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Depression and Marital Therapy

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Given its incidence and prevalence across the lifespan, depression has considerable potential to disrupt the lives of both sufferers and family members, with tremendous social and familial costs, along with economic costs estimated at $83 billion annually in the United States alone. It is not surprising, therefore, that depressed individuals often report problems with family relationships, and that concerns about family relationships are prominent for many depressed persons (Whisman, 2006). This has led to suggestions that depressed persons may often benefit from marital therapy, and has created interest in marital approaches to intervention with depressed patients.

Historical roots

Marital therapy for depression began as an adjunctive treatment for depressed patients (Beach et al., 1990), and as an adjunctive treatment it has steadily gained adherents over the past 20 years. Its popularity is driven by the need for, and potential benefits of, enhanced social functioning for depressed patients, particularly in the context of their closest relationships. Initially, the conceptual foundation for marital therapy for depression was provided by the empirical literature on stress and social support in depression, which suggested that addressing social difficulties in depression would be palliative for most depressed individuals and in some cases might be curative. Marital

therapy for depression was also offered as a treatment for depressed persons with marital role disputes, highlighting its similarity to interpersonally oriented psychotherapy (IPT) which has also gained adherents over the past 20 years. For this reason, marital therapy for depression is typically presented as having a more focused target population and more modest claims for its range of applicability than are individual treatments for depression.

Marital distress and depression

How strong is the link between marital distress and depression? There is a moderate, negative association between marital quality and depressive symptomatology for both women ($r = -.42$) and men ($r = -.37$), indicating a significant relationship overall, and a significant, albeit small, gender difference. It is also reliably found that the average depressed individual scores in the maritally distressed range of widely used inventories of marital quality. For instance, on the Dyadic Adjustment Scale the mean score for the diagnosed population is 93.7 (S.D. = 25.2) which falls below the cutoff for marital distress (97). Thus, the marital relationships of depressed men and women are often (but not always) distressed. This finding is consistent with work indicating that marital satisfaction is the strongest predictor of life satisfaction across many specific domains of life satisfaction and that marital dissolution is strongly associated with increases in depression and depressive symptoms for both men and women. In addition, marital dissolution by the death of a partner is associated with a 9-fold increase in major depression and a 4-fold increase in depressive symptoms among recently bereaved older adults. Underscoring the importance of the broader interpersonal realm, the effect of bereavement is especially pronounced for those lacking alternative sources of social

support.

Marital events and etiology of depression

Events in the marital relationship can precipitate or exacerbate depressive symptoms among the vulnerable and so initiate a stress-generation process the results in depression. For example, several researchers have reported that an index of humiliating marital events such as partner infidelity and threats of marital dissolution resulted in a significant increase in depression. In one study these events resulted in a six-fold increase in diagnosis of depression, and that this increased risk remained after controlling for family and personal history of depression. Further, marital dissatisfaction has been found to increase risk of subsequent diagnosis of depression by 270% in a large, representative community sample, and the increased risk remained significant after controlling for demographic variables and personal history of depression. Similarly, marital conflict that includes physical abuse predicted increased depressive symptoms over time controlling for earlier symptoms. As these findings suggest, marital distress and specific types of marital events may be sufficiently potent to precipitate a depressive episode. In keeping with this growing literature, the targets of marital therapy for depression have been broadened and the goal of marital therapy for depression has been conceptualized as both increases in positive marital behavior as well as interruption of patterns that may be stressful and humiliating.

Interestingly, recent work in behavioral genetics, using genetically informed designs, suggests that some interpersonal environments, such as the marital environment are best represented as "non-shared environmental effects." That is, they are not well modeled as resulting from the same genetic factors that produce general vulnerability for

depressive symptoms. This means that the genetic diathesis that produces depression is not one that also produces conflicted marital relationships. One implication is that the marital environment is a causally significant, non-redundant point of intervention that may yield therapeutic results. It also suggests the potential for marital therapy to exert its therapeutic effects through different mechanisms than do individual or pharmacological interventions.

