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Development of a Brief Couples Therapy for Depression: Targeting Illness-Related
Attitudes and Behaviors, Empathy, and Support

A Dissertation Presented

by

Shiri Cohen

to

The Graduate School

in Partial fulfillment of the

Requirements

for the Degree of

Doctor of Philosophy

in

Clinical Psychology

Stony Brook University

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Abstract of the Dissertation

Development of a Brief Couples Therapy for Depression: Targeting Illness-Related

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Interpersonal and social support models of depression emphasize the role of conflictual and unsupportive relationships in maintaining a person's depression. Factors such as high negativity, low empathy and a lack of support have been shown to predict relapse and prolong recovery. Research has also documented the negative impact of depression on marital satisfaction, as well as the distress and burden experienced by the spouses of depressed individuals. To address these negative sequelae of depression in a dyadic context, the current study aimed to develop a brief couples therapy for depressed women and their husbands. Treatment was designed to increase partners' knowledge and understanding of depression, reduce negative attitudes and behaviors towards depression, foster more empathy and support toward the depressed partner, and alleviate the psychological distress and burden experienced by non-depressed husbands. To participate, women had to meet diagnostic criteria for either major depression or dysthymia, and their husbands did not meet criteria for clinical depression. Thirty-five

community couples participated in a randomized clinical trial investigating the effects of our brief couples therapy (BCT) on two primary outcomes—depression and relationship satisfaction. Couples were randomly assigned to either the five-week treatment group or a waitlist control group, and were compared at three time points—pre, post, and three-month follow-up. Compared to waitlist controls, women who received the treatment showed significant reductions in depressive symptomatology and half of the women had recovered from their depressive episode by follow-up. Both husbands and wives experienced significant improvements in marital satisfaction following treatment, and husbands in the treatment group experienced significantly reduced levels of depression-specific burden compared to waitlist controls. Mediation analyses revealed that reductions in women’s depression and increases in both partners’ marital satisfaction were significantly mediated by positive changes in partners’ illness-related attitudes and behaviors, increased mutual support, and reduced negativity toward depression. Findings support the growing applicability of brief, problem-focused couples interventions to treat co-existing depression and marital problems. Implications and directions for future research are discussed.

Table of Contents

List of Tables	vii
List of Figures	viii
Acknowledgments	ix
Introduction.....	1
Spouses' Negative Impact on their Partner's Depression.....	2
Negative Impact of Depression on Significant Others	4
Preliminary Support for Development of a Brief Couples Intervention.....	6
Mediating Mechanisms of Treatment Effects.....	7
Study Overview	8
Method	9
Participants.....	9
Interviews.....	12
Self-Report Measures	14
Procedure	17
Brief Couples Therapy (BCT) for Depression.....	21
Treatment Integrity	22
Results.....	24
Women's Medication Status and Adherence.....	25
Treatment Integrity	25
Treatment Outcome Data.....	27

Mediating Mechanisms of Treatment Outcomes.....	40
Discussion.....	44
Strengths and Limitations	52
Clinical Implications and Future Directions.....	54
References.....	58
Tables.....	68
Figures.....	81
Appendix: Treatment Manual and Protocol.....	86

List of Tables

Table 1.	Medication Status and Adherence for Women in Treatment versus Waitlist Control	68
Table 2.	Hamilton Rating Scale for Depression and Beck Depression Inventory Scores at Pre, Post, and Follow-up for Wives and Husbands in Treatment Compared to Waitlist Control.....	69
Table 3.	Clinically Significant Outcome on the Hamilton Rating Scale for Depression and the Beck Depression Inventory for Wives in Treatment and Waitlist Control.....	70
Table 4.	Dyadic Adjustment Scale Scores at Pre, Post, and Follow-up for Wives and Husbands in Treatment Compared to Waitlist Control.....	71
Table 5.	Clinically Significant Outcome on the Dyadic Adjustment Scale for Couples in Treatment versus Waitlist Control.....	72
Table 6.	Symptom Checklist-90 and Family Distress Scale for Depression Scores at Pre, Post, and Follow-up for Wives and Husbands in Treatment Compared to Waitlist Control.....	73
Table 7.	Illness-Related Behaviors and Attitudes Scale Scores at Pre, Post, and Follow-up for Wives and Husbands in Treatment Compared to Waitlist Control.....	74
Table 8.	Dimensions of Spousal Support Scale Scores at Pre, Post, and Follow-up for Wives and Husbands in Treatment Compared to Waitlist Control.....	75
Table 9.	Perceived Negative Spousal Behaviors and Self-Esteem Support Scale Scores at Pre, Post, and Follow-up for Wives in Treatment Compared to Waitlist Control.....	76
Table 10.	Test of Hypothesized Mediators of Wives' Treatment Outcomes.....	77
Table 11.	Test of Hypothesized Mediators of Husbands' Treatment Outcomes...	79

List of Figures

Figure 1.	Hypothesized mediating mechanisms of Brief Couples Therapy (BCT) for Depression.....	81
Figure 2.	Predicted Hamilton Rating Scale for Depression (HAM-D) scores over time for women in treatment versus waitlist control.....	82
Figure 3.	Trajectories of Beck Depression Inventory (BDI) scores for wives and husbands in treatment versus waitlist control.....	83
Figure 4.	Trajectories of Dyadic Adjustment Scale (DAS) scores for wives and husbands in treatment versus waitlist control.....	84
Figure 5.	Trajectories of Illness-Related Behaviors and Attitudes Scale (IRBAS) scores for wives and husbands in treatment versus waitlist control.....	85

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Introduction

There has been a recent shift in the understanding of unipolar major depressive disorder as more of a chronic, recurring condition than an acute, single episode (e.g., Judd, 1998; Keller, Lavori, Lewis & Klerman, 1983; Keller, Lavori, Rice, Coryell, & Hirschfeld, 1986). Given the high risk and prevalence of recurrence, particularly among patients with multiple past episodes, there is a substantial need for new and improved treatments that address the episodic nature of depression and aim to prevent its recurrence and relapse. Due to the chronic and recurrent nature of depression, spouses of depressed individuals will likely be living with the disability for many years (Coyne & Benazon, 2001). This intervention was designed to address this issue by enlisting partners to support the depressed person through the long-term, chronic struggle (Beach, 2002).

Although there are several well-validated individual and marital treatments for depression that could potentially be applied to treating depression, the majority of these treatments are not tailored to address the specific needs of couples, namely those of the spouses of depressed individuals, in learning to understand and cope effectively with one partner's depression. Individual treatments for depression cannot address dyadic problems or marital distress within the couples, and the potential success of marital therapy is often disrupted by factors such as the intensity of their conflict, the impairment of the depressed individual, and the frustration and impatience of the spouse. Moreover, marital therapy for depression has been shown to be optimal for maritally distressed couples, whereas for nondistressed couples, marital therapy is far less effective in treating depression (Beach & O'Leary, 1986; Jacobson, Dobson, Fruzzetti, Schmalings, & Salusky, 1991). Thus, alternative couples interventions are needed that are better suited

for treating depression within mildly or non-discordant couples, and that specifically target the needs of the non-depressed spouse in learning to live adaptively with a depressed partner. A problem-focused intervention that provides brief psychoeducation about depression and training in coping skills may be more practical and more likely to engage these non-depressed spouses than individual or standard marital therapy. Similar interventions have been successfully applied to the spouses of individuals suffering from a range of other psychiatric conditions and medical illnesses, including alcoholism (Honig & Spinner, 1986), cancer (Wasserstein, 2002), brain tumors (Horowitz, Passik, & Malkin, 1996), Alzheimer's (Nathan, 1986), and HIV/AIDS (Pomeroy, Rubin, & Walker, 1996). Findings across these various studies consistently showed that the treatments were very effective in alleviating spouses' own levels of depression, anxiety and stress, as well as enhancing their ability to cope with their partners' illness. Thus, developing a comparable intervention that is tailored for the non-depressed partners of depressed individuals could potentially demonstrate similar benefits.

Spouses' Negative Impact on their Partner's Depression

Spouses of depressed individuals commonly express critical and hostile attitudes toward their depressed partners (Hooley, 1986; Vaughn & Leff, 1976). Researchers have observed that in couples in which one spouse is depressed, there are more negative communications (e.g., blaming, criticism, etc.) than in couples where there is no depression (Biglan et al., 1985; Lewinsohn & Shaffer, 1971; Nelson & Beach, 1990; Schmaling & Jacobson, 1990). Spouses' expressions of criticism and hostility toward their depressed partners have been found to be highly predictive of patient relapse

(Hooley, Orley, & Teasdale, 1986). In fact, Hooley and Teasdale (1989) found that perceived criticism was the single best predictor of depression relapse. Thus, the attitudes and behaviors of spouses toward their depressed partners, particularly their criticism and underlying feelings of intolerance, are critical areas of therapeutic intervention.

Research has also indicated that spouses of depressed individuals lack an accurate and thorough understanding of the causes and nature of depression, which can contribute to their negative and critical attitudes towards their depressed partners. Jacob, Frank, Kupfer, and Carpenter (1987) found that significant others' beliefs about the etiology of a depressive disorder are not comprehensive or well integrated. Significant others only partially recognized the possible biological basis of the disorder and tended to place heavy emphasis on external or situational causes, which may contribute to their blaming and criticizing of the patient for not being better able to control environmental influences. Moreover, spouses who are high in expressed emotion—that is, high in criticism—are also more likely to perceive symptoms of depression as controllable and themselves as having good coping and problem-solving skills (Hooley, 1998). Such attitudes may reflect spouses' unrealistic expectations of their partners' ability to cope with the illness, as well as an illusion that they are responsible for their partners' symptoms. Thus, providing spouses with psychoeducation about depression may enhance their understanding of the difficulties and impairment associated with depression thereby fostering more acceptance and support of their depressed partner, as well as greater attention to their own needs and emotional well-being.

The aforementioned body of research points to the assumption that effective interventions with the spouses of depressed individuals may have direct benefit for the

depressed partner. This premise is theoretically grounded in interpersonal theories of depression, which emphasize that depressed persons' difficulties often arise and are maintained in the context of conflictual and unsupportive relationships. Coyne (1976a, b) delineated an interactional theory of depression in which he postulated that depressed individuals act in ways to evoke negative responses from others, which then serve to maintain the person's depression. More specifically, depressed individuals engage in aversive interpersonal behaviors (e.g., complaining and excessive reassurance seeking), which lead their partners to become impatient, hostile, and rejecting. These negative responses from others create further emotional distress and unwittingly perpetuate the depression. Thus, by helping spouses to inhibit negative responses and increase positive responses to their depressed partners, the partners would in turn feel more secure and reassured and their depressive symptoms would lessen or perhaps even remit. Indeed, a warm, supportive marital relationship can have protective effects on the depressed partner (Coyne & Benazon, 2001; Waite and Gallagher, 2000). McLeod, Kessler, and Landis (1992) found evidence for the unique importance of spouses' positive responses to their partner's depression, namely warmth and compassion, in predicting more rapid recovery. This suggests that receiving positive feedback from one's spouse may be as important as not receiving negative feedback.

Negative Impact of Depression on Significant Others

Depression can be a debilitating and distressing condition not only for the depressed individuals but for their spouses as well. The negative impact of depression on the significant others of depressed individuals has been repeatedly demonstrated in

empirical studies. The behavior of a depressed person profoundly impacts others (Coyne 1976a, b), and the close relationships of depressed persons are generally characterized by marital disturbance and problems of inhibited communication, resentment, friction, and dependency (Weissman & Paykel, 1974). More recent research has documented the negative impact of depression on significant others' physical and mental health, including an increased incidence of mild to severe symptoms of hypertension, migraine, diabetes, coronary artery disease and arthritis (Coyne, Kessler, Tal, Turnbull, & Wortman, 1987; Kreitman, 1964), as well as heightened psychological distress as a result of the burdens associated with living with a depressed person (Benazon & Coyne, 2000; Dudek et al., 2001; Fadden, Bebbington, & Kuipers, 1987; Jacob, Frank, Kupfer, & Carpenter, 1987). Coyne et al. (1987) demonstrated that nearly all of the distress experienced by adults living with a depressed patient was accounted for by the burden associated with their depressed partners' symptoms. Similarly, Jacob et al. (1987) reported that a majority of the significant others of those who suffer from recurrent major depressive disorder were frequently strained by many troublesome aspects of the patients' depression, particularly their feelings of worthlessness, lack of interest in usual activities and social interactions, and constant rumination and worrying.

