PARENTAL DEPRESSION AND THE SEVERITY OF ADOLESCENT SUICIDE IDEATION AND BEHAVIOR: A TEST OF A MEDIATION MODEL

by

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ABSTRACT

An extensive literature has implicated parental depression in child and adolescent psychopathology (Downey & Coyne, 1990). However, less is known about the mechanisms through which parental depression affects the adolescent. The current study tested parental attitudes toward conflict discussions with their adolescent as a potential mechanism linking parental depression to adolescent suicide severity in a sample of 65 adolescents and their parents. Parental attitudes (punitive, abdicating, or supportive) were measured using self-report ratings of emotion attitudes and reactions immediately before and after a videotaped conflict discussion with their adolescent. I hypothesized that parental depression would be associated with punitive, abdicating, and less supportive parental attitudes, and that these attitudes would also be associated with an increase in adolescent suicide severity. Results indicate that parental depression was associated with adolescent's suicidal thoughts and behavior. Of the three parental attitudes, only parental abdication was associated with the severity of adolescents' suicide ideation and behavior. Additionally, the relationship between parental depression and adolescent suicide severity is partially accounted for when parents report an attitude of abdication and withdrawal toward conflict discussions with their adolescent. The findings suggest that parental abdication may lead to withdrawal from the parenting role and force the adolescent to maintain the relationship, reducing his/her ability to use the parent as a resource (Lyons-Ruth et al., 2013; Lyons-Ruth, Bureau, Holmes, Easterbrooks, & Brooks, 2013).

INTRODUCTION

Social and situational factors play an especially important role in the development of depression, specifically among caregivers. Given the known risks for adjustment problems among children of depressed parents, many researchers have focused their study on potential contextual factors that may play a role in its emergence among this specific group. Gjesfjeld, Greeno, Kim, and Anderson (2010), as well as others, have cited general "maternal reported stress," as one of the leading factors contributing to the high rates of depression and depressive symptomology among mothers. Whether the stress stems from economic, marital, or work-related problems, each of these areas is particularly impacted by the birth of a child and has the potential to cause psychological distress for mothers as they care for their children (Cairney, Boyle, Offord, & Racine, 2003; Moss, Rousseau, Parent, St.-Laurent, & Saintonge, 1998). Despite the challenges associated with motherhood, some studies have observed that high levels of social support may buffer the negative effects of these stressors (Gjesfjeld et al., 2010). Conversely, however, a lack of social support, whether real or perceived, may exacerbate them and increase the possibility of translation to the child.

Transmission of Caregiver Depression in Infancy, Early Childhood, and Childhood

An extensive literature has demonstrated that caregiver depression poses significant risk for the development of offspring adjustment problems, specifically during their youth (Downey & Coyne, 1990). One proposed explanation for this

relationship maintains that infancy and early childhood mark a period of time in which the child depends on the parent to support him/her in developing important physiological and emotional regulation strategies (Bureau, Easterbrooks, & Lyons-Ruth, 2009). Proponents of this theory argue that depressed parents may not be able to provide the support and care needed for children to develop the ability to regulate themselves in an appropriate way. Functional emotion regulation strategies are important both in childhood and into adulthood, as individuals with poor emotion regulation are at an increased risk for developing a variety of internalizing symptoms.

As part of their development of regulation strategies, all young children form and maintain attachment bonds over the course of infancy, childhood and adolescence. According to Bowlby (1982), the function of an attachment bond is to serve as a source of protection or safe-haven at times of stress, and as a supportive base for exploration of the environment when the youth is feeling secure. A secure attachment is especially important in the emotional development of children as they learn to regulate their feeling and behaviors, whereas an insecure attachment bond reduces the child's capacity to use the caregiver as a source of comfort and protection at times of distress or challenge (Solomon & George, 2011b). The attachment bond ultimately becomes internalized as a representation of, or expectation for, a caregiver's availability and responsiveness.

Some studies have reported a link between maternal depression and a specific form of insecure attachment that is described as disorganized (George & Solomon, 2011). According to Main and Hesse (1998), these disorganized children often have caregivers who are either frightened or frightening, and are thus unable to respond appropriately or predictably to their children. Depressed and disorganized caregivers

often view themselves as inept and incapable, and their withdrawn and helpless behavior can be described as abdication from the parenting role and from the position as the dominant member of the dyad (Solomon & George, 2011a; George & Solomon, 2011). Given the volatile nature of their caregiver's behavior, these children are unable to develop an organized attachment strategy that allows them to simultaneously seek both autonomy and support from their parents. Without the ability to use their parent as a stable resource and source of comfort, these children are often unable to develop appropriate emotion regulation strategies and have an increased likelihood of susceptibility to future stressors. More specifically, disorganized children show higher levels of internalizing and externalizing behaviors, including an elevated risk for developing psychiatric symptoms (Solomon & George, 2011b; George & Solomon, 2011).

Much remains to be learned about how caregiver depression creates risk for child problems. Parenting style may be one possible factor that may account how maternal depression is transmitted to the child. When parents have problems, it can impair their ability to serve as supportive and reliable caregivers, which suggests that their behavior as parents may help explain how their depression is passed on to their children. In their discussion of the mediating role of parental behavior on child adjustment, Elgar, Mills, McGrath, Waschbusch, and Brownridge (2007) identified three categories that classify and describe the different types of parenting that research has demonstrated negatively affects the child – "(1) lack of nurturance and positive involvement with the child, (2) parent-child hostility and parental rejection of the child, and (3) poor monitoring and supervision of the child's activities." Parenting described as lacking nurturance and positive involvement is characterized by less

frequent praise, less positive feedback, less encouragement, and less supportive behaviors during an interaction task (Kam et al., 2011). Hostile parenting typically involves the use of more controlling, punitive, and negative child management strategies, as well as discipline techniques that are more severe, strict, and physical (Cunningham & Boyle, 2002; Pettit, Bates, & Dodge, 1997). Comparatively, parents who poorly monitor and supervise their children are often more avoidant and disrupted in their parenting practices (Conger, Patterson, & Ge, 1995). Although each of these parenting styles has been associated with social, academic, and behavioral problems in children, they may not encompass all types of negative parenting behaviors and focus only on effects during childhood.

