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Current maternal depression moderates the relation between critical expressed emotion in mothers and depressive symptoms in their adolescent daughters



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ABSTRACT

Prior studies have examined critical expressed emotion (EE-Crit) in mothers in the intergenerational transmission of depression. However, the potential moderating effect of maternal depression diagnostic status in relation to EE-Crit and youth depressive symptoms has yet to be determined. A total of $N=121$ biological mother/daughter dyads that differed in maternal depression diagnostic status were recruited for the present study: (1) currently depressed mothers (current depression, $n=29$); (2) formerly depressed mothers (past depression, $n=39$); and (3) mothers free from any psychiatric history (healthy controls, $n=53$). Mothers were administered structured clinical interviews and completed self-report measures of EE-Crit and psychopathology, and daughters self-reported depressive symptoms. Results indicated no significant group differences in EE-Crit; however, current maternal depression status moderated EE-Crit such that the magnitude of the relation between EE-Crit and adolescent depressive symptoms was significantly greater in daughters of currently depressed mothers. These findings highlight the importance of considering current maternal depression, rather than a history of maternal depression, in relation to EE-Crit and adolescent depressive symptoms, providing impetus for future investigations.

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1. Introduction

Major Depressive Disorder (MDD) is a debilitating clinical syndrome that typically emerges during adolescence (Hankin et al., 1998). MDD is highly recurrent (Boland and Keller, 2009) and even subclinical depressive symptoms during adolescence are predictive of MDD in adulthood (Pine et al., 1999). Importantly, adolescence marks the time in which depression comes to disproportionately affect females, resulting in the 2:1 female to male ratio seen in adult depression (Rudolph, 2009). For these reasons among others, it is imperative to examine the factors that influence depressive symptoms among high-risk adolescents, particularly adolescent girls.

While a variety of psychosocial factors increase risk for childhood depression (i.e., stressful life events, childhood abuse or neglect; Bhatia and Bhatia, 2007), maternal depression has been consistently implicated as a predominant risk factor for children of all ages—from infancy through adolescence (Goodman and Gotlib, 1999). Children of depressed mothers are at greater risk for developing psychopathology, with a specific risk for depression (Downey and Coyne, 1990). Maternal depression has adverse

effects on the child's attachment style (Jameson et al., 1997) and contributes to negative, disengaged parent–child interactions (Lovejoy et al., 2000). Depressed mothers make more negative, critical, and hostile comments about their children (Brennan et al., 2002), further increasing risk for youth depression.

Not surprisingly then, several studies have considered the effects of expressed emotion (EE) in mothers in relation to childhood (child and adolescent) depression. EE is a construct that refers to the presence of negative components such as criticism, hostility, and/or emotional over-involvement (EOI), and positive components such as warmth and positive comments (Hooley, 2007). This growing body of literature points to EE, particularly high maternal critical EE (EE-Crit), as a significant factor in the development of childhood depression (Burkhouse et al., 2012). Some of these studies have employed high-risk designs to examine youth at high familial risk for depression, before they experience a major depressive episode. These study designs are especially informative as they allow for the identification of factors that may increase vulnerability to depression (Gotlib et al., 2010). We are aware of three high-risk design studies that investigated the relations between maternal depression, EE-Crit, and youth depression (Tompson et al., 2010; Burkhouse et al., 2012; Silk et al., 2009). We present these findings to highlight the established relations between these variables; however, it is not our intent to investigate causal relations in the current study.

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Conducting a high-risk cross-sectional study with children (ages 8–12) of mothers with a history of depression, [Tompson et al. \(2010\)](#) found that maternal depression was positively associated with EE-Crit. Both maternal depression history and EE-Crit were significantly associated with MDD in children; however, maternal depression history was the stronger predictor of child depression. Additionally, maternal depression history did not moderate the relation between EE-Crit and child depressive symptoms, but it is important to note that the authors made no distinction between *current* and *past* maternal depression. In examining EE-Crit's contribution to childhood initial MDD onset, [Burkhouse et al. \(2012\)](#) conducted a multi-wave high-risk longitudinal study of children (ages 8–12) of mothers with or without a history of depression. EE-Crit predicted children's depression onset over a 14-month period, even after controlling for maternal and child depressive symptoms at a 6-month follow-up. Maternal depression status, defined as a history of MDD during the child's lifetime, was examined as a moderator of EE-Crit and results were non-significant; however, this was attributed to low statistical power due to an insufficient sample size. Finally, a high-risk longitudinal study conducted by [Silk et al. \(2009\)](#) examined EE-Crit among mothers of children (ages 8–19) with differential depression statuses. EE-Crit was significantly higher among mothers of currently depressed, remitted, and high-risk children as compared to healthy controls. No significant differences were found between the first three groups on EE-Crit. Additionally, EE-Crit was associated with an increased likelihood of depressive onset in children at-risk or with a history of depression, suggesting a potential causal role of EE-Crit. Thus, [Silk et al.'s \(2009\)](#) study emphasizes the transactional nature of EE-Crit. Collectively, the literature suggests that maternal depression is positively associated with EE-Crit, and EE-Crit appears to be a significant, independent predictor of youth depression.

While this research is highly informative, the potential moderating effect of *current*, as compared to *past*, maternal depression on the relation between EE-Crit and adolescent depression has yet to be determined. Prior high-risk studies have generally operationalized maternal depression as mothers with a lifetime history of depression ([Tompson et al., 2010](#)) or mothers who had a major depressive episode during the child's lifetime ([Burkhouse et al., 2012](#)). This failure to distinguish between currently and formerly depressed mothers in the study of EE-Crit likely has implications, as distinct behavioral and emotional changes occur in mothers during the course of major depressive episodes. There are many ways in which *current* maternal depression is associated with compromised parenting (see [Joormann et al., 2009](#)). For instance, currently depressed mothers are more critical and disengaged from their children ([Cox et al., 1987](#)). Moreover, current depression, rather than a history of psychopathology, is predictive of this negative parent–child interaction style ([Adrian, 1989](#)). Taken together, these findings suggest that *current*, rather than *past*, maternal depression may distinctly influence the relation between EE-Crit and child depressive symptoms.

