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REVIEW

Family Dynamics and Depression Among Children: An Integrative Review of Theoretical Models and Attachment-Based Interventions

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Purpose: Childhood depression is a significant global public health concern, and family dynamics are a primary context for its development. While the link between family life, attachment, and depression is established, the field lacks a coherent framework that systematically integrates the core, measurable dimensions from major family systems theories to explain the specific pathways to depression. This review aims to develop and propose such a framework by synthesizing these foundational theories through the lens of attachment theory.

Patients and Methods: A narrative review of the literature was conducted. Major English- and Chinese-language databases, including PubMed, PsycINFO, and China National Knowledge Infrastructure, were searched for seminal theoretical papers, meta-analyses, and empirical studies on family dynamics, parenting, attachment, and childhood depression published up to August 2025. A narrative synthesis methodology was employed to facilitate theory integration and development.

Results: The proposed integrative framework maps the core dimensions from four foundational models of family systems (Olson, Beavers, McMaster, Skinner)—such as communication, cohesion, affective involvement, and role performance—onto the mechanisms of attachment security. The framework posits that these dimensions of family dynamics collectively shape the quality of the parent-child attachment relationship, which serves as the central mediating pathway to childhood depression. Parental rejection and hostility are identified as particularly potent mechanisms within this pathway. The framework's utility is illustrated using the case of China's "left-behind children", where systemic family disruption predictably elevates depression risk.

Conclusion: Dysfunctional family dynamics contribute to childhood depression primarily by undermining the security of the parent-child attachment bond. This integrative, attachment-centered model provides a robust theoretical foundation for research and clinical practice. It suggests that interventions such as Attachment-Based Family Therapy, which directly target the repair of attachment ruptures, represent a theoretically sound and evidence-informed strategy for preventing and treating childhood depression.

Keywords: family dynamics, childhood depression, attachment theory, parenting, family therapy

Introduction

Depression in children and adolescents constitutes a major and escalating global public health challenge. The scope of this problem has become increasingly apparent in recent years.[1,2] Data from the United States Centers for Disease Control and Prevention (CDC) for 2021–2023 indicate that 19.2% of adolescents aged 12–19 experienced depression, with a pronounced gender disparity: 26.5% among females versus 12.2% among males.[3] In China, a large-scale meta-analysis published in 2024 reported a pooled prevalence of clinically significant depressive symptoms of 26.17% among children and adolescents.[4]

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While these estimates reflect symptom prevalence, rates of formally diagnosed depressive disorders are lower yet remain concerning. In 2023, US surveillance data revealed that 8.4% of adolescents aged 12–17 met criteria for a current depressive disorder, with higher prevalence among females (10.9%) than males (6.0%).[5] Similarly, the World Health Organization (WHO) projected in 2025 that major depressive disorder affects approximately 1.4% of children aged 10–14 and 3.5% of adolescents aged 15–19.[6] In China, 2.8% of children and adolescents meet diagnostic thresholds for depressive disorders and 19.9% for depressive symptoms; however, only 5.8% of those with depressive disorders have sought professional help.[7,8] The striking discrepancy between the high prevalence of clinically significant symptoms and the comparatively lower rates of formal diagnosis underscores the existence of a large subclinical population: young people who are impaired and suffering but either do not meet full diagnostic criteria for major depressive disorder (MDD) or lack access to appropriate clinical care. This gap underscores an urgent public health priority: addressing not only diagnosed cases but also implementing preventive interventions to mitigate progression from symptoms to disorder.

If untreated, depression exerts profound and multifaceted functional impairment and ranks among the leading causes of illness and disability worldwide in adolescents.[9] Its impact permeates multiple domains of life, disrupting family relationships, social development, and academic performance.[10–13] A recent systematic review and meta-analysis quantified the cognitive burden of youth depression, showing significant deficits across neurocognitive domains compared with healthy controls—moderate impairments in working memory and long-term memory, and smaller but significant deficits in attention and executive function.[14] These deficits translate into substantial real-world consequences. CDC data indicate that nearly 88% of adolescents and adults with depression report functional impairment in work, home, or social activities.[3] Importantly, childhood depression seldom occurs in isolation. Comorbidity is the norm rather than the exception, with anxiety disorders being the most prevalent co-occurring conditions.[15,16] One study reported that over 95% of children with MDD had at least one comorbid psychiatric diagnosis.[17] Given the high prevalence, severe consequences, and strong comorbidity profile, advancing understanding of the developmental pathways of childhood depression and translating this knowledge into timely identification and intervention represent critical priorities for global mental health research and practice.

The Family Context of Childhood Depression: A Synthesis of the Evidence

The family represents the primary microsystem in which a child develops, and its influence on mental health is profound.[6,18,19] A substantial body of evidence, including systematic reviews and meta-analyses, has established a robust association between the family environment and childhood depression.[20–24] Across this literature, four domains consistently emerge as key influences: overall family dynamics, parenting styles, parental depression, and the role of the family in treatment.