Caregiver Depression and Risk for Adolescent Psychopathology

Although parent depression may impact the adolescent in similar ways that it does the child, the parent-child relationship functions much differently in adolescence. As these children transition into more adult-like roles, they encounter a variety of new stressors, including romantic relationships, employment opportunities, and more. During this time, they must be able to use their parent as a source of support and guidance while also maintaining and gaining their independence through discussion and negotiation (Obsuth, Hennighausen, Brumariu, & Lyons-Ruth, 2014). It is during this time that they develop what Bowlby (1982) refers to as a goal-corrected partnership, in which the adolescent finds more flexible and adaptive ways to seek support from their attachment figure. More specifically, there is a shift from needing parental proximity as a child, to needing parental availability as an adolescent.

Not surprisingly, the effects of caregiver depression on adolescent functioning have received less attention than related research on infants and young children.

However, at least some research has documented that its risks extend beyond these earlier sensitive periods and into adolescence. Much of the research on parent-adolescent relationships suggests that maternal depression increases adolescent risk for a number of internalizing and externalizing problems, with adolescent depression being the most common outcome. In fact, Hammen and Brennan (2003) found that adolescents of depressed parents were twice as likely to develop diagnosable depression than the children of parents who had never experienced depression. Even further, Diamond, Reis, Diamond, Siqueland, and Isaacs (2002) have cited parental psychopathology as a source of the development, maintenance, and potential relapse of adolescent depression. However, adolescent depression is just one potential consequence associated with parental depression, as parental depression may negatively impact the adolescent adjustment in a number of ways. According to Wagner, Silverman, and Martin (2003), parental affective disorders, such as depression, have been associated not only adolescent depression, but with co-occurring suicidal behaviors as well.

Joiner's Interpersonal Theory of Suicide is one of the most accepted theories explaining the processes that result in suicidal thoughts and behaviors. The theory identifies two interpersonal factors, thwarted belongingness and perceived burdensomeness, that predispose the individual toward suicide risk (Van Orden et al, 2010; Van Orden, Cukrowicz, Witte, & Joiner, 2012). Thwarted belongingness refers to the unmet need to belong and feel social connectedness, while perceived burdensomeness refers to the perception that one's mere existence is a hindrance to his/her family and friends. Together with an acquired capability to commit suicide,

these two interpersonal factors may be partially responsible for the development and persistence of suicide in both adolescents and adults.

Despite the applicability of this theory across age groups, perceived burdensomeness may play a particularly powerful and unique role in the emergence of suicidality in adolescents. According to Sabbath's (1969) Family Systems Theory of Adolescent Suicidal Behavior, adolescents are particularly susceptible to feelings that they are expendable members of the family. They are more inclined to interpret negative or aversive parental attitudes toward them as indications that the family would be better off if the adolescent were not around. This theory has been empirically supported in other research in which adolescent perceptions of expendability were positively correlated with adolescent suicidal behavior (Van Orden et al., 2010). With this theory in mind, there might be an increased risk for parental depression and negative parental affect to be communicated to the adolescent and interpreted in this way.

One of the challenges in testing Joiner's theory is examining the processes through which adolescents come to see themselves as not belonging, or as being a burden to their parents. Conversations about conflict, which are often studied by asking parents and adolescents to identify and discuss areas of disagreement, are a medium through which parents may facilitate or interfere with adolescents' feelings of being understood and accepted. On the one hand, these discussions can provide opportunities for adolescents to seek support in instances of distress, as well as to discuss bids for autonomy (Kobak & Duemmler, 1994). Conversely, they may also result in conflict and feelings of not being wanted or supported. As a result, the quality of parent-adolescent communication, and the degree to which the parent is able to

respond to their adolescent's concerns in a supportive way, may contribute to adolescents' feelings of belonging or being a burden to parents. Respectful and balanced conflict negotiations help provide a foundation with which the adolescent is able to cope with stressful situations, as well as successfully navigate through future conflict as an adult (Obsuth et al., 2014).

The ideal parent-child conflict discussion is one in which the pair can directly talk about their concerns, attempt to understand each other, and agree to disagree if they cannot reach a solution (Kobak & Duemmler, 1994). Given that the discussion of serious areas of concern elicit feelings of vulnerability in the adolescent and parent, negotiations that focus on cooperation and perspective taking are described as being especially secure. Conversely, failure to engage in cooperative and supportive discussions is described as insecure and risky, and ultimately undermines adolescents' confidence in the relationship. One or both members of the dyad may view voicing their concerns as a chance to be ridiculed or invalidated, or as an opportunity to be ignored, rejected, or abandoned.

One of the methods for assessing security and quality of communication in an attachment dyad is the Goal-Corrected Partnership in Adolescence Coding System (GPACS; Lyons-Ruth, Hennighausen, & Holmes, 2005). The GPACS uses ten 5-point scales to first evaluate the communication and collaboration of the dyad as a whole, and then rate the adolescent and parent separately on a number of behaviors. Both adolescents and parents are assessed on their tendency to engage in punitive/hostile, odd/out-of-context, and distracted/disoriented behaviors. Adolescent-parent role confusion is assessed with a scale addressing adolescent caregiving behaviors towards the parent, and another rating the extent to which parents fail to structure and guide the

interaction. Parents are also rated on their ability to support and reassure their adolescent during the discussion. The GPACS extends earlier coding systems that rate similar parent-adolescent behaviors, such as anger, assertiveness, avoidance, and parental support (Kobak, Cole, Ferenz-Gillies, Fleming, & Gamble, 1993). However, in addition to evaluating secure and insecure aspects of communication, the GPACS adds scales that focus on behaviors associated with disorganized attachment.