Against this background, the present cross-sectional, high-risk study examined whether the relation between EE-Crit and depressive symptoms in adolescent daughters was moderated by maternal depression diagnostic status (current depression, past depression, and healthy controls). We were specifically concerned with depressive symptoms in adolescent girls due to the fact that a disproportionate number of girls become affected by depression during adolescence ([Rudolph, 2009](#)). Moreover, there are important female-specific factors, particularly in regards to social cognition ([McClure, 2000](#)) and interpersonal style ([Purdie and Downey, 2000](#)) that makes girls particularly susceptible to depressive reactions to EE-Crit and maternal depression ([Davies and Windle, 1997](#)). We had two hypotheses: 1) mothers with current depression would report significantly higher EE-Crit than mothers with past depression and healthy controls; and 2) maternal depression status would moderate the relation between

EE-Crit and depressive symptoms in daughters, such that the magnitude of the relation between EE-Crit and depressive symptoms would be greater among mothers with *current* depression. While positive findings would not establish a causal relationship between EE-Crit and adolescent depression, they would suggest that emphasizing the treatment of EE-Crit, particularly in currently depressed mothers, is warranted. By examining EE-Crit specifically, rather than the general parenting impairments associated with maternal depression (i.e., less warmth and nurture), we aim to provide therapists with a well-operationalized treatment target.

2. Methods

2.1. Participants

A total of $N=121$ biological mother/daughter dyads formed three groups that differed in maternal depression diagnostic status: (1) currently depressed mothers (current depression, $n=29$); (2) formerly depressed mothers (past depression, $n=39$); and (3) mothers free from any history of psychopathology (healthy controls, $n=53$). See [Table 1](#) for the ages of mothers and daughters, respectively. The sample was racially diverse, composed of 23% African American, 44% Caucasian, 15% Multiracial, and 5% Other; 13% chose not to identify. Average annual household income among families was \$42,64K (S.D.=34,74K). Comorbidity among mothers with a history of depression included: panic disorder (current depression: $n=1$, past depression: $n=3$), generalized anxiety disorder (current depression: $n=6$, past depression: $n=1$), social phobia (current depression: $n=5$, past depression: $n=3$), obsessive–compulsive disorder (current depression: $n=1$, past depression: $n=1$), anxiety disorder not-otherwise-specified (current depression: $n=2$, past depression: $n=4$), current alcohol dependence (current depression: $n=0$, past depression: $n=1$), past alcohol dependence (current depression: $n=7$, past depression: $n=7$), and past substance abuse (current depression: $n=7$, past depression: $n=8$).

Inclusion criteria required that mothers in the groups with a history of depression report a lifetime diagnosis of recurrent MDD, and meet criteria for a current major depressive episode (current depression group, specifically), on the Structured Clinical Interview for DSM-IV-TR (SCID-I; [First et al., 2002](#)). Healthy control mothers had to be free of any psychiatric history per the SCID-I. All mothers were required to have biological daughters between the ages of 10 and 16 years-old who are fluent in English, with adequate reading skills for completing self-report measures as determined by the Wide Range Achievement Test 4 (WRAT4; [Wilkinson and Robertson, 2006](#)). If participants failed to meet full criteria, had bipolar I or any psychotic disorder, or any learning disability or mental retardation, they were excluded. Participants were recruited from a diverse major metropolitan area in the continental United States through community advertisements and from local inpatient and outpatient clinics. Advertisements were posted on craigslist and local radio, and flyers were placed at various locations at the university. In all, seventy-two dyads were recruited through advertising, and the remaining forty-two from clinics. Participants in the current and past depression groups responded at similar rates to each recruitment source.

2.2. Measures

2.2.1. The structured clinical interview for DSM-IV TR axis I disorders ([First et al., 2002](#))

The SCID-I was conducted to determine MDD status in mothers. For the assessment of MDD and comorbid psychiatric disorders, all modules were used. Inter-rater reliability on audiotaped SCID-I interviews, with raters blind to the diagnosis of the mother, found Kappa to be 1.00 for current diagnosis of depression and 0.81 for past diagnosis of depression ([Sharp et al., 2014](#)).

2.2.2. General health questionnaire (GHQ, 28-item version) ([Goldberg, 1978](#))

Mothers completed the GHQ as a measure of general psychopathology. The GHQ has a maximum total score of 84 which indicates extreme severity of symptoms. The reliability and validity of the GHQ have received support ([Failde et al., 2000](#); [Lincoln et al., 2003](#)). In the current study, the GHQ had a Chronbach's α of 0.93.

2.2.3. The mood and feelings questionnaire ([Angold et al., 1987](#))

The MFQ was used to measure depressive symptoms in daughters over the previous two-week period. The MFQ is a widely used self-report measure that assesses symptoms of depression in children and adolescents 6–17 years of age and has been extensively used in clinical and epidemiological research ([Sund et al., 2001](#); [Wood et al., 1995](#)). The MFQ has a maximum score of 66, indicating extreme depression. The criterion validity and re-test reliability have been supported in previous work ([Vander Stoep et al., 2012](#); [Wilkinson et al., 2013](#); [Wood et al., 1995](#)). In the current study, the MFQ had a Chronbach's α of 0.93.

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