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Longitudinal associations between depression symptoms and peer experiences: Evidence of symptoms-driven pathways

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ABSTRACT

Although most studies suggest that depression is a consequence of poor treatment by peers, these studies have often failed to consider alternative models. We compared the *interpersonal risk model* (poor peer relations leading to depression), the *symptoms-driven model* (depression leading to poor peer relations), and the *transactional model* (depression and poor peer relations sharing a bidirectional association) using a multi-informant cascade modelling approach. Data were collected annually from 703 youth and their parents beginning in grade 5 (age 10–11) and concluding in grade 12 (age 17–18). Accounting for within and across time associations, a symptoms-driven model was replicated across parent- and self-reported depression symptoms in predicting later perceived peer rejection. This relation was stronger during school transition than later years. Self-reported depression symptoms also predicted self-reported peer victimization. This study adds to a growing literature demonstrating the need to consider different models as depression symptoms can precede peer relations difficulties.

Depression is one of the most common mental disorders in adolescence with a 1-year prevalence of approximately 4–5% and a lifetime prevalence of 19% (Merikangas et al., 2010; Thapar, Collishaw, Pine, & Thapar, 2012). The developmental progression of depression suggests that it is relatively rare in childhood but increases substantially during adolescence following puberty (Birmaher et al., 1996; Costello, Erkanli, & Angold, 2006; Thapar et al., 2012; Wade, Cairney, & Pevalin, 2002). Considering that prevalence rates of depression increase during adolescence (APA, 2013; Birmaher et al., 1996) and that depression symptoms show strong stability over time (Cole, 2006; Rudolph, Flynn, Abaied, Groot, & Thompson, 2009), it is important to focus on developmental periods during which symptoms of depression are emerging (Cole, 2006), and to examine risk factors or consequences associated with its development and maintenance (Rudolph et al., 2009). In this study, we were interested in how peer relations influence or are influenced by symptoms of depression across late childhood to late adolescence. Specifically, we examined self- and parent-reports of depression symptoms, self-reports of peer victimization (i.e., being bullied), and perceived peer rejection in a randomly drawn non-clinical sample of Canadian youth assessed yearly on eight occasions. We focused on symptoms of depression and not on the clinical diagnosis of depression because adolescents with subthreshold levels of depression have been shown to not differ from adolescents diagnosed with major depressive disorder in terms of their risk for self-harming behaviour, level of impairment, depression in adulthood, and rate of treatment for the disorder (Angold, Costello, Farmer, Burns, & Erkanli, 1999; Rutter, Kim-Cohen, & Maughan, 2006).

1. Depression symptoms and poor peer experiences

Depression and symptoms of depression in childhood and adolescence are strongly linked to two separate but related constructs: peer victimization and peer rejection (Choukas-Bradley & Prinstein, 2014). Peer victimization occurs when an individual is the repeated recipient of intentional aggression, in the presence of a power imbalance (Olweus, 2001). Peer rejection is defined as being actively disliked by peers (Coie, Dodge, & Coppotelli, 1982). Although peer victimization and peer rejection are moderately correlated (e.g., $r = 0.57$; Knack, Tsar, Vaillancourt, Hymel, & McDougall, 2012), they do differ conceptually. Peer victimization occurs with one other person or a small group of individuals, typically in dyadic interactions, whereas peer rejection is usually related to a group-level phenomenon (Choukas-Bradley & Prinstein, 2014). Peer rejection has been often measured using peer reports, but has also been measured using self-reports. Both peer- and self-reported peer rejection have been linked to depression symptoms (Zimmer-Gembeck, Hunter, & Pronk, 2007).

Longitudinal studies suggest that peer rejection normally precedes peer victimization (e.g., Buhs & Ladd, 2001; Buhs, Ladd, & Herald,

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2006; Ostrov, 2008; Serdiouk, Rodkin, Madill, Logis, & Gest, 2015), which is consistent with the idea that rejected youth are more likely to be victimized by peers than non-rejected youth because of their low social status (Boivin & Hymel, 1997; Buhs & Ladd, 2001). Experiencing peer victimization may also lead to low peer acceptance (Kochel, Ladd, & Rudolph, 2012). The relation between peer victimization and peer rejection has been described as reciprocal in nature where peer victimization can lead to peer rejection and vice versa (Card & Hodges, 2008; Hodges & Perry, 1999).

There are multiple ways individuals can be victimized by their peers. Some research has shown support for the categories of overt (i.e., verbal and physical) victimization, relational/social victimization, and cyber-victimization (Dempsey, Sulkowski, Nichols, & Storch, 2009) and each have been related to depression symptoms (Hamilton et al., 2016; Landoll, La Greca, Lai, Chan, & Herge, 2015; Marshall, Arnold, Rolon-Arroyo, & Griffith, 2015; Schwartz, Gorman, Nakamoto, & Toblin, 2005). Previous research on children's definitions of bullying has indicated that children refer to physical aggression, verbal aggression, and general harassing behaviour the most and social aggression the least (Vaillancourt et al., 2008). This suggests that asking a general question about bullying (e.g., “How often have you been bullied?”) may elicit answers relating to only physical and verbal types of aggression and not social aggression, thus underestimating the prevalence of bullying (Vaillancourt et al., 2010). Indeed, asking questions about multiple forms of bullying has been shown to be a more sensitive measure of victimization experiences, yielding more accurate prevalence rates than the general question alone (Vaillancourt et al., 2008; Vaillancourt et al., 2010).