The adverse consequences of depression on close others have also been demonstrated in samples comprised exclusively of spouses. Fadden et al. (1987) interviewed the spouses of depressed patients and found that they experience restrictions in social and leisure activities, reductions in family income, and strained marital relations. Moreover, spouses of depressed patients experience significantly higher levels of depressed mood than general population norms and report numerous specific burdens as a

result of living with a depressed person (Benazon & Coyne, 2000). Thus, the depressed mood among spouses seems to reflect the degree to which they are burdened by their partner's depression, rather than a simple mood contagion. In fact, the burden experienced by spouses of depressed individuals is comparable to that of spouses of individuals suffering from other chronic, more progressive illnesses (Leinonen et al., 2001). Taken together, these findings highlight the extent to which being married to a depressed individual can have detrimental effects on spouses' physical and mental health. Thus, the spouses of depressed individuals themselves represent an important population for clinical intervention.

Preliminary Support for Development of a Brief Couples Intervention

Based on the previous discussion, it is reasonable to assume that both partners are likely to benefit from interventions that include the spouses of depressed individuals in order to target the dyadic issues and clinical needs of the couple. Although there is a relative paucity of research on couples-based interventions with depressed populations, the limited research that does exist provides support for the benefits of psychoeducational approaches to depression. For example, Jacob, Frank, Kupfer, Cornes, and Carpenter (1987) described a daylong psychoeducational workshop that was quite helpful in educating friends and family members about depression and teaching them basic skills for tolerating life with a depressed individual. Although participants' evaluations suggested that they benefited from the psychoeducational intervention, its effectiveness could not be accurately determined due to the lack of quantitative measures of pre- and post-treatment variables and the absence of a no-treatment comparison group. Similar

research by Anderson et al. (1986) provides more concrete support for the effectiveness of psychoeducational groups in increasing both the patient's and the spouse's sense of competency in dealing with the depression. Clarkin et al. (1990) also found that female inpatients with unipolar depression showed enhanced response to standard medication treatment when psychoeducational family therapy was added.

While these findings are very promising, they cannot be directly generalized to the spouses of individuals with major depression because most of the studies included samples of heterogeneous close relationships (e.g., partners, family members, and friends) and patients whose depression ranged in severity (i.e., inpatients and outpatients) and diagnosis (i.e., patients with both unipolar and bipolar depression). Moreover, conclusions about the effectiveness of such interventions are in some cases limited by the lack of quantitative measures and experimental research designs. Thus, there is a need for more controlled treatment studies that focus exclusively on the partners of depressed persons. The present study is one of the few to develop a brief, problem-focused couples therapy for depression and test its efficacy in a randomized controlled design.

Mediating Mechanisms of Treatment Effects

In addition to the practical significance of the proposed study, we also aimed to explore the underlying mechanisms through which our brief couples therapy might reduce wives' depression and improve both partners' relationship satisfaction. More specifically, we examined the following three factors as potential mediators of the anticipated treatment effects on depression and marital satisfaction: (1) partners' attitudes and level of understanding about depression, (2) husbands' negativity towards

depression, and (3) exchange of support and empathy between partners. Figure 1 illustrates the hypothesized mediating mechanisms. We hypothesized that providing psychoeducation aimed at enhancing both partners' understanding and knowledge of depression would mediate the effects of treatment on wives' depression and both partners' marital satisfaction. Consistent with Coyne's interpersonal theory, we also hypothesized that reductions in both partners' negative attitudes and behaviors toward depression, particularly perceived negativity and criticism from the non-depressed spouse, would mediate treatment effects on alleviating wives' depression and improving both partners' marital satisfaction. Finally, we expected both depression and marital satisfaction outcomes to be further mediated by improvements in global dimensions of support and specifically in wives' perceptions of self-esteem support from their husbands.

Study Overview

The present study sought to establish the efficacy of a brief couples therapy for women with unipolar depression. The proposed intervention had two primary goals: (1) to reduce depressive symptomatology in the primary depressed patient (wives) and increase the likelihood of recovery, as well as help the non-depressed spouses (husbands) reduce their own psychological distress and burden; and (2) to improve marital satisfaction in both partners. More specifically, we hypothesized that reductions in depressive and global symptomatology as well as increases in marital satisfaction would result from interventions targeting partners' attitudes and behaviors towards depression, communication patterns, empathy and support. To achieve these goals, the treatment was designed to provide couples with psychoeducation about the nature of depression (i.e.,

symptomatology, course, etiology, and impact on social and marital functioning); teach the non-depressed spouses coping strategies to reduce specific burdens and psychological distress; help both partners to minimize negative interactions (i.e., criticism, hostility, and blame) toward the depressed person and increase empathic and mutually supportive interactions; and guide the non-depressed spouse in becoming a long-term resource and source of support for their depressed partner. The present study used a randomized design with a waitlist control condition to empirically test the effects of treatment and to investigate hypothesized mediating mechanism of treatment effects.

Method

Participants

Thirty-five couples were recruited from the Suffolk County Long Island community to participate in a free therapy program for depressed women and their partners. Twenty-eight of the couples were recruited through newspaper advertisements, radio and TV announcements, and local flyers and pamphlets, and seven of the couples were referred to the study from the Family Medicine Clinic of Stony Brook University Hospital. To be included in the study, couples had to be married or living together for at least one year, and both partners had to be at least 18 years old and fluent in English.

The treatment that was offered was targeted for mildly to moderately distressed couples in which women were identified as the depressed partner and men were comparatively identified as the non-depressed partner. Accordingly, to be included in the study, female partners had to meet diagnostic criteria for major depression and/or

dysthymic disorder and have a score of 21 or higher on the Beck Depression Inventory, as this is the cut-off point which best discriminates depressed from nondepressed individuals (Taylor & Klein, 1989; Kendall, Hollon, & Beck, 1987). Male partners could not meet diagnostic criteria for a depressive disorder, although they were still eligible if they reported depressive symptomatology on either the BDI or the diagnostic interview. This criterion was necessary to ensure that male partners were not sufficiently depressed themselves to be considered the “primary” patient within the relationship—that is, they were not experiencing depression of equal or greater severity than their female partners. To ensure that severely discordant and/or unhappily married couples could be appropriately referred for more intensive couples therapy, both partners had to score 75 or higher on the Dyadic Adjustment Scale (DAS) upon entry into the study.

To avoid confounding therapy results with the presence of alternative treatments, couples could not already be receiving couples therapy and male partners could not be in individual psychotherapy or on anti-depressant medication. Female partners, however, were not restricted from receiving alternative treatments for their depression including individual psychotherapy and/or psychotropic medication, as long as they had been in therapy for a minimum of 12 weeks or taking a stable dose of the medication for a minimum of 8 weeks. To ensure that our sample did not include physically aggressive couples, both partners’ reports of the frequency and severity of violent acts during the preceding year were used to eliminate couples in which one or both partners had engaged in two or more acts of violence. Finally, to ensure that partners were sufficiently committed to working on their relationship in treatment, we excluded couples if one or both partners disclosed a recent act of infidelity in the preceding six months.

Most of the participants in the study were Caucasian (88.2% of both female and male partners). Other ethnicities included Latino/Hispanic (5.9% of female and male partners), African American (2.9% of female and male partners), and Asian (2.9% of female and male partners). Women ranged in age from 21 to 72 years ($M = 43.18$ years, $SD = 10.64$), and men's ages ranged from 26 to 78 years ($M = 45.09$ years, $SD = 10.75$). Thirty-three (94.3%) of the couples were married and two couples (5.7%) were cohabitating. Couples had been married on average for 15.33 years ($SD = 11.91$) and had an average of 2.06 ($SD = 1.37$) children. Cohabitating couples had been living together for a mean of 3.50 years ($SD = 0.71$) and did not have children. Two percent of men had not completed high school, 24% percent had a high school education, 50% were college educated, and 24% were educated at the graduate level. Thirty-two percent of women had a high school education, 44% were college educated, and 24% were educated at the graduate level. Eighty-five percent of the men worked full-time, 6% worked part-time, 3% were fulltime graduate students, and 6% were retired. Twenty-six percent of women worked fulltime, 18% worked part-time, 6% were fulltime graduate students, 44% were unemployed, and 6% were retired. The median family income was approximately \$85,000. Seventy-one percent of women and 41% of men had received individual psychotherapy in the past. Twenty-nine percent of couples had been in previous couples therapy. At baseline, mean marital satisfaction (DAS) scores were 93.5 ($SD = 17.9$) for women and 102.5 ($SD = 18.5$) for men, and mean depression (BDI) scores were 30.8 ($SD = 10.1$) for women and 9.3 ($SD = 9.2$) for men.

There were no group differences between couples in the treatment and waitlist control groups for age, ethnicity, years married, number of children, education level, or

employment status. There was a significant group difference in mean family income, with couples in the waitlist control group having significantly higher incomes on average than couples in the treatment group. Groups did not differ on initial levels of marital satisfaction or depressive symptomatology.

Interviews

Baseline diagnosis. Diagnoses were assessed with both partners at the initial assessment session using the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First, Gibbon, Spitzer, & Williams, 1996). The SCID-I is one of the most widely used structured interviews for Axis I disorders and has been shown to have good interrater reliability for most diagnoses (Williams et al., 1992). Wives were administered the full SCID to screen for the presence of clinical depression and other psychiatric conditions. Husbands were administered only the Mood Disorders module to rule out the presence of clinical depression. To assess the reliability of women's depression diagnoses, a second diagnostician independently derived diagnoses from 12 audiotapes of SCIDs with female patients. There were 100% concordance rates between diagnosticians for major depressive disorder and for dysthymia.

Depression severity. The severity of women's depressive symptoms was assessed at pre, post, and follow-up using the 24-item modified Hamilton Depression Rating Scale (HAM-D; Miller, Bishop, Norman & Maddever, 1985). Reductions in depression severity were used as an indicator of treatment response, which is typically defined as a 50% reduction in HAM-D score. This semi-structured interview has demonstrated excellent reliability and concurrent validity with other measures of depression (Miller et al., 1985).

We assessed the reliability of HAM-D assessments by having a second diagnostician independently rate audiotapes of 5 patients at each time point. The intraclass correlation coefficients were .85 at baseline, .97 at post, and .97 at 3-month follow-up.

Recovery. Recovery was assessed using the Longitudinal Interval Follow-Up Evaluation (LIFE; Keller et al., 1987). The LIFE is a semi-structured interview that assesses the longitudinal course of axis I disorders and has been used successfully for follow-up periods ranging from 3-12 months (Keller et al., 1987). Interviewers assign weekly psychiatric status ratings (PSRs) on a scale of 1 to 6 (with ratings of 1 and 2 = minimal to no symptoms; 3 = obvious evidence of depression with no more than moderate impairment in functioning; 4 = major signs of impairment without meeting full DSM-IV criteria; and 5 = meets DSM-IV criteria for definite MDD). According to LIFE conventions, recovery is defined as a period of at least 8 consecutive weeks with minimal or no symptoms of depression. To assess interrater reliability on the LIFE, one rater independently rated 9 audiotapes (33%) of randomly selected LIFE interviews conducted by the other interviewers. Kappas were 0.81 for recovery from major depressive episode.