Family Dynamics

The overall health of the family system functions as both a protective and a risk factor. Healthy family dynamics—characterized by emotional warmth, effective communication, and adaptability—are reliably associated with a reduced risk of depression.[25–27] In contrast, dysfunctional family patterns predict elevated risk. A meta-analysis reported that family dysfunction increased the likelihood of depressive symptoms in youth with an odds ratio of 3.72.[28] Similarly, family environments marked by high conflict and poor communication are linked to elevated stress and greater depressive symptomatology in children.[28]

Parenting Styles

Specific parenting behaviors exert a powerful influence on child mental health. A pivotal meta-analysis by McLeod, Weisz, and Wood (2007) demonstrated that parental rejection, more than parental control, was strongly associated with childhood depression.[29] Within this domain, parental hostility emerged as the most significant correlate of depressive outcomes.[29,30] These findings underscore that relational experiences of rejection or criticism are particularly potent developmental pathways to depression. Consistently, parenting characterized by low warmth and high hostility is linked to increased risk of childhood depression.[29,31]

Parental Depression

Depression frequently runs in families, transmitted through both genetic and environmental mechanisms.[32–34] Children of depressed parents face a threefold greater risk of experiencing a major depressive episode.[35] While genetic vulnerability contributes, environmental pathways are equally critical. Goodman et al (2011) confirmed in a meta-analysis that maternal depression is significantly associated with higher levels of internalizing problems in children.[36] Transmission occurs through multiple channels: depressed parents may model maladaptive cognitions, engage in hostile or withdrawn parenting practices, and exhibit impaired mentalizing, limiting their ability to accurately perceive and respond to a child's emotional needs.[36,37]

Family-Based Interventions

Recognizing the centrality of family influence, many treatment approaches for childhood depression incorporate parents. While individual therapies such as Cognitive Behavioral Therapy (CBT) are widely regarded as first-line interventions, their effect sizes for youth are often modest.[38] This has generated growing interest in family-based modalities. A recent meta-analysis found that family-based interventions yielded larger effects compared with inactive controls, but the advantage over active controls was small and not statistically significant ($g = 0.22$).[38] Nonetheless, the evidence base remains in development, and approaches such as Attachment-Based Family Therapy (ABFT) show theoretical promise and warrant further empirical evaluation.[38]

Rationale, Analytical Framework, and Research Questions

While the existing body of research has firmly established that family factors play a central role in childhood depression—and the association between family processes, attachment, and depressive outcomes is well recognized—the field still lacks a comprehensive, integrative framework that explains how the various dimensions described by different family systems theories collectively shape this outcome.[39] Seminal models proposed by theorists such as Olson, Beavers, McMaster, and Skinner each provide valuable but fragmented vocabularies for conceptualizing family dynamics. Yet, to our knowledge, no previous reviews have attempted this specific theoretical synthesis—that is, mapping the core constructs of these models onto attachment theory to explain the pathways to childhood depression—leaving the interrelationships among these theoretical dimensions and their convergence on developmental pathways to depression insufficiently understood.

This review argues that these constructs can be meaningfully synthesized through the lens of attachment theory, positioning the parent–child attachment relationship as the central mechanism linking broader family dynamics to child psychopathology. To ensure conceptual breadth, this review examines literature addressing both clinically diagnosed depressive disorders and subclinical depressive symptoms, as the underlying familial mechanisms operate across this continuum.

To pursue this synthesis, the review adopts a narrative inquiry methodology, which is particularly well-suited for theoretical integration and the development of novel conceptual models. Its distinctive contribution lies in bringing together diverse strands of evidence to generate a coherent framework that advances theoretical understanding. The phenomenon of China's "left-behind children" (LBC) provides a compelling case study through which to explore the consequences of systemic family disruption. Existing research has shown that family satisfaction mediates the relationship between left-behind experiences and depression in this population.[40] This group offers a powerful real-world demonstration of the review's central proposition: that severe disruptions within the family system—manifesting as profound attachment ruptures—constitute a primary and predictable pathway to childhood depression.[41]

Accordingly, this review is guided by four core research questions:

1. How can the core dimensions of major family systems theories (Olson, Beavers, McMaster, Skinner) be integrated into a single, coherent framework?
2. What role does the parent–child attachment relationship play as a central mediating mechanism linking broader family dynamics to childhood depression?
3. How can this integrative framework be applied to explain the heightened risk of depression among China's LBC?
4. What are the direct clinical implications of this framework for the development and implementation of evidence-based interventions for childhood depression?

Methods

This narrative review was conducted to synthesize foundational theories and empirical evidence. A literature search was performed within major English- and Chinese-language databases, including PubMed, PsycINFO, and China National Knowledge Infrastructure (CNKI), covering publications up to August 2025. Search terms included combinations of "family dynamics", "family functioning", "parenting", "attachment", "childhood depression", and "family therapy". The selection process was iterative, aimed at identifying seminal theoretical papers, key meta-analytic findings, and empirical studies that illustrate the theoretical mechanisms being discussed. This narrative synthesis approach was chosen for its suitability for theory development and the integration of diverse literature to form a new conceptual understanding.

