Family Relationships and Depression

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Bronfenbrenner's (1986) ecological systems model emphasizes the importance of understanding individuals within the multiple contexts in which they live and interact. Consistent with this model, the role of the family context has received considerable attention in the research literature on mental health. The family context is generally characterized as dynamic, including the marital and parent-child, as well as sibling relationships, which are interrelated, each influencing and, in turn, being influenced by the other (see Erel & Burman, 1995 for a review). While healthy families, or families characterized by low levels of stress and conflict, have been linked to resilience and mental health and adjustment in both children and adults, unhealthy families, or families characterized by high levels of stress and conflict, have been linked to a wide range of adjustment difficulties, including mental illness (Cummings, Davies, & Campbell, 2000). Children who grow up in families characterized by high levels of conflict are more vulnerable to internalizing and externalizing problems, and are more likely to engage in high-risk behaviors, including substance use and sexual risk-taking. Moreover, the consequences of family conflict may persist beyond childhood and adolescence into adulthood and affect not only individual adjustment (Jones, Forehand, & Beach, 2000), but also later adult romantic relationships (Delsing, Oud, DeBruyn, & van Aken, 2003; Sabatelli & Bartle-Haring, 2003).

Marital and parent-child relations also are associated with mental health and well-being in adulthood, prompting the development of marital- and family-based interventions to treat adult mental health problems, including mood disorders, anxiety disorders, and substance use disorders (see Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998 for a review). One area in which the link between family relationships and mental health has been particularly well-examined is depression.

Depression

It is not uncommon to hear someone say that they are feeling "depressed". Feeling sad is a virtually universal phenomenon and "sadness" and "depression" are often used interchangeably

in the lay community. In the professional community, the definition of depression also varies. Some consider "clinical" depression, as diagnosed by the DSM-IV-TR (American Psychiatric Association, 2000), the "gold standard" for clinical outcome research. A clinical diagnosis of depression, referred to as major depression in the DSM-IV-TR, requires an individual to have five symptoms for at least a two week period (e.g., depressed mood, anhedonia, loss of sleep, loss of appetite, suicidal ideation), with the symptoms representing a change in previous functioning. Additionally, one of the five symptoms has to be either depressed mood or anhedonia. Alternatively, others are more interested in subclinical depression, or any state in which depressive symptoms are present, but in which they are not present in sufficient number or severity to quality for major depression, given that such milder forms of depression are far more common and also disruptive (Ingram & Siegle, 2002). Given the variability in the definition and use of the term, the term depression will be used broadly throughout this chapter to refer to research examining both clinical depression and subclinical depressive symptoms.

Depression is the most common of all psychiatric disturbances, affecting nearly 20% of people in the United States at some point in their lives (Karno et al., 1987). Notably, the prevalence of depression prompted the World Health Organization to rank depression as the single most burdensome disease in the world (Murray & Lopez, 1996). Adding to the burden, depression is associated with poor physical health, with evidence mounting for an association between depression and cardiovascular disease in particular (e.g., Jones, Matthews, Bromberger, & Sutton-Tyrrell, 2003), as well as health compromising behaviors (e.g., Roy, Mitchell, & Wilhelm, 2001). The economic costs of depression are also rising, with some estimates suggesting that lost work productivity associated with depression in the United States exceeds $33 billion (Greenberg, Kessler, Nells, Finkelstein, & Berndt, 1996). For a significant portion of these individuals, depression will result in a suicide, with some estimates suggesting that 15 percent of depressed individuals will commit suicide (Hirschfeld & Goodwin, 1988).

In addition to health, workplace, and economic burdens associated with depression, there are also costs for family members. Depressed individuals are more likely to divorce (e.g., Wade & Cairney, 2000) and the children of depressed parents are more likely to experience depressive symptoms themselves (see Gotlib & Goodman, 1999 for a review). Thus, the family has become an important context within which to study and treat depressive symptoms in both children and adults. Surprisingly, however, reviews of the association between family distress and depression tend to focus either on adults or children, rather than on both as sub-systems within a family context. Marital researchers tend to focus on the relation of marital distress and depression in adults, while child and family researchers tend to focus on the relation of family distress, including marital, parenting, and parent-child distress on child depression, with little communication between the two groups.

