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Female Depression: Adverse Childhood and Adolescent Experiences and its relations with Depressive Triggers

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Abstract

Background: It is widely accepted that adversities during development may impact depression in adulthood, but its relations with current depression triggers are unclear.

The present research aimed to explore the association between self-reported adverse childhood and adolescent experiences with self-reported depressive triggers, according to interpersonal classification, in depressed women.

Methods: The sample consisted of 822 women with Depressive Disorders, who attended Psychotherapy at a Central Hospital in Lisbon (Portugal).

Problems in childhood and adolescence and triggering factors were obtained through open-ended questions from a psychotherapy screening questionnaire.

Descriptive statistics and Pearson´s correlation coefficients were calculated.

Results: The most commonly reported adversities in childhood and adolescence took place in the family context, namely and in order of frequency, family conflicts, relational difficulties between parents and children and family violence. Higher reports of significant problems at an early age were associated with higher reports across development. Higher reports of interpersonal disputes as depressive triggers were associated with higher reports of interpersonal disputes problems during childhood and adolescence.

Conclusion: Interpersonal disputes seem a major precursor of depressive symptomatology in women later in life. The classification of childhood and adolescent problems and depression triggers according to interpersonal theory proved to be a consistent association criterion and allowed us to assess priority intervention areas in depressed patients, such as interpersonal disputes and role transitions.

This study highlights the unmet needs of families, that could be a target for conflict management and interpersonal communication intervention programs early in parental-child relationships. This is an important contribute to the development of family-friendly public policies and action plans.

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1. Introduction

The World Health Organization recognizes depression as a public health problem, highly prevalent worldwide and one of the psychopathologies that lead to greater commitment and mental suffering (World Health Organization [WHO], 2017). The identification of the etiological factors, capable of helping to minimize the incidence of depressive disorders becomes a priority, in which research in clinical contexts is relevant. It is widely accepted that adversities during development may impact depression in adulthood, but its relations with depression triggers are unclear.

A large body of research suggests specific associations between childhood adversity and psychiatric disorders (Bruni et al., 2018; Midolo et al., 2020; Xie et al., 2018), although it is currently unclear how childhood experiences could increase vulnerability to depression (Saleh et al., 2017). The literature points to an association between depressive disorders in adulthood and some adverse interpersonal experiences in early life (Neumann, 2017), highlighting the importance of knowledge about the differential effects of specific childhood adversity events on symptoms, severity, onset, course and response to treatment of depressive disorders (Nelson et al., 2017).

Studies that examine multiple adversities in childhood underline emotional / psychological abuse as the factor most strongly related to depressive disorders in adulthood (Martins et al., 2014; Martins-Monteverde et al., 2019; Neumann, 2017; Norman et al., 2012). Emotional / psychological abuse is usually defined as a verbal or nonverbal hostile treatment, including experiences of isolation, patterns of being belittled, rejected, blamed, threatened or humiliated, by someone close to the child and in a position of power or responsibility for the child (WHO, 2006). In a meta-analysis of 184 original articles (Nelson et al., 2017), emotional neglect, in which

caregivers do not respond to the basic needs of the child, was the most commonly reported type of childhood adversity in depressive adults, and emotional / psychological abuse was most closely related to depression severity.

The evidence for long-term risk for depression was also linked with experiences of sexual and physical abuse (Cutajar et al., 2010; Kaplow & Widom, 2007), physical neglect (Neumann, 2017), childhood poverty and exposure to loss and violence (Shanahan et al., 2011). Furthermore, the relationship between parental alcohol abuse and depression in adulthood appears to be significant and higher as the number of reported adversities increases (Anda et al., 2002).

Studies also suggest associations between depression disorders in adulthood and adversities during adolescence, such as family dysfunction (Shanahan et al., 2011), major conflicts between parents and youth (Alaie et al., 2020) and exposure to violence (Heinze et al., 2018).

A study with a Portuguese women sample indicated that adversity in childhood and adolescence explains 6.6% of the variance in depressive symptoms, and those who had family members with drug addiction or mental illness, reported emotional and physical abuse and emotional neglect, presented more depressive symptoms than controls with no history of adversity until adulthood (Pinto et al., 2015).