Theoretical Foundations of Family Dynamics: Toward an Integrative Framework

Foundational Models of Family Systems

Family dynamics refers to the processes through which a family organizes itself to meet the needs of its members, manage tasks, and adapt to life's challenges.[42] Over the past several decades, a number of influential theoretical models have been developed to conceptualize and assess these processes. Broadly, these models can be classified into two approaches: result-oriented models, which define and categorize families based on observable characteristics and interactional styles, and process-oriented models, which evaluate family functioning in terms of the essential tasks the family system must accomplish. Four of the most prominent models form the foundation of our integrative analysis.

Result-Oriented Models

The Olson Circumplex Model

Developed by David Olson, this model is among the most widely used frameworks in family science.[43] It conceptualizes family dynamics along three dimensions: cohesion (the degree of emotional bonding among family members), flexibility (the extent of change in leadership, roles, and rules), and communication (a facilitating dimension that enables movement along the other two).[42] The central hypothesis is that balanced, moderate levels of cohesion and flexibility are optimal for family functioning, whereas extremes on either dimension are associated with dysfunction.

The Beavers Systems Model

Proposed by Robert Beavers and Robert Hampson, this model evaluates families along two primary axes: family competence and family style.[44] Family competence ranges from optimal to severely dysfunctional, reflecting a family's capacity for adaptation and effective problem-solving. Family style captures the typical interactional orientation of the family, ranging from centripetal (members turn inward for gratification) to centrifugal (members turn outward). Together, these dimensions yield nine distinct family types, which have been applied in both clinical assessment and treatment planning.[44]

Process-Oriented Models

The McMaster Model of Family Functioning (MMFF)

Developed by Epstein, Bishop, and Levin, the MMFF is a clinically oriented framework that views the family as a system organized to accomplish essential developmental tasks.[45] Its central proposition is that the family's primary function is to provide a supportive environment for the physical, psychological, and social development of its members. Functioning is assessed across six domains: (1) Problem Solving, (2) Communication, (3) Roles, (4) Affective Responsiveness (the capacity to respond with appropriate emotions), (5) Affective Involvement (the degree of interest and value placed on one another's activities), and (6) Behavior Control.

Skinner's Family Process Model

Building on elements of the McMaster model, Harvey Skinner et al advanced a framework emphasizing the dynamic processes by which families develop and adapt.[46] The model assumes that family growth occurs through the collaborative accomplishment of essential tasks. It identifies seven interrelated dimensions of functioning: (1) Task Accomplishment (the

central process), (2) Role Performance, (3) Communication, (4) Affective Expression, (5) Involvement, (6) Control, and (7) Values and Norms (the family's belief system guiding its functioning).

Explaining Core Concepts: The Curvilinear "Inverted-U" Relationship

A central and clinically significant concept within the Olson Circumplex Model is the curvilinear, or "inverted-U", relationship between the dimensions of cohesion and flexibility and overall family health.[47] This hypothesis posits that optimal functioning is achieved not at the extremes of these dimensions, but rather within a balanced, moderate range. Excessively high or low levels of either cohesion or flexibility are regarded as dysfunctional and detrimental to long-term development.

Cohesion

The cohesion dimension assesses the degree of emotional bonding among family members. At the extreme low end lies disengagement, characterized by emotional separateness, minimal attachment, weak commitment, and limited mutual support. In such families, individuals function in isolation and struggle to rely on one another in times of need. At the opposite extreme is enmeshment, where excessive closeness and rigid demands for loyalty suppress individuality. In these families, boundaries are blurred, autonomy is restricted, and internal relationships dominate at the expense of external connections. By contrast, balanced family systems fall within the separated and connected ranges. Separated families maintain autonomy while preserving some emotional support, whereas connected families prioritize closeness and shared time while allowing for individual independence. These balanced states enable family members to be both securely connected and functionally independent.

Flexibility

The flexibility dimension refers to the family's capacity to adapt leadership, roles, and rules in response to developmental or situational challenges. At the extreme low end, rigidity is marked by authoritarian leadership, strictly prescribed roles, and resistance to change, producing a brittle and unresponsive family system. At the opposite extreme, chaos reflects the absence of stable leadership, consistent rules, or clear roles. Decision-making is erratic, structure is lacking, and predictability is compromised, leaving members without a reliable framework for stability. Balanced families fall within the structured and flexible ranges. Structured families maintain clear leadership and consistent rules while permitting limited negotiation and input, whereas flexible families are more egalitarian, with shared leadership and adaptable rules. Both styles provide the balance of stability and adaptability essential for healthy functioning.

