Depressive Disorders

Marital and Family Therapy for Depression

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INCIDENCE

Depression is the most common of all the psychiatric disorders, and is perhaps the most lethal. It has been estimated that one in five depressed persons receives psychiatric treatment, that one in 50 is hospitalized, and that one in 100 commits suicide. Each year, more than 100 million people worldwide develop clinically recognizable depression, an incidence 10 times greater than that of schizophrenia. Furthermore, the World Health Organization expects that this number will increase over the coming years (Sartorius, 1979). Epidemiological studies indicate that 18 to 26 percent of female adults and 8 to 12 percent of males will experience at least one clinically significant episode of depression at some time in their lives (Weissman & Boyd, 1983); currently, there are estimated to be between 10 million and 14 million people in the United States who are exhibiting diagnosable depression (Weissman & Boyd, 1983).

There is also a significant cost associated with depression, in terms of suicide. The National Institute of Mental Health has reported that, of the 22,000 suicides committed each year in the United States, 80 percent can be traced to a precipitating depressive episode. The mortality risk from all causes appears to be elevated in depressed individuals (Lehmann, 1971). Therefore, when one

considers the various medical and diagnostic categories of which depression is an intricate part or with which it is frequently associated and the number of patients who show a subclinical form of this disorder, it is apparent that the problem of depression is considerable.

No single set of factors can adequately explain the full range of phenomena associated with depression, but, over the past decade, researchers have gained a growing appreciation of the significance of the psychosocial aspects of this disorder (Brown & Harris, 1978; Cane & Gotlib, 1985; Coyne, Kahn, & Gotlib, 1987; Hooley, 1985; Kessler, Price, & Wortman, 1985). As part of this examination of interpersonal functioning, investigators have begun to assess the role of intimate relationships in the etiology, course, and treatment of depression, as well as the negative impact of depression on close relationships. In this context, the marital and family relationships of depressed persons have recently become a major focus of interest.

Paralleling this escalation of research examining interpersonal aspects of depression is a growing interest in marital and/or family-oriented approaches to the treatment of this disorder. Thus, there has been a considerable increase in both the number and the methodological sophistication of studies assessing the efficacy of therapies for depression that focus on altering depressed persons' problematic relationships with their spouses and families. In this chapter, we will examine the current state of knowledge concerning the use and effectiveness of

marital/family therapy for depression. We will begin with a brief examination of the literature that has underscored the importance of focusing on interpersonal factors in depression. In this context, we will review two distinct groups of investigations: those assessing the marital relationships and interactions of depressed persons, and those examining the effects of parental depression on the adjustment and psychosocial functioning of children in the family.

Following this review we will examine the results of outcome studies conducted to assess the efficacy of marital and/or family-oriented therapies for depression. We will outline the basis of an interpersonal systems approach to the treatment of depression (Gotlib & Colby, 1987), and will conclude the chapter with a case example illustrating the application of this therapy in the treatment of a depressed woman.

THE FAMILY RELATIONSHIPS OF DEPRESSED PERSONS

The literature examining the relationships of depressed individuals with their spouses and children developed, in part, from a sizable body of studies demonstrating that depressed persons are characterized by problematic interpersonal functioning. For example, at a broad level, depressed individuals report having smaller, less integrated, and less supportive social networks than do their nondepressed counterparts (Brim, Witcoff, & Wetzel, 1982; Lin, Dean, & Ensel, 1986). Indeed, Henderson, Byrne, and Duncan-Jones (1981) found that depressed persons also judged a higher portion of their interactions with others to be affectively unpleasant. In a study recently completed in our laboratory, Gotlib and Lee (in press-b) found depressed psychiatric outpatients to report that they engaged in fewer social activities and had fewer close relationships than did nondepressed psychiatric outpatients and nondepressed community controls. The depressed patients in this study also rated the quality of their significant relationships more negatively and reported that there were arguments in their families over a greater number of issues than was the case for the nondepressed subjects. Moreover, results from a diverse set of investigations have implicated a lack of supportive interpersonal relationships in the etiology of depression (Barnett & Gotlib, 1988; Brown & Harris, 1978; Costello, 1982). A number of investigators have demonstrated in observational studies that depressed persons are characterized by deficits in social skills (Gotlib, 1982; Libet & Lewinsohn, 1973) and that people interacting with depressed persons respond to them in a

negative manner (Coyne, 1976; Gotlib & Robinson, 1982). Considered collectively, these findings underscore the importance of interpersonal aspects of depression and provide the impetus for investigations examining the marital and family relationships of depressed persons.

Depressed Persons and Their Spouses

There are clear indications in the psychiatric literature that the relationships between depressed individuals and their spouses may be problematic. For example, epidemiological investigations indicate not only that women are 1.6 to 3 times more likely to be depressed than are men (Weissman & Klerman, 1977) but that married women are at significantly greater risk for developing depression than are unmarried women (Overall, 1971). In a finer-grained analysis, Renne (1971) reported that both males and females who were unhappily married were more depressed than were those who were separated and divorced. Beach, Winters, Weintraub, and Neale (1983, July) found 84 percent of the depressed patients in their sample to show a "negative course" of marital change in the four years following discharge from hospital, and Merikangas (1984) found the divorce rate in depressed patients two years after discharge to be nine times that of the general population. It has long been accepted that living with a psychiatrically disturbed person exerts a significant toll on the individual's spouse and family (Claussen & Yarrow, 1955). Targum, Dibble, Davenport, and Gershon (1981) found that over half of the spouses of bipolar depressed patients indicated that

they regretted having married; similarly, Coyne et al. (1987) found that 40 percent of the spouses of depressed persons were themselves sufficiently distressed to warrant referral for psychotherapy.