Because parental depression may lead to feelings of ineptitude or inadequacy, specifically in terms of the attachment relationship, it is important to consider how these feelings might influence parents' behaviors in a goal conflict discussion. Depressed parents' tendencies to engage in negative parenting styles that increase risk for adolescent problems may shape their attitudes toward engaging in conflict discussions with their adolescents. If the parent is unable or unwilling to cooperatively engage the adolescent, the adolescent may doubt the parent's ability to be available and supportive. These parental attitudes and behaviors may even be interpreted as a negative attitude toward the adolescent and his problems, reinforcing his view of himself as a burden on the parent and family.

Although the quality of communication during parent-adolescent conflict discussions has been associated with adolescent psychopathology, less is known about how parental attitudes toward these discussions account for these effects. The goal of this study is to test a mediation model that attempts to examine how parental attitudes toward conflict discussions with their adolescent might mediate the relationship between parental depression and severity of adolescent suicide. The first step in the model was to examine the association between parental depression and hostile, abdicating, and less supportive parental attitudes toward conflict discussions. The

second step in the model was to test the association between hostile, abdicating, and less-supportive parental attitudes and severity of adolescents' suicide ideation and behavior. Finally, I will test parental attitudes as a potential mechanism that accounts for the association between maternal depression and the severity of adolescents' suicidality, by examining the indirect effect of parental attitudes on the severity of adolescents' suicidal ideation and behaviors.

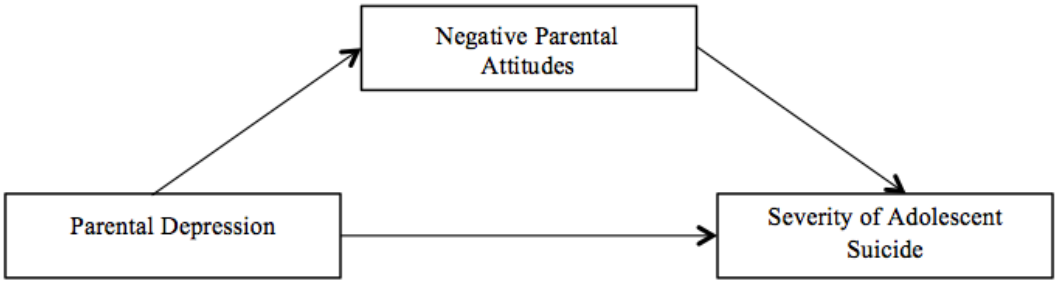


Figure 1 Proposed mediation model for parental depression, adolescent suicide risk, and negative parental attitudes toward conflict discussions with their adolescent.

METHODS

Participants

The current sample included 65 adolescents undergoing treatment as part of a randomized clinical trial comparing Attachment Based Family Therapy (ABFT; Diamond et al., 2002) with Nondirective Supportive Therapy (NST; Brent et al., 1998) for depressed and suicidal adolescents and their families. Study inclusion criteria were severe suicide ideation (SIQ $\geq$ 31) and depression (BDI $\geq$ 20).

Adolescents in the sample were predominately female (77%), with ages ranging from 12 to 18. Forty-nine percent of the adolescents were African-American, 34% were Caucasian, 6% were Hispanic/Latino, and an additional 11% were from other backgrounds. Sixty-three percent of the adolescents have seen or are currently seeing a doctor, psychiatrist, psychologist, or therapist for behavioral or emotional problems. Additionally, 64% of the adolescents reported that they engage in non-suicidal self-injurious behaviors, such as cutting.

Of the caregivers who participated in the study, the majority (92%) was a biological parent of their adolescent. Eighty percent were mothers, 11% were fathers, and 9% had other relationships to the adolescent, including grandparent or older sibling. Twenty-six percent of the adolescents and their families were below the poverty line.

Measures

Maternal Depression. Maternal depression was measured using the Beck Depression Inventory II (BDI-II; Beck, Steer, & Brown, 1996; see Appendix A). The BDI-II is a self-report measure consisting of 21 items that is designed to identify the

presence and severity of depression in participants. Items address feelings such as sadness, loss of pleasure, self-dislike, and worthlessness, and each item contains a 4-point scale ranging from 0 to 3. For example, choices for the self-dislike item range from 0 (*I feel the same about myself as ever*) to 3 (*I dislike myself*). To score the measure, each of the items is summed. A total score of 0-13 is considered in the minimal depression range, 14-19 is mild, 20-28 is moderate, and 29-63 is severe.

Adolescent Severity of Suicide Risk. Adolescents' severity of suicide ideation and behavior was measured using the Columbia Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011; see Appendix B). The C-SSRS is a semi-structured interview that is used to assess both the severity and frequency of participants' suicidal thoughts and behaviors. It consists of nine items that identify suicide risk ranging from passive suicide ideation (*Have you wished you were dead or wished you could go to sleep and not wake up?*) to an actual suicide attempt (*Have you made a suicide attempt?*). Each item elicits a binary response, asking participants to identify whether they have ever had these types of thoughts or engaged in these types of behaviors. Two variables were developed from this measure. The severity of adolescent suicide ideation variable examined how active participants' suicidal thoughts were and the degree to which they intended to act on them. This item was scored based on the highest confirmatory response in the first five questions of the interview designed to address suicide ideation. Severity of adolescent suicide behavior was measured as the number of times the adolescent had attempted suicide. This item was scored based on responses to question number nine in the interview, in which adolescents report their total number of suicide attempts. To account for the presence of outliers, the variable

was truncated so that any number of attempts three or greater was scored the same. Of the 65 participants, four adolescents had greater than three suicide attempts.