The current chapter therefore integrates and summarizes the literature linking family relationship distress and depression, focusing on both children and adults within the family context. Understanding the association between family distress and depression, rather than studying children and adults separately, provides an opportunity to think within a developmental framework that has the potential to inform prevention and intervention efforts focusing on at-risk families, rather than targeting individuals. First, we review the literature linking family relationship distress in both adults and children. Then, we summarize the literature suggesting a bi-directional association between family relationship distress and depression. Finally, we discuss how our understanding of the interrelationship of family relationship distress and depression should guide our use of family-based prevention and intervention efforts. As such, the current chapter is not meant as a review of the connections between the full spectrum of mental disorders and close relationships. The interested reader can find more general summaries regarding the role of close relationships in the development of mental disorders in Beach, Wamboldt, Kaslow, Hayman, & Reiss (in press) and Whisman and Bruce (1999). In addition, more information regarding the use of close relationships in the treatment of mental illness can be

found in Baucom, Shoham, Mueser, Daiuto, and Stickle (1998) and a general theoretical formulation for the role of close relationships in mental health and well-being can be found in Baumeister and O'Leary (1995).

Family Relationship Distress and Depression in Adults

Recent estimates suggest that up to 20% of adults report significant depressive symptoms in the past 1 week to 6 months (Kessler, Avenevoli, & Merikangas, 2001). Rates of major depression are much lower, suggesting that more adults experience subclinical levels of depressive symptoms than depressive disorders. Whether focusing on major depression in particular, or depressive symptoms more generally, depressive symptomatology is associated with family relationship distress in adults.

Marital Distress and Depression in Adults

In a quantitative and exhaustive review of the marital literature, Whisman (2001) found that, across 26 cross-sectional studies, marital quality was negatively associated with depressive symptomatology for both women (r = -.42) and men (r = -.37), indicating a significant, albeit small gender difference. Across 10 studies using diagnosed patient populations, Whisman (2001) found that the magnitude of the association was somewhat stronger for both women and men (r = -.66). The average Dyadic Adjustment Scale (DAS) score for the diagnosed population was 93.7 (SD = 25.2), indicating that the average depressed individual is also maritally distressed (DAS cutoff = 97). Thus, marital relationships are often (but not always) distressed among depressed men and women. Serious marital dissatisfaction predicts increased risk for a major depressive episode in the year following initial assessment, even after controlling for history of depression (Whisman & Bruce, 1999), and marital conflict with physical abuse predicts increases in depressive symptoms over time controlling for earlier symptoms (Beach et al., 2004). In addition to the effect of the chronic stress of marital dissatisfaction, the effect of particular humiliating marital events is also substantial (Cano & O'Leary, 2000). Accordingly, the influence of marital context and marital events on depressive symptoms appears to be substantial. Interestingly,

recent work suggests that the effect of marital satisfaction is a non-shared environmental effect and is not well modeled as resulting from the same genetic factors that produce vulnerability for depressive symptoms (Reiss et al., 2001). This means that it is not simply the case that the same genetic diathesis that produces depression also produces conflicted marital relationships. Accordingly, it appears that disturbance in intimate adult relationships is important in understanding the etiology of depressive symptoms for many individuals, and will continue to be important as we develop a broad bio-psycho-social developmental model of depression.