The results of other studies provide more direct evidence of the link between marital distress and depression. Both Coleman and Miller (1975) and Crowther (1985), for example, obtained significant correlations between depressive symptomatology and marital distress in samples of psychiatric patients. Paykel et al. (1969) found that the most frequent life event preceding the onset of depression was a reported increase in arguments with the spouse. Schless, Schwartz, Goetz, and Mendels (1974) demonstrated that the impact of marriage- and family-related stresses persists after depressed patients recover. Finally, as we noted earlier, a number of recent investigations have reported that the lack of an intimate relationship with a spouse or boyfriend increased women's vulnerability for depression (Brown & Harris, 1978; Costello, 1982; see Gotlib & Hooley, 1988, for a more detailed review of this literature).

These and other similar findings have provided the foundation for studies examining more explicitly the nature of the marital relationships of depressed persons. In an early investigation, Weissman and her colleagues (Rounsaville, Weissman, Prusoff, & Herceg-Baron, 1979; Weissman & Paykel, 1974) interviewed depressed female psychiatric patients over the course of their treatment. Weissman found these patients to report marital relationships characterized by

friction and hostility; they also reported being more dependent and less affectionate toward their spouses than did nondepressed controls (see Freden, 1982, for similar findings from a study conducted in Sweden). Rounsaville et al. (1979) noted subsequently that the presence of marital disputes was an important determinant of treatment outcome for these depressed women. Those women who reported marital difficulties on entry to treatment showed less improvement in their depressive symptoms and social functioning and were more likely to relapse after a course of individual therapy. In fact, these marital problems were found to persist at a one-year follow-up, even though the women had recovered symptomatically. These findings led Weissman to view the marital relationship as a "barometer" of clinical status.

Subsequent research replicated and extended Weissman's results. In one of the first observational studies of depressed patients, Hinchliffe, Hooper, and Roberts (1978) examined the marital interactions of male and female depressed inpatients and their spouses while in the hospital and again after recovery. These interactions were compared with the interactions of nonpsychiatric surgical patients and their spouses and with the interactions of the depressed patients with strangers. Hinchliffe et al. found that, while they were in hospital, the conversations of couples with a depressed spouse were marked by conflict, tension, negative expressiveness, high levels of disruption, negative emotional outbursts, and a high frequency of interruptions. Moreover, on almost every dimension measured, the interactions of the depressed patients with their

spouses were more negative than were their interactions with strangers, indicating that the marital couple behaves as a "system." After recovery, the marital interactions of the male depressed patients were less negative, resembling those of the surgical controls; in contrast, the depressed women and their spouses continued to show high levels of tension and negative expressiveness.

In a similar study, Hautzinger, Linden, and Hoffman (1982) examined the marital interactions of couples seeking marital therapy, half of whom had a depressed spouse. Consistent with Hinchliffe et al.'s (1978) results, Hautzinger et al. found that communication in couples with a depressed spouse was more disturbed than in couples without a depressed partner. Couples with a depressed spouse more frequently discussed emotional difficulties; their conversations also tended to be more uneven, negative, and asymmetrical than were those of the distressed but nondepressed couples. Spouses of depressed partners seldom agreed with the depressive, offered help in an ambivalent manner, and evaluated the depressed spouse negatively. In contrast, the depressed spouses spoke positively of their partners and negatively of themselves.

Several studies have found the marital interactions of depressed persons to be characterized by hostility. Kahn, Coyne, and Margolin (1985) reported that, compared to nondepressed control couples, couples with a depressed spouse were more sad and angry following marital interactions and experienced each other as more negative, hostile, mistrusting, and detached, as well as less

agreeable, nurturant, and affiliative. Biglan and Hops and their colleagues (Biglan et al., 1985; Hops et al., 1987) examined the marital interactions of couples in which the wife was clinically depressed. These authors found that depressed women exhibited higher rates of depressive affect and behavior and lower rates of problem-solving behavior than did either their husbands or nondepressed control spouses.

Three studies conducted in our laboratory provided further evidence of the negative marital interactions of depressed persons. Kowalik and Gotlib (1987) had depressed and nondepressed psychiatric outpatients and nondepressed nonpsychiatric controls interact with their spouses while simultaneously coding both the intended impact of their own behavior and their perceptions of their spouses' behavior. Compared with the nondepressed controls, the depressed patients were found to code a lower percentage of their messages as positive and a higher percentage as negative, indicating that they perceived the interactions and their spouses as problematic. Ruscher and Gotlib (1988), who examined the effects of depression on the marital interactions of depressed couples from the community and nondepressed control couples, found that couples in which one partner was depressed emitted a relatively low proportion of positive verbal behaviors and a high proportion of negative verbal and nonverbal behaviors. In the third study, Gotlib and Whiffen (1989) examined marital satisfaction and interpersonal behavior in groups of depressed psychiatric inpatients, nondepressed medical patients, and nondepressed community controls. Both the

depressed and the medical patients and their spouses reported significantly lower marital satisfaction and exhibited more negative behavior during the interactions than did the nondepressed control couples.

The results of recent investigations suggest that the behavior of the depressed patients' spouses may be as influential in predicting clinical course and outcome as the patients' own symptoms and behaviors. Vaughn and Leff (1976), for example, interviewed family members (typically spouses) of depressed patients around the time of the patients' hospitalizations. On the basis of the extent to which they expressed critical or hostile comments to the researcher when talking about the patient, relatives were classified as high or low in expressed emotion (EE; Hooley, 1985). Hooley (1986) demonstrated that spouses who were classified as high-EE on the basis of what they said to an interviewer *about* their depressed partners were also significantly more negative in interactions *with* their partners than were low-EE spouses. Vaughn and Leff found that depressed patients who returned from the hospital to live with high-EE spouses were more likely to relapse during a nine-month follow-up period than were patients who returned home to live with low-criticism family members (Hooley, Orley, & Teasdale, 1986). Both Vaughn and Leff and Hooley et al. found that depressed patients relapsed at even lower rates of criticism than those typically associated with relapse of schizophrenic patients.