Depression disorders are highly prevalent, considered a public health problem that affects patients´ lives and their families and has huge societal costs (Chisholm et al., 2016), justifying an investment in medical and psychotherapeutic treatments. Interpersonal psychotherapy (IPT) was developed for the treatment of depression (Weissman et al., 2017), with evidence of effectiveness in the treatment and preventing of relapse after treatment (Cuijpers et al., 2011, 2016). One of the main principles of Interpersonal psychotherapy is that mood and life events are related. This connection is practical, not etiological (Markowitz & Weissman, 2004), based on the fact that depression can be triggered by a disturbing change in the interpersonal environment, as well as disturbing life events might follow the mood disturbance. IPT recognizes 4 categories of interpersonal problems that significantly increase the chance of developing depression, considered the proximal triggers (Weissman et al., 2000): interpersonal disputes, defined as a conflict in an affective, social or professional relationship; role transitions, when changes in personal life and/or the surrounding context causes changes in the relational or social role played by the self; grief, concerning the death of a significant person; and interpersonal deficits, defined as difficulties in the interpersonal relationship caused by personal characteristics.

Although childhood and adolescent adversities on depressive populations have been widely studied, there is a large heterogeneity in the sampling procedures, adversities definitions/categories and methods of assessment across studies (Nanni et al., 2012). Moreover, prevalence rates and effects of specific types of adversities vary in different samples (Infurna et al., 2016; Xie et al., 2018) and the relationship between adversities throughout development and depressive triggers in adulthood is unclear.

This study investigated self-reported significant problems in childhood and adolescence and self-reported depressive triggers, in a clinical sample of women with a diagnosis of depressive disorder.

We hypothesized that, according with IPT categories of interpersonal problems, there is a relationship between problems reported across childhood and adolescence (Hp1) and problems reported across childhood and adolescence can be related with self-reported current triggers for depression (Hp2).

Thus the specific aims of this study were to examine (1) the distribution of the number and type of self-reported problems during childhood and adolescence, considering single variables and variables recoded according to the interpersonal problems categories; (2) the relation between problems reported across childhood and adolescence, according to interpersonal problems categories; and (3) the relations between self-reported triggers for depression and type of problems identified during childhood and adolescence, both classified according to interpersonal theory.

2. Method

2.1 Participants and procedure

This work uses data collected in the broad Study of the Epidemiological Characteristics of the Clinical Population that attends Psychotherapy at the Psychiatric Service of a Central Hospital in Lisbon (Portugal). Data related to sociodemographic aspects, triggering factors associated with complaints, significant problems in childhood and adolescence and psychiatric diagnosis (DSM-5) were collected. This study was approved by the CHLN Health Ethics Committee (nº1184/13).

The sample consisted of women (N = 822), aged between 18 and 65 years (*M*=43.2, *SD*=12.24), diagnosed with Major Depression Disorder (MDD; n = 465, 56.6%), Persistent Depression Disorder (PDD; n = 183, 22.3%) and Unspecified Depression Disorder (UDD; n = 174, 21.2%) according to the DSM-5 criteria (American Psychiatric Association [APA], 2013), who were

enrolled for psychotherapy, between October 2011 and October 2019. The maximum period between the enrollment for psychotherapy, performed by the assistant psychiatrist, and the screening appointment was two months. Only data that were collected as part of the psychotherapy screening routine care, filled out by a clinical psychologist, were processed for this study. In total 1103 outpatients' women with a depression diagnosis were indicated for psychotherapy screening. For the present study 281 patients were excluded due to missing data in the screening sheets.

2.2 Measures and variables

An analysis grid was built for data collection, related to sociodemographic aspects, psychiatric diagnosis (APA, 2013), triggering factors associated with depressive complaints and significant problems in childhood and adolescence.

The psychiatric diagnosis, made by the assistant psychiatrist, were recorded on the psychotherapy signaling sheets, which is part of the psychotherapy screening records.

Triggers for depression were assessed with the question "What factors do you consider contributed to the difficulties experienced?" 20 self-reported triggering factors, were identified using a content analysis carried out after the first year of data collection and were considered as dichotomous variables.

Based on the interpersonal theory conceptualization (Weissman et al., 2000), 4 variables were created, with the following descriptions: 1. Interpersonal disputes (ID) - conflict in an affective, social or professional relationship; 2. Role transitions (RT) - when changes in personal life and/or the surrounding context causes changes in the relational or social role played by the self; 3. Grief (G) - death of a significant person; 4. Interpersonal deficits (IDef) - difficulties in the interpersonal relationship caused by personal characteristics.