Parent-Child Relationship Distress and Depression in Adults

It has long been noted clinically that depressed patients report considerable distress and difficulty in their parenting relationships (e.g., Weissman & Paykel, 1974) and some have attributed depressed mothers' level of dysphoria, at least in part, to her belief that she is an inadequate parent (Teti & Gelfand, 1991). Supplementing clinical observation and patient self-report is a large body of direct observation documenting problems in parenting behavior. In a review of 46 observational studies of the parenting behavior of depressed women, Lovejoy, Gracyk, O'Hare, and Neuman (2000) found evidence that depressed mothers displayed more withdrawn behavior with an overall average correlation between depression and withdrawn behavior of .14. They also found support for Forehand, Lautenschlager, Faust and Graziano's (1986) hypothesis that depressed mothers display more negative parenting behavior (Forehand et al., 1986) with an overall average correlation between depression and negative parenting behavior of .22, with a stronger effect for those in a current depressive episode than those with only a history of depression. As with marital relationships, there is reason to believe that many, but not all depressed persons, experience difficulty in the area of parenting.

Family Relationship Distress and Depression in Children and Adolescents

Up to 50% of children and adolescents report depressive symptoms in periods ranging from 1 week to 6 months, with less than 1% of children and 6% of adolescents meeting criteria for major depression (Kessler et al., 2001), again, suggesting that children and adolescents are

more likely to experience depressive symptoms than disorders. Moreover, the prevalence of depression among young people has been rising, with higher rates of depression among adolescents in more recent than in earlier decades (Weissman, Bland, Joyce, & Newman, 1993). Accordingly, understanding correlates of child and adolescent depression, including the role of family relationship distress, is critical for prevention and intervention efforts (Kaslow, Deering, & Racusin, 1994).

Marital and Parent-Child Relationship Distress and Depression in Children

Bowlby's (1980) theory of attachment suggests that children with an insecure attachment style are predisposed to developing depression. In particular, children whose family environments lack security, comfort, and acceptance are less likely to view relationships positively and trustworthy and, hence, will be less satisfied and more wary of relationships in the future (Gotlib & Hammen, 1992).

Extreme family relationship distress is also associated with depressive symptoms in children. Infants exposed to serious abuse and neglect are more likely to evidence depressive symptoms (Trad, 1994). The infant's response to abuse, including failure to exhibit normal emotional expressions and heightened withdrawal, in turn, further interferes with the parent-child relationship, heightening the risk for low-self esteem, as well as further abuse in the future (Lamb, Gaensbauer, Malkin, & Schultz, 1985; Trad, 1987). Marital conflict between parents is also associated with other important family outcomes, including poorer parenting (see Erel & Burman 1995), poorer child adjustment (see Grych & Fincham 1990), problematic attachment to parents (e.g., Owen & Cox 1997), increased likelihood of parent-child conflict (e.g., Margolin, Christensen, & John, 1996), and conflict between siblings (e.g., Brody, Stoneman, & McCoy, 1994). Indeed, when manipulated experimentally, marital conflict increased subsequent parent-son conflict (Jouriles & Farris 1992), suggesting that marital conflict may lead to and cause

disturbances in other family sub-systems, which, in turn, may further increase a child's vulnerability for depression.

Aspects of marital conflict that have a particularly negative influence on children include more frequent, intense, physical, unresolved, child-related conflicts and conflicts attributed to the child's behavior (see Cummings & Davies 1999, Fincham & Osborne, 1993). Accordingly, it may be that physical violence and physical altercations are particularly problematic with regard to child outcomes.

Moreover, the context of marital conflict in the home may be important for correctly specifying genetic effects. For example, women who were adopted soon after birth and who were at high genetic risk for depression showed no evidence of the disorder if they were reared in an adoptive family without marital difficulties or psychopathology in the rearing parents (Cadoret, Winokur, Langbehn, & Troughton, 1996). Accordingly, although individuals may be genetically vulnerable to depression, family relationships characterized by low levels of distress may offer some protection, while family relationships characterized by high levels of distress may exacerbate risk.