It is clear, therefore, that the marital relationships of depressed persons are

characterized by tension and hostility and that negative marital interactions can increase the likelihood of depressed patients' relapse. In an attempt to gain a broader understanding of the interpersonal functioning of depressed persons, investigators have recently begun to examine the relationships of depressed individuals with their children.

Depressed Persons and Their Children

Although the relationships of depressed women with their children have received less attention than have their marital relationships, results of a number of diverse studies suggest that this may be an important area of investigation. For example, epidemiological investigations indicate that women who are raising children and who are not employed outside the home are particularly vulnerable to depression (Brown & Harris, 1978; Gotlib, Whiffen, Mount, Milne, & Cordy, 1989). Depressed women have also been found to report difficulty being warm and consistent mothers, and they indicate that they derive little satisfaction in being mothers and feel inadequate in this role (Bromet & Comely, 1984; Weissman, Paykel, & Klerman, 1972). Interestingly, several studies have found currently depressed adults to report having experienced difficult early family environments and problems in their relationships with their parents (Gotlib, Mount, Cordy, & Whiffen, 1988; Parker, 1981). Given these findings, it is not surprising that accumulating evidence suggests that the children of depressed parents are at increased risk for a variety of psychological and social difficulties

(Beardslee, Bemporad, Keller, & Klerman, 1983; Gotlib & Lee, in press-a).

A number of studies have examined the relationships between depressed women and their children. Compared with their nondepressed counterparts, depressed mothers have been found to report being less involved, less affectionate, and more emotionally distant with their children, and to experience more irritability and resentment (Weissman et al., 1972). Depressed mothers have also been found to report various psychological and physical problems in their children, including depressed and anxious mood, suicidal ideation, and difficulties in school (Billings & Moos, 1983; Weissman et al., 1984). Furthermore, Billing and Moos (1986) found that depressed mothers continued to report problems in their children's functioning even after remission of their own depressive symptoms.

Several investigators have moved beyond the self-reports of depressed women to examine more directly and objectively both the interactions of depressed mothers and their children and the psychosocial functioning of the children themselves. Bettes (1988), for example, found that depressed mothers took longer to respond to their infants' vocalizations than did nondepressed mothers and, further, failed to modify their own speech after their infants had vocalized. In addition, the speech of the depressed women was more monotonous, failing to provide "affective signals" that allow infants to regulate their affective state. In a study conducted in our laboratory, Whiffen and Gotlib (in press) examined the effects of postpartum depression on infant cognitive and

socioemotional development. Depressed mothers in this study rated their infants as more temperamentally difficult than did nondepressed mothers. Independent observers also rated the infants of the depressed mothers as more tense, less happy, and deteriorating more quickly under the stress of testing (Cohn, Matias, Tronick, Connell, & Lyons-Ruth, 1986; Ghodsian, Zayicek, & Wolkind, 1984; Zekoski, O'Hara, & Wills, 1987).

Two studies have attempted to delineate the specific characteristics of depressive mothering. Breznitz and Sherman (1987) reported that in a nonthreatening situation, depressed mothers of two- to three-year-old children spoke less than did nondepressed mothers. When placed in a more stressful situation, however, they increased their speech rate and decreased their response latency, a speech pattern indicative of anxiety. Breznitz and Sherman proposed that the children of depressed mothers were being socialized to respond to stress with exaggerated emotionality. In a similar study, Kochanska, Kuczynski, Radke-Yarrow, and Welsh (1987) compared the interactions of depressed and control mothers in situations in which the mother initiated an attempt to control or influence the child's behavior. Kochanska et al. found that the depressed mothers were more likely than were the nondepressed mothers to terminate the attempt before resolution, and were less likely to reach a compromise solution. These investigators proposed that the premature termination of control attempts may have been due to the depressed mother's fear of confrontation, a hypothesis consistent with the results of studies demonstrating that depressed adults cope by

avoiding stressful situations (Coyne, Aldwin, & Lazarus, 1981).

Studies of the older children of depressed mothers indicated that these children demonstrate poorer functioning than do children of nondepressed parents. Weiner, Weiner, McCrary, and Leonard (1977) reported that the children of the depressed parents had more depressed mood, death wishes, frequent fighting, somatic complaints, loss of interest in usual activities, hypochondriacal concerns, and disturbed classroom behavior. The results of a recent observational study indicated that children of depressed mothers emit more irritated affect than do children in nondepressed families (Hops et al., 1987). Lee and Gotlib (1989a, 1989b) recently examined child adjustment in families in which the mother was diagnosed as suffering from a nonpsychotic, unipolar depression. Lee and Gotlib found that children of depressed mothers demonstrated higher rates of both internalizing and externalizing problems than did children of nondepressed psychiatric and medical control mothers. Clinical interviewers identified a greater number of psychological symptoms and poorer overall adjustment in the children of depressed mothers than they did in the children of community control mothers. Moreover, these deficits appeared to persist at a 10-month follow-up, even after the mothers' depressive symptoms had dissipated (Hammen et al., 1987; Hirsch, Moos, & Reischl, 1985; Turner, Beidel, & Costello, 1987).

Several investigators have demonstrated that a remarkably high proportion of children of depressed parents meet diagnostic criteria for psychiatric disorder.

Beardslee, Schultz, and Selman (1987), Klein, Clark, Dansky, and Margolis (1988), and Orvaschel, Walsh-Ellis, and Ye (1988), for example, found that between 40 and 50 percent of the adolescent children of depressed parents met criteria for a diagnosis of past or current psychiatric disturbance. Hammen et al. (1987) obtained similar results in a more extensive investigation, but also reported that group differences were attenuated when psychosocial stresses were covaried. Finally, in a study described earlier, Lee and Gotlib (1989a, 1989b) reported that two-thirds of the children of the depressed mothers in their sample were placed in the clinical range on the Child Behavior Check List, an incidence three times greater than that observed in the nondepressed controls.