Clinical Implications

This curvilinear principle offers an essential diagnostic framework for clinicians. The therapeutic objective is not to simply increase cohesion or flexibility, but to guide families away from maladaptive extremes and toward the functional middle range. For example, an enmeshed family requires support in developing boundaries and fostering autonomy rather than greater closeness, while a chaotic family benefits from establishing consistent structure rather than additional freedom. This nuanced understanding enables clinicians to design targeted interventions that address each family's specific imbalance and promote sustainable, healthy functioning.

An Integrative Framework: The Centrality of Attachment

Although the four foundational models of family systems employ distinct terminologies and emphasize different facets of family life, they are not mutually exclusive. This review advances an integrative framework suggesting that their core dimensions converge on a single, critical psychological mechanism: the formation and maintenance of the parent–child attachment relationship.

Attachment theory, pioneered by John Bowlby, posits that a child's capacity for emotional regulation and psychological well-being depends on the establishment of a secure bond with a primary caregiver who functions as a secure base—a reliable source of comfort, protection, and support from which the child can explore the world.[48] The quality of this attachment, internalized as a working model of self and others, is a powerful predictor of later mental health. Insecure attachment, in particular, is a well-documented risk factor for the development of both anxiety and depressive disorders.[49]

The dimensions articulated by family systems theories can be interpreted as the constituent elements of the caregiving environment that either support or undermine attachment security:

1. Process-oriented dimensions (McMaster and Skinner models)—including Communication, Affective Responsiveness, Affective Involvement, and Role Performance—represent the foundational components of sensitive and responsive caregiving. Families in which communication is open and direct, emotions are expressed and acknowledged appropriately, and parental roles of nurturance and support are fulfilled inherently foster conditions conducive to secure attachment.[42] Conversely, miscommunication, emotional unresponsiveness, and role confusion disrupt attunement and contribute to insecure attachment.
2. Result-oriented dimensions (Olson and Beavers models) describe the broader relational climate emerging from these processes. A family balanced in cohesion—supporting both connection and autonomy—parallels the function of a secure base, which simultaneously enables proximity-seeking and exploration.[42] By contrast, enmeshed families often foster anxious-preoccupied attachment patterns, while disengaged families foster avoidant tendencies. Likewise, families balanced in flexibility can adapt to a child's evolving developmental needs, a hallmark of sensitive parenting, whereas rigid or chaotic systems fail to provide consistent and attuned caregiving.

Within this integrative framework, attachment security functions as the core mediating variable linking family system dynamics to the development of childhood depression. This proposition is supported by robust empirical evidence. A multilevel meta-analysis by Spruit et al (2020), encompassing over 120 independent samples, demonstrated a significant moderate effect size for the association between insecure attachment and depression in children and adolescents.[48] These findings underscore that attachment insecurity is a powerful and consistent correlate of youth depression.

Accordingly, the systemic dimensions outlined by major family theories can be understood as upstream determinants of the caregiving environment, shaping the attachment relationship. Dysfunction at this systemic level fosters insecure attachment patterns, which in turn generate psychological vulnerabilities—such as negative internal working models of self and others—that manifest as depressive symptoms. This framework thus bridges macro-level family systems theory with micro-level psychopathology, offering a coherent pathway from family processes to clinical presentation.

Pathways from Family Dynamics to Childhood Depression

The Bidirectional Influence of Family Dynamics and Child Depression

A core tenet of family systems theory is the principle of circular causality, which posits that relationships within a system are governed by reciprocal influence rather than linear, unidirectional effects.[50] The association between family dynamics and childhood depression exemplifies this principle. The relationship is bidirectional: dysfunctional family dynamics can precipitate or exacerbate a child's depression, while a child's depression can, in turn, disrupt and degrade the functioning of the entire family system.[51]

On one hand, a maladaptive family environment—characterized by high levels of conflict, poor communication, emotional distance, or instability—creates a stressful and unpredictable context that depletes a child's psychological resources and increases vulnerability to depression.[28] Longitudinal studies have shown that early family functioning predicts the later emergence of depressive symptoms in adolescence.[42] On the other hand, the presence of a depressed child constitutes a major stressor for the family system. Symptoms such as irritability, social withdrawal, anhedonia, and oppositional behaviors can undermine parents' sense of competence, increase marital discord, and destabilize daily routines.[52,53] These child effects can erode family functioning, thereby intensifying the child's depression and fueling a self-perpetuating negative feedback loop.

Emerging evidence increasingly supports this child-to-parent pathway, moving beyond simplistic parent-blaming models. For instance, one longitudinal study found that adolescent boys' depressive symptoms prospectively predicted reductions in subsequent parental care, indicating that child psychopathology can erode positive parenting behaviors over time.[54] Other studies have demonstrated that child depression and anxiety predict increases in parental depression,

underscoring a cycle of escalating distress within the family.[51] Dysregulated emotions or behaviors in the child can elicit more negative, controlling, or inconsistent parenting, which then exacerbates the child's underlying difficulties.[54]

This transactional model provides a compelling rationale for why interventions targeting only the child are often insufficient. When parents and children are locked in a self-reinforcing negative cycle—for example, a child's irritability eliciting parental hostility, which deepens the child's sense of rejection and fuels further depressive symptoms—the dyadic interaction itself becomes the locus of pathology. Sustained improvement requires systemic interventions that address these relational processes directly. From this perspective, family-based approaches are indispensable, as they aim to repair dysfunctional interactional patterns rather than focusing solely on the child's internal symptoms or the parent's behaviors in isolation.

