined behavioral-pharmacological intervention (Pelham, Wheeler, & Chronis, 1998). While both stimulant medication and behavior therapy rely on

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parents to administer the respective treatment consistently, effective ADHD treatments typically do not directly address the psychological well-being of parents (Chronis, Chacko, Fabiano, Wymbs, & Pelham, 2004). Although there is some evidence to suggest that behavioral and pharmacological treatments result in improvements in parent-child interactions and parenting stress/depression (e.g., Anastopolous, Shelton, DuPaul, & Guevermont, 1993), the impact of these interventions on parental well-being is limited (Chronis, Pelham, Gnagy, Roberts, & Aronoff, 2003). Furthermore, maternal depression and parental marital problems are associated with a higher dropout rate from, and poorer outcomes following (Griest & Forehand, 1982; McMahon, Forehand, Griest, & Wells, 1981; Webster-Stratton, 1985, 1992), behavioral parent training programs for noncompliant children and predict response to behavioral, pharmacological, and combined treatments for ADHD (Owens et al., 2003). Parental cognitions about themselves, their ADHD children, and their parenting have also been found to be significant predictors of child ADHD treatment outcomes (Hoza et al., 2000). These findings suggest that parental depression and child-related cognitions may be important targets for intervention in order to maximize treatment response among ADHD children. Indeed, parental adjunctive interventions have been shown to improve maintenance and outcomes following parent training for noncompliant and aggressive children (Griest et al., 1982; Webster-Stratton, 1990). Thus, it is likely that interventions that improve parental well-being, for example by increasing use of coping skills and decreasing depressive symptomatology, may have salutary effects on ADHD treatment outcomes as well.

In addition to predicting poor treatment response, our recent work suggests that maternal depression predicted the future course of conduct problems over 8 years, controlling for demographic variables, early observed parenting, and baseline conduct problems (Chronis et al., in press). These results highlight the importance of treating maternal depression in order to enhance developmental outcomes of children with ADHD.

Given that depression is the most commonly encountered psychological disorder in this population (Chronis, Lahey, et al., 2003), and has been found to predict both poorer treatment outcomes (Owens et al., 2003) and adverse developmental outcomes (Chronis et al., in press) for children with ADHD, it can be argued that it is not only important to treat mothers who are suffering from depression, but also to attempt to *prevent* depression in this at-risk population.

The Coping With Depression Course (CWDC; Lewinsohn, Antonuccio, Steinmetz, & Teri, 1984) is an empirically supported psychoeducational group treatment for depression. This behavioral intervention emphasizes the relationship between thoughts, feelings, and behaviors, and includes four treatment modules (relaxation training, increasing pleasurable activities, cognitive restructuring, and social skills/assertiveness training) that teach participants skills to intervene in each of these areas. Relative to wait-list control groups, the CWDC has been shown to significantly reduce the severity of depressive symptoms and to lead to a greater recovery rate from depressive episodes (Cuijpers, 1998; Lewinsohn, Hoberman, & Clarke, 1989). Furthermore, the CWDC reduces risk for future depressive episodes among recently remitted individuals (e.g., Kühner, Angermeyer, & Veiel, 1996), and has been adapted for use with diverse populations, including adolescents (e.g., Lewinsohn, Rohde, & Seeley, 1998), the elderly (Breckenridge, Zeiss, & Thompson, 1987), minority groups (Organista, Muñoz, & Gonzalez, 1994), and caregivers for the elderly (Lovett & Gallagher, 1988). Based upon the extant research, the CWDC appears to be a nonstigmatizing, cost-effective intervention for both depressed individuals and individuals at risk for depression. It is possible, then, that this intervention would also be helpful for other populations at risk for high levels of stress and distress. Mothers of children with ADHD are one such high-risk group (Fischer, 1990).

The CWDC treatment components appear particularly relevant for mothers of children with ADHD. The relaxation component may help mothers to remain neutral during punishment situations and to ignore mildly inappropriate behaviors. The pleasant activities component is relevant because mothers of children with ADHD often describe spending all of their time fulfilling parenting or work obligations, with little time left to do the things that they enjoy (Johnston & Mash, 2001). The cognitive restructuring module may be helpful in changing negative expectations and attributions related to child behavior that may influence parenting as well as treatment response. Finally, mothers of children with ADHD are required to be assertive in discipline situations with their children, in advocating for their children's educational needs, and in responding to critical family members. As such, they may benefit from assertiveness training, which is included in the CWDC social skills module. Consistent with research findings based on applications of the CWDC to other at-risk populations, it is likely that these cognitive-behavioral skills would have a positive impact on the stress levels and general life

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