Children of depressed mothers have been found in a number of studies, using a diverse range of methodologies, to demonstrate problematic psychosocial adjustment and functioning. Moreover, these difficulties are apparent at a wide range of ages. A consistent finding in this literature is that, even when their mothers are no longer overtly symptomatic, children continue to demonstrate behavioral difficulties, indicating that there may be a substantial lag between alleviation of maternal symptomatology and improvement in child functioning. This finding parallels results of studies reviewed earlier, suggesting that marital difficulties also persist beyond the depressive episode. Thus, alleviation of maternal symptomatology should not be taken as a signal that all family members are functioning adequately. Given the pervasiveness of the problematic interpersonal functioning of depressed persons, a number of interventions for

depression have been developed that focus on the marital and family relationships of the depressed patient.

MARITAL AND FAMILY THERAPY

Descriptions of the problematic marital relationships of depressed persons and of the adverse impact of parental depression on young children in the family have provided the impetus for investigations assessing the efficacy of therapies for depressed persons focused on improving the quality of their marital and/or family interactions. The concept of treating depression from a marital/family perspective is a relatively new one and, consequently, there is not a large body of outcome studies in this area. There are, however, a small number of investigations that have reported the successful treatment of depression using marital or family-oriented therapies.

In an early series of case studies, Lewinsohn and his colleagues described an approach to the treatment of depression that focuses on reestablishing an adequate schedule of positive reinforcement for the individual by increasing the quality and range of interpersonal interactions. Lewinsohn postulated that providing depressed patients and their spouses with feedback about their interpersonal behaviors in the home can lead to a decrease in the level of depression and an improvement in their social relationships. Thus, Lewinsohn and Atwood (1969) and Lewinsohn and Schaffer (1971) presented cases in which feedback about interpersonal behavior between depressed women and their husbands was used in combination with conjoint marital therapy to effect behavior change. The results demonstrated significant decreases in the women's

MMPI-Depression scores and improvement in their marital communication and family interactions.

In a subsequent controlled investigation, McLean, Ogston, and Grauer (1973) examined the effects of behaviorally oriented conjoint marital therapy on the valence of the marital communications of depressed outpatients and their spouses. McLean et al. compared a non-treatment control group of depressed couples with a group of couples who received behavioral marital therapy. Twenty married depressed outpatients received either conjoint behavioral marital therapy with their spouses or "treatment as usual," which typically involved medication, group therapy, individual psychotherapy, or some combination of these treatments. Couples in the behavioral marital therapy treatment group received eight one-hour-weekly sessions with male and female cotherapists. During these sessions they received training in social learning principles, and the spouses were given feedback regarding their partners' perceptions of their verbal interactions. Using reciprocal behavioral contracts, spouses were taught how to communicate to their partners the changes they desired in their relationships and how to monitor the feedback they were giving to their spouses. Couples were given "feedback boxes" designed to signal positive and negative feedback during ongoing conversation.

Prior to beginning treatment, patients were assessed with the Depression Adjective Checklist (DACL). They were tape-recorded at home, discussing their

problems with their spouses, and were asked to list five target behaviors that were attributed to the patients' depression. Both at the end of treatment and at a three-month follow-up, couples indicated any changes they noted in these five target behaviors. McLean et al. (1973) found that, overall, patients in the marital therapy group demonstrated greater improvements than did the control patients. At both review points, couples in the marital therapy group reported significantly greater reductions in their DACL scores and greater improvements in their problematic interpersonal behaviors. In contrast, couples in the comparison group exhibited only minor improvement in these areas. Finally, couples who received marital therapy demonstrated more adaptive verbal behavior, including a significant reduction in the frequency of their negative interchanges.

In a widely cited investigation of the effectiveness of marital therapy in the treatment of depression, Friedman (1975) conducted a 12-week therapy program designed to assess the separate and combined effects of amitriptyline and "marital and family-oriented psychotherapy" in depressed patients. Subjects were male and female depressed outpatients whose spouses agreed to make regular visits to the clinic. Patients were randomly assigned to one of four treatment conditions: drug therapy and marital therapy, drug therapy and minimal contact, marital therapy and placebo, and placebo and minimal contact. A total of 150 depressed patients completed the full course of treatment. In the drug treatment groups, patients received amitriptyline hydrochloride for the first 10 weeks of treatment; during the last two weeks they were drug-free, in order to assess withdrawal

reactions. Patients in the marital therapy conditions had 12 hours of contact with a therapist using marital and family-oriented psychotherapy. Finally, patients in the minimal contact group received seven individual sessions with a physician, each lasting a half-hour.

Several assessment measures were utilized to evaluate outcome at the end of treatment, including a Psychiatric Rating Scale, a Global Improvement Clinical Scale, a self-report Inventory of Psychic and Somatic Complaints, a Family Role Task and Activity Scale, and a Marital Relations Inventory. Essentially, Friedman (1975) found that both drug and marital therapy were more effective than were their respective control conditions (placebo and minimal individual contact). However, there also appeared to be differential effects of these two types of treatment. Whereas drug therapy was associated with early improvement in clinical symptoms, marital therapy was associated with longer-term improvement in the patient's participation in and performance of family role-tasks, the reduction of hostility in the family, and the patient's perceptions of the quality of the marital relationship. Overall, for most of the outcome measures, the combined drug-marital therapy group demonstrated the greatest improvement. In discussing these results, Friedman stated that it is possible that "the marital therapy approach is more effective and quicker to achieve a positive effect with neurotically depressed married patients than is either individual or peer group therapy" (p. 634).