Key Mechanisms: Parenting Styles and Attachment Security

Within the broader family system, parenting styles function as the primary behavioral mechanism through which family dynamics are translated into the day-to-day interactions that shape child development. Parenting behaviors represent the most immediate pathway to the formation of secure or insecure attachment bonds, which, according to the proposed integrative framework, constitute the central mediator of depression risk.

A pivotal meta-analysis by McLeod et al (2007) identified parental rejection and hostility as the parenting dimensions most strongly associated with childhood depression, explaining more variance than parental control.[29] This finding is critical because it highlights a mechanism that is directly aligned with attachment theory. Parenting characterized by rejection, hostility, and low warmth undermines a child's core attachment needs, conveying that the child is unwanted, unlovable, or burdensome. Such experiences lay the groundwork for the development of a negative internal working model of the self—a central cognitive vulnerability in depression, wherein the self is perceived as inherently flawed and unworthy of love and care.[55]

This pathway provides a particularly compelling account of depression, distinct from that of anxiety. While anxiety is often linked to parental overcontrol, which diminishes a child's sense of competence and fosters perceptions of the world as threatening, depression emerges more directly from parental rejection, which shapes a negative self-concept. This distinction aligns with the core principles of both attachment theory and cognitive models of depression. The developmental trajectory is clear: dysfunctional family systems give rise to rejecting and hostile parenting; this parenting style fosters insecure attachment, characterized by a negative self-mo and this self-model forms the psychological foundation upon which depressive symptoms are built.[56]

The robust meta-analytic association between insecure attachment and youth depression provides compelling empirical support for this theoretical pathway.[48] Thus, parenting style should not be regarded as merely correlated with childhood depression; it is better understood as the primary mechanism that shapes attachment security and, in turn, builds the foundation for mental health and vulnerability to depression.

Application of the Framework: The Chinese Context and LBC

The proposed integrative framework, which identifies attachment as the key mediator between family systems and childhood depression, finds a particularly powerful validation in the real-world context of China's LBC. This phenomenon—arising from one of the largest internal migrations in human history—has created a large-scale "natural experiment" in the psychological effects of systemic family disruption.[57] In China, tens of millions of rural parents migrate to urban centers for work, leaving their children in the care of grandparents, other relatives, or, in some cases, unattended.[58,59] This separation is not typically voluntary but rather a necessity imposed by the hukou (household registration) system, which restricts access to education and healthcare for rural migrants in cities, making it prohibitively difficult for parents to bring their children.[60]

This mass parental migration profoundly disrupts the family system, affecting nearly every dimension of functioning outlined in foundational family theories. It creates role confusion, as elderly grandparents are thrust into primary caregiving responsibilities for which they may be unprepared; it fractures communication channels and weakens parental behavioral monitoring; and it generates a chronic state of emotional deprivation.[61] From the perspective of the integrative framework, the most consequential outcome is a severe and prolonged attachment rupture. Children separated from

parents during critical developmental periods are deprived of opportunities to establish and maintain secure bonds, thereby undermining their ability to use caregivers as a secure base for emotional regulation.[62,63]

As predicted, the combination of systemic dysfunction and disrupted attachment has profound consequences for the mental health of LBC. A substantial body of research shows that LBC experience significantly higher rates of mental health problems compared to peers who reside with their parents.[62] Specifically, studies consistently report elevated levels of depression, anxiety, loneliness, and reduced self-esteem.[64] A systematic review and meta-analysis by Xu et al (2019) estimated the pooled prevalence of depression among LBC at 26.4%, substantially higher than in the general adolescent population.[65] Other reviews have documented prevalence rates ranging from 12.1% to 51.4%, depending on sampling methods and measurement tools.[64]

The case of LBC provides compelling, evidence-based justification for this review's focus on the Chinese context. It is not merely a cultural aside but a striking demonstration of the central thesis: disruptions to the family system—manifesting most saliently as attachment ruptures—constitute a primary and predictable pathway to the development of childhood depression. Moreover, this case highlights a principle of universal relevance: while the scale and structural drivers may vary across societies, systemic disruptions to family functioning, when they compromise attachment bonds, represent a global risk factor for child and adolescent depression.

Discussion

Synthesis of Findings and Theoretical Contributions

This literature review was guided by a set of research questions aimed at moving beyond a simple synthesis of existing studies to propose a new, integrative understanding of the relationship between family systems and childhood depression. The findings provide clear answers to these questions and offer a significant theoretical contribution to the field.