Medication and therapy status interview. In order to be able to control for changes in female partners' medication and/or treatment status during the course of the study, relevant information was collected at the pre-, post-treatment, and follow-up assessments. Specifically, female partners were asked about changes in or new medications, adherence to their medication (i.e., whether they have taken the medication without discontinuation and as indicated by their physician), and dosage changes. Females were also asked whether they had sought psychotherapy since the prior assessment, and the nature of the treatment (i.e., type of therapy, frequency of sessions, and duration of treatment).

Self-Report Measures

A battery of self-report measures was repeatedly administered at pre, post, and follow-up to examine changes over time in depressive and global symptomatology, stress and burden, marital functioning, perceived partner criticism and negative attitudes toward depression, and dimensions of spousal support.

Depressive symptomatology. The Beck Depression Inventory – Revised (BDI-II; Beck, Steer, & Brown, 1996) is a widely used 21-item measure of current depressive symptoms. The BDI has high internal consistency (alphas above .90), and has demonstrated good convergent validity with other depression measures (Beck et al., 1996). In the present sample, Cronbach’s alpha was .88 for wives and .92 for husbands.

Relationship satisfaction. The Dyadic Adjustment Scale (DAS; Spanier, 1976) is a widely used 32-item measure of overall relationship satisfaction, and a widespread measure of couple treatment outcome. Scores range from 0-153, with higher scores indicating greater satisfaction and lower scores indicating greater marital discord. DAS scores of 100 or below typically constitute the distressed range, and the mean DAS score in a discordant, treatment-seeking population is 94.7 ($SD = 15.47$) (Crane, Allgood, Larson, & Griffin, 1990). Psychometric studies have documented excellent internal consistency (Carey, Spector, Lantinga, & Krauss, 1993), good convergent validity (Heyman, Sayers, & Bellack, 1994), and criterion-related validity of the DAS for distinguishing distressed and non-distressed couples (Eddy, Heyman, & Weiss, 1991). In the present study, internal consistency of the DAS (Cronbach’s alpha) was .91 for wives and .93 for husbands.

Global symptomatology. The Symptom Checklist-90 (SCL-90; Derogatis, 1983) is a 90-item measure of various non-specific symptoms of psychological distress. Individuals assigned ratings on a 0-4 scale as to what degree they had experienced each of the 90 symptoms during the past 3 months. This measure was used as an outcome measure of both partners' general mental health and negative symptomatology. The SCL-90 has been shown to have satisfactory reliability and validity (Bonicatto, Dew, Soria, & Seghezze, 1997). Cronbach's alpha was .97 for wives and .98 for husbands in the current study.

Depression-related spousal distress. The Family Distress Scale for Depression (FDSD; Jacob et al., 1987) is a 25-item questionnaire that measures the impact of a patient's depression on a significant other. Husbands/male partners rated the frequency of distress and burden associated with their partners' various depressive symptoms and behaviors. Internal consistency of the FDSD was .93.

Illness-related behaviors and attitudes. The IRBAS (Beardslee, Salt et al., 1993) was originally designed to include two interviewer-rated scales of changes in illness-related behaviors and attitudes following participation in an intervention for families with depression. For the present study, we modified the IRBAS into a shortened, 10-item self-report version including the following: (1) *behavior change* items reflecting adoption of new and adaptive coping strategies, increased or improved communication, improved individual and partner functioning, and seeking out additional information about depression; and (2) *attitude change* items reflecting normalization or destigmatization of the illness, increased factual understanding of depression, recognition and increased understanding of spouses' perspectives, and generalization of intervention concepts

leading to global attitude change towards depression and one's partner. Studies have documented excellent reliability of this measure (Beardslee et al., 1993, 1997). In the present study, Cronbach's alpha was .71 for wives and .78 for husbands.

Perceived negative spouse behaviors. The Perceived Negative Spouse Behaviors scale (PNSB; Manne, Taylor, Dougherty, & Kemeny, 1997) was originally developed to measure unsupportive and critical behaviors by spouses of cancer patients. In the present study we used a modified 9-item version, completed by wives only. Six items assessed critical responses from one's husband, which were defined as impatience or criticism of the patient's ability to cope with her illness. The remaining three items assessed husbands' avoidance and withdrawal, including physical avoidance of the patient or a perception that one's husband was not interested in talking about the patient's problems. Wives were asked to rate items on a four-point Likert Scale (from 1 = *never responds this way* to 4 = *often responds this way*), with higher scores indicating more perceived negativity from their husbands. Cronbach's alpha was .93 in the present study.

Dimensions of spousal support. A 19-item and 10-item version of this questionnaire (DSS) for male and female partners, respectively, was used to assess a broad range of social support dimensions among partners including: (1) positive support (5 items), (2) negative interactions (5 items), and (3) men's reported reactions to their female partners' depression, including feelings of burden (8 items), warmth and compassion (4 items). The items measuring positive partner support and negative partner interactions were developed for a study examining predictors of recovery from major depression in a community sample (McLeod, Kessler, & Landis, 1992). The items measuring males' reactions to their partners' depression were originally developed for a

study of adults living with a depressed patient (Coyne et al., 1987). Higher scores on the women's version of the DSS scale reflect more positive feelings towards one's partner and higher levels of perceived positive support (e.g., openness, understanding, concern, warmth, and dependability) from their husbands. Higher scores on the men's version additionally reflect increased support provision *to* their depressed wives. Internal consistency coefficients were .86 for wives and .92 for husbands.

Self-esteem support. The Self-Esteem Support Scale (SESS), adapted by Katz, Beach, and Anderson (1996) is a nine-item measure of wives' perceptions of their spouses' efforts to build their self-esteem through expressions of respect, appreciation, attraction, interest, and encouragement. Wives rated each item on a nine-point Likert scale for the degree to which each statement was true of their spouse (from 1 = *not at all true* to 9 = *completely true*), with higher scores indicative of greater perceived self-esteem support from their husbands. Cronbach's alpha was .89 in the present sample.

Procedure

Couples were assessed during three visits to the Marital Clinic at Stony Brook University. Each visit lasted about two hours, and the visits were scheduled according to each couple's timeline in the study. Specifically, treatment couples participated in their second assessment following completion of the 5-week treatment and their third assessment three months later. Matched waitlist control couples completed their second assessment approximately 5 weeks after their initial interview and their third assessment approximately three months later. All assessments were conducted by advanced graduate students who were blind to couples' group assignment. Procedural details of the

screening process and assessments are described below. In addition, all couples received the brief therapy for free and were paid for participation in each of the assessment visits.

Couples who responded to advertisements for the study first participated in a phone interview to screen for basic eligibility on the following criteria: (1) depression, (2) marital satisfaction, and (3) suitability for a brief couples therapy based on levels of aggression and infidelity. More specifically, we used the Patient Health Questionnaire (PHQ-9), a 9-item self-rated depression screening measure, to screen female partners for the presence of significant depressive symptomatology and male partners for the absence of depressive symptoms. The PHQ-9 has been well validated as a brief depression severity and screening measure in primary care practice (Kroenke, Spitzer, & Williams, 2001; Spitzer, Kroenke, & Williams, 1999). We also administered a shortened version of the DAS (i.e., a compilation of items that were felt to adequately reflect levels of marital satisfaction) to gauge whether partners' full DAS scores would be above the cutoff criteria of 75. Finally, we asked both partners to report on the number and severity of acts of physical aggression perpetrated by themselves and their partners in the previous year. Similarly, we asked both partners whether they were involved in an extramarital affair in the most recent six months. Couples were excluded if more than two acts of physical aggression were reported or one of those acts had resulted in injury, and were excluded if a recent infidelity was disclosed. Prior to scheduling the initial assessment session, couples were informed of the possibility of being excluded from the study based on the information provided in their initial interview and the possibility of waiting four months for treatment if assigned to the waitlist control condition.

Potentially eligible and interested couples were then scheduled for an initial interview at the Marital Clinic to confirm their eligibility with psychiatric interviews and to collect baseline data. During the first clinic visit, couples provided informed consent and each partner completed a battery of self-report measures and participated in a structured interview. Wives were administered the full Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) to assess for depression and other Axis I diagnoses. Husbands were administered only the Mood Disorders module of the SCID-I to rule out the presence of a depressive disorder. Wives were also administered two interviews, the Hamilton Rating Scale for Depression (HAM-D) to determine depression severity, and the Medication/Treatment Status Interview to gather information about psychotropic medications, including adherence, and past or current individual psychotherapy.

Based on information obtained in the phone screening and the initial interview, 28 couples were excluded because the wives did not meet criteria for a depression diagnosis; 37 couples were excluded because the husbands were also clinically depressed (i.e., reported significant levels of depressive symptomatology or met diagnostic criteria for depression); 15 couples were excluded because one or both partners were too dissatisfied with the marriage; 5 were excluded because of current or recent infidelity; and 2 were excluded for being too physically aggressive. In addition, 76 couples decided not to continue past the phone screening due to lack of interest or scheduling/time constraints.

The second (post) assessment session was conducted immediately following the completion of treatment for couples in the therapy group, and 5 weeks following entry into the study for waitlist control couples. During the second clinic visit, both spouses completed the same battery of questionnaires as in the initial assessment session. Wives

were also administered the HAM-D to assess the severity of their depression and the Medication/Treatment Status Interview to collect updated information on changes in their medications or individual therapy since the previous assessment. At three-month follow-up, husbands and wives completed the same battery of questionnaires as at pre and post. The questionnaire packets were mailed home to couples approximately two weeks prior to their follow-up date. This allowed partners to complete the packets at home and return them to study personnel when wives came in to the clinic for their follow-up interview. At this visit, wives were again interviewed with the HAM-D and the Medication/Treatment Status Interview. They also completed the LIFE interview to determine recovery status at follow-up.

Of the 35 couples that entered the study, 30 (85.7%) completed their post-assessment and 27 (77.1%) completed their 3-month follow-up. Of the 8 couples who did not complete the study, 3 were in the treatment group and 5 were in the waitlist control group (Fisher's exact test probability = 0.31). Thus, analyses of complete follow-up data are based on 15 treatment couples and 12 waitlist control couples. Couples who dropped out of the study did not significantly differ from the rest of the sample on demographic variables or on initial levels of depression and marital satisfaction. However, husbands who dropped out of the study were reporting slightly higher levels of depression at baseline ($M = 14.71$, $SD = 13.30$) than husbands who remained in the study ($M = 7.96$, $SD = 7.63$), although this difference did not reach statistical significance, $t(33) = -1.79$, $p = .08$. The mean length of time to complete the post-assessment and the follow-up was 9.73 weeks and 24.15 weeks, respectively.

Brief Couples Therapy (BCT) for Depression

The goals of BCT for depression are to promote an increased understanding of depression as an illness, reduce negative attitudes and behaviors towards depression, and increase empathy and mutual support between partners (refer to the Appendix for a full description of the treatment manual and protocol). Couples in the treatment condition met weekly for five, 2-hour conjoint sessions. In the first session, the therapist met with each partner individually to conduct a detailed assessment of the couples' strengths and deficits in the areas described above (i.e., knowledge about depression, behaviors and attitudes towards depression, and levels of negativity, empathy, and support). In the last 30 minutes of the session, the therapist met with both partners conjointly to summarize the couple's difficulties surrounding the wife's depression and to formulate critical areas for dyadic and individual change. Spouses also received a brief introduction to the therapy (i.e., rationale, aims, and treatment methods).

Session two focused on psychoeducation regarding the symptomatology, course, etiology, and treatment of depression. More specifically, both spouses received basic information about the symptoms of depression and how particular symptoms can impact the patient's functioning, the spouse, and the marriage. Couples were also informed about features of depression (e.g., duration, comorbidity, the high likelihood of recurrence, and ways to minimize recurrence).

The third session emphasized coping and communication strategies that can aid husbands in reducing their specific burdens and psychological distress related to their wives' depression. Cognitive-behavioral techniques were used to help spouses replace negative thinking with a more constructive, optimistic outlook, thereby relieving some of

the worry that is commonly experienced by spouses of depressed individuals. Spouses were also encouraged to focus not only on their depressed partners' demands, but also on their own needs. For example, the therapist emphasized the importance of maintaining personal interests, engaging in social activities, and seeking support from close others.