The usefulness of including the spouse in therapy was also examined in an uncontrolled retrospective study of 100 couples in which one partner was diagnosed with a primary affective disorder (PAD). Greene, Lustig, and Lee (1976) examined 40 unipolar depressed, 42 bipolar depressed, and 18 unipolar manic patients and their spouses. All PAD spouses received psychotherapy and/or somatotherapy, while the therapist gave supportive psychotherapy to the non-PAD spouse. The major emphasis of Greene et al.'s approach was to utilize the non-PAD partner as an "assistant therapist," with the goal of stabilizing the marriage. Greene et al. reported that approximately 10 percent of the couples receiving this treatment achieved stabilization for at least 15 years. Nevertheless, the authors cautioned that "our current practice in premarital counseling is usually to advise against marriage when there is a history of a primary affective disorder. . . . Marriage to an individual with a PAD involves serious risks: the deep emotional consequences of suicide attempts or suicide, the strong hereditary component, and the intermittent incompatibility of the marriage are emotionally disturbing not only to the spouses but also to the children" (p. 829).

Davenport, Ebert, Adland, and Goodwin (1977) also reported on the effectiveness of couples therapy in the treatment of bipolar affective disorder. Sixty-five married bipolar patients who had been previously hospitalized for an acute manic episode were followed for two to 10 years subsequent to their discharge. The patients and their spouses were arbitrarily assigned to one of three groups at the time of discharge: a couples psychotherapy group with lithium

maintenance *(N* = 12), a lithium maintenance group with no regular psychotherapy (*N* =11), and home community aftercare (*N* = 42). Each couples group consisted of three to five couples who met for approximately 90 minutes per week with male and female cotherapists. The focus of therapy, conducted with cotherapists, was on couple interactions and the acquisition of more adaptive behaviors. Davenport et al. found the overall outcome to be quite poor for those couples who did not receive the couples therapy. Patients in the lithium/no psychotherapy and home aftercare groups demonstrated high rates of rehospitalization and marital failure; in fact, three of these patients committed suicide. In contrast to this pattern of functioning, none of the 12 patients in the couples group required rehospitalization or experienced marital failure. Although there were a number of demographic differences among these groups that must be taken into account, Davenport et al. concluded that bipolar patients and their spouses can benefit from participation in a homogeneous conjoint marital therapy group.

Two preliminary reports on the effectiveness of marital therapy for the treatment of depression, both with small samples, warrant mention. Waring et al. (1988) described an ongoing investigation in which they used essentially the same four treatment groups as did Friedman (1975). They reported results from 12 couples who had completed the 10 weeks of therapy sessions. The subjects were all dysthymic women whose husbands agreed to participate in treatment. Patients received either doxepin or a placebo drug crossed with either minimal contact or

cognitive marital therapy, selected for its focus on the intimacy between couples and the use of self-disclosure to improve intimacy. Waring et al. found that all patients showed an improvement in depressive symptomatology and an increase in reported intimacy. In addition, there was a trend for these effects to be most pronounced for patients in the cognitive marital therapy condition. Waring et al. suggested that the simple presence of dysthymic women's spouses in therapy may itself be beneficial.

In the second preliminary study, Beach and O'Leary (1986) described the clinical outcome for eight couples in which the wife met diagnostic criteria for unipolar depression. Couples were randomly assigned to one of three groups: conjoint behavioral marital therapy, cognitive therapy for the depressed spouse only or a wait-list control group. Whereas the marital therapy treatment focused on improving communication and problem-solving, cognitive therapy focused on examining the manner in which the patients structured their worlds and how this in turn influenced their affect and behavior. Couples in the wait-list control group were told that they could request therapeutic consultation, although none did during the 14 weeks of treatment. Beach and O'Leary assessed depressive symptoms and marital discord at every second week throughout treatment, by having subjects complete the Beck Depression Inventory and the Dyadic Adjustment Scale. Couples also completed these measures one week after the last session and at a three-month follow-up. The results of this study indicated that both active treatment conditions were more (and equally) effective than was the

wait-list condition in reducing depressive symptoms. In addition, however, couples in the behavioral marital therapy condition reported significantly more rapid and larger increases in marital functioning than did couples in either the cognitive therapy or the wait-list control groups, and similar data were obtained for their husbands. Beach and O'Leary found this pattern of results to persist at the three-month follow-up assessment. Because this study is based on only eight couples, it is inappropriate to draw firm conclusions about the differential effectiveness of these intervention approaches. Nevertheless, it is noteworthy that whereas wives receiving behavioral marital therapy and individual cognitive therapy showed clinically significant reductions in depressive symptomatology, only those wives receiving the conjoint marital therapy also showed a marked reduction in marital dissatisfaction.

O'Leary and Beach (1988) reported the results of an expanded version of their study. Married women who received a diagnosis of dysthymia or major depressive disorder were randomly assigned to conjoint marital therapy, cognitive therapy for the depressed spouse only, or a wait-list control group. Both the behavioral marital therapy and the individual cognitive therapy involved 15 or 16 weekly sessions. As was the case in the earlier study, at the end of the treatment patients in both therapy groups demonstrated a significant reduction in depressive symptomatology, whereas the wait-list control group did not. In addition, patients who received marital therapy demonstrated higher marital satisfaction scores at the end of treatment than did patients in either of the other

groups, who did not differ significantly from each other in this regard. At a one-year follow-up, although patients in the marital therapy and the cognitive groups did not differ on depressive symptoms, patients who had received marital therapy continued to report greater marital satisfaction than did patients in the other two groups. O'Leary and Beach suggested that the fact that the marital therapy subjects demonstrated as much change in depression as the cognitive behavior therapy subjects reflects the impact that marital satisfaction can have on depression. They further suggested that when significant marital discord is found in conjunction with clinically significant depression, marital therapy may be the most effective and appropriate treatment.