Treatment efficacy

Several studies have examined the efficacy of well-specified marital therapy approaches in both reducing symptoms of depression and in enhancing marital satisfaction. Three trials compared a standard couple therapy, behavioral marital therapy, to individual therapy (see Beach et al., in press). Two further clinical trials have involved adaptation of individual therapies for depression to a couple format. There has been one trial of cognitive couple therapy and one trial comparing marital therapy to antidepressant medication, but these did not examine change in marital satisfaction. In addition, there has been a published pilot test of emotion focused marital therapy for depression which indicated the likelihood of positive effects using this approach, but its very small sample size precluded reliable statistical analyses. Finally, there is also a large, interesting study of marital therapy for depression that has not yet been published, but that offers some new ideas for the marital treatment of depression focused on support provision.

The three studies comparing behavioral marital therapy to individual therapy all produced similar results. Across the three studies, behavioral marital therapy and individual therapy yielded equivalent outcomes when the dependent variable was depressive symptoms and a better outcome in marital therapy than in individual therapy

when the dependent variable was marital functioning. In addition, in one of the studies, marital therapy was found to be significantly better than a wait-list control group.

However, it does not appear that the potentially positive effects of marital therapy for depression are confined to behavioral approaches. A conjoint marital (CM) format for Interpersonal Psychotherapy (IPT-CM) examined outcome for 18 depressed outpatients who were randomly assigned to either individual interpersonal psychotherapy (IPT) or a newly developed, couple-format version of IPT. Consistent with the findings of the studies comparing behavioral marital therapy with an individual approach, participants in both treatments exhibited a significant reduction in depressive symptoms, but there were no significant differences between treatment groups in reduction of depressive symptoms. Consistent with observations in behavioral marital therapy, participants receiving couple IPT-CM reported marginally higher marital satisfaction scores on one measure of marital quality, the Locke-Wallace Short Marital Adjustment Test, and scored significantly higher on one subscale of the Dyadic Adjustment Scale at session 16 than those receiving IPT with no marital component. Similarly, the investigation of emotionally focused therapy in the treatment of depression provided suggestive evidence that emotionally focused therapy would provide a useful framework for intervention with depressed couples as well.

Because we suspect that enhancement of relationship quality and interruption of vicious cycles maintaining depression are key to any successful approach to marital therapy for depression, it follows that any marital therapy approach that can be shown to be efficacious has the potential to be efficacious in the treatment of depression as well. Accordingly, marital therapy for depression is open to the potential for alternative

formats and innovative developments that may be useful depending on particular couple characteristics.

Should we expect marital interventions to be useful for all depressed persons who are married? Predictors of response to marital therapy suggest that there are decision rules that may help guide the application of marital therapy for depression. Behavioral marital therapy, and perhaps other forms of marital intervention, appears to work best when the marital problems are salient to the depressed spouses or when the depressed persons believe that their marital difficulties have caused their current episode of depression. Likewise, although severity of depressive symptoms may influence the ease of treatment, moderate to severe depression does not appear to preclude the use of marital therapy as an adjunctive intervention strategy. It seems, therefore, that behavioral marital therapy can be a safe and effective alternative to individual therapy for depression. Although it is in need of additional direct examination, it also seems likely that marital therapy could prove a useful adjunctive treatment to medication. Similar conclusions are likely to hold for IPT provided in a couples format (IPT-CM). Although predictors of response to treatment have not been examined empirically for IPT-CM, it is consistent with IPT to choose as targets those problem areas that are salient to the patient and that may be related to the maintenance of the current depressive episode. Given the loss of positive interactions that is common in depression, it may be that marital approaches focused on the enhancement of positive interactions would be more universally applicable to depressed patients, suggesting the potential to develop marital approaches that interrupt stress-generating processes and are more universally applicable than are current approaches.

Conclusion

We have come a long way in the study of effective ways to intervene with the families of depressed patients. Although the current level of success should not be oversold, a solid conceptual foundation grounded in a stress-generation framework is emerging to guide and support marital and family interventions with depressed patients. A large and robust literature indicates that marital and parenting relationships are often problematic for depressed persons. From the perspective of the Stress Generation framework, difficulties in the area of marital and parenting relationships, and the likelihood that these processes will continue even after successful individual treatment, is troubling. At the same time, there is good evidence that these problematic relationships can be repaired and it seems appropriate to recommend an efficacious, targeted intervention to effect that repair.

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