Sessions four and five were devoted to minimizing negative interactions with depressed partners (e.g., criticism, hostility, blame) and fostering more positive, supportive interactions. Husbands received training in more constructive ways of interacting with their depressed wives, such as providing emotional validation of their partner's pain and suffering while also encouraging their partner to take gradual steps toward overcoming their difficulties. Couples were also instructed about various forms of support (e.g., emotional support versus problem-focused support) and how to adaptively communicate mutual needs for support. Specifically, the sessions helped husbands to become more aware of contradictory messages that they may send to their partners (e.g., offering help to the patient or being over-involved while complaining about the burden) that contribute to resentment and/or self-blame in their wives. Finally, sessions four and five aimed to foster greater empathy for the depressed partner and acceptance of the depression as a complicated, debilitating illness.

Treatment Integrity

We recruited three advanced graduate students in the clinical psychology doctoral program at Stony Brook University to serve as therapists on the study along with the author. As advanced students, all of the therapists had a minimum of four years of predoctoral clinical training and were selected on the basis of their reputation in the

program and interest in the study. Therapists were extensively trained in the treatment protocol by reading the treatment manual and attending a workshop provided by the author that covered issues related to the delivery and implementation of the treatment (e.g., treatment protocol and rationale, session content, potential complications, and referral guidelines). Workshop training also involved didactic instruction and role-playing. Moreover, all therapists were supervised by the principal investigator of the project, who developed the brief therapy and delivered treatment as well. Intense supervision was maintained throughout the study to ensure adherence to treatment protocol and quality of treatment delivery. Audiotapes of every session were provided to the supervisor each week, who then listened to the sessions and met with the therapists weekly to provide feedback prior to the next session.

All of the session audiotapes were then coded for therapy adherence. Our adherence scale, developed for the present study, measured the degree to which therapists carried out various treatment criteria on a scale from 1 to 7 (with 1 = poorly, 4 = satisfactorily, and 7 = excellently). Specifically, therapists were rated on their interventions targeting the following areas: psychoeducation (8 items), communication (4 items), empathy-building (3 items), and support-building (3 items). Additionally, the scale included eight items reflecting general skills of the therapist (e.g., ability to set and follow an agenda and communicate goals to the couple) and non-specific factors such as rapport-building, expression of warmth and concern, and instilling hope for the couple and treatment. For each therapy case ($N = 15$ couples), sessions two through five (all except the first assessment session) were coded by the same adherence rater. We felt that

adherence to the treatment protocol was best determined by reviewing therapists' interventions towards the four major goals across all four sessions.

Three advanced undergraduate students were extensively trained in the adherence coding system using practice tapes of sessions from two couples who had dropped out mid-treatment. Each student independently coded sessions from seven therapy cases, with four of those cases randomly assigned to another rater (i.e., two cases to each of the other two raters). Thus, a total of six cases (40%) were used to assess interrater reliability on our adherence coding scale.

Results

Thirty of the women in the study were diagnosed with major depressive disorder (1 of whom was dually diagnosed with dysthymia), and the remaining five women were diagnosed with dysthymic disorder only. The average age at onset for major depressive disorder was 31.54 years ($SD = 16.13$) and subjects had an average of 19.59 ($SD = 36.98$) lifetime major depressive episodes. The mean duration of women's current depressive episode was 21.65 months ($SD = 43.28$). There were no significant group differences on any clinical variables. Women in the control group had a noticeably higher number of lifetime major depressive episodes ($M = 29.13$, $SD = 43.74$) than women in the treatment group ($M = 9.36$, $SD = 25.84$); however, this difference was not statistically significant.

Women's Medication Status and Adherence

Data was collected at each time point on women's current medication status (i.e., whether they were taking any psychotropic medications during the previous assessment period) and adherence to their prescribed medication regimen (i.e., computed as a percentage of days since the prior assessment that the medication of interest was taken in a compliant manner). Since female participants were free to initiate, change, and/or discontinue any trial of psychotropic medication during the course of the study, this data was analyzed to ensure that any observed treatment outcomes were in fact due to the treatment, above and beyond any pharmacological effects. Accordingly, we conducted a series of chi-square tests to compare women's medication status and level of adherence at each time point across the two groups, i.e., treatment vs. waitlist control. As shown in Table 1, there were no significant group differences in medication status or adherence at any of the time points. That is, the number of women who were taking anti-depressant medication at each time point did not significantly differ between the treatment and the waitlist control groups, nor did the groups differ in the degree to which women were adherent to their medication(s). Thus, we can assume that the contribution of any pharmacological effects to changes in the measured outcome variables is evenly distributed and not significantly different across groups.

Treatment Integrity

Using our adherence coding system, we obtained a separate summary score for the four major areas of intervention: psychoeducation, communication, empathy-building, and support-building. We present herein descriptive statistics (i.e., mean

summary scores on each subscale across all therapists) representing the degree to which therapists adhered to and competently addressed the four major goals of treatment. Generally, higher scores indicate greater adherence to the criteria, as well as therapists' greater competence in meeting those objectives. On the psychoeducation subscale, out of a maximum possible score of 49, adherence ratings ranged from 38 to 48, and the mean adherence rating was 43.45 ($SD = 2.69$). On the communication subscale, out of a possible 28 points, scores ranged from 23 to 28, and the mean adherence rating was 26.23 ($SD = 1.69$). On the empathy-building and support-building subscales, out of a maximum possible score of 21 on each scale, adherence scores ranged from 17 to 21 and 15 to 21, respectively, and the mean adherence ratings were 19.41 ($SD = 1.37$) for empathy-building interventions and 18.86 ($SD = 1.88$) for support-building interventions. Overall, therapists received high adherence ratings across all scales, and even the lowest ratings on each scale were still in the good-to-excellent range for adherence. Clearly, therapists were performing interventions in accord with the treatment protocol across all therapy cases. Moreover, there were no significant differences between therapists on summary scores for each subscale (psychoeducation: $F = 2.82, p = .09$; communication: $F = 0.50, ns$; empathy-building: $F = 2.49, p = .11$; and support-building: $F = 2.32, p = .13$). Thus, therapists did not differ in the degree of adherence to the treatment protocol and were equally skilled in executing the intended interventions. Finally, with respect to general skills of the therapist, ratings averaged 52.95 ($SD = 2.44$), with mean scores for each therapist ranging from a low of 45 (midway between *good* and *very good*) to a high of 56 (the maximum possible score). In sum, these ratings suggest high levels of treatment fidelity for the major goals of therapy, as well as general proficiency across all therapists.

Treatment Outcome Data

To examine the impact of our treatment across repeated assessments (pre-treatment, post-treatment, and 3-month follow-up), we used hierarchical linear modeling techniques (HLM; Raudenbush & Bryk, 2002). HLM was a suitable analytic technique for the present study for several reasons. First and foremost, HLM allows for the analysis of repeated measures data that is unbalanced, that is, obtained at different and unequally spaced intervals for each participant. This was the case in the present study, where the post-treatment and 3-month follow-up intervals (or the matched 5-week and 3-month intervals for waitlist couples) varied greatly across couples depending on their individual scheduling issues. In addition, HLM is well designed to handle the problem of attrition and missing data, which is common in any longitudinal design. Specifically, HLM maximizes power through a maximum likelihood estimation procedure that enables the inclusion of all data, even when participants do not complete assessments at every time point. Finally, HLM is well suited for multi-level modeling, as in the current study in which time was nested within persons (i.e., each individual is assessed at multiple time points), and persons were nested within couples, who were randomly assigned to one of two groups (i.e., treatment or waitlist control). HLM easily accommodates this nested data structure and accounts for inter-dependence of couple data in which partners' data are often highly correlated.

Multi-level modeling in HLM operates as follows. First, a level-1 regression model uses each individual's repeated measures data to estimate his/her trajectory over time, fit with an intercept and slope. The intercept estimates the individual's initial level

of depression and marital satisfaction when he or she entered the study, and the slope estimates his/her linear change over time. The slopes and intercepts estimated for each subject in the level-1 model then serve as outcome variables in the higher level models. In the present study, we used either a two-level or three-level model to analyze couple data depending on the degree to which there were dependencies in the couple data. Specifically, for outcome variables where couple data was not found to be significantly correlated, we used a two-level multivariate model to represent husbands' and wives' trajectories separately. In these models, repeated measures and individuals (either husbands or wives) served as the two levels, with group assignment (treatment vs. waitlist control group) as the level-2 predictor. For outcome variables where wives' and husbands' data were found to be significantly correlated, we used a three-level model to estimate couples' trajectories, with repeated measures, persons, and couples as the three levels. In these models, gender was the level-2 predictor and treatment vs. waitlist group was the level-3 predictor, allowing for the examination of the fixed effects of gender and treatment on outcome variables, as well as the gender-by-group interaction.

To determine whether the couple data was indeed inter-dependent, we examined correlations between husbands' and wives' mean scores on the BDI, DAS, SCL, IRBAS, and DSS at each time point. As would be expected given a sample of depressed women and non-depressed men, we did not find dependencies in husbands and wives' data on the depression and general symptomatology measures (the BDI and SCL, respectively). That is, husbands' and wives' mean BDI and SCL scores at each time point were not significantly correlated (for the BDI, $r = 0.18, 0.18, \text{ and } 0.37$ at pre, post, and follow-up, respectively, all *ns*; for the SCL, $r = 0.27, 0.06, \text{ and } 0.28$ at pre, post, and follow-up,

respectively, all *ns*). Thus, husbands' and wives' data on the BDI and SCL were represented separately with two-level HLM models. In contrast, couple data on measures of marital satisfaction, illness-specific attitudes and behaviors, and dimensions of spousal support (the DAS, IRBAS, and DAS, respectively) were found to be inter-dependent. That is, husbands' and wives' mean DAS scores were significantly correlated at every time point ($r = 0.64, 0.56, \text{ and } 0.77$ at pre, post, and follow-up, respectively; all significant at the $p < .01$ level). Similarly, husbands' and wives' mean DSS scores were significantly correlated at every time point ($r = 0.46, 0.58, \text{ and } 0.63$ at pre, post, and follow-up, respectively; all significant at the $p < .01$ level). Finally, husbands' and wives' mean IRBAS scores were significantly correlated at post ($r = 0.57, p < .01$) and at follow-up ($r = 0.48, p < .05$), but not at pre ($r = 0.30, p = .09$). This indicates that while husbands' and wives' illness-related attitudes and behaviors slightly differed at baseline, their attitudes and behaviors were mutually converging at post and follow-up. Given the dependencies between partners' scores on the DAS, IRBAS, and DSS, couple data on these measures were represented with a three-level model.

To test for significant effects of our treatment, we examined whether the slopes of couples' or individuals' trajectories differed between those who received treatment versus waitlist controls. In the three-level models, we further tested whether change occurred differently for husbands and wives across the two groups by comparing the slopes of their trajectories. In addition to these hypotheses, we compared the trajectories of couples who received treatment from the principal investigator of the project versus from all other therapists in the study. These analyses aimed to explore whether the desired treatment outcomes could be achieved uniformly by all therapists irregardless of their specific

expertise in the areas of couples therapy and/or depression treatment (as the principal investigator was the most knowledgeable and experienced with our treatment). For all HLM analyses presented below, we calculated effect sizes as well. Given the general lack of consensus regarding how effect sizes should be computed in multilevel models, we followed the approach used by Davila, Karney, Hall, and Bradbury (2003) in which they reported effect sizes based on a formula that converts t -values to Pearson r values: $r = \sqrt{t^2 / (t^2 + df)}$. We then converted the Pearson r values into Cohen's d statistics.