As children age, certain parenting styles are also associated with a vulnerability to depression. Children who perceive their parents as less warm and supportive and more controlling and intrusive are at greater risk for depression than their peers (e.g., Stein et al., 2000). The vulnerabilities associated with these parenting behaviors persist beyond childhood and adolescence and into young adulthood (Jones et al., 2000).

Families of depressed children are also higher in conflict than families of non-depressed children. Depressed children report higher levels of conflict in the parent-child, family, and marital relationships, including more verbal and physical aggression (see Kaslow et al., 1994 for a review). In particular, it is thought that marital conflict negatively impacts the parent-child relationship and parenting behaviors which, in turn, increase children's vulnerability to depression. Importantly, the association between family relationship distress and child

depression is not merely a function of depressed children perceiving their families more negatively. That is, both observations of family interactions and parent-report of their own parenting behavior confirms that families of depressed children have more negative interactions, are more hostile, and are more rejecting than families of nondepressed children (Lefkowitz & Tesiny, 1984).

Although the biological mechanisms by which family distress may impact depression is beyond the scope of this text, the animal literature offers an interesting possibility in terms of the link between family distress and child depression. For example, animal data suggest that poor maternal care (by rat dams of their pup) within the first 10 days of life can influence gene expression by leading to increased hippocampal glucocorticoid receptor messenger RNA expression and so to enhanced glucocorticoid feedback sensitivity. This appears to be the basis for lifetime sensitivity to stress of the maltreated pups (Liu et al., 1997). Extending this research, the family distress and depression literature suggests that family relationship characterized by high levels of distress may influence children's psychosocial adjustment directly, but also indirectly by modifying their physiological stress response systems and, in turn, emotional, cognitive, and behavioral functioning. Accordingly, some literature suggests that one's vulnerability to depression depends on early adverse family experiences.

Is Everyone at Equal Risk?

Are all persons equally reactive or vulnerable to negative interpersonal events? A large literature suggests that this is not the case. Personality variables (Davila, 2001), interpersonal sensitivities (Joiner, 2000), individual differences in biological vulnerability (Gold, Goodwin, & Chrousos, 1988), various negative childhood experiences (Kessler & Magee, 1993; Hammen, Henry, & Daley, 2000), and other individual difference variables, have been linked to differential vulnerability to depression, differential vulnerability to stress, and differential vulnerability to recurrence. This literature suggests that everyone does not start with an equal chance of responding to negative interpersonal events with depression, but that early adverse experiences

may exacerbate an individual's risk (see Goodman, 2002 for a review). Importantly, the adverse events examined to date have typically been associated with the family, with events ranging from maternal stress in-utero and its effects on a fetus' physiological stress response system to infants and children's exposure to maladaptive or inadequate parenting and its effect on children's emotional regulation and social interaction. Moreover, the impact of adverse experiences on predisposition for depression has to be considered within a developmental framework (see Goodman, 2002 for a review). That is, depending on an individual's developmental accomplishments, adverse events may have more or less of an impact. At the earliest stages of development, maternal stress during pregnancy has been associated with emotional disturbances in children. Several theories attempt to account for this link, including that maternal stress leads to elevations in maternal cortisol (a primary stress response), which in turn crosses the placenta and may lead to irreversible elevations in infants' hypothalamic-petuitary-adrenal (HPA) activity (increased cortisol), and yield subsequent dysregulation of emotion and behavior (for a review see Goodman, 2002). Experiences during infancy and early childhood may also shape an individual's vulnerability to depression. The primary focus of research in this area has been on maladaptive parenting, with findings suggesting that infants and children exposed to maladaptive parenting, including neglectful, harsh, and inconsistent parenting, are more likely to experience difficulties with emotion regulation, social skills, and dysfunctional stress responses (for a review see Goodman, 2002). Dysregulation in these physiological, emotional, and behavioral systems during early developmental periods may, in turn, increase an individual's predisposition to depression in response to stressors throughout the lifetime. In support of this hypothesis, Hammen and colleagues (2000) reported that young women with exposure to one or more childhood adversities, such as family violence or parental psychopathology, were more likely to become depressed following less overall stress than women without such adversity.