The 20 triggers were then recoded into the four variables as follows:

1. Interpersonal disputes - family conflicts, marital conflicts, marital violence, husband alcohol abuse, family violence (report of violence between parents and children), relational problems with the family of origin, professional problems, interpersonal conflicts (extra-family). Score 0 to 8.

2. Role transitions – divorce / affective breakdown, family member physical illness, family member psychiatric illness, childbirth or pregnancy, psychological / psychiatric problems, physical illness, financial difficulties / unemployment, moving from country / city, theft / accident. Score 0 to 9.

3. Grief - death of a loved one. Score 0 to 1.

4. Interpersonal deficits - social difficulties / isolation. Score 0 to 1.

The trigger child sexual abuse was excluded from this classification.

Problems in childhood and adolescence were obtained in the screening records through an open-ended question: "What significant problems have you got in your childhood and adolescence?". A content analysis carried out after the first year of the data collected, allowed the identification of 19 self-reported significant problems, considered as dichotomous variables.

Using the same methodology as for the triggers, these variables were recoded into the 4 variables of the interpersonal theory, according to the following computation:

1. Interpersonal disputes - family conflicts, family violence (report of violence by parents and/or sibling), violence between parents, parental alcohol abuse, child-parent relational difficulties (report of rigid education or emotional distance) and fear of school/bullying. Score 0 to 6

2. Role transitions - parents´ divorce or second marriage, raised out of the natural family, mother or father absence, family member psychiatric illness, family member physical illness, physical illness, psychological / psychiatric problems, moving from country / city / home, poverty / child labour and pregnancy / early marriage. Score 0 to 10

3. Grief - death of a loved one. Score 0 to 1

4. Interpersonal deficits – social difficulties / isolation. Score 0 to 1

Child sexual abuse was excluded from this classification.

In order to identify the age where problems in childhood and adolescence were reported, we considered four main age groups (G1 = 0 to 3 years old, G2 = 4 to 7 years old, G3 = 8 to 12 years old and G4 = 13 to 18 years old).

A second step was conducted to obtain 4 variables, corresponding to a summative score of all problems reported in each age group. A third step aimed at computing a total summative score of each of the 4 variables according to the interpersonal theory - the sum score of each of these variables in the four age groups (G1, G2, G3 and G4) was used.

2.3 Data analysis

Data processing and analysis were performed using SPSS Statistics 25. Data were analyzed descriptively: frequencies for categorical variables, mean and standard deviation values regarding continuous variables. A Pearson correlation was performed to determine the relationship

between depression triggers and self-reported problems in childhood and adolescence, and among reported problems across the four age groups.

3. Results

Table 1 includes the sociodemographic characterization of the total sample.

This study sample was made up of women aged 18 and over, the mean age was 43.2 years (SD= 12.24) and the mean education 11.6 years (SD= 4.7). Nearly half of the sample was married or on a non-marital partnership (47.5%), and only 14.4% lived alone. The depression diagnosis (DSM 5) with the highest prevalence was MDD (*n* = 455, 56.6%), followed by PDD (*n* = 183, 22.3%) and UDD (*n* = 174, 21.2%).

Table 1. Sociodemographic description of total sample (N=822)

Variables	Total Sample N=822
Average age (M±SD)	(43.2±12.24)
Average Education (M±SD)	(11.6±4.7)
Marital status	
Married / Non-marital partnership	390(47.4)
Single	208(25.3)
Divorced	191(23.2)
Widow	32(3.9)
Live alone	118(14.4)
Psychiatric diagnosis	
MDD	455(56.6)
PDD	183(22.3)
UDD	174(21.2)

Abbreviations: *MDD,* Major Depressive Disorder; *PDD,* Persistent Depression disorder; *UDD,* Unspecified Depressive Disorder

Table 2 shows the frequency of self-reported depression triggers and the problems in childhood and adolescence by age groups.

The most frequently self-reported triggers identified were family conflicts (22.6%), death of a loved one (21.2%), marital conflicts (20.6%), divorce / affective breakdown (14.6), professional problems (13.6%), family member physical illness (11.3%) and physical illness (11.1%). From the remaining thirteen triggers, six were reported by less than 2% of the total sample, and the other seven had frequencies between 8.9% and 2.9%.