Depression. We examined the impact of our treatment on both partners' BDI scores and on women's HAM-D scores using HLM2 models, as described previously. Table 2 presents the means and standard deviations for HAM-D and BDI scores for wives and husbands in the treatment and waitlist control group. As would be expected in a randomized study, there was no effect of group assignment on husbands' or wives' intercepts. That is, men and women assigned to the treatment group did not significantly differ on initial levels of depression from those in the waitlist control group.

Analysis of wives' HAM-D and BDI scores across both groups demonstrated a non-significant overall slope for the trajectories of the HAM-D ($\beta = -0.021$, $SE = 0.111$, $t(88) = -0.193$, ns) and the BDI ($\beta = -0.131$, $SE = 0.134$, $t(85) = -0.980$, ns). Thus, considering all women in the study irrespective of group assignment, there was very little change detected in HAM-D and BDI scores over time, as would be expected. There was, however, a significant effect of therapy on the slope of the HAM-D, $\beta = -0.469$, $SE = 0.136$, $t(88) = -3.441$, $p < .001$, as well as on the slope of the BDI, $\beta = -0.410$, $SE = 0.164$, $t(85) = -2.506$, $p < .01$. [For all analyses, the treatment group was coded as 1 and waitlist control group as 0; thus, these beta coefficients represent the deviation of the

therapy group's slope from the overall slope.] Compared to women in the waitlist group, women who received treatment showed significantly greater reductions in depression levels at an average rate of 0.49 HAM-D points per week and 0.54 BDI points per week, which computes into average total reductions of 11.83 points on the HAM-D and 13.04 points on the BDI across the mean 24.15-week duration of follow-up in the study. Figures 2 and 3 plot the HAM-D and BDI trajectories, respectively, for women in each of the two groups, illustrating the beneficial effects of treatment on reducing women's depression. The effect size of this overall change from pre-treatment to 3-month follow-up for women in the therapy group was $d = .72$ on the HAM-D and $d = .54$ on the BDI. Among the women in the therapy group, we compared the trajectories of those who received treatment from the principal investigator of the project versus those who received treatment from all other therapists in the study. There was no significant effect of therapist on the slope of HAM-D scores, $\beta = -0.253$, $SE = 0.166$, $t(45) = -1.525$, *ns*, or on the slope of wives' BDI scores, $\beta = -0.228$, $SE = 0.178$, $t(45) = -1.289$, *ns*.

Analysis of husbands' BDI scores across both groups also revealed a non-significant overall slope for the trajectories ($\beta = 0.040$, $SE = 0.071$, $t(33) = 0.560$, *ns*). Thus, considering all men in the study irrespective of group assignment, there was very little change detected in BDI scores over time, as would be expected. There was, however, a significant effect of therapy on the slope of the BDI, $\beta = -0.220$, $SE = 0.090$, $t(33) = -2.447$, $p < .02$. Compared to men in the waitlist group, men who received treatment showed significant reductions in depression levels at an average rate of 0.18 BDI points per week, i.e., an overall average reduction of 4.35 points on the BDI across the duration of the study ($M = 24.15$ weeks follow-up). The trajectories of husbands' BDI

slopes for each of the two groups are illustrated in Figure 3. The effect size of this overall change from pre-treatment to 3-month follow-up for men in the therapy group was $d = .85$. Among the men who received treatment, there was no significant effect of therapist on the slope of BDI scores, $\beta = -0.077$, $SE = 0.125$, $t(16) = -0.617$, *ns*.

Next, we examined the clinical significance of wives' depression outcomes by treatment condition (we did not compute clinical significance statistics on husbands' depression outcomes given that men were generally non-depressed and reported relatively much lower BDI scores). We defined two categories of clinical significance: (1) improved (defined as a 50% reduction in HAM-D or BDI scores from pre-to-follow-up) and (2) recovered (defined by standard conventions as HAM-D scores below 6 and BDI scores below 9 at follow-up; Pilkonis, Heape, Ruddy, and Serrao, 1991). Table 3 provides these data on the HAM-D and BDI. In the treatment group, 67% of women showed improvement on the HAM-D and 47% showed recovery, compared to only 17% of women who improved and 8% who recovered in the waitlist control group. This represents a significant difference in clinical outcome between the two groups for both improvement, $\chi^2(3, N = 27) = 6.75$, $p < .01$, and recovery, $\chi^2(3, N = 27) = 4.70$, $p < .05$. Similarly, on the BDI, 67% of women in treatment were improved and 27% were recovered by follow-up, whereas only 20% of women in the comparison group improved and 8% recovered. This represents a significant group difference in rates of improvement on the BDI, $\chi^2(3, N = 27) = 4.64$, $p < .05$, while rates of recovery did not significantly differ between groups, $\chi^2(3, N = 27) = 1.49$, $p = .22$.

Recovery from major depression. In addition to the HLM analyses presented above, we also examined data from the LIFE interview to assess the course of women's

depression from post-treatment to 3-month follow-up ($M = 15.64$ weeks, $SD = 3.23$). Specifically, we compared the two groups on rates of recovery from a major depressive episode, defined as a minimum of 8 consecutive weeks with minimal or no symptoms. Data was analyzed for 25 of the 27 women who completed their follow-up and whose primary diagnosis was MDD. Seven (50%) of the 14 women in the therapy group showed full recovery from their major depressive disorder by follow-up, in comparison to none of the women in the waitlist control group ($N = 11$). This represents a significant difference in recovery outcome between groups, $\chi^2(1, N = 25) = 7.64, p < .01$. We also compared the two groups on women's mean PSR rating for major depression across all weeks of follow-up. Women in the treatment group showed significantly lower PSR ratings on average ($M = 3.12, SD = 1.09$) than women in the waitlist group ($M = 4.15, SD = 0.78$), $t(23) = 2.65, p < .01$.

Marital satisfaction. We examined the impact of our treatment on couple DAS scores using a three-level HLM model. Table 4 presents the means and standard deviations for DAS scores for wives and husbands in the treatment and waitlist control group. There was no effect of group assignment on the intercept of DAS scores, indicating that couples assigned to the treatment and waitlist control groups did not significantly differ on initial levels of marital satisfaction. There was an expected significant gender difference on the intercept, $\beta = -9.110, SE = 3.632, t(33) = -2.508, p < .02$, with women reporting significantly lower marital satisfaction scores than husbands at baseline, by a mean difference of 9.11 DAS points.

Analysis of the slope of DAS scores revealed an overall significant downward trend in couples' marital satisfaction, $\beta = -0.317, SE = 0.158, t(170) = -2.011, p < .05$,

with couples' levels of marital satisfaction falling an average of 0.32 DAS points per week (i.e., an overall reduction of 7.68 DAS points over the 24-week duration of the study). This overall trend, however, was significantly effected by group assignment and in the opposite direction for couples in treatment, $\beta = 0.546$, $SE = 0.193$, $t(170) = 2.829$, $p < .01$, with treatment couples showing significantly greater improvements in their marital satisfaction than waitlist control couples by a rate of 0.229 DAS points per week (i.e., 0.546 points above the overall slope of -0.317). Figure 4 illustrates couple DAS trajectories for each of the two groups over time, illustrating the beneficial effects of treatment on improving couples' marital satisfaction. Across the course of the study, couples who received the brief therapy improved in marital satisfaction on average by a total of 5.55 DAS points. The effect size of this change from pretreatment to follow-up was $d = .43$ for couples who received treatment. There was no significant effect of therapist (i.e., principal investigator versus other therapists) on the slope of treatment couples' DAS scores, $\beta = -0.058$, $SE = 0.202$, $t(90) = -0.289$, *ns*.

For gender main effects, we observed a noticeable though non-significant outcome of gender on the slope, $\beta = 0.295$, $SE = 0.220$, $t(170) = 1.342$, $p = 0.152$ (in the three-level HLM analyses, men were coded as 0 and women as 1; thus, this beta coefficient represents the deviation of women from the overall slope, i.e., 0.295 points above the overall slope for men). This suggests an overall trend for wives' marital satisfaction to increase more than husbands' at a rate of 0.30 DAS points per week (5.1 total DAS points over the course of the study); however, this trend did not reach statistical significance. Moreover, in contrast to our expectations, the gender-by-group interaction was not significant, $\beta = -0.193$, $SE = 0.269$, $t(170) = -0.716$, *ns*. Thus, gender

did not significantly moderate the effects of treatment on men's and women's DAS scores (i.e., couples in treatment were generally improving on the DAS but not differentially by gender).

As we did with the BDI, we examined the clinical significance of marital satisfaction outcomes using wives' and husbands' DAS scores by treatment condition. We used the following three categories of clinical significance: deteriorated (a decrease of approximately one standard deviation—i.e., 15 DAS points—from pre to follow-up), unchanged (no reliable change in either direction), and improved (an increase of about one standard deviation—i.e., 15 DAS points—from pre to follow-up). Table 5 provides these data. In the therapy group, 60% of wives and 27% of husbands showed clinically significant improvement in marital satisfaction, compared to 0% of women and men in the waitlist control group. This represents a significant group difference in outcome for both women, $\chi^2(2, N = 27) = 11.81, p < .01$, and men, $\chi^2(2, N = 27) = 6.95, p < .05$.

Global symptomatology. As described previously, we used an HLM2 model to examine the impact of treatment on husbands' and wives' SCL-90 scores. Table 6 presents the means and standard deviations for SCL-90 scores for wives and husbands in the treatment and waitlist control group. We again found no effect of group assignment on initial levels of both partners' global symptomatology. Analysis of SCL-90 scores revealed a non-significant overall slope for the trajectories of both husbands ($\beta = 0.306, SE = 0.400, t(33) = 0.766, ns$) and wives ($\beta = -0.494, SE = 0.559, t(84) = -0.883, ns$). Thus, irrespective of group assignment, there was a non-significant trend for men's negative symptoms to increase over time, while women's global symptomatology decreased over time. We observed a non-significant effect of therapy on the slope of

husbands' SCL-90, $\beta = -0.436$, $SE = 0.523$, $t(33) = -0.834$, *ns*. Although a non-significant trend, compared to men in the waitlist group, men who received treatment experienced an overall decrease in their global symptom levels at a rate of 0.13 SCL points per week. For wives, we observed an effect of therapy on the SCL-90 slope that approached significance, $\beta = -1.076$, $SE = 0.682$, $t(84) = -1.577$, $p = 0.098$, and would likely have reached a significant level if the sample of women were slightly larger. Although this trend was non-significant, it demonstrates a considerable difference between groups in the magnitude of change in women's global symptomatology over time, with women in the treatment group demonstrating a decrease in negative symptoms compared to women in the control group at an average rate of 1.57 SCL-90 points per week (this equates to an overall reduction of 37.92 points on the SCL-90 over the course of the study). Given the lack of statistically significant findings for the impact of treatment on SCL-90 scores, we did not consider differential therapist effects on this outcome.

Depression-related spousal distress. We used a two-level model to explore the impact of treatment on husbands' levels of distress and burden related to their wives' depression using their scores on the FDSO. Means and standard deviations of husbands' FDSO scores are presented in Table 6. As expected, there was no effect of group assignment on husbands' intercepts (i.e., husbands in each group did not differ on initial levels of distress and burden). Looking at the overall model, we find that the slope of the FDSO trajectory is non-significant and nearly flat over time, $\beta = 0.008$, $SE = 0.141$, $t(33) = 0.058$, *ns*. There was a significant therapy effect, $\beta = -0.416$, $SE = 0.180$, $t(33) = -2.311$, $p < .05$, with husbands in treatment showing a significant decrease in distress and burden levels over time compared to husbands in the control group. The rate of this decrease

over time was 0.41 FDSO points per week, an average reduction on the FDSO of nearly 10 points by the end of the study. The effect size of this overall change from pre-treatment to 3-month follow-up for husbands in the therapy group was $d = .80$. There was no significant effect of therapist on the slope of FDSO scores, $\beta = -0.149$, $SE = 0.227$, $t(16) = -0.658$, *ns*.