Of course, it is also the case that not all individuals who experience family distress experience depression. A thorough review of the full scope of the potential moderators of the

link between early family distress and vulnerability for depression is beyond the scope of this chapter. Given the chapter's focus on the role of the family, however, one potential moderator merits mention, family support. The buffering role of social support against the development of depressive symptoms is well established (Cohen & Wills, 1985). Individuals who experience higher levels of social support generally experience lower levels of depressive symptoms. One mechanism by which social support may serve as a buffer against the development of depressive symptoms is by influencing the way individuals think about negative events (Cohen & Wills, 1985). That is, social support networks may encourage individuals to make more adaptive attributions about negative events, in turn, leading to lower levels of depressive symptoms. Consistent with this prediction, Joiner (2001) and colleagues demonstrated that higher levels of social support were associated with lower levels of depressive symptoms and this association was partially mediated by individuals with higher levels of social support making more adaptive attributions about the causes of events. Importantly, family relations may serve as a significant source of support. Most notably, several theorists suggest that support from a marital partner may buffer the impact of family-of-origin distress on adult depression (see Coyne & Benazon, 2001 for a review). Evidence seems to suggest that a supportive spouse may prevent depression in response to stress in individual who have a history of early family-of-origin distress, or at least delay the onset of the first episode. Accordingly, although the focus of this chapter is on the role of family distress and depression, it is important to note that families may also serve supportive roles.

What Comes First the Depression or the Family Distress?

As alluded to earlier, it is generally accepted that the association between family distress and depression is bi-directional. Specifically, possible causal relationships between family difficulties and depression include an effect of marital or family difficulties on depression, an effect of depression on marital or family difficulties, and a bi-directional pattern of causation. It is also possible that the nature of the relationship might change across different types of

relationships, as a function of the number of episodes of depression experienced, as a function of age, or as a function of other personal or symptom characteristics. The potential complexity of the relationships is somewhat overwhelming relative to currently available analytic strategies (Beach, Davey, & Fincham, 1999), yet some generalizations can be made based on available evidence. In addition, a model is available to guide further investigation and to help draw implications for clinical intervention.

What generalizations can be drawn regarding the link between family relationships and depression? In the marital area, many theorists have adopted some variant of Hammen's (1991) Stress Generation theory to guide their theorizing about the link between marital discord and depression. Stress Generation theory suggests a bi-directional pattern of causation between family relationships and depression. It is posited that depressed individuals can generate stress in their interpersonal environments in a variety of ways, but this interpersonal stress can also exacerbate depressive symptoms. Illustrating the vicious cycle between depressive symptoms and marital difficulties, Davila, Bradbury, Cohan, and Tochluk (1997) found that persons with more symptoms of depression were more negative in their supportive behavior toward the spouse and in their expectations regarding partner support. These negative behaviors and expectations, in turn, were related to greater marital stress. Finally, closing the loop, level of marital stress predicted subsequent depressive symptoms (controlling for earlier symptoms). Likewise, in his review of self-propagating processes in depression, Joiner (2000) highlights the propensity for depressed persons to seek negative feedback, to engage in excessive reassurance seeking, to avoid conflict and so withdraw, and to elicit changes in the partner's view of them. In each case, the behavior resulting from the individual's depression carries the potential to generate increased interpersonal stress or to shift the response of others in a negative direction. Joiner suggests that increased interpersonal negativity, in turn, helps maintain depressive symptoms.

Recent research also provides illustrations of the way in which stressful marital or family events can precipitate or exacerbate depressive symptoms among the vulnerable and so initiate

the stress generation process. For example, Cano and O'Leary (2000) found that humiliating events such as partner infidelity and threats of marital dissolution 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, Whisman and Bruce (1999) found that marital dissatisfaction increased risk of subsequent diagnosis of depression by 2.7 fold in a large, representative community sample, and again the increased risk remained significant after controlling for demographic variables and personal history of depression. As these studies suggest, marital distress and specific types of marital events may be sufficiently potent to precipitate a depressive episode. Thus, in the marital area, the broad outlines of the reciprocal relationship between depression and marital difficulties are already coming into focus.