Concerning self-reported problems in childhood and adolescence, the frequency of reported problems progressively increased across age groups, but most noticeably until early adolescence (G3). Analyzing the most frequently reported problems, all except family conflicts tended to decrease between the end of childhood (G3) and adolescence (G4), namely child-parent relational difficulties, family violence, parental alcohol abuse and family member psychiatric illness.

Family conflicts were the most reported problem in all age groups and the older the age group the bigger the percentage of family conflicts (G1=19.7%, G2=27.9%, G3=36.3% and G4=38,7%).

Child-parent relational difficulties were the second-highest reported problem in all age groups except in early childhood (0 to 3 years), namely 16.4% in G2 19.5% in G3 and 15.3% in adolescence (G4).

Family violence, which includes reports of violence by parents and/or siblings, was the third most reported problem in all groups except in G1, and the older the age group until adolescence the bigger the percentage of family violence (G1=9.0%, G2=13.6%, G3=15.3% and G4=14.0%).

Parental alcohol abuse was reported in about 10% of the sample, with a range between 9.4% and 10.9%. Family member psychiatric illness at G3 was reported by 10.2%. Psychological/psychiatric problems presented higher frequencies as age increase, with 13% of the sample reporting these problems in adolescence (G4). All the other problems in childhood and adolescence had less than 10% of reports.

Nonetheless the low frequency, we highlight social difficulties / isolation that doubled between G2 (3.8%) and G3 (7.5%).

Results concerning the self-reported problems in childhood and adolescence classified according to the interpersonal theory, showed that interpersonal disputes had the highest percentages in all age groups, with an increase of values until adolescence and a small decrease in G4 (G1=34.4%, G2=48.5%, G3=58.4% and G4=56.0%). Role transitions had the second-highest frequency, with frequencies increasing with age, namely 24.8%, 30.2%, 38.4% and 46.2%. Grief had the lower percentage in G2, G3 and G4.

Table 2. Triggers for depression and significant problems reported by age groups, single variables and variables recoded according to the interpersonal classification

Triggers Variables	Triggers	**Problems Variables**	0 to 3 years	4 to 7 years	8 to 12 years	13 to 18 years
			n (%)	*n (%)*	*n (%)*	*n (%)*
Interpersonnal Disputes (ID)	483(58.8)	**Interpersonnal Disputes (ID)**	283(34.4)	329(48.5)	480(58.4)	460(56.0)
Family conflicts	186(22.6)	Family conflicts	162(19.7)	229(27.9)	298(36.3)	318(38.7)
Marital conflicts	169(20.6)	-	-	-	-	-
Professional problems	112(13.6)	-	-	-	-	-
Relational problems with family of origin	73(8.9)	Child-parent relational difficulties	66(8.0)	135(16.4)	160(19.5)	126(15.3)
Marital violence	58(7.1)	Violence between parents	56(6.8)	62(7.5)	54(6.6)	49(6.0)
Interpersonal conflicts (extra-family)	24(2.9)	Fear of school, Bullying	-	-	17(2.1)	10(1.2)
Family violence	13(1.6)	Family violence	74(9.0)	112(13.6)	126(15.4)	115(14.0)
Husband alcohol abuse	7(0.9)	Parental alcohol abuse	77(9.4)	87(10.6)	90(10.9)	79(9.6)
Role Transitions (RT)	420(51.1)	**Role Transitions (RT)**	204(24.8)	248(30.2)	316(38.4)	380(46.2)
Divorce, Affective breakdown	120(14.6)	Parents´divorce or second marriage	30(3.6)	33(4.0)	39(4.7)	19(2.3)
Family member physical illness	93(11.3)	Family member physical illness	4(0.5)	3(0.4)	4(0.5)	6(0.7)
Physical illness	91(11.1)	Physical illness	6(0.7)	14(1.7)	12(1.5)	17(2.1)
Psychological or psychiatric problems	62(7.3)	Psychological or psychiatric problems	1(0.1)	14(1.7)	46(5.6)	107(13.0)
Financial difficulties, Unemployment	39(4.7)	Poverty, Child labour	57(6.9)	40(4.9)	47(5.7)	60(7.3)
Childbirth, Pregnancy	29(3.5)	Pregnancy, Early marriage	-	-	-	52(6.3)
Theft, Accident	14(1.7)	-	-	-	-	-
Family member psychiatric illness	11(1.3)	Family member psychiatric illness	54(6.6)	66(8.0)	84(10.2)	54(6.6)
Moving from country, city or home	6(0.7)	Moving from country, city or home	2(0.2)	13(1.6)	17(2.1)	28(3.4)
-	-	Mother or father absence	29(3.5)	37(4.5)	35(4.3)	25(3.0)
-	-	Raised out of the natural family	36(4.4)	40(4.9)	47(5.7)	20(2.4)
Grief (G) Death of a loved one	174(21.2)	**Grief (G)** Death of a loved one	13(1.6)	25(3.0)	33(4.0)	39(4.7)
Interpersonal Deficits (IDef) Social difficulties, Isolation	37(4.5)	**Interpersonal Deficits (IDef)** Social difficulties, Isolation	9(1.1)	31(3.8)	62(7.5)	65(7.9)
Others Child sexual abuse	8(1.0)	**Others** Child sexual abuse	-	13(1.6)	17(2.1)	15(1.8)