Illness-related behaviors and attitudes. We examined the impact of our treatment on couple IRBAS scores using a three-level HLM model to account for inter-dependence of couple data. Table 7 presents the means and standard deviations for IRBAS scores for wives and husbands in the treatment and waitlist control group. There was no effect of group assignment on the intercept of IRBAS scores, indicating that couples assigned to the treatment and waitlist control groups did not significantly differ in their behaviors and attitudes towards depression at baseline. There was a significant gender difference on the intercept, $\beta = -3.826$, $SE = 1.964$, $t(33) = -1.949$, $p = .059$, surprisingly with women reporting slightly more negative behaviors and attitudes towards depression than husbands at baseline, by a mean difference of 3.83 IRBAS points.

Analysis of the slope of IRBAS scores revealed an overall nearly flat trajectory in couples' illness-related behaviors and attitudes, $\beta = -0.018$, $SE = 0.087$, $t(168) = -0.210$, *ns*. There was, however, a significant main effect of therapy on the slope, $\beta = 0.269$, $SE = 0.106$, $t(168) = 2.544$, $p < .01$, with treatment couples showing increased understanding and more positive behaviors/attitudes towards depression over time than waitlist control couples by a rate of 0.251 IRBAS points per week (i.e., 6 total points over the course of the study). Figure 5 illustrates the slope of IRBAS trajectories for husbands and wives in the therapy and waitlist control groups. The effect size of this change from pretreatment

to follow-up was $d = .39$ for couples who received treatment. There was no significant effect of therapist assignment on the slope of couples' IRBAS scores, $\beta = 0.110$, $SE = 0.138$, $t(90) = 0.799$, *ns*. Similarly, there was no significant main effect of gender on the slope of IRBAS scores, $\beta = -0.025$, $SE = 0.123$, $t(168) = -0.206$, *ns*, and the gender-by-group interaction was not significant as well, $\beta = 0.092$, $SE = 0.150$, $t(168) = 0.612$, *ns*. Thus, while couples in treatment were overall improving their behaviors and attitudes towards depression, there was neither differential change between wives and husbands overall or by group.

Dimensions of spousal support. We examined the impact of our treatment on couple DSS scores using a three-level HLM model to account for inter-dependence of couple data. Table 8 presents the means and standard deviations for DSS scores for wives and husbands in the treatment and waitlist control group. There was no effect of group assignment or gender on the intercept of DSS scores, indicating that men and women assigned to the treatment and waitlist control groups did not significantly differ in their baseline levels of global spousal support. Analysis of the slope of DSS scores revealed an overall non-significant, slightly upward trajectory in global dimensions of spousal support, $\beta = 0.027$, $SE = 0.100$, $t(33) = 0.272$, *ns*. We observed a noticeable though non-significant effect of treatment on the slope, $\beta = 0.184$, $SE = 0.125$, $t(33) = 1.466$, $p = 0.15$. This suggests an overall trend for couples in treatment to report greater increases in positive spousal support than waitlist control couples. There was no significant main effect for gender on the DSS slope, $\beta = -0.058$, $SE = 0.120$, $t(168) = -0.487$, *ns*.

Perceived negativity. A major target of our treatment was husbands' negativity towards their wives' depression. We used a two-level HLM model to examine the impact

of treatment on wives' perceptions of negativity from their husbands using their PNSB scores. Means and standard deviations of wives' PNSB scores are presented in Table 9. Initial levels of partner negativity did not differ between groups. Across time, the slope of the trajectory of the PNSB was nearly significant, $\beta = 0.180$, $SE = 0.091$, $t(20) = 1.977$, $p = .06$, with wives reporting an overall steady increase in husbands' levels of negativity at a rate of 0.18 points per week. This overall trend, however, was significantly effected by group assignment and in the opposite direction for women in treatment, $\beta = -0.321$, $SE = 0.114$, $t(20) = -2.812$, $p < .01$. Wives in the therapy group reported a significant decline in their husbands' negativity at the rate of 0.14 PNSB points per week. The effect size of this change from pre-treatment to follow-up was very large, $d = 1.25$. Treatment effects did not differ across therapists, $\beta = 0.106$, $SE = 0.142$, $t(10) = 0.746$, *ns*.

Self-esteem support. In order to examine changes in wives' perceptions of their husbands' self-esteem support, we analyzed scores on the SESS using a two-level HLM model as well. Means and standard deviations of wives' SESS scores are presented in Table 9. Again, wives' reports of initial levels of self-esteem support did not differ between groups. Similar to the findings on the PNSB, there was an overall significant slope of the SESS trajectory, $\beta = -0.422$, $SE = 0.185$, $t(20) = -2.283$, $p < .05$, with wives reporting a steady decline in the level of self-esteem support from their husbands at a rate of 0.42 points per week. However, when we considered the effect of therapy on the slope, this trend was significantly reversed in the treatment group, $\beta = 0.596$, $SE = 0.232$, $t(20) = 2.568$, $p < .01$. Wives in the therapy group reported significant increases in self-esteem support from their husbands at a rate of 0.17 SESS points per week. The effect size of

this change from pre-treatment to follow-up was also very large, $d = 1.15$. Treatment effects did not differ across therapists, $\beta = -0.126$, $SE = 0.235$, $t(10) = -0.536$, *ns*.

Mediating Mechanisms of Treatment Outcomes

To test the hypothesized mediations, we conducted a series of regressions for the two primary dependent variables, depressive symptomatology and marital satisfaction (BDI and DAS scores, respectively). Specifically, we examined the following variables as hypothesized mediators of reductions in depression and increases in marital satisfaction: (1) both partners' illness-related behaviors and attitudes (IRBAS scores); (2) both partners' reports of global dimensions of spousal support (DSS scores); (3) wives' perceived negativity from their husbands (PNSB scores); and (4) wives' reports of self-esteem support provided by their husbands (SESS scores). Extending Baron and Kenny's (1986) criteria for mediation to the present randomized intervention study, we tested the following conditions in order for mediation to be supported:

- (1) Participants in the treatment condition show significantly greater change on the outcome over time than controls (therapy predicts change in the follow-up; Path c in Figure 1).
- (2) Participants in the treatment condition show significantly greater change on the mediator than controls (therapy predicts change in the mediator at post; Path a).
- (3) Change in the mediator over time is significantly correlated with change in the outcome at follow-up (Path b, in the context of Path c).
- (4) The predictive effect of treatment condition on change in the follow-up outcome, controlling for change in the mediator (Path c'), is significantly

reduced (partial mediation) or eliminated (complete mediation) relative to when the outcome is regressed only on treatment condition (Path c).

In addition to the above criteria, it has been noted that in order to establish mediation in randomized trials, it is vital to document that change in the mediator precedes change in the outcome (Kraemer, Stice, Kazdin, Offord, & Kupfer, 2001). Accordingly, we used post (time 2) variables for all mediators and follow-up (time 3) variables for all outcomes in order to ensure the proper temporal sequencing for mediation.

Criterion 1. Linear regression supported the HLM findings above that our brief couples therapy (BCT) predicted change in follow-up outcomes on depression and marital satisfaction. Wives in treatment showed significantly greater reductions in depression and increases in marital satisfaction than waitlist controls (Table 10), and husbands showed similar outcomes at follow-up (Table 11).

Criterion 2. To determine whether treatment predicted change in mediators at post (Path a), we ran a series of regressions with group assignment as the independent variable and each mediator as the dependent variable. Analyses revealed significant effects of treatment on all mediators except for husbands' reports of global support from their wives (Tables 10 and 11). Compared to waitlist controls, both wives and husbands in treatment showed significantly more positive illness-related behaviors and attitudes at post, and wives reported more positive global support from their husbands. Wives in treatment also reported significantly greater reductions in husbands' negativity toward their depression and increases in self-esteem support from their husbands (Table 11).

Criterion 3. To determine whether change in the mediator at post significantly correlated with change in the follow-up outcome (Path b), we ran a series of regressions

with each mediator as the independent variable predicting depression and marital satisfaction as the dependent variables. Consistent with Baron and Kenny's (1986) criteria for mediation, we also included group assignment as an independent variable in these regressions in order to see if the mediator→outcome effect was robust (i.e., significant when controlling for the treatment→outcome effect, Path c). Reductions in wives' depression and increases in their marital satisfaction at follow-up were significantly predicted by post-treatment changes in their own and their husbands' depression-related behaviors and attitudes, as well as by wives' reports of increased positive, global support from their husbands (Table 10). Moreover, changes in wives marital satisfaction but not their depression was significantly predicted by reduced negativity and increased self-esteem support from their husbands (Table 10). For husbands in treatment, none of the mediators significantly predicted reductions in their depression at follow-up. Increases in husbands' marital satisfaction were significantly predicted by post-treatment changes in their own depression-related behaviors and attitudes, as well as by wives' reports of increased positive, global support from husbands (Table 11).

Criterion 4. To assess whether the predictive effects of treatment on change in the outcome (Path c) were significantly reduced when change in the mediator was statistically partialled (Path c'), we used Sobel's test to measure the strength of the mediated Path c', or the significance of the mediation effect. As shown in Table 10, the significant unmediated effect of treatment on wives' depression (path c; $\beta = -0.42$) was reduced and became non-significant when change in the following mediators was statistically controlled: wives' IRBAS (path c'; $\beta = -0.24$), husbands' IRBAS (path c';

$\beta = -0.27$), and wives' DSS (path c' ; $\beta = -0.32$). Calculation of Sobel's test revealed that the mediation effect nearly reached statistical significance in the case of wives' IRBAS ($Z = 1.86, p = .06$), but was non-significant for husbands' IRBAS ($Z = 1.43, p = .15$) and wives' DSS ($Z = 1.41, p = .16$). That is, reductions in wives' depression were significantly mediated by increased understanding and positive changes in wives' own behaviors and attitudes towards their depression.

Similarly, for wives' marital satisfaction outcomes (Table 10), the significant unmediated treatment effect (path c ; $\beta = 0.37$) was reduced and became non-significant when change in the following mediators was statistically controlled: wives' IRBAS (path c' ; $\beta = 0.22$), husbands' IRBAS (path c' ; $\beta = 0.22$), wives' DSS (path c' ; $\beta = 0.13$), wives' PNSB (path c' ; $\beta = 0.01$), and wives' SESS (path c' ; $\beta = 0.19$). Calculation of Sobel's test revealed significant mediation effects for wives' DSS ($Z = 1.89, p = .05$) and wives' PNSB ($Z = 2.36, p = .02$), as well as a nearly significant mediation effect for wives' IRBAS ($Z = 1.79, p = .07$). That is, increases in wives' marital satisfaction were significantly mediated by increases in husbands' positive global support and reductions in husbands' negativity toward depression.

For mediating effects of husbands' marital satisfaction outcomes, the significant unmediated treatment effect (path c ; $\beta = 0.38$) was reduced and became non-significant when change in the following mediators was statistically controlled: husbands' IRBAS (path c' ; $\beta = 0.20$) and wives' DSS (path c' ; $\beta = 0.08$) (Table 11). Calculation of Sobel's test revealed a significant mediation effect for wives' DSS ($Z = 1.90, p = .05$), but was non-significant for husbands' IRBAS ($Z = 1.42, p = .15$). That is, increases in husbands' marital satisfaction was significantly mediated by wives' reports of increased positive

global support from their husbands. There is also suggestive evidence that husband's improved marital satisfaction was partially mediated by increased understanding of depression and positive changes in their own attitudes and behaviors, which may reflect the importance of fostering more accepting attitudes in the non-depressed partner as a path to healthier marital functioning.