In the area of parenting relationships, the reciprocal relationships between depression, parenting behavior, and parenting stress are also clear in broad brush. The data reviewed above, for example, suggest that parental depression is associated with a shift toward more lax, detached, inconsistent, and ineffective child management (see also Cummings & Davies, 1999 for a model and review), and problematic parenting practices in turn increase child deviance (e.g., Conger, Patterson, & Ge, 1995). As a consequence, depressed parents perceive their children as having more problems, their children do have more problems on average, and relationships between depressed parents and their children are more distressed. Recent research suggests that strained parent-child relationships may also predict maintenance of depressive symptoms (Jones, Beach, & Forehand, 2001). Jones et al. (2001) examined family stress generation among intact community families with adolescent children, and found that mothers' depressive symptoms generated perceived stress in both marital and mother-adolescent relationships one year later. In turn, greater mother-reported family relationship stress was related to greater exacerbation of her depressive symptoms. It appears, therefore, that parenting behavior is another area in which stress-generation may connect depression and family relationships.

Role of Family-Based Treatments for Family Distress and Depression

What are the implications of Stress Generation theory for family interventions with depressed persons? If depressive symptoms are maintained by a vicious cycle in which symptoms lead to stress-generating processes which in turn help maintain symptoms, it should be useful to treat the stress-generating processes using efficacious interventions. Marital relationships and parenting relationships may provide excellent points of therapeutic intervention with depressed persons if 1) the stress-generating behaviors in each domain are amenable to change, 2) depressed persons can make the necessary changes in response to treatment, and 3) these changes can be maintained over time. Even if intervention in these domains did not produce rapid reduction in depressive symptoms, these are areas in need of attention by many depressed persons and appear to be implicated in the maintenance of depressive episodes via stress-generation processes. In fact, a growing body of literature suggests that failure to address marital and family issues in therapy for depression may interfere with the recovery process and increase the risk for relapse (cf. Hooley & Gotlib, 2000). Accordingly, the stress generation perspective suggests that the marital and parenting relationships may be particularly useful targets of intervention for depressed individuals. An intervention for a vicious cycle requires the application of some efficacious method for interrupting the cycle. Once the vicious cycle is interrupted, more beneficial feedback processes may be set in motion, perhaps without additional direct therapeutic intervention. Marital and parenting interventions therefore seem to be appropriate and promising starting points for family intervention with depressed adults.

Are There Effective Interventions for Both Depression and Family Distress?

We will only briefly touch on the general efficacy of interventions here as this is the focus of another chapter in this volume (see Baucom et al., this volume), but family-based interventions have proven efficacious in the treatment of both family distress and depression.

With regard to marital distress, several approaches to marital therapy have been found to be efficacious, including behavioral marital therapy, cognitive-behavioral marital therapy, emotion-focused therapy, and insight-oriented marital therapy (see Baucom et al., 1998 for a

comprehensive review). Behavioral Marital Therapy, in particular, is an efficacious and specific treatment for marital discord that has been successfully applied cross-culturally (Hahlweg & Markman, 1988), is well specified, and is widely available for clinical application on a broad scale (e.g., Markman, Stanley, & Blumberg, 1994). Likewise, parent management training (Patterson, 1982; Patterson, Reid, & Dishion, 1992) is an efficacious intervention for a range of child behavior problems including conduct disorder (Kazdin, 1998), and has been elaborated and applied to a range of child behavior problems (e.g., McMahon, Forehand, Griest, & Wells, 1981; Taylor & Biglan, 1998). Accordingly, there is substantial reason to expect that depressed persons could be helped to enhance their functioning in these areas and so interrupt stress-generation processes triggered by an ongoing depressive episode. If so, one might expect benefit both with regard to greater relationship satisfaction and with regard to decreased symptoms over time.