Parental Attitudes. Parents' attitudes toward the conflict discussion were assessed with a 21-item measure of their emotional attitudes *(I expect I will feel… uninterested)* and reactions *(I felt… uninterested)* that was administered immediately before and after a videotaped conflict discussion with their adolescent. Participants rated each emotion on a 1 (*not at all*) to 4 (*very much*) scale, depending how much they felt or expected to feel that particular emotion (see Appendix C). Prior to the conflict discussion, both adolescents and parents identify their perceived relational "top area of disagreement" that causes them the most conflict. Beginning with the adolescent's chosen topic, they discuss each one for five minutes, with pre and post interview assessments given for each one. If the parent and adolescent agree on a top area of disagreement, they discuss it for ten minutes, completing just one pre and post attitude assessment.

RESULTS

Overview of Data Analytic Plan

The results will be presented in three steps. In the first step, I will discuss the exploratory factor analysis of the parental attitude measure. Second, descriptive statistics and correlation coefficients will be presented. Demographic variables will be tested as possible confounding factors that influence associations between main study variables. Third, I will test a meditational model in which parental attitudes are evaluated as a potential mechanism through which parental depression is associated first with adolescent suicidal ideation, and second with adolescent suicidal behaviors.

Preliminary Data Analysis

Prior to data analysis, I conducted exploratory factor analyses of the parental attitude ratings, which indicated that the items clustered into three scales with high levels of pre-post stability. An angry/punitive scale (items including both expectations (pre-conflict task) and reports (post-conflict task) of feeling mad, annoyed, frustrated, and misunderstood), a supportive scale (expectations and reports of feeling respected, supported, and in control), and an abdication scale (expectations and reports of feeling nervous, afraid to talk, bullied/picked on, and uninterested) all showed good internal consistency ($\alpha = 0.865$, 0.850 and 0.817, respectively). Examinations of the correlations among the three parental attitude scales indicated some relatedness between scales. Angry/hostile parental attitudes were significantly correlated with both supportive (r=-.36, p = .004) and abdicating attitudes (r= .58, p = .000).

However, parental abdication and support were not correlated (r = -0.12, p= .361). Correlations between these variables may indicate that a parent could respond in more than one way to a conflict discussion.

Results

The frequency distributions of the areas of disagreement identified by adolescents and parents are presented in Tables 1 and 2. Both adolescents and parents most frequently identified communication as their top area of disagreement. Adolescents also identified grades as another common area of disagreement while fewer parents agreed with this selection. Disagreements reported in the "other" category included topics such as sexual orientation, self-harming behaviors, and personal appearances, such as weight, personal hygiene, body image, and wardrobe and hair choices, as well as others.

Table 1 Frequency Distribution of Adolescent-Identified Areas of Disagreement

Problem	Frequency	Percent
Money	3	4.6
Communication	15	23.1
Friends	5	7.7
Grades	14	21.5
Household Rules	4	6.2
Plans for the Future	2	3.1
Religion	2	3.1
Dating	6	9.2
Brother or Sister	2	3.1
Other	7	10.8
Total	60	92.3

Note. There were 5 missing adolescent responses. Top areas of disagreement identified as other include: sexual orientation, self-

harm, body image/physical characteristics, criticism, and personal space.

Table 2 Frequency Distribution of Parent-Identified Areas of Disagreement

Problem	Frequency	Percent
Money	2	3.1
Communication	20	30.8
Friends	5	7.7
Grades	5	7.7
Household Rules	2	3.1
Plans for the Future	3	4.6
Alcohol and Drugs	1	1.5
Religion	1	1.5
Dating	3	4.6
Brother or Sister	1	1.5
Other	6	9.2
Total	49	75.4

Note. There were 16 missing parent responses. Top areas of disagreement identified as other include: electronic use, self-harm, body image/physical characteristics, and school behavior.

Table 3 presents the descriptive statistics and correlation coefficients between main study variables. Results indicate that parental depression was significantly positively associated with severity of adolescent suicide ideation (r= .26, p = .030), and positively, yet insignificantly, correlated with severity of adolescent suicide behavior (r= .11, p = .351). Parental depression was also significantly positively associated with parental attitudes of abdication (r= .45, p =.000) and anger (r=.53, p= .000), but not significantly correlated with parental support. Of the three parental attitude scales, only parental abdication was associated with severity of adolescent suicide ideation (r=.35, p= .004) and behavior (r=.30, p= .014). Surprisingly, parental

support trended toward significance with severity of adolescent suicide ideation (r= .24, p= .057). The key variables were then examined for gender, age, and income effects, but no significant covariate effects were found.

Table 3 Summary of Intercorrelations, Means, and Standard Deviations

Variable	1	2	3	4	5	6	7	8	9
1. Ideation Severity	--								
2. Suicidal Behavior	.48**	--							
3. Anger	.19	.08	--						
4. Support	.24	.18	-.36*	--					
5. Abdication	.35**	.30*	.58**	-.12	--				
6. Age	.01	.09	.07	.00	-.08	--			
7. Gender	-.02	.08	.09	.10	.17	-.14	--		
8. Income to Needs	.09	.04	-.08	.15	-.13	-.03	-.03	--	
9. Parental BDI	.26*	.11	.53**	-.14	.45**	.10	.20	-.23*	--
Mean	3.90	.67	1.75	2.51	1.41	15.5	.76	2.25	12.57
Standard Deviation	1.18	1.01	.69	.82	.57	1.49	.43	1.47	10.37

Note. BDI = Beck Depression Inventory
*p < .05, **p < .01

Mediation analyses are presented in Figures 2 through 4. Analyses depicted in Figure 2 indicate that parental abdication partially accounted the relationship between parental depression and adolescent suicide severity. Sobel tests for this model show that the mediating effects of parental abdication are statistically significant for both severity of suicide ideation (t = 2.4, p = .02) and behavior (t = 2.1, p = .03). Angry parental attitudes mimic the mediating effects of abdication, but are not statistically significant (see Figure 3). No mediation effects were found for a lack of parental support (see Figure 4).

