

Commentary: Why positive psychological resources are important for alleviating childhood adversity-related effects in adult patients with depressive disorders?

Na et al¹ reported a remarkable finding that the relationship between childhood adversity and stress responses is mediated by positive psychological resources in adult patients with depressive disorders. A multilevel meta-analysis revealed a strong association between emotional abuse and depression in terms of childhood adversity.² In addition, a systematic review showed that the relationship between childhood adversity and depression was mediated by maladaptive schema, negative automatic thoughts, and avoidance. In addition, it has been shown that the relationship between childhood adversity and depression is not only mediated but also moderated by resilience.³ In the realm of a vulnerability model for depressive disorders, the relationship between childhood adversity and depression can be partly mediated by allostatic overload of the hypothalamic-pituitary-adrenal (HPA) axis. Permanent epigenetic modifications of glucocorticoid receptors can contribute to the association between early environmental adversity and long-term dysregulation of the HPA axis. Moreover, the modulation of neurotrophic factors, serotonergic neurotransmission, or the HPA axis can be affected by the interaction between childhood adversity and candidate genes for depression.⁴ In addition, this modulation pathway can be associated with structural changes not only in the white matter tract, including the corpus callosum, cingulum, and uncinate fasciculus, but also in the hippocampus, amygdala, anterior cingulate cortex, and prefrontal cortex.⁵ Thus, depressed patients with childhood adversity can be characterized by more severe symptomatology and poorer clinical outcomes related to allostatic overload of the HPA axis than those without childhood adversity.

One study reported that both optimism and resilience were negatively associated with depressive symptoms, and optimism was negatively associated with anxiety symptoms in patients with hematological cancers. In addition, enhancing positive psychological resources can be proposed as an intervention for improving the symptoms of depression and anxiety in patients with hematological cancers.⁶ These findings can support the mediation of the relationship between childhood adversity and depression through positive psychological resources. Therefore, enhancing positive psychological resources can be suggested as an intervention strategy for alleviating childhood adversity-related effects among adult patients with depressive disorders.

Network analysis approach is based on the idea that "symptoms are not outcome factors of an underlying disease; symptoms and the associations between them are the disease itself." In addition, the network analysis approach mainly uses a bottom-up approach, whereas the standard biomedical and reductionistic model mainly uses a top-down approach.⁷ A novel finding has been reported from several network analysis studies as follows: Using data from the Research on Asian Psychotropic Prescription Patterns for Antidepressants (REAP-AD), network analysis has revealed that guilt or self-blame is situated most centrally and agitation or retardation is situated least centrally within the International Classification of Disease, tenth revision (ICD-10) diagnostic criteria for depressive disorder in 643 East Asian patients with depressive disorders.⁸ It is expected that a novel perspective can be extracted from a network analysis study for symptomatology of depressed patients with childhood adversity. In addition, network structure changes for the positive psychological resource-based alleviation of childhood adversity-related impacts may be estimated for patients with depressive disorders.



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Seungwon Cho¹ 

Seon-Cheol Park^{2,3} 

¹Department of Psychiatry, Hanyang University Hospital, Seoul, Korea

²Department of Psychiatry Hanyang University College of Medicine, Seoul, Korea

³Department of Psychiatry, Hanyang University Guri Hospital, Guri, Korea

Corresponding author:
Seon-Cheol Park
✉ psc76@hanyang.ac.kr

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