Two recently developed interpersonal approaches to the treatment of depression have yielded promising results. Klerman, Weissman, Rounsaville, and Chevron (1984) described their Interpersonal Psychotherapy (IPT) for depression, which is based on the assumption, corroborated by the findings of the empirical investigations reviewed earlier in this chapter, that depression can result from difficulties in the interpersonal relationships between depressed persons and their significant others. IPT, therefore, attempts to improve interpersonal functioning and to alleviate depressive symptoms by focusing on how the patient is coping with current interpersonal stressors. DiMascio et al. (1979) and Weissman et al. (1979) demonstrated that IPT is as effective as pharmacotherapy in reducing depressive symptomatology and is more effective than pharmacotherapy in improving interpersonal functioning. At a one-year

follow-up, patients who had received IPT alone or in combination with pharmacotherapy demonstrated significantly better social functioning than did patients who had received only pharmacotherapy (Weissman, Klerman, Prusoff, Sholomskas, & Padian, 1981). Foley, Rounsaville, Weissman, Sholomskas, and Chevron (1987, May) reported preliminary results of an important study designed to compare the effects of IPT conducted with and without the depressed person's spouse. While both treatment conditions led to a reduction in depressive symptomatology, patients who received IPT with their spouses showed greater improvement on measures of marital functioning.

The second interpersonal approach to therapy for depression is Inpatient Family Intervention (IFI; Clarkin et al., 1986), developed for the treatment of depressed inpatients. In IFI, depressed patients and relevant family members meet regularly during the patient's hospitalization, with a family therapist and the patient's primary therapist acting as cotherapists. IFI is a brief, problem-focused therapy aimed at helping patients and their families accept and understand the current illness and identifying possible precipitating stressors, both within and outside of the family. IFI also attempts to identify family interaction patterns that may produce stress for the patient, and helps the family to plan strategies to minimize potential stressors.

In the first report of the efficacy of IFI, Glick et al. (1985) randomly assigned 54 schizophrenic and 47 depressed inpatients to either standard hospital

treatment, which included individual, group, and milieu activities, and somatic therapy, or to standard treatment plus IFI. The IFI patients participated in at least six one-hour family sessions. The goals of these sessions included the identification of precipitating and/or future stressors, identification of stressful family interactions and strategies for dealing with these interactions, and acceptance of the need for continuing treatment. Glick et al. reported that, at discharge as well as at the six-month follow-up, there were no significant treatment differences for the depressed patients. The schizophrenic patients with good prehospital functioning, however, demonstrated a more favorable response to IFI, exhibiting better global outcomes at discharge.

In a second report, on a somewhat larger sample, Haas et al. (1988) provided greater detail concerning group differences in treatment outcome at discharge. Although IFI was found to be generally more effective than standard hospital treatment, female patients, particularly depressed female patients, appeared to benefit more from this form of treatment than did male patients. This pattern of results was also maintained at six-month and 18-month follow-ups, at which time female schizophrenic and depressed inpatients and their families demonstrated greater improvement with IFI than did their male counterparts (Clarkin, Haas, & Glick, 1988; Spencer et al., 1988). In general, therefore, IFI seems most effective in the treatment of female inpatients.

Interpersonal Systems Treatment of Depression

Gotlib and Colby (1987) presented an interpersonal systems approach to the conceptualization of depression and outlined explicit strategies and procedures to be used in assessing and treating depressed patients and their spouses. The conceptualization of depression proposed by Gotlib and Colby, and subsequently expanded upon by Gotlib (in press), maintains that depression has both cognitive and interpersonal aspects and that an effective approach to the treatment of this disorder must therefore consider both these areas of functioning. Essentially, Gotlib and Colby suggested that, because of aversive early experiences, some individuals develop cognitive and/or personality characteristics that predispose them to become depressed in the face of certain types of circumstances or life events, such as marital turmoil or the behavior of a high-EE spouse. If these individuals then begin to exhibit depressive symptoms, two factors may interact to maintain or exacerbate the depression. First, as the literature we reviewed earlier in this chapter clearly indicated, depressed persons are less skillful and, perhaps because of the aversiveness of their symptomatic depressive behavior, they engender less social support from others in their environment than do nondepressed persons. Second, depressed individuals have been found to be characterized by a "readiness" to perceive and attend to negative aspects of their environment (Gotlib, 1983; Gotlib, McLachlan, & Katz, 1988), and to be more sensitive to negative stimuli than are nondepressed individuals (Lewinsohn, Lobitz, & Wilson, 1973). Thus, depressed persons will readily perceive the lack of support and the negative behavior in others around them and may respond by

becoming more depressed and more symptomatic. Significant others, in turn, become even more negative and rejecting, and a vicious cycle continues (see Gotlib, in press, for a more detailed discussion of this conceptualization).

It is clear from this formulation that clinicians must attend to both the individual and his or her significant others if they are to deal comprehensively with the depression. In terms of dealing with the individual, it is important that therapists assess both the nature of aversive early experiences that may increase the individual's vulnerability to depression and the cognitive or information-processing style of the depressed person. With respect to the interpersonal system of the depressed person, therapists must focus on the marital or family dynamics and must attempt to understand the depression within the context of the family system. Therapists must examine what the family is doing that may be maintaining or exacerbating the depression and must also explore what the family can do differently. Finally, therapists must integrate the diverse information obtained through this assessment in developing an appropriate intervention designed to alter the dysfunctional patterns of cognitive and interpersonal behavior.

In terms of assessment, Gotlib and Colby (1987) suggested that three specific aspects of depressed patients' functioning be examined in a comprehensive assessment: the symptomatology manifested by the patients, their current cognitive functioning, and the nature and quality of their current

interpersonal behavior. A number of psychometrically sound measures are available to assess these aspects of the patients' functioning. To assess depressive symptomatology, we recommend the clinician-completed Schedule for Affective Disorders and Schizophrenia (SADS; Endicott & Spitzer, 1978) and the self-report Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). The cognitive functioning of depressed patients can be assessed with the Dysfunctional Attitude Scale (Weissman & Beck, 1978, April) and the Attributional Style Questionnaire (Peterson et al., 1982). A number of measure are available to assess various aspects of the depressed patient's interpersonal functioning, including the self-report Social Support Questionnaire (Sarason, Levine, Basham, & Sarason, 1983), Family Environment Scale (Moos & Moos, 1981), and Dyadic Adjustment Scale (Spanier, 1976); the clinician-rated Social Adjustment Scale (Weissman & Paykel, 1974); and the spouse-completed Spouse Observation Checklist (Weiss, Hops, & Patterson, 1973). The clinician should observe the interactions of patients and their spouses and families, both to gain a more complete understanding of the nature and quality of the depressed patients' interactions and to identify potential targets for intervention.