Table 3 presents descriptive statistics for the childhood and adolescence' problems, considering the variables classified according to the interpersonal theory, namely: total values of reported problems (ID + RT + G + IDef) in each age group; and total values of each of the 4 interpersonal classification variables (ID, RT, G and IDef) reported in the set of all ages.

Considering the total number of problems reported in each age group, increasing age corresponded to a progressive increase in the average of reported problems, namely: *M*=0.822 on G1, *M*=1.145 on G2, *M*=1.425 on G3 and *M*=1.447 on G4.

Regarding the total values of problems reported throughout childhood and adolescence, in each of the 4 variables classified according to interpersonal theory, the average of Interpersonal Disputes was the highest (*M*=3.04, *SD*=3.38), followed by Role Transitions (*M*=1.46, *SD*=1.44) and, with less expression, Interpersonal deficits (*M*=0.20, *SD*=0.69) and Grief (*M*=0.1, *SD*=0.36).

Table 3. Descriptive statistics for reported problems across age groups and across interpersonal classification variables

	Minimum	Maximum	MEAN	*SD*	Variance
G1 (0 to 3 Years) *Summative score*	.00	6.00	.822	1.014	1.028
G2 (4 to 7 Years) *Summative score*	.00	5.00	1.145	1.102	1.215
G3 (8 to 12 Years) *Summative score*	.00	5.00	1.425	1.106	1.224
G4 (13 to 18 Years) *Summative score*	.00	5.00	1.447	1.062	1.127
Sum of values *ID* All ages	.00	19.00	3.044	3.378	11.413
Sum of values *RT* All ages	.00	5.00	1.457	1.438	2.068
Sum of values *G* All ages	.00	3.00	.134	.365	.133
Sum of values *IDef* All ages	.00	4.00	.203	.690	.476

Abbreviations: *SD*, standard deviation; *Sumative score*, ID+RT+G+IDef; *ID*, Interpersonal disputes, *RT*, Role transitions; *G*, Grief; *IDef*, Interpersonal deficits

Table 4 shows the correlational analysis between the summative score of significant problems reported by age group.

In all age groups the summative score of significant problems reported was positively and strongly correlated with the summative score of significant problems identified on the other age groups.

Total problems reported at 0-3 years (G1) were positively and strongly correlated with problems reported at age 4-7 (G2), r (822) = .77, $\rho \leq .001$, at age 8-12 (G3), r (822) = .62, $\rho \leq .001$ and at age 13-18 (G4), , r(822) = .59, $\rho \leq .001$.

Total problems reported at 4-7 years (G2) were positively and strongly correlated with problems reported at age 8-12 (G3), r (822) = .76, $\rho \leq .001$ and at age 13-18 (G4), r (822) = .70, $\rho \leq .001$.

Total problems reported at 8-12 (G3) years were positively and strongly correlated with problems reported at age 13-18 (G4), r (822) = .82, $\rho < .001$.

The results allowed us to conclude that in this study there is a relationship between problems reported across childhood and adolescence (Hp1), the higher score of reported problems in one age group seems to be related with higher scores of reported problems in the other age groups.