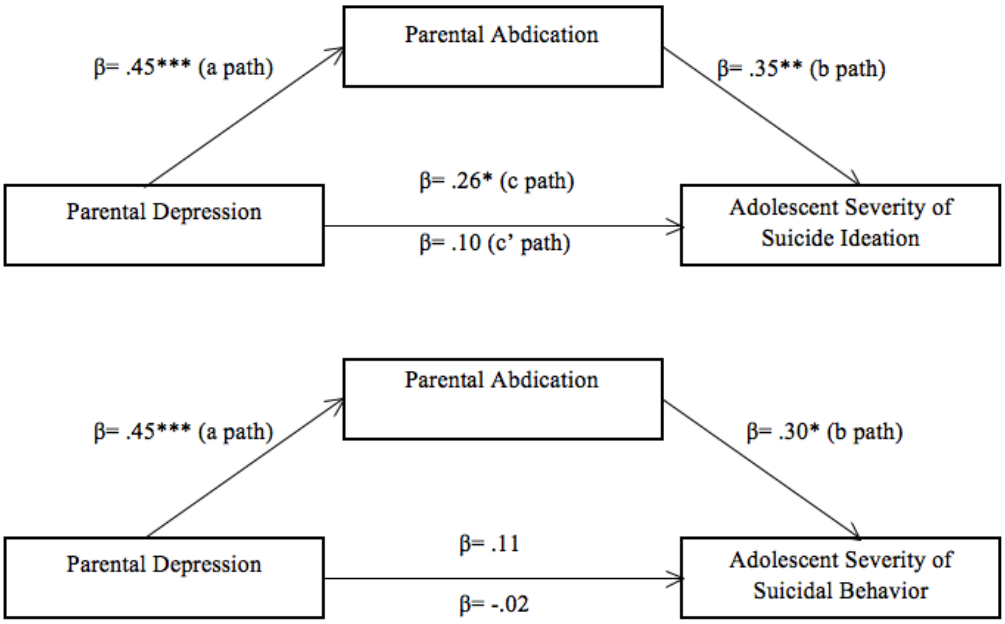


Figure 2 Mediating effects of parental abdication on the relationship between parental depression and severity of suicide risk in adolescents. Note. *p < .05, **p < .01, *** p < .001

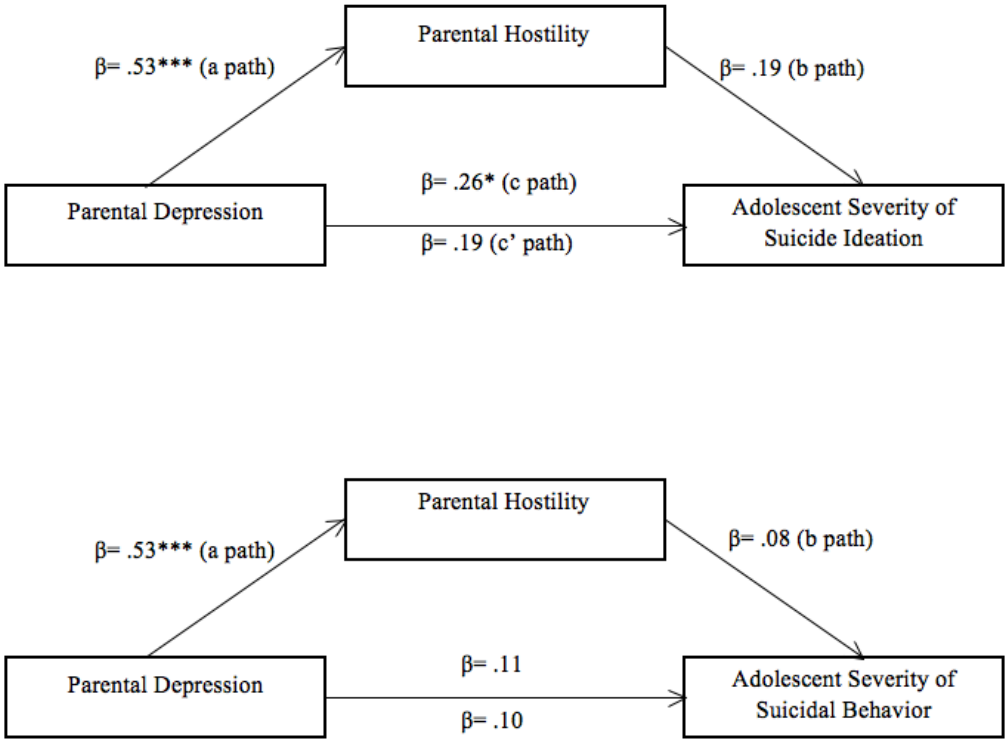
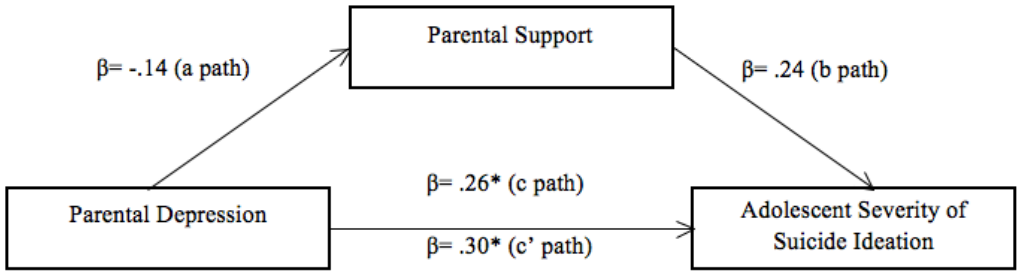