First, the review demonstrates that the core dimensions of four major family systems theories—Olson's Circumplex Model, the Beavers Systems Model, the McMaster Model of Family Functioning, and Skinner's Family Process Model—can be coherently integrated. Although these models employ different terminologies and are categorized as either result-oriented or process-oriented, they all describe fundamental features of the family's relational environment. This review proposes that these dimensions are not independent constructs; rather, they represent constituent elements that collectively shape the conditions under which the parent–child attachment relationship develops.

Second, the central theoretical contribution of this review lies in positioning the parent–child attachment relationship as the core mediating mechanism linking the broader family system to the specific outcome of childhood depression. This integrative framework clarifies the causal sequence: the family system provides the context, parenting behaviors constitute the mechanism, and attachment quality represents the proximal outcome that directly influences a child's vulnerability to or protection from depression. In particular, parenting behaviors characterized by warmth versus rejection and hostility emerge as the primary behavioral drivers shaping attachment security.[29] Meta-analytic evidence supports this model, demonstrating a moderate association between insecure attachment and depression ($r = 0.31$), thereby bridging macro-level systemic concepts with micro-level cognitive–emotional processes underlying psychopathology.[48]

Third, the application of this attachment-based framework to the context of China's LBC provides compelling real-world validation. This case illustrates how severe systemic disruptions to family structure and parental presence predictably lead to attachment ruptures, which in turn manifest as significantly elevated rates of depression in this vulnerable population, with a pooled prevalence of 26.4%.[65] This serves as a powerful case study demonstrating the explanatory power and practical utility of the proposed framework in a large and clinically significant population.

Practical Implications for Clinical Intervention: The Role of ABFT

A central goal of this review was to translate theoretical insights into concrete, actionable guidance for clinicians. The finding that attachment security functions as the key mediating pathway between family systems and childhood depression carries direct and profound implications for intervention. It suggests that the most effective clinical strategies

are those that move beyond general calls to "improve family functioning" and instead explicitly target the repair of attachment ruptures and the re-establishment of the family as a secure base.

A prime example of such an approach is ABFT, a manualized, empirically supported treatment originally developed for adolescent depression and suicidality, and subsequently adapted for anxiety and trauma.[38] ABFT is an emotion-focused, process-oriented therapy designed to repair relational ruptures and restore the parent–child relationship as a source of security and support. While the evidence base for family therapies in youth depression remains mixed—one meta-analysis found a non-significant effect size (g = 0.22) for family-based interventions versus active controls—ABFT stands out for its strong theoretical alignment with the etiological pathways identified in this review.[66] Its explicit focus on healing attachment ruptures stemming from criticism, neglect, or rejection makes it uniquely well-suited as an intervention for depression. Structured around five distinct therapeutic tasks, ABFT provides clinicians with a clear, evidence-based roadmap for operationalizing the principles outlined in this framework.

The five therapeutic tasks of ABFT provide a structured clinical guide:

Relational Reframe

The therapist shifts the family's focus away from seeing the child as the "identified patient" and instead reframes the treatment goal as repairing and strengthening family relationships. The relationship itself becomes both the target of intervention and the vehicle of healing.

Adolescent Alliance

The therapist meets individually with the adolescent to build trust, validate experiences, and help construct a coherent narrative of distress linked to relational ruptures (eg, feeling criticized, neglected, or misunderstood). This process prepares the adolescent to express these experiences in later joint sessions.

Parent Alliance

The therapist also meets individually with parents to explore their stressors and intergenerational attachment histories, fostering empathy for the child's perspective and reducing defensive or critical reactions. This process prepares parents to engage more openly and supportively.

Attachment Task

In a facilitated family session, the adolescent shares experiences of relational pain and unmet attachment needs, while parents, guided by the therapist, respond with empathy, validation, and remorse rather than defensiveness or problem-solving. This corrective attachment experience allows trust and security to be rebuilt.

Promoting Autonomy

With attachment bonds restored, therapy shifts toward supporting the adolescent's age-appropriate independence, competence, and engagement in prosocial activities, with parents serving as a secure and supportive base rather than a source of conflict.

By detailing these structured therapeutic tasks, this review provides clinicians with a practical, evidence-based, and theoretically grounded roadmap for intervention. This approach moves beyond abstract recommendations, offering a tangible method for fostering the secure family relationships that are foundational to child and adolescent mental health.

To facilitate understanding, Figure 1 summarizes the proposed conceptual model. The diagram illustrates the integrative framework linking family dynamics to childhood depression, highlights the mediating roles of parenting styles and attachment security, and situates ABFT as a targeted intervention designed to repair these disrupted pathways.