Table 4. Pearson correlation between the summative score of significant problems reported by age group

Summative score	G1 (0-3 years)	G2 (4-7 years)	G3 (8-12 years)	G4 (13-18 years)
G1 (0 to 3 Years)		.769**	.623**	.588**
G2 (4 to 7 Years)			.760**	.699**
G3 (8 to 12 Years)				.821**

Abbreviations: *Sumative score*= ID+RT+G+IDef; ** $\rho \leq 0.001$

Table 5 shows the correlational analysis between triggers for depression and problems reported in all age groups, presenting variables classified according to interpersonal theory.

Triggers of Interpersonal disputes (ID) were positively correlated with interpersonal disputes (ID) reported problems, r (822) = .28, $\rho \leq 001$, with interpersonal deficits (IDef) problems reported, r (822) = .12, $\rho \leq 001$ and role transitions (RT) problems, r (822) = .08, ≤ 0.05.

Triggers of role transitions (RT) were negatively correlated with the sum of Interpersonal disputes (ID) problems, r (822) = -.07, $\rho \leq 0.05$.

There were no correlations between triggers of grief and of interpersonal deficits and the sum of any problems reported (ID Sum., RT Sum., G Sum. IDef Sum).

Table 5. Pearson correlation between triggers and significant problems reported in all age groups, according to interpersonal classification

Probls Triggers	*ID Sum.*	*RT Sum.*	*G Sum.*	*IDef Sum.*
ID	.227**	.081*	.009	.120**
RT	-.072*	.015	.015	-.017
G	.002	.005	.039	-.062
IDef	.039	.066	.033	.038

Abbreviations: *Probls*, Self-reported problems from 0 to 18 years; *ID Sum.*, ID problems from 0 to 18 years; *RT Sum.*, RT problems from 0 to 18 years; *G Sum.*, G problems from 0 to 18 years; *IDef Sum*,. IDef problems from 0 to 18 years; ** $r\rho \leq 0.001$; * $r\rho \leq 0.05$

Our results showed that problems reported across childhood and adolescence can only be partially related with self-reported current triggers for depression (Hp2).

4. Discussion

Family conflicts were the most commonly reported type of childhood and adolescent adversity in our study. Child-parent relational difficulties and family violence obtained the second and third-highest frequency of reports from the age of 4 to 18 years. These data are very important as emerging evidence suggests that family conflict, including experiencing physical or verbal aggression, criticism, anger, or arguments between parents and/or between parents and children, tends to persist across generations in women (Rothenberg et al., 2016); furthermore intergenerational family conflict can be more intense than conflict experienced in a single generation (Rotherberg et al., 2017); and that women's adolescence and young adulthood represent periods of vulnerability, in which depressive symptoms are more likely to mediate continuity in family conflict from one generation to the next (Rothenberg et al., 2018). Considering that higher family conflicts are associated with an increase in depressive symptoms (Alaie et al., 2020), we can face a self-reinforcing conditioning circle. In addition, family violence, namely harsh parenting behaviour, is indicated in longitudinal studies as having significant prospective associations between two generations of parents and children (Bailey et al., 2009; Conger et al., 2012).

This study pointed that the increase in the value of significant problems reported in an age group corresponded to a growing trend mostly until early adolescence. Coupled with the fact that the problems identified were mainly within the family of origin, this data seems to indicate a repeated and continued exposure to adverse situations across childhood and adolescence development. Most major family stressors can be considered as a complex set of changing conditions with a past and a future course, capable of leading to cumulative strains and multiple and persistent challenges (Walsh, 2016). These data imply an increased risk due to the recurrence of suffering and suggest the need for preventive actions for most vulnerable families, where interpersonal disputes are present.

With regard to the problems classified according to interpersonal theory, although the increase in age corresponded to a progressive increase in reported problems, in this study the older age group (13 to 18 years old) presented a decrease in interpersonal disputes and an increase in role transition problems. The focus on problems with other members of the family of origin seemed to be progressively replaced by the primacy attributed to personal problems, with an emphasis on psychological/psychiatric problems reflected in the high reported percentage and on tasks associated with early demands for autonomy such as pregnancy/early marriage and child labour. These data are consistent with the idea that early adolescence can directly increase vulnerability to psychological problems and intensify the negative consequences of previously experienced problems (Davies et al., 2016). Since most adolescents, even those with severe psychological problems, avoid seeking clinical help and may remain untreated (Corry & Leavey, 2017), high reports of psychological/psychiatric problems in the age group of 13 to 18 years old should alert to the need of psychoeducation, namely to help adolescents, families and educational agents to identify signs of mental health difficulties. Particular importance must be attached to autonomy-supportive practices as literature points its impact on healthy and emotional intelligence in adolescents (Barberis et al., 2021).