Do these approaches work not only to alleviate family distress, but also depression? Given the reciprocal link between marital discord and depression, a number of clinicians and researchers have suggested that family-based interventions are indicated in treatment of depression. Several studies have examined well-specified approaches and have examined their efficacy in reducing symptoms of depression and in enhancing marital satisfaction. A recent review of this literature (Beach & Jones, 2002), suggests that efficacious forms for marital therapy can be safely and usefully applied to a depressed population. *Furthermore, behavioral marital therapy (BMT) emerges as a specific and efficacious treatment for marital discord,* even when the marital discord is occurring in the context of depression. That is, BMT has been shown in three independent studies to produce significant change in marital distress in a discordant and depressed population, and in each case it has outperformed a control group and/or an alternative intervention (Beach & O'Leary, 1992; Emanuels-Zuurveen & Emmelkamp, 1996; Jacobson, Dobson, Fruzzetti, Schmaling, & Salusky, 1991). Because the marital relationship appears to be an important context for stress-generation, successful intervention of this sort can be viewed as particularly promising and provides a strong rationale for recommending marital intervention,

where appropriate, with depressed patients. Given the promising effects on reduction of depressive symptoms, it is important that work continues to establish as well that marital therapy may be an efficacious treatment for depression, and to clearly specify the conditions under which it may serve as a treatment for depression in its own right.

Although the focus of relatively less research attention than marital therapy for depression, growing evidence suggests that parent-training may also be an important intervention with depressed parents. Forehand, Wells, and Griest (1980) examined the effect of a parent training program, including teaching parents to use social reinforcement and time-out with their children, on both child and parent adjustment. Their findings revealed that mothers of clinic-referred, but not non-clinic referred children, evidenced a significant reduction in depressive symptoms from pre- to post-treatment (see also Dadds & McHugh, 1992; Webster-Stratton, 1994 for other demonstrations with depressive symptoms), suggesting that alleviation of parenting stress may also alleviate depressive symptoms.

In a direct test of the value of parent training for clinically depressed mothers, Sanders and McFarland (2000) compared two forms of behavioral family intervention to examine the effect of a parent training intervention (Behavioral Family Intervention) with that of a combination cognitive therapy-parent training intervention (Cognitive Behavioral Family Intervention). Those assigned to the traditional Behavioral Family Intervention (n = 24, with 19 completing treatment) received instruction, role-playing, feedback, and coaching in the use of social-learning principles. Those assigned to the cognitively enhanced BFI condition (n = 23, with 20 completing treatment) received cognitive interventions that were integrated into each treatment session and that were designed to increase personally reinforcing family activities, identify and interrupt dysfunctional child related cognitions and automatic thoughts, and increase relaxation. In each case, therapy was provided individually once a week and was accompanied by two home visits each week. There were 12 sessions with either one or both parents present, with treatment completed over a three to five month time period.

Of importance for the current review, both parenting interventions produced substantial reduction in depressive symptoms and negative cognitions, and there was no interaction of condition with time of assessment. There was also significant improvement in child behavior problems in both conditions. Significantly more mothers in the CBFI condition (72%) than in the BFI condition (35%) were non-depressed at follow-up, however, suggesting a superior effect for CBFI with regard to maternal depression at follow-up. Accordingly, it appears that a highly structured and comprehensive version of parent training can benefit parents who are depressed, but some direct attention to cognitive symptoms of depression may enhance longer term effects on depression.