Limitations and Future Directions

This review, while offering a novel theoretical integration and clear clinical implications, has several limitations inherent to its narrative methodology. Unlike systematic reviews, narrative reviews do not employ quantitative synthesis of effect sizes, and the selection of literature, while guided by research questions, is subject to authors' interpretation and potential

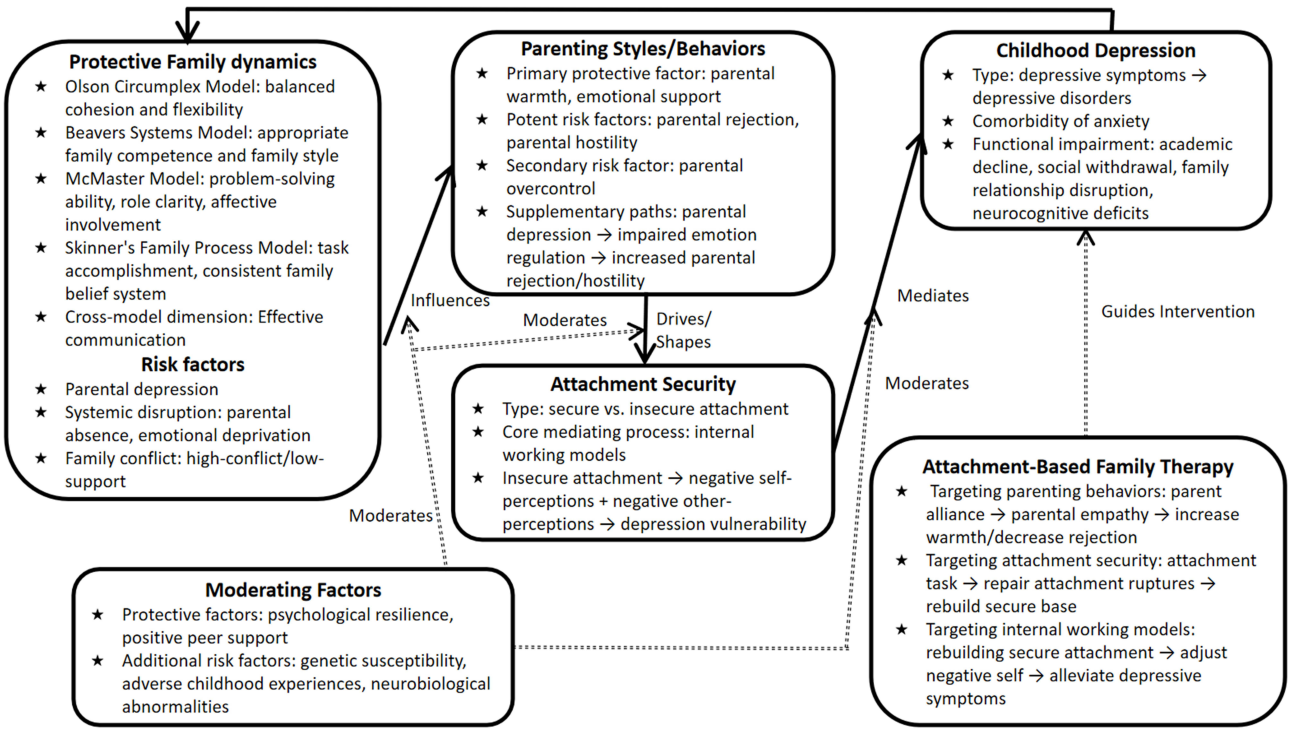

Figure 1 Conceptual diagram of the integrative framework of family functioning, the mediating roles of parenting styles and attachment security, childhood depression, and attachment-based family therapy for depression. This figure constructs a coherent, evidence-driven logical chain that maps the multi-level interplay between family dynamics and childhood depression, while integrating bidirectional feedback loops, mediating mechanisms, and targeted interventions—all grounded in the core arguments of the manuscript. At the upstream level, the framework begins with the family dynamics, which encompasses two opposing sets of influences: protective core functional dimensions (eg, effective communication, role clarity, balanced cohesion/flexibility from Olson's model, and task accomplishment from Skinner's model) and disruptive risk factors (eg, parental depression, systemic family disruption in China's left-behind children, and high-conflict environments). These upstream family factors then shape the midstream mediating mechanisms, starting with parenting behaviors—where protective factors (parental warmth, emotional support) and potent risk factors (parental rejection, hostility) directly influence the quality of parent-child attachment. Secure attachment fosters positive internal working models (eg, perceptions of self as lovable and others as reliable), while insecure attachment (anxious-ambivalent or avoidant) cultivates negative internal working models—a key cognitive vulnerability to depression. This midstream process ultimately drives the downstream outcome: childhood depression, which is categorized into subclinical symptoms and clinical depressive disorders, alongside associated comorbidities and functional impairments (academic decline, social withdrawal, neurocognitive deficits in working memory/executive function). Critically, the framework incorporates bidirectional feedback loops to reflect circular causality: childhood depressive symptoms (eg, irritability, anhedonia) reduce parental self-efficacy, exacerbate parental hostility or withdrawal, and Erode family functioning—creating a self-perpetuating cycle that further intensifies the child's depression; additionally, child depression increases parental caregiving stress, worsening parental depressive symptoms and further degrading parenting quality and attachment security. To address this cycle, the framework integrates Attachment-Based Family Therapy (ABFT) as a targeted intervention, which acts on midstream mechanisms via three key pathways: the "Parent Alliance" task reduces parental defensiveness and enhances empathy to improve parenting behaviors (eg, less rejection, more warmth); the "Attachment Task" repairs attachment ruptures by facilitating the child's expression of unmet needs and the parent's empathetic response, rebuilding the secure base; and the restoration of secure attachment adjusts negative internal working models, alleviating depressive symptoms and preventing progression from subclinical to clinical status. Finally, the chain includes moderating factors to account for individual differences: protective influences (eg, psychological resilience, positive peer support) buffer against depression risk, while additional risk factors (eg, genetic susceptibility, adverse childhood experiences) amplify vulnerability, ensuring the framework captures the multifactorial nature of childhood depression as emphasized in the manuscript.