The observed decrease in reported problems with the family of origin may be justified by the typical rise of concerns about socialization and peer approval in adolescence (Memmott-Elison et al., 2020), when self-esteem is shaped by the quality of friendship, romantic attraction and academic skills (Corry & Leavey, 2017).

This support form peers progressively gains a wider relevance until adulthood, where emotional support, perceived comprehension, and need for support, - as dimensions of social support - has been reported with direct effects on depressive symptoms (Schetsche et al., 2021).

Main self-reported triggers of depression were interpersonal disputes, highlighting family and marital conflicts; followed by role transitions problems, namely divorce/affective breakdown and physical illness from the subject or of a family member.

Once again, issues of close relationship seem to assume a prominent role, reinforcing the need for psychotherapeutic interventions capable of enhancing the development of interpersonal communication skills, conflict management and strengthening of emotional bonds. Interpersonal group psychotherapy has been proposed in clinical contexts, aiming to enhance an improvement in interpersonal dynamics and/or a change in patients' expectations, along with the development of a more effective social support network, capable to offer patients the necessary support to deal with distressing experiences (Fonseca et al., 2021).

It is well known that depression is a frequent comorbidity in physical illness, with emphasis on chronic medical diseases (Martino et al., 2019; Puyat et al., 2017; Sheikh et al., 2019). Between depressive disorders and chronic medical diseases, there is often negative reciprocal conditioning, either in the symptomatic increase or in non-adherence to the treatment of both disorders (Gold et al., 2020). Physical illness as a trigger for depression in adulthood women needs special attention if we´re talking about mothers. The impact of the parents' physical illness on the child and adolescent's suffering has been widely investigated, with the prevailing idea that more important than the type of illness is the parents´ adaptive reaction, which may be associated with the children´s adjustment (Chen & Panebianco, 2020). Mediating variables, such as the parental relationship´s quality and the increase in financial difficulties, has also been considered (Sieh et al., 2012). Psycho-social interventions that support physically ill parents should be considered, restoring the possible sense of normality in the processes of family adaptation (Chen & Panebianco, 2020).

In what concerns the physical illness of a family member as triggers for depression, studying disease perceptions in family members allows identifying beliefs that enhance adaptation problems and psychological suffering (Fletcher et al., 2020). This data alerts us to the need for support interventions for family caregivers.

The current study showed that high reports of interpersonal disputes as depressive triggers were associated with high reports of interpersonal disputes problems during childhood and adolescence. These data seem to indicate that experiences of conflictual family dynamics in childhood and adolescence, hamper the acquisition of effective strategies for conflict resolution or reduction in adulthood. Our findings are aligned with the existence of behavioural learning from models' observation, the more effective the greater the degree of affinity with the model

person (Bandura, 2017). Considering that family is the first and one of the most powerful contexts of experience, learning, and modelling emotion regulation, children and youth exposed to significant problems in familial relationships are at an extreme disadvantage for acquiring adaptive self-regulation strategies (Gruhn & Compas, 2020). The existence of interpersonal conflicts in the context of growth and/or the absence of secure figures seems to limit the learning of social skills and relationships of trust and perpetuate the difficulties in establishing and maintaining affective bonds, potentiating a depressive disorder. Moreover, the severity of such conflicts in childhood may influence the affective development, conditioning interpersonal experience representation and affect regulation abilities (Mitolo et al., 2020).

This data suggests that child and adolescents care services may offer a public health intervention, improving individual protective factors, to mitigate the negative impact of family conflicts.