Another combination approach was attempted by Gelfand, Teti, Seiner, and Jameson (1996). They evaluated a multi-component program in which registered nurses visited depressed mothers of infants at their homes to assess mothers' parenting skills, enhance mothers' self-confidence, and to reinforce mothers' existing parenting techniques. Depressed mothers were either assigned to the intervention group (n = 37) or the usual mental health care group (i.e., ongoing treatment with referral source). The intervention group involved assessment of mothers' needs and the development of individualized programs including modeling warm interactions with the infants, offering mild suggestions, and building self-confidence by appropriately reinforcing parenting skills. Nurses visited mothers and infants 25 times in 3 week intervals over a period of 6 to 12 months, then phased out home visits over 4 final visits. Although there were no differences on depression scores for mothers in the intervention and control group at study entry, mothers in the intervention group demonstrated significantly greater improvement in depressive symptoms post-therapy than those in usual care. Once again, this program suggests that parent training may be a useful point of intervention to break into a stress-generation process for some depressed individuals.

One reason that parent training might have been under investigated as an intervention for parents with a diagnosis of depression is that depressed parents seem to do somewhat less well in

parent training than do other parents. For example, depressed mothers have greater difficulty learning parenting skills (e.g., Dumas, Gibson, & Albin, 1989) and are more prone to drop out of treatment prematurely (e.g., McMahon et al., 1981). Accordingly, one obstacle to the use of parent training may be providing it in a way that allows it to be successful with a depressed population. However, a similar objection might have been raised with regard to marital interventions for depression, as there are also studies showing that depression predicts poorer response to treatment than in a general sample of couples seeking couples therapy (Sher, Baucom, & Larus, 1990; Snyder, Mangrum, & Wills, 1993) and that any serious individual problem predicts premature dropout from marital therapy (Allgood & Crane, 1991). In both cases, the data reviewed above suggest that appropriate delivery of the interventions in a manner targeted at depressed individuals can overcome whatever obstacles depressed persons may experience in untargeted marital and family interventions. Indeed, it is possible that the most important requirement for effective delivery of marital and family interventions for depression is recognition that one of the participants is depressed and so may require some special assistance.

In summary, sufficient evidence does not exist to demonstrate that parent training, by itself, is an efficacious intervention for major depression among parents dealing with problematic children. However, the research does suggest that parent training, itself an efficacious form of therapy for child management problems, can be provided to depressed persons in a safe and efficacious manner and may have beneficial effects both with regard to child outcomes as well as with regard to parental depression. As the Sanders and McFarland (2000) study suggests, it will be useful to consider ways to enhance parent training to make it easier to consume for depressed parents and perhaps to enhance its long-term effects on depressive symptoms. Combinations with various elements of cognitive therapy may be useful in this regard.

Accordingly, there is substantial reason to expect that depressed persons could be helped to enhance their functioning in these areas and so interrupt stress-generation processes triggered

by an ongoing depressive episode. If so, one might expect benefit both with regard to greater relationship satisfaction and with regard to decreased symptoms over time.

Summary and Conclusions

Depression is the most prevalent and burdensome of mental illnesses. It has long been known that there are strong links between family processes and depression. Increasingly it appears that depression can not be well understood from a developmental perspective or from a genetic perspective unless marital and family processes are included as contextual factors. Likewise, marital and parenting relationships appear to continue to exert important influence on depressive symptoms in adulthood. Accordingly, marital and family interventions are important in the treatment and management of depression as well as sub-clinical depressive symptoms. Although it might appear at first that family interventions would be more difficult to implement with depressed persons, and there is evidence that depression is associated with poorer outcomes for both marital therapy and parent training when clinicians are not prepared to work with depressed patients, in both cases it has been possible to overcome these difficulties by providing depressed persons with the additional help they may need for some aspects of the interventions. As a result, marital therapy has been established as an efficacious intervention for marital problems occurring in the context of depression and parent training is well on its way to being established as an efficacious treatment for parenting problems in the context of depression. As a result, although there is considerable room for improvement, there is also reason for optimism that marital and parenting interventions will prove especially helpful in the treatment and perhaps in the prevention of depressive episodes and elevated symptoms.

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