selection bias. The proposed integrative framework is therefore a conceptual model that requires direct empirical validation. Moreover, while attachment security is positioned as the central mediator between family systems and childhood depression, the model is not exhaustive. Other pathways—including genetic vulnerabilities, neurobiological factors, and extra-familial influences such as peer relationships—also contribute to the development of depression and should be incorporated into a more comprehensive etiological account.

A balanced appraisal of intervention evidence is also warranted. Although ABFT aligns strongly with the theoretical framework advanced in this review, the empirical evidence supporting its efficacy remains mixed. Meta-analyses have found that ABFT does not consistently outperform active controls such as enhanced usual care or supportive therapies, with effect sizes limited by small samples and high heterogeneity.[66,67] Nonetheless, emerging findings suggest ABFT may hold particular promise for subpopulations, including LGBQ adolescents,[68] and its explicit focus on repairing attachment ruptures makes it theoretically compelling. For now, ABFT should be regarded as a promising but not yet definitively validated intervention.

These limitations point toward several critical directions for future research.

1. Longitudinal designs are needed to empirically test the proposed mediational pathway. Studies that track family system variables, parenting behaviors (especially rejection and hostility), attachment security, and child depressive symptoms across multiple time points would provide direct validation of the model.
2. Rigorous intervention trials are required to strengthen the evidence base for ABFT and related approaches. Large-scale, high-quality randomized controlled trials, alongside component analyses, could help clarify which therapeutic tasks are most essential in reducing depressive symptoms.
3. Cross-cultural research is essential to examine the framework's generalizability. While the application to China's LBC provides a compelling demonstration, further work is needed to test its applicability across diverse socio-cultural contexts and to adapt interventions like ABFT for cultural specificity.

By acknowledging these limitations and outlining a clear research agenda, this review not only synthesizes existing knowledge but also sets the stage for advancing a more comprehensive, empirically grounded, and culturally sensitive understanding of how family systems influence childhood depression.

Conclusion

The complex interplay of factors within a family system profoundly shapes a child's emotional development. This review has synthesized a broad body of evidence to argue that dysfunctional family dynamics—characterized by poor communication, confused roles, and unhealthy extremes of cohesion and adaptability—contribute to the development and maintenance of childhood depression primarily by undermining the security of the parent–child attachment bond. Within this pathway, parental rejection and hostility emerge as particularly potent mechanisms.

The primary theoretical contribution of this work is the novel integration of four major family systems models into a unified, attachment-centered framework. By positioning attachment as the central mediator, this framework provides a coherent theoretical bridge between broad systemic concepts and the specific psychopathology of childhood depression. It also highlights parenting behaviors, especially warmth versus rejection and hostility, as the proximal drivers shaping attachment security.

This conceptual model has direct implications for clinical practice. Interventions that move beyond symptom management to directly target the repair of attachment ruptures and the cultivation of a secure family base represent a theoretically sound and evidence-informed strategy for prevention and treatment. ABFT exemplifies such an approach, offering a structured and practical roadmap for clinicians seeking to operationalize these principles in practice.

Future research should prioritize the empirical validation of the proposed pathways through longitudinal and cross-cultural studies, while continuing to evaluate the effectiveness of attachment-focused interventions such as ABFT. By keeping the family relationship at the center of both research and practice, the field can move toward more comprehensive and impactful strategies for promoting child and adolescent mental health.

Declaration of Generative AI and AI-Assisted Technologies in the Writing Process

During the preparation of this work the authors used Doubao 1.67.3 Pro exclusively to refine language fluency, enhance readability, and correct grammatical inaccuracies. No AI-generated content was incorporated into the manuscript at any stage of the writing process. The conceptual framework, methodological design, data interpretation, and scholarly conclusions remain entirely original to the authors. After using this tool/service, the authors reviewed and edited the content as needed and take full responsibility for the content of the published article.

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