Discussion

A large body of research shows that depression in one partner, particularly depression of a recurrent nature, is associated with negative outcomes in both partners and the relationship. More specifically, it can lead to heightened psychological distress, increased negativity and reduced support from the non-depressed partner, which, in turn, can diminish partners' marital satisfaction and further exacerbate the depressed partners' depressive symptoms. With these negative sequelae of depression, we set out to develop a brief therapy aimed at improving couples' understanding of depression as an illness. Specifically, our intent was to reduce negative behaviors and attitudes towards depression and to increase gestures of positive support toward the depressed partner. In addition, we wanted to help the non-depressed partner learn ways of living and coping with their wives' depression. It was hypothesized that targeting such individual and dyadic factors in a brief therapy would have beneficial effects on the two primary treatment outcomes, depression and marital satisfaction. The results generally supported these hypotheses.

We observed significant effects of brief couples therapy on reducing depression and improving marital satisfaction in both husbands and wives. Our brief therapy also

produced significant change in specific targets of the treatment, i.e., depression-related behaviors and attitudes, partner negativity toward depression, various support dimensions, and husbands' levels of distress and burden resulting from their wives' depression. Mediation analyses further elucidated the mechanisms by which intervening with spouses can positively influence one partner's depression and mutual relationship satisfaction, thereby providing further support for Coynes' interpersonal theory and social support models that emphasize the important role of spouses' negative attitudes and support provision in affecting their partner's depression. We further elaborate on these findings below.

Our first hypothesis addressed the impact of brief couples therapy on depression outcomes first and foremost in wives, as their illness was the primary target of treatment. However, we also hypothesized that secondary to reductions in wives' depression, husbands would also experience mild reductions in their own depressive symptoms. Both hypotheses were supported. Compared to women in the waitlist control condition, we found a significant effect of therapy on change in wives' depression over time, with average total reductions of nearly 12 points on the HAMD and 13 points on the BDI after 6 months. The corresponding effect sizes of these depression reductions were in the medium-to-large range (.54 for the BDI and .72 for the HAMD), and significantly larger than outcomes typically found for other brief or longer interventions for depressed patients. A recent meta-analysis (Westen & Morrison, 2001) of 12 studies testing the efficacy of manualized psychosocial therapies for depression with a randomized controlled design found a median effect size of $d = 0.3$ for pre-to-post change (medians were reported to avoid undue impact of outliers). Comparatively, the effect sizes found in

the present study for reductions in wives' depression represent particularly robust treatment outcomes, especially given the brief nature of our treatment.

Secondary to reductions in wives' depression, we found a statistically significant effect of therapy on change in husbands' depression over time, with an average total reduction of nearly 5 points on the BDI for husbands in treatment compared to waitlist controls. The effect size for this treatment change was large ($d = .85$), and surprisingly larger than the effect sizes found for wives' depression outcomes. However, given that the absolute magnitude of the change is greater for women, this is likely due to the small variability in men's depression scores. These findings for husbands' BDI reductions reflect the utility of a couples-based approach to treating depression in that the non-depressed spouse can clearly benefit from interventions that alleviate some of their own depressive symptoms as well.

We were also interested in whether our therapy could achieve outcomes of clinical significance, that is, demonstrate reliable improvement and/or recovery in women's depression at follow-up. We found that significantly more women showed improvement and recovery in the treatment group compared to the waitlist group. Two-thirds of women in treatment improved by at least a 50% reduction in their depression scores on both the HAMD and BDI, and nearly half of the women in treatment were recovered by follow-up. Data from the LIFE interview corroborated that 50% of women in treatment fully recovered from major depression, compared to no women who recovered in the control group.

Our rates of clinically significant change compare favorably with other data in the psychotherapy and pharmacotherapy literatures on improvement and recovery from

depression. In the meta-analysis described above, Westen and Morrison (2001) found improvement rates of 54% following treatment (generally defined across studies as a clinically meaningful reduction in mean levels of symptomatology). Similar rates have been observed in the pharmacotherapy literature. The Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial, the most recent authoritative work on response and remission rates with antidepressant medication, found that 50% of patients with major depression had a response (i.e., 50% improvement) in 12-16 weeks with adequate doses of an antidepressant, and 33% had a remission of their depressive episode. Thus, findings from the present study are comparable to overall findings from other psychotherapy and medication studies indicating that roughly half of patients who complete these treatments will benefit significantly from them. Moreover, as observed in ours and other studies, patients who improve may still maintain a mild level of symptoms after treatment, and a sizeable number of patients will continue to be highly symptomatic.

Our second hypothesis explored the impact of our brief couples therapy on marital satisfaction. We found a statistically significant effect for treatment on couples' improved relationship satisfaction, with couples in treatment showing an overall improvement of nearly 6 points on the DAS, compared to waitlist control couples whose overall levels of marital satisfaction significantly decreased by nearly 8 DAS points over the duration of the study. Thus, for couples living with depression, there is a trend for marital satisfaction to lessen over time; however, with intervention, we were able to reverse this trend and affect a significant positive change in both partners' marital adjustment. The effect size of the improvement in marital satisfaction in this study ($d = .43$) was slightly lower than other studies of marital therapy. For example, the largest and most recent meta-analysis

of couple therapy (Shadish & Baldwin, 2005) found an overall effect size of $d = .585$ for 30 randomized studies comparing cognitive-behavioral marital therapy with no-treatment control. The slightly lower effect size in our study may reflect a difference in the initial levels of distress reported by couples in our sample compared to those in the studies reviewed. In general, our study had less severe cases with overall higher DAS scores at baseline, creating a smaller range for improvement on the DAS. Moreover, evidence from their meta-analysis also suggested that publication bias may exist in the literature whereby small sample studies with small effects are missing compared to other studies. The effect size found in the present study is comparable to those found in more recent studies of marital therapy. As reported by Shadish and Baldwin (2005), all seven studies published since 1990 had a trend toward having lower effect sizes on average ($d = .43$) compared to those published prior to 1990 ($d = .76$).

We did not find evidence for a statistically significant main effect of gender on DAS outcome or for a gender-by-group interaction. However, we did observe a trend for wives' marital satisfaction to increase more than husbands' by five total DAS points over the course of the study ($p = 0.15$), and perhaps given a larger sample of couples, this trend may have reached statistical significance. Moreover, although the interaction effect was non-significant, descriptive data also suggests a trend for wives in treatment to report more improved marital satisfaction than husbands in treatment (i.e., wives in treatment demonstrated a mean increase of 8 DAS points from pre to follow-up, compared to a mean increase of 3 DAS points for husbands). We would expect such a trend given that husbands generally reported higher levels of marital satisfaction at baseline and therefore had a smaller margin for improvement on the DAS than wives. Similar to the depression

outcomes, the treatment effects on marital satisfaction were clinically meaningful. Among the couples in treatment, 60% of wives and 27% of husbands showed clinically significant improvement on the DAS (i.e., an increase of at least one standard deviation, or 15 DAS points), compared to 0% in the waitlist control group. The rates of clinically significant change observed in the present study compare favorably with other data. In their review of several studies on behavioral marital therapy, Jacobson et al. (1984) found that nearly 55% of couples showed reliable improvement in marital satisfaction, and Shadish et al. (1993) obtained a similar percentage of recovery in their meta-analysis of 27 studies of couples therapies. Of note, we observed lower rates of clinical improvement on the DAS among husbands in the present study. However, across each time point, husbands were generally more satisfied in their marriages than wives, and therefore the margin was lower for clinically significant change on the DAS.

In addition to the impact of our brief couples therapy on the two principal outcomes, depression and marital satisfaction, we found statistically significant treatment effects on wives' global symptomatology, husbands' levels of distress and burden, illness-related behaviors and attitudes, dimensions of global support, and wives' perceptions of negativity and self-esteem support from their husbands. More specifically, wives in treatment demonstrated a substantial decrease in global, negative symptoms (i.e., nearly 38 points on the SCL-90 over the course of the study) compared to women in the control group. Similarly, husbands in treatment showed a significant decrease in their levels of distress and burden associated with their wives' depression as compared to husbands in the control group. This lessening of the negative impact of depression on husbands was one of the larger treatment effects in the study ($d = .80$). Treatment couples

also showed significantly increased levels of understanding and more positive behaviors/attitudes towards depression over time than waitlist control couples, with a small effect size of this change from pretreatment to follow-up ($d = .39$) for couples who received treatment. Finally, we found the biggest treatment effects for the two major targets of our treatment—reductions in wives’ perceived negativity from their husbands ($d = 1.25$) and increases in wives’ experience of self-esteem support from their husbands ($d = 1.15$). These findings reflect very large effect sizes and bolster the importance of targeting negative interactions and partner support, specifically support aimed at validating and affirming the depressed partner’s worth and self-esteem.

The present study aimed not only to test the efficacy of a brief couples therapy for depression, but also to understand the underlying mechanisms by which a brief, problem-focused couples intervention can affect change in individual depression and relationship outcomes. More specifically, we examined whether pre-to-post changes in four variables—illness-related behaviors and attitudes, global dimensions of spousal support, husband negativity and self-esteem support toward wives—mediated follow-up depression and marital satisfaction outcomes in both partners. For wives’ depression outcomes, we found evidence for one significant mediator—changes in their own behaviors and attitudes towards depression. That is, post-treatment improvements in wives’ understanding of and positivity towards their own depression significantly mediated reductions in their BDI scores at follow-up. This finding highlights the importance of helping depressed patients to suspend self-judgment about having a mental disorder and overcome their own stigmatizations about depression. We also found suggestive evidence for partial mediation of wives’ depression outcomes by positive

changes in husbands' behaviors and attitudes towards depression, in addition to wives' perceptions of increased global, positive support from their husbands, although these mediations did not reach statistical significance ($p = .15$ and $.16$, respectively). These mediation findings highlight the role of illness-related behaviors and attitudes as targets for reducing wives' depression, and seem to reflect the unique benefits of the psychoeducation component in a brief, problem-focused therapy. That is, educating both partners about depression as a treatable and often biologically caused illness, and challenging their misconceptions about depression, is an important mechanism in helping depressed individuals to feel less stigmatized within themselves and by their partners, thereby beginning to feel more accepting and hopeful about getting well. Improvement in wives' marital satisfaction was significantly mediated by increases in positive global support from their husbands and reductions in husbands' negativity towards their depression. Furthermore, increases in wives' marital satisfaction was nearly significantly mediated by changes (i.e., increased and more positive understanding) in wives' behaviors and attitudes towards their own depression.

When examining hypothesized mediating mechanisms for husbands' outcomes, we found that increases in husbands' marital satisfaction was mediated by wives' reports of increased positive global support from husbands. There was evidence for partial and nearly significant mediation of husbands' marital satisfaction outcomes by positive changes in their own behaviors and attitudes towards depression. Finally, there were no significant mediators of husbands' depression outcomes, which likely reflect the overall low levels of their depressive symptoms and thus a limited range for detecting significant mediation effects. In sum, our analyses substantiated more of the mediating mechanisms

for relationship satisfaction outcomes than depression outcomes, as would be expected for husbands given that they were largely non-depressed and their depressive symptoms were not an identified target of treatment. For wives, reductions in husbands' negativity and increases in husbands' self-esteem support significantly mediated their marital satisfaction but not depression outcomes. This finding is likely explained by the couple modality of treatment and the inherent focus on dyadic issues at play between partners.

Strengths and Limitations

There are a number of noteworthy strengths of the present study. First and foremost, we were able to obtain many significant effects of the treatment with a relatively small sample. In addition, we were able to see clinically significant changes in women's depression and marital satisfaction outcomes. Moreover, the use of a randomized clinical trial design (with inclusion of a waitlist control group) allowed for empirical validation of the efficacy of the present therapy. The present study represents the first to utilize such a design when exploring the benefits of an intervention involving the spouses of depressed individuals. Finally, while the goal was to recruit almost twice the sample size in a year, we screened 217 couples for the present study, and from that number we were able to successfully recruit 35 couples and retain 27 of those couples until completion of the study (i.e., a 77% retention rate). This is considered to be a strong point of the present study given the obstacles we encountered in attempting to recruit a sample of depressed women and their partners. These challenges included not only finding enough eligible patients who met the inclusion criteria of the study, but whose significant others were also willing and motivated to participate in a clinical trial. In the

present study, this was especially difficult given the stigmatization and resistance to therapy that is common among men, and of the 217 couples screened for the study, approximately 25% discontinued the screening process because of husbands who were not interested or motivated to come in for treatment. Moreover, with the changes in healthcare provision, namely increasing insurance reimbursement for mental health services, many potentially eligible research participants are utilizing providers within their insurance networks, thereby reducing the need for and willingness to participate in free clinical trials.