Interpersonal theories related to the development of depression symptoms have emphasized previously adolescents' reactions to their interpersonal environment instead of the influence of the adolescents on their interpersonal environment (Rudolph, 2009). During adolescence, the need for affiliation with peers becomes stronger. This need arises amidst changing relationships involved in the transition to middle school and/or secondary school, negotiating independence from parents, and beginning to date. Most adolescents successfully navigate these challenges. Disturbances in relationships such as peer victimization and perceived peer rejection can add to the interpersonal stress of the already fluctuating interpersonal environment of adolescence, which may lead to symptoms of depression (i.e., *interpersonal risk model*: poor peer relations leading to depression symptoms). For those already experiencing symptoms of depression, the changing interpersonal environment may be an especially vulnerable time where disturbances in relationships may be difficult to manage (i.e., *symptoms-driven model*: depression symptoms leading to poor peer relations). These peer problems, in turn, may further exacerbate symptoms of depression (i.e., *transactional model*: depression symptoms and poor peer relations sharing a bidirectional association).

2. Interpersonal risk model

Research on the link between peer victimization, peer rejection, and depression symptoms has tended to focus on the interpersonal risk model in which the stressor of poor peer relations confers a risk for increased symptoms of depression (Cole, 1990; Nolan, Flynn, & Garber, 2003; Schwartz, Lansford, Dodge, Pettit, & Bates, 2015; Schwartz et al., 2005; Ttofi, Farrington, Lösel, & Loeber, 2011; Zimmer-Gembeck, Waters, & Kindermann, 2010). For example, Schwartz et al. (2005) found that peer victimization (peer- and teacher-reported) was linked to depression symptoms (self-reported) concurrently and over time. Peer rejection (self-, parent- and teacher-reported) has also been linked to depression symptoms (self- and parent-reported) concurrently and over time (Nolan et al., 2003). The dominant assumption in the interpersonal risk model was that problems with peers lead to maladaptive outcomes. This assumption may have dissuaded some researchers from examining both variables at both time points. The cross-lagged path from one variable to another (e.g., peer problems to depression symptoms) can be accounted for by within- and across-time relations among constructs (e.g., between peer problems and depression symptoms within time point, and the stability of peer problems and depression symptoms; Masten & Cicchetti, 2010). Said differently, the relations from peer problems to later depression symptoms may be attenuated by within- and across-time relations among constructs. Thus, these relations can be controlled for.

3. Symptoms-driven model

Less research attention has been paid to a *symptoms-driven* pathway in which the reverse relation is observed (i.e., depression symptoms conferring a risk for maladaptive interpersonal outcomes, particularly in the area of peer relations; Agoston & Rudolph, 2013; Kochel et al., 2012; Rudolph, 2009; Sourander, Helstelä, Helenius, & Piha, 2000; Vaillancourt, Brittain, McDougall, & Duku, 2013). The scar hypothesis predicts that those who have experienced an episode of depression (or symptoms of depression) will experience long-lasting effects (Lewinsohn, Steinmetz, Larson, & Franklin, 1981; Nolen-Hoeksema, Girgus, & Seligman, 1992; Rohde, Lewinsohn, & Seeley, 1990). This hypothesis has been incorporated into interpersonal theories of depression in children and adolescents where symptoms of depression interfere with the development of skills associated with initiating and maintaining interpersonal relations (Rudolph, 2009). For example, Kochel et al. (2012) demonstrated support for a symptoms-driven model of depression and peer relations where parent- and teacher-reported depression symptoms predicted self-, peer-, and teacher-reported victimization (grade 4 to 5 and grade 5 to 6) and low peer-reported acceptance (grade 4 to 5). Self-reported depression symptoms at age 8 have also been shown to be associated with peer victimization at age 16 (parent-, teacher- and self-report; Sourander et al., 2000). This relation between depression symptoms and peer victimization was found when accounting for prior experiences with victimization; however, the stability of depression symptoms was not accounted for. In these studies, problems with mood preceded problems with peers.

4. Transactional model

There is also evidence supporting a *transactional model* (Sameroff, 2009) in which qualities of the individual (i.e., depression symptoms) and the environment (i.e., peer relations) share a bidirectional relation over time (Kaltiala-Heino, Fröjd, & Marttunen, 2010; Platt, Kadosh, & Lau, 2013; Sweeting, Young, West, & Der, 2006). The transactional model emphasizes the changing nature of the environment and the changing nature of the individual where the individual influences the environment and their own development (Sameroff, 2009). For example, Sweeting et al. (2006) found bidirectional relations between depression symptoms and peer victimization at ages 11 to 13, and that depression symptoms at age 13 predicted victimization at age 15. Kaltiala-Heino et al. (2010) found that, for girls and boys aged 15–17, depression symptoms predicted being left alone by peers (not by choice) and peer victimization predicted later depression symptoms for boys only. For girls but not for boys, depression symptoms predicted subsequent victimization by peers.

The increased attention to the longitudinal associations between depression symptoms and peer relation difficulties has produced evidence supporting an *interpersonal risk model* (poor peer relations leading to depression symptoms), a *symptoms-driven model* (depression symptoms leading to poor peer relations), and a *transactional model* (depression symptoms and poor peer relations sharing a bidirectional association). The temporal priority is particularly difficult to assess because most of the studies conducted to date share notable substantive problems including: (1) being short in duration (i.e., 1–2 years; e.g., Kaltiala-Heino et al., 2010; Schwartz et al., 2005), (2) having long time periods between assessments (i.e., 8–9 years) that lack consistent

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