In terms of treatment, it is important that the principles and strategies utilized by the therapist to alleviate the patients' depression focus on both cognitive and interpersonal functioning. Briefly, with respect to cognitive functioning, the therapist must recognize that depressed individuals demonstrate increased attention and sensitivity to negative aspects of their environment. A

major goal in working individually with depressed patients is to attenuate this accessibility to negative stimuli. This goal is typically accomplished through education and through making the patients aware of how they are processing information and how this manner of processing affects their perceptions of their interactions with others. It is also important to help depressed individuals become more accurate in monitoring their own and other people's behaviors. Keeping daily records and increasing the number of pleasurable experiences in which they engage are useful procedures in meeting this objective.

Treatment strategies and procedures aimed at improving the depressed patients' interpersonal functioning are more complex. Because depression was conceptualized by Gotlib and Colby (1987) as involving not only the depressed persons but people with whom they have an intimate relationship (most typically, their spouses and families), attempts to alleviate the depression often involved concomitant changes in the interpersonal system. It is to the therapist's benefit, therefore, to have a working knowledge of principles of General Systems Theory (von Bertalanffy, 1968). Gotlib and Colby described a number of intervention strategies and procedures, derived from systems theory, in outlining an interpersonal systems approach to the treatment of depression. The primary goal of this therapy is to stimulate new patterns of communication and behavioral sequences that interrupt the depression-maintaining interactions that brought the depressed person into therapy. In general, therefore, interpersonal systems therapy focuses on the present rather than on historical events, with the therapist

adopting an active, problem-solving approach to treatment. The therapist typically broadens the focus of treatment from the depressed patient in order to involve as much of the system (i.e., the marital dyad or the family) as possible in therapy.

Gotlib and Colby (1987) specified circumstances under which the spouses or relatives of depressed individuals should be involved in therapy and described the effective use of a number of techniques and procedures that the systems-oriented therapist can utilize to initiate change in depressed patients and their families. They described such therapeutic procedures as joining, enactment, reframing, restructuring, and altering family boundaries. Although additional empirical work is required to refine these techniques and to further validate the efficacy of this intervention, the results of preliminary work utilizing this interpersonal systems approach to the treatment of depression are promising. In the following section we present the case of a depressed woman who was assessed and treated from an interpersonal systems perspective.

CASE EXAMPLE

Brenda T., a 38-year-old mother of three, was the youngest daughter of a well-known public figure. Brenda described her early years at home as replete with episodes of "despair and rejection." She portrayed her father as a cold, demanding, and self-absorbed authority figure. Her mother was painted with gentler strokes—artistic, emotional, and devoted to her husband and children. Brenda's relationships with her siblings were characterized by fluctuating periods of intense closeness and profound separation. Her views of her current family closely matched these early childhood perceptions. Brenda felt that from a very early age there was enormous pressure in her family to achieve outstanding accomplishments, a pressure she thought emanated primarily from her father. Her two older siblings had measured up to the family standards and had both been quite successful in achieving high-profile careers. In contrast, Brenda viewed herself as the "family failure." Although she had made early attempts to match the success level of her family, she was repeatedly faced with obstacles she could not overcome. Brenda ultimately abandoned her own career efforts and turned instead to the task of raising a family. She married a somewhat older man who was well on his way to acquiring the same type of public image as her father had.

At the time Brenda was referred for counseling by her family physician, she was very depressed. Although she was somewhat vague in her initial descriptions of her concerns, she was specific in detailing the intense degree to which she felt

she was suffering. After several interviews it was clear to both the therapist and Brenda that she felt little satisfaction in the major areas of her life. Specifically, Brenda described her current marital satisfaction as “rock bottom”; she was only slightly more satisfied with her parenting skills. Brenda’s career satisfaction was minimal; her relationship with her family of origin was minimal as well. She noted that her outside interests and hobbies were in need of improvement and that her friendships, such as they were, were impoverished. In sum, Brenda presented as a bright, talented woman who, despite her “assets,” was a troubled and needy person. Compounding her difficulties was Brenda’s strong tendency to blame others (husband, father, children) for her failures and consequent despair.

In the initial assessment phase of therapy, both interview and self-report measures were administered to determine Brenda’s psychological profile. She was interviewed with the SADS, and the Hamilton Rating Scale for Depression, and she completed the BDI. The results of these measures were consistent with a diagnosis of depression. Brenda’s repeated statements about her marital dissatisfaction, coupled with her clear belief that her father and her husband were the primary sources of her unhappiness, suggested the utility of involving her husband in therapy. Although initially reluctant, Brenda and her husband, John, finally agreed to this approach. They completed the Dyadic Adjustment Scale, indicating their perceptions of their marital adjustment, and the Family Environment Scale was administered to assess the interpersonal relationships among family members and the social-environmental characteristics of the family.

During the assessment phase of therapy, the therapist was careful to elicit both Brenda's and John's perceptions about the problems facing their family. The therapist was also actively involved in observing the quality and pattern of interaction between the couple. The integration of interview, self-report, and observational data provided the therapist with the necessary information to formulate at least preliminary hypotheses concerning the dynamics of this couple's relationship and the role played by Brenda's depressive symptomatology. Case formulation is a challenging task, as it must include an integration of all available information and should be presented to the couple in a meaningful and coherent manner. The second important function of the assessment phase of therapy is to determine specific treatment goals and a consequent treatment plan aimed at achieving these goals.