Despite these strengths, the study has limitations. First, in spite of the major obstacles in recruiting the targeted sample for this study, as mentioned above, the sample size was rather small, which limits the power of statistical tests. We observed a few striking trends in the data (e.g., the effect of treatment on global dimensions of partner support), as well as a few hypothesized mediations that were near or approaching statistical significance, but did not reach the criterion level. A second limitation of the study is that we were unable to evaluate the success of treatment with a longer follow-up period (i.e., preferably 6 – 12 months), which would provide a more robust assessment of treatment gains. Third, our design included only three assessment points, which potentially limited the resolution of the data. Inclusion of more time points would have allowed for a more fine-grained, analysis of temporal changes following treatment, specifically when testing potential mediations. Unfortunately, balancing the resolution of data while minimizing the burden on participants is something researchers grapple with constantly. Finally, a key issue in evaluating psychotherapy research is the extent to which the findings may be generalized. The motivation of couples responding to media

advertisements offering free couples' therapy may differ from couples seeking therapy privately. Specifically, couples in the present study were not as distressed as couples typically presenting with more chronic and/or severe relationship issues, as we excluded couples based on low DAS scores, physical aggression, and/or recent infidelity. In such cases where the discord appears entrenched, the commitment to the relationship is in question, and domestic violence or a power imbalance is suspected within the couple, either individually focused treatments or standard, marital therapy are indicated. Moreover, the findings of this study may have limited generalizability to a more diverse or lower socioeconomic sample of couples, as the present sample was largely Caucasian and middle class. These limitations notwithstanding, this study contributes to the literature on couples therapy and depression in many significant ways that we address below.

Clinical Implications and Future Directions

Results of this study support the growing applicability of couples interventions in treating individual problems. This is particularly true in the case of depression where one partner's illness exists in a broader dyadic context that may also require intervention. As research has shown, the interpersonal nature of depression is one that often engenders conflict and negativity in close relationships, and maladjustment is common in marriages where one partner is depressed. A meta-analysis conducted by Whisman (2001) of 26 cross-sectional and longitudinal studies overwhelmingly supports a strong association exists between depression and marital dissatisfaction. Marital dissatisfaction has been shown to contribute to a depressive illness or become a barrier to recovery, which can

further maintain the erosion in the relationship. For example, in a large representative sample of couples ($N = 994$), dissatisfied spouses were nearly 3 times more likely than non-dissatisfied spouses to develop MDE during the year, and nearly 30% of the new occurrences of MDE were attributed to the marital dissatisfaction (Whisman & Bruce, 1999). Even for relatively well adjusted couples, the depression is likely to create specific burdens and distress as a result of the anhedonic and often hopelessness-engendering nature of the illness. Such ongoing burden has the potential to slowly erode both partners' individual and relationship functioning, thereby requiring intervention to prevent potentially devastating longer-term consequences. Thus, couples therapy for depressed women, especially for those who are maritally discordant, can be dually effective in alleviating the depression and targeting any dyadic issues or problems that are either caused by or maintaining one partner's depression.

Taken together, the present findings suggest that while individual therapy for depression can be effective in decreasing the depressive symptomatology, couples therapy is uniquely able to address any co-existing dyadic problems that are likely to be present in the relationship and would otherwise go unaddressed. Moreover, the results of the present study identify the mechanisms through which intervention is effective, namely in targeting problems of high negativity and lack of empathy and support. Finally, given the substantial reductions in depression and improvements in marital satisfaction observed after only 10 hours of treatment (all medium-to-large effect sizes), the present findings lend strong support for the viability of a brief, problem-focused therapy. Moreover, because of its brief nature, this treatment is likely to be more cost-

effective and reimbursable in clinic settings, more desirable to patients, and adaptable for delivery by physicians in psychiatric and general medical settings.

To elaborate, there are many settings and populations to which this brief couples therapy could be applied. Perhaps of greatest relevance is the need for brief psychological interventions for depression in general medical settings. Depression is one of the most common disorders, not just mental disorders, found in primary care (Katon, 1982), and depression is treated by primary care professionals as often, if not more, than by mental health specialists. According to data from the Epidemiological Catchment Area (ECA) project, only between 16% and 23% of those who meet diagnostic criteria for affective disorders seek treatment from a mental health professional (Regier et al., 1993; Shapiro et al., 1984). In comparison, nearly half of persons who are treated for an affective disorder are treated by primary care physicians (Narrow, Regier, Rae, Manderscheid, & Locke, 1993). These figures suggest that primary care settings have an important role to play in the detection, assessment, and treatment of depression.

Another logical extension of this study is to test the efficacy of our brief couples therapy for depression in a sample of depressed men. For reasons including the higher prevalence of depression among women and the higher rates of treatment seeking among women in comparison to men, we chose to focus the present study exclusively on the impact of treatment on depressed women. Given the challenges of recruiting a sample of depressed men, there is a relative paucity of data on the unique dyadic issues facing couples in which the male partner is depressed and how to treat such couples accordingly. Thus, development and evaluation of the proposed intervention with a sample of

depressed men and their wives, and the consideration of gender differences in treatment outcomes, are all worthwhile areas for future research.

In conclusion, the current study provides encouraging evidence that targeting illness-related attitudes and behaviors, negativity, empathy and support in a brief, couples therapy framework is an effective and efficient way to help depressed women and their partners. Not only did our brief couples therapy reduce rates of depression and improved marital satisfaction, but also reduced burden and distress in the non-depressed spouse, and increased overall levels of positive support. Finally, treatment outcomes on depression and marital satisfaction were mediated by changes in illness-related attitudes and behaviors, reduced negativity towards the depressed partner, and increased levels of global and self-esteem support.

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Tables

Table 1

Medication Status and Adherence for Women in Treatment versus Waitlist Control

	Treatment		Waitlist Control		
Medication Status	N	%	N	%	χ^2
Time 1					
Medication	9	50.0	9	52.9	0.03 (ns)
No Medication	9	50.0	8	47.1	
Time 2					
Medication	6	37.5	5	35.7	0.01 (ns)
No Medication	10	62.5	9	64.3	
Time 3					
Medication	6	40.0	5	41.7	0.01 (ns)
No Medication	9	60.0	7	58.3	
Adherence	N	%	N	%	χ^2
Time 1					
Adherent	6	85.7	4	50.0	2.68 (ns)
Non-adherent	1	14.3	4	50.0	
Time 2					
Adherent	6	100.0	3	60.0	2.93 (ns)
Non-adherent	0	0.0	2	40.0	
Time 3					
Adherent	6	100.0	4	80.0	1.32 (ns)
Non-adherent	0	0.0	1	20.0	

Table 2

Hamilton Rating Scale for Depression and Beck Depression Inventory Scores at Pre, Post, and Follow-up for Wives and Husbands in Treatment Compared to Waitlist Control

Measure	Pre-treatment		Post-treatment		3-Month Follow-up	
	M	SD	M	SD	M	SD
Hamilton Rating Scale for Depression						
Treatment	26.89	6.76	18.38	10.77	13.60	11.43
Waitlist Control	28.53	6.93	26.29	10.55	26.42	12.25
Beck Depression Inventory						
Wife						
Treatment	31.38	9.32	20.34	13.48	14.41	10.56
Waitlist Control	30.16	11.13	25.28	13.86	26.92	17.16
Husband						
Treatment	9.72	10.63	4.50	4.24	3.87	5.14
Waitlist Control	8.88	7.76	8.82	5.49	8.67	5.90

Table 3

Clinically Significant Outcome on the Hamilton Rating Scale for Depression and the Beck Depression Inventory for Wives in Treatment and Waitlist Control^a

	Improved	Recovered
Hamilton Depression Rating Scale		
Treatment	10 (67%) ^b	7 (47%) ^c
Waitlist Control	2 (17%)	1 (8%)
Beck Depression Inventory		
Treatment	10 (67%) ^d	4 (27%)
Waitlist Control	3 (20%)	1 (8%)

^a Rates based on study completers ($n = 15$ for treatment group; $n = 12$ for waitlist group).

^b Significant group difference in improvement, $\chi^2(1, N = 27) = 6.75, p < .01$.

^c Significant group difference in recovery, $\chi^2(1, N = 27) = 4.70, p < .05$.

^d Significant group difference in improvement, $\chi^2(1, N = 27) = 4.64, p < .05$.

Table 4

Dyadic Adjustment Scale Scores at Pre, Post, and Follow-up for Wives and Husbands in Treatment Compared to Waitlist Control

Measure	Pre-treatment		Post-treatment		3-Month Follow-up	
	M	SD	M	SD	M	SD
Dyadic Adjustment Scale						
Wife						
Treatment	96.55	17.44	100.57	20.52	104.33	19.01
Waitlist Control	90.25	18.37	91.87	23.54	92.94	19.77
Husband						
Treatment	105.74	18.99	110.74	19.86	108.96	16.65
Waitlist Control	98.98	17.93	101.43	14.00	95.06	18.78

Table 5

Clinically Significant Outcome on the Dyadic Adjustment Scale for Couples in Treatment versus Waitlist Control^a

	Deteriorated	Unchanged	Improved
Wife DAS ^b			
Treatment	0 (0%)	6 (40%)	9 (60%)
Waitlist Control	2 (17%)	10 (83%)	0 (0%)
Husband DAS ^c			
Treatment	0 (0%)	11 (73%)	4 (27%)
Waitlist Control	3 (25%)	9 (75%)	0 (0%)

^a Rates based on study completers ($n = 15$ for treatment group; $n = 12$ for waitlist group).

^b Significant difference for treatment vs. waitlist control, $\chi^2(2, N = 27) = 11.81, p < .01$.

^c Significant difference for treatment vs. waitlist control, $\chi^2(2, N = 27) = 6.95, p < .05$.

Table 6

Symptom Checklist-90 and Family Distress Scale for Depression Scores at Pre, Post, and Follow-up for Wives and Husbands in Treatment Compared to Waitlist Control

Measure	Pre-treatment		Post-treatment		3-Month Follow-up	
	M	SD	M	SD	M	SD
Symptom Checklist-90						
Wife						
Treatment	112.82	52.96	73.53	46.93	63.60	36.13
Waitlist Control	125.58	60.79	113.20	70.31	107.00	74.04
Husband						
Treatment	47.69	57.94	43.50	44.18	36.99	39.62
Waitlist Control	41.90	33.65	37.70	20.49	41.76	31.82
Family Distress Scale for Depression – (H)						
Treatment	52.28	15.27	49.91	16.15	42.20	12.87
Waitlist Control	49.74	13.47	50.91	13.06	48.86	15.26

Table 7

Illness-Related Behaviors and Attitudes Scale Scores at Pre, Post, and Follow-up for Wives and Husbands in Treatment Compared to Waitlist Control

Measure	Pre-treatment		Post-treatment		3-Month Follow-up	
	M	SD	M	SD	M	SD
Illness-Related Behaviors and Attitudes Scale						
Wife						
Treatment	31.61	8.37	42.00	7.13	40.40	9.12
Waitlist Control	31.30	8.79	35.45	7.97	33.83	10.84
Husband						
Treatment	34.11	6.34	40.44	4.57	40.80	5.53
Waitlist Control	34.69	5.10	39.06	5.08	35.66	3.89

Table 8

Dimensions of Spousal Support Scale Scores at Pre, Post, and Follow-up for Wives and Husbands in Treatment Compared to Waitlist Control

Measure	Pre-treatment		Post-treatment