Figure 3 Mediating effects of parental hostility/anger on the relationship between parental depression and severity of suicide risk in adolescents.
Note. *p < .05, **p < .01, *** p < .001



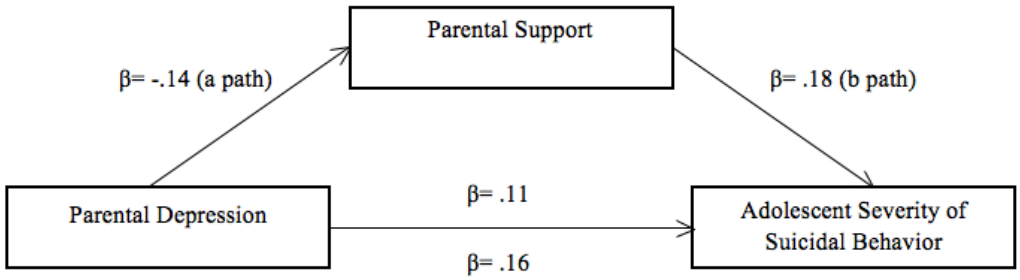


Figure 4 Mediating effects of parental support on the relationship between parental depression and severity of suicide risk in adolescents. Note. *p < .05, **p < .01, *** p < .001

DISCUSSION

Consistent with other studies on maternal depression and child risk, the current study demonstrates that maternal depression is concurrently associated with adolescent maladjustment. Adolescents with mothers who had higher levels of depressive symptoms exhibited more severe suicide ideation than adolescents with mothers who had lower or nonexistent levels of depression. The aim of this study was to test parental attitudes toward conflict discussion as a potential mechanism through which parental depression influenced adolescent suicidality. The study focused on three potential parental attitudes toward conflict – abdicating, punitive, and supportive – that might account for the link between parental depression and adolescent suicide risk.

As expected, the results yielded strong support for parental abdication as a mediator of the effects of parental depression on adolescent suicidality. This finding is consistent with other literature that has identified disorganized attachment as a risk factor for parental abdication and subsequent child maladaptive behaviors. According to Solomon & George (1996), caring for children requires an important shift to a caregiving role that moves the individual from seeking protection, to offering protection and nurturance. They argue that this shift to a caregiving role is disrupted in disorganized attachments, and that the caregivers in these relationships are unable to function as the stronger and wiser member of the caregiver-child dyad. Maternal disengagement and passivity leave the child in the position of maintaining the relationship and may contribute to the development of parent-child role confusion, in which the child fills the vacuum that the parent has created by taking control of their

interactions and using caregiving and controlling techniques in order to maintain the relationship (Lyons-Ruth et al., 2013a; Lyons-Ruth et al., 2013b). These behaviors are believed to be an attempt for the child to manage the uncertainty associated with having an unreliable source from which to seek protection and build autonomy (Main & Hesse, 1998).

Children who adopt a "caregiving-controlling" approach to maintaining relationships with their parents are vulnerable to developing more severe psychopathology. Overall, disorganized children show higher levels of internalizing and externalizing behaviors, including a more elevated risk for developing psychiatric symptoms (Solomon & George, 2011b; George & Solomon, 2011). Children who adopt this caregiving-controlling role in the attachment relationship may be especially prone to internalizing symptoms, such as depression and anxiety, which may result from their inclination to favor the needs of the parent, who appears helpless and incapable (Hennighausen, Bureau, David, Holmes, & Lyons-Ruth, 2011; Fearon, Bakermans-Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010). The current findings extend what is known about parental abdication and its effects on children to the period of adolescence and to a clinical sample that is experiencing high levels of internalizing and suicidal symptoms.

The results supporting parental abdication as a risk factor for adolescent suicidality are strengthened by the non-significant study findings. The trending positive correlation between parental support and adolescent severity of suicide might be interpreted as the tendency of a more secure parent to act more supportive and protective in interactions as their child becomes more suicidal. Conversely, a lack of findings with parental attitudes of anger suggests that parental abdication is a specific

negative parenting behavior that might account for the transmission of parental depression to the adolescent.

It is important to note that with all of my findings, my variables predicted suicide ideation more strongly and consistently than they predicted suicidal behavior. These results might be explained by the distinction Van Orden and colleagues (2010) make between suicide desire and suicide intent. As previously discussed, a desire to commit suicide requires feelings of perceived burdensomeness and thwarted belongingness. However, to transition from a desire to an actual intent or behavior, an individual needs an acquired capability for suicide. This acquired capability results from habituation that occurs through repeated expose to physically painful and fear-inducing situations, so that the individual's fear of these things is reduced. These findings may suggest that parental attitudes and behaviors influence adolescent's suicide ideation in that they affect his/her feelings of burdensomeness and belongingness, but that these adolescents need an acquired capability independent of parental action to develop the tendency to engage in suicidal behaviors. However, this interpretation is speculation until tests can be conducted to see if statistically significant differences exist between the effect sizes for ideation and behavior.

A practical example of these findings might be seen in therapy focused on improving the parent-child relationship, in order to train parents to work more effectively with their suicidal adolescents. If parents who are depressed can learn to become aware of their tendencies to abdicate and withdraw, they might be able to more closely monitor their behavior and avoid engaging in these types of behaviors. Additionally, with further support, this mediation model could identify a potential risk

factor for the transmission of parental depression and provide direction for a preventative intervention for depressed parents and their adolescents.