Based on an interpersonal systems approach, the therapist hypothesized the following case formulation: Brenda, faced with a long history of failure, was able to shed some of her resulting esteem problems by blaming her father and/or her husband, and their lack of support and encouragement, for her perceived low level of achievement. In her marriage, this resulted in frequent, scathing outbursts at John for his selfish concern for his own needs and career interests at the expense of Brenda's needs. John's reaction to these often unpredictable attacks was to completely withdraw from Brenda, focusing his energies on his career and public interests, where he received much appreciation and positive reinforcement. During these periods John was totally absorbed in his life away from home and

treated Brenda in a cold, critical, and often indifferent manner. Of course, the more John devoted his attention to people and activities outside the family, the more rejected and isolated Brenda felt. Brenda interpreted John's lack of interest in her as evidence of her unworthiness, which further fostered her low self-esteem, feelings of depression, and depressive behaviors. In a recurring pattern in the relationship, this depression or state of despondency led to hostility toward John and was followed by his withdrawal and lack of interest. This circular pattern had existed for so long that Brenda's depression was reaching extreme depths and the marriage was hanging by a thread. Both saw the other as selfish, demanding, and uncaring. John and Brenda agreed that two important treatment goals were to find more constructive ways to communicate their needs and feelings to each other and to help Brenda find appropriate avenues to pursue her own talents. Toward this end, therapy involved both marital and individual counseling.

Throughout the therapy sessions, the therapist actively joined with one spouse and then with the other. The therapeutic activity of joining served the function of offering support and understanding to the "joinee" as well as serving as a role model to the other spouse. Through this process the couple was able to begin the lengthy task of nurturing and understanding each other. Even with a slight indication of improved communication, the therapist was able to reframe the original problem description from selfish, uncaring spouses to one of a fear on both their parts that they would not be able to meet each other's needs. Framed in this way, both spouses were able to make more of an effort to give to each other in

ways they had not previously been able to do. Given the long history of pathology in their relationship, however, this was a fragile improvement. In order to clarify the negative pattern of their interaction as well as to solidify the improvements, the therapist repeatedly had the couple involved in enactments, in which they were required to "act out" in complete detail both the negative and positive situations that had transpired between therapy sessions. An ongoing challenge throughout the sessions was the therapist's task of dealing with the couple's resistance to change and to acceptance of new ways of dealing with problems; both spouses were quick to blame, retaliate, and feel cheated.

In the individual sessions with Brenda, the therapist explained how depressed persons process and attend to negative information from their environment and how they can have an adverse impact on significant others around them through their depressive behavior. Brenda was taught to monitor her own behavior, to keep a daily record of the occurrence of positive and negative events, and to increase her involvement in pleasant activities. In the marital sessions the therapist actively sought to highlight the strengths of each spouse. John and Brenda had been so accustomed to being viciously attacked by the other spouse that they eagerly absorbed this type of response. Over time the therapist turned more and more to the couple to generate their own solutions. As a result of greater mutual support and understanding, Brenda was able to refocus some of her energies into career planning. In a pragmatic way, she developed both a short-term and long-term set of objectives. John was instrumental in bringing

the short-term goals to fruition; his increased parenting responsibilities allowed Brenda to take the first step toward her career objectives.

Therapy came to a close over a period of two months, with longer intervals between sessions. Progress was evaluated by a comparison of the initial therapy goals with the couple's current functioning. To substantiate their impressions, the couple completed the original interview and self-report measures. Although progress had actually been only moderate, both spouses and therapist concluded that any further change would be a slow process. Follow-up sessions were set for two six-month intervals. At the first follow-up, it was clear that the couple had continued to maintain their original therapeutic gains, although only marginal progress had been made beyond that point. Brenda was showing no signs of depression and was happily progressing in her career. It was agreed at this session that, with the career issue more stable, the couple could afford to devote more time to their marriage. In two additional sessions, specific goals were established toward this end. By the second follow-up session, Brenda and John were devoting more time to their marriage, and both expressed satisfaction with their current functioning as a couple. No further follow-ups were scheduled, and the couple was invited to contact the therapist if they felt the need to do so.

SUMMARY

We have attempted in this chapter to provide an understanding of the theoretical and empirical foundations of marital and family-focused therapies for depression and an overview of research examining the efficacy of marital and family therapy in the treatment of this disorder. We described the basis of an interpersonal system therapy for depression and presented a brief case study that was conceptualized and treated from this framework.

It should be clear from our review that marital/family therapy or family involvement in therapy represents a promising direction in the treatment of depression. Although individual therapy has been demonstrated to be effective in reducing the level of depressive symptomatology, it has been found to be less effectual in ameliorating difficulties in marital and family functioning. In contrast, marital therapy has been demonstrated to achieve both symptom relief and a reduction in marital discord. Although few studies report data addressing the long-term effectiveness of marital therapy, given the role played by marital and family discord in relapse of depression, it is possible that marital/family therapy would prove to be more effective than individual therapy in the prevention of further depressive episodes. This hypothesis, of course, awaits additional research.

There are a number of issues that, because of space limitations, we could not address here. The differential importance of marital discord and depression in

contributing to the outcome of therapy and the importance of the causal nature of the relation between depression and marital/family distress in affecting outcome are but two issues that clearly warrant further investigation. Similarly, we reviewed research examining the efficacy of marital and family therapy in alleviating depression. The use of marital/family therapy in the *prevention* of depression is an area of study that deserves serious consideration (Haas, Clarkin, & Glick, 1985). We believe that the application of interpersonally focused therapies to the treatment of depression is an exciting development in the study of this disorder. It is our hope that this chapter will serve to stimulate further research in this field.

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Notes

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