High reports of interpersonal disputes as depressive triggers were also associated with high reports of interpersonal deficits during development. This data is aligned with evidence indicating that interpersonal deficits contribute to the development of depressive symptoms (Hammen et al., 2004). Difficulties in interpersonal relationships throughout childhood and adolescence condition the ability to establish later interpersonal bonds and autonomous adult functioning (Masten & Tellegen, 2012; Oudekerk et al., 2015). Healthy autonomy develops within a social context and implies the ability to initiate and maintain meaningful relationships, so problems in its structuring process can be risk factors for depression (Bekker, 2006) and for future relationship problems. However, these data should be interpreted with caution, since our sample presented a low value of interpersonal deficits during childhood.

The classification of childhood and adolescent problems and depression triggers according to interpersonal theory proved to be a valuable criterion and allowed us to assess priority areas of intervention in depressed patients, such as interpersonal disputes and role transitions. These data reinforce the results of previous work (Fonseca et al., 2021), emphasizing the importance of designing psychotherapeutic interventions according to specific needs, namely focus in the most prevalent depression triggers. The development of structured interventions for research in clinical practice is a challenge for health professionals and institutions. Limited in time, with individual and group intervention models, enabling a quantitative assessment of interpersonal problems and the psychotherapeutic intervention, and focused on helping the patient regain control of mood and functioning, interpersonal psychotherapy is adequate to provide a framework useful for working with depressed patients in public health contexts.

5. Strengths and limitations

Our findings are based on a self-reported retrospective assessment of early adverse experiences during the course of the psychotherapy screening, which could introduce recall bias. On the other hand, some literature points to mood-congruent recall biases toward negative memories in depressed individuals (Colman et al., 2016). Nevertheless, in recent studies that related depression with childhood adversity experiences, retrospective and prospective assessment strategies had similar results (Patten et al., 2015), helping to reduce concerns of bias. The retrospective recall in adults of adverse experiences in childhood can be considered sufficiently valid, even though there is a tendency to significant under-reporting (Hardt & Rutter, 2004).

Given the study design, we were unable to examine time variations between self-reported significant problems exposure and psychiatric diagnosis. Furthermore, our measure of significant problems did not take into account the severity, frequency and duration of exposure, an element to consider in future investigations since the intensity of childhood problems might predict symptom severity in adulthood (Martins et al., 2014).

We emphasize the importance of data collection having been carried out in the context of a clinical interview, where the psychologist is particularly attentive to the quality of the relationship established with the patients, which constitutes an essential trust base for the exposure and acceptance of the difficulties. Other strengths of this study are the sample size and the data collected over several years.

The systematic recording of data in hospital contexts allows the study of clinical populations, being of great importance for the interventions adjustment to the patients' needs, but also for the identification of risk and protective factors of psychological suffering and, consequently, for the design of mental health prevention actions.

6. Conclusions

Interpersonal conflicts and disputes during childhood and adolescence seem to be related with women depressive symptomatology later in life. Further studies are needed, paying attention to both individual forms and cumulative exposures of childhood and adolescence adversities, and analyzing their relationship with depressive triggers to propose psychotherapeutic and psycho-social interventions, included in public health policies.

Our findings suggest that interventions for families with conflicts, child-parent relational difficulties and family violence might help to reduce depressive problems in adult women.

It is important to look at how exposure to childhood and adolescent adversities may impact the aetiology, course and treatment of depressive disorders in adulthood, as well as consider any mitigating influences that can protect against the damaging influence of exposure.

Understanding how gender roles and other personal characteristics moderate continuity in family conflict and violence and their association with depressive disorders could lead to developing prevention programs and electing a psychotherapeutic focus.

Epidemiological research has proved to be an area of great multidisciplinary interest, essential for the proper planning and evaluation of health policies. In this area, we highlight the need to increase data reliability, creating and maintaining updated clinical records and electronic data records across the board of healthcare institutions.

Initiatives combining research and clinical intervention on psychological and developmental issues must be promoted. The impact of practice with documented efficacy and effectiveness should allow the development of clinical protocols and psychotherapeutic guidelines, as well as to design preventive public health policies.

Primary health services physicians should consider information about childhood and adolescence problems as an important marker in identifying individuals at risk of depression. These data can also integrate population studies for prevention efforts in mental health, helping to inform the general public and leading to better recognition of risk problems during development.

The idea of universal prevention in a school environment is also relevant, as a way to promote communication skills, problem and conflicts solving and self-regulation, providing information and skills to students, teachers and families.

Ethical standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

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Conflict of Interest Statement

The authors declare that the research was conducted in the absence of any potential conflict of interest.

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