Several limitations of the study should be addressed. Firstly, due to the cross-sectional nature of the data, no claims about causality can be made. While much of the literature supports the direction of mediation discussed, a reversed mediation model could exist in which adolescent suicidality predicts parental depression and is mediated by parental attitudes. In this case, having a more suicidal adolescent might cause the parent to feel nervous and unsure of how to manage her parenting role, which could contribute to her depressive symptomology. Second, a source variance problem exists in the relationship between parental depression and parental attitudes, as both of these measures are self-report. Here, depressed parents might have a tendency to identify their expectations and feelings as more negative due to their depressive symptoms, rather than the actual nature of the interaction. This problem could be avoided by using objective coding of the conflict tasks to gauge parents' attitudes and behaviors during the discussion. Finally, the clinical nature of the sample and its small size limit the generalizability of the current findings to a sample with extreme adolescent problems, such as severe depression and suicide.

Despite these issues, the present study provides an important test of a potential intergenerational transmission mechanism for parental depression. Future studies should attempt to confirm the order of effects in the mediation model by using a longitudinal design. Additionally, parental variables like neuroticism, attachment style, and abuse history, should be tested as potential variables that might co-occur with parental abdication.

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Appendix A

BECK DEPRESSION INVENTORY II

Please read each group of statements carefully, then pick out the **one statement** in each group which best describes the way you have been feeling during the **past week** including today! Place an "X" beside the statement you have picked. **Do not** leave any statements blank.
If several statements in the group seem to apply equally well simply place an "X" in the box for the statement which has the largest number. Be sure that you do not mark more than one statement for Item 16 (change in sleeping pattern) and Item 18 (change in appetite).

Sadness
ə 0 I do not feel sad.
ə 1 I feel sad much of the time.
ə 2 I am sad all the time.
ə 3 I am so sad or unhappy that I can't stand it.

Pessimism
ə 0 I am not discouraged about my future.
ə 1 I feel more discouraged about my future than I used to be.
ə 2 I do not expect things to work out for me.
ə 3 I feel my future is hopeless and will only get worse.

Past Failure
ə 0 I do not feel like a failure.
ə 1 I have failed more than I should have.
ə 2 As I look back, I see a lot of failures.
ə 3 I feel that I am a total failure as a person.

Loss of Pleasure
ə 0 I get as much pleasure as I ever did from the things I enjoy.
ə 1 I don't enjoy things as much as I used to.
ə 2 I get very little pleasure from the things I used to enjoy.
ə 3 I can't get any pleasure from the things I used to enjoy.

Guilty Feelings

ə 0 I don't feel particularly guilty.
ə 1 I feel guilty over many things I have done or should have done.
ə 2 I feel guilty most of the time.
ə 3 I feel guilty all of the time.

Punishment Feelings
ə 0 I don't feel I am being punished.
ə 1 I feel I may be punished.
ə 2 I expect to be punished.
ə 3 I feel I am being punished.

Self Dislike
ə 0 I feel the same about myself as ever.
ə 1 I have lost confidence in myself.
ə 2 I am disappointed in myself.
ə 3 I dislike myself.

Self Criticism
ə 0 I don't criticize or blame myself more than usual.
ə 1 I am more critical of myself than I used to be.
ə 2 I criticize myself for all my faults.
ə 3 I blame myself for everything bad that happens.

Suicidal Thoughts about Dying
ə 0 I don't have any thoughts of killing myself.
ə 1 I have thoughts of killing myself, but I would not carry them out.
ə 2 I would like to kill myself.
ə 3 I would kill myself if I had the chance.

Crying
ə 0 I don't cry any more than I used to.
ə 1 I cry more than I used to.
ə 2 I cry over every little thing.
ə 3 I feel like crying but I can't.

Agitation
ə 0 I am no more restless or wound up than usual.
ə 1 I feel more restless or wound up than usual.
ə 2 I am so restless or agitated that it's hard to stay still.
ə 3 I am so restless or agitated I have to keep moving or doing something.

Loss of Interest

ə 0 I have not lost interest in other people or activities.
ə 1 I am less interested in other people or things than before.
ə 2 I have lost most of my interest in other people or things.
ə 3 It's hard to get interested in anything.

Indecisiveness

ə 0 I make decisions about as well as ever.
ə 1 I find it more difficult to make decisions than usual.
ə 2 I have much greater difficulty I making decisions than I used to.
ə 3 I have trouble making any decisions.

Worthlessness

ə 0 I do not feel I am worthless.
ə 1 I don't consider myself as worthwhile or useful as I used to.
ə 2 I feel more worthless compared to other people.
ə 3 I feel utterly worthless.

Loss of Energy

ə 0 I have as much energy as ever.
ə 1 I don't have as much energy as I used to.
ə 2 I don't have enough energy to do very much.
ə 3 I don't have enough energy to do anything.

Change in Sleeping Pattern

ə 0 I have not experienced any change in my sleeping pattern.
ə 1a I sleep somewhat more than usual.
ə 1b I sleep somewhat less than usual.
ə 2a I sleep a lot more than usual..
ə 2c I sleep a lot less than usual.
ə 3a I sleep most of the day.
ə 3b I wake up 1-2 hours early and can't get back to sleep.

Irritability

ə 0 I am no more irritable than usual.
ə 1 I am more irritable than usual.
ə 2 I am much more irritable than usual.
ə 3 I am irritable all the time.

Changes in Appetite

ə 0 I have not experienced any change in my appetite.

ə 1a My appetite is somewhat less than usual.
ə 1b My appetite is somewhat greater than usual.
ə 2a My appetite is much less than before.
ə 2c My appetite is much greater than usual..
ə 3a I have no appetite at all.
ə 3b I crave food all the time.

Concentration Difficulty
ə 0 I can concentrate as well as ever.
ə 1 I can't concentrate as well as usual.
ə 2 It's hard to keep my mind on anything very long.
ə 3 I find I can't concentrate on anything.

Tiredness or Fatigue
ə 0 I am no more tired or fatigued than usual.
ə 1 I get more tired or fatigued more easily than usual.
ə 2 I am too tired or fatigued to do a lot of things I used to do.
ə 3 I am too tired or fatigued to do most of the things I used to do.

Loss of Interest in Sex
ə 0 I have not noticed any recent changes in my interest in sex.
ə 1 I am less interested in sex than I used to be.
ə 2 I am much less interested in sex now.
ə 3 I have lost interest in sex completely.

Appendix B

COLUMBIA-SUICIDE SEVERITY RATING SCALE

SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5.

1. Wish to be Dead
Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.
Have you wished you were dead or wished you could go to sleep and not wake up?
If yes, describe:
Yes No □□

2. Non-Specific Active Suicidal Thoughts
General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself/associated methods, intent, or plan.
Have you actually had any thoughts of killing yourself?
If yes, describe:
Yes No □□

3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act
Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it."
Have you been thinking about how you might do this?
If yes, describe:
Yes No □□

4. **Active Suicidal Ideation with Some Intent to Act, without Specific Plan**
Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them."

Have you had these thoughts and had some intention of acting on them?
If yes, describe:
Yes No □□

5. Active Suicidal Ideation with Specific Plan and Intent
Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.
Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
If yes, describe:
Yes No □□

SUICIDAL BEHAVIOR

Actual Attempt:
A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is *any* intent/desire to die associated with the act, then it can be considered an actual suicide attempt. *There does not have to be any injury or harm*, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt.
Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.
Have you made a suicide attempt?
Have you done anything to harm yourself?
Have you done anything dangerous where you could have died?
What did you do?
Did you_____ as a way to end your life?
Did you want to die (even a little) when you_____?
Were you trying to end your life when you _____?
Or did you think it was possible you could have died from_____?
Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?
*(*Self-Injurious Behavior without suicidal intent)
If yes, describe:
Has subject engaged in Non-Suicidal Self-Injurious Behavior?
Yes No □□
Total # of Attempts_____

Interrupted Attempt:
When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (*if not for that, actual attempt would have occurred*). Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so.
Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?
If yes, describe:
Yes No □□
Total # of interrupted_____

Aborted Attempt:
When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior**.** Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.
Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?
If yes, describe:
Yes No □□
Total # of aborted_____

Preparatory Acts or Behavior:
Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).
Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?
If yes, describe:
Yes No □□

Appendix C

PARENTAL EMOTIONAL ATTITUDES AND REACTIONS TO CONFLICT DISCUSSIONS

Parent Pre-Discussion Questionnaire

Please answer the following questions about the conversation you and your child are going to have about something you disagree about in your relationship. Circle the number that best describes how you feel using the scale below for each statement. Try to go with your first impulse and do not spend too much time thinking about each question.

During this conversation, I think I will feel:	Not at all			Very Much
1. Nervous	1	2	3	4
2. Mad	1	2	3	4
3. Annoyed	1	2	3	4
4. In control	1	2	3	4
5. Uninterested	1	2	3	4
6. Afraid to talk	1	2	3	4
7. Bullied or picked on	1	2	3	4
8. Misunderstood	1	2	3	4
9. Frustrated	1	2	3	4
10. Supported	1	2	3	4
11. Respected	1	2	3	4
During this conversation, I think my teen will feel:				
12. Nervous	1	2	3	4
13. Mad	1	2	3	4
14. Annoyed	1	2	3	4
15. In control	1	2	3	4
16. Uninterested	1	2	3	4
17. Afraid to talk	1	2	3	4
18. Bullied or picked on	1	2	3	4
19. Misunderstood	1	2	3	4
20. Scared	1	2	3	4
21. Supported	1	2	3	4

22. Respected	1	2	3	4

During the discussion, I think my child will:

Not be at all angry			Be somewhat angry			Be really angry
1	2	3	4	5	6	7

During the discussion, I think my child will:

Be able to make him/herself very comfortable			Be able to feel moderately comfortable			Not be able to make him/herself comfortable
1	2	3	4	5	6	7

Parent Post-Discussion Questionnaire

Please answer the following questions about the conversation you and your child just had about an area of disagreement in your relationship. Circle the number that best describes how you feel using the scale below for each statement. Try to go with your first impulse and do not spend too much time thinking about each question.

During this conversation, I felt:	Not at all			Very Much
1. Nervous	1	2	3	4
2. Mad	1	2	3	4
3. Annoyed	1	2	3	4
4. In control	1	2	3	4
5. Uninterested	1	2	3	4
6. Afraid to talk	1	2	3	4
7. Bullied or picked on	1	2	3	4
8. Misunderstood	1	2	3	4
9. Frustrated	1	2	3	4
10. Supported	1	2	3	4
11. Respected	1	2	3	4
During this conversation, I think my teen felt:				
12. Nervous	1	2	3	4
13. Mad	1	2	3	4
14. Annoyed	1	2	3	4
15. In control	1	2	3	4
16. Uninterested	1	2	3	4

17. Afraid to talk	1	2	3	4
18. Bullied or picked on	1	2	3	4
19. Misunderstood	1	2	3	4
20. Scared	1	2	3	4
21. Supported	1	2	3	4
22. Respected	1	2	3	4

During the discussion, I think my child was:

Not at all angry			Somewhat angry		Really angry	
1	2	3	4	5	6	7

During the discussion, I think my child was:

Able to make him/herself very comfortable			Able to feel moderately comfortable			Not able to make him/herself comfortable
1	2	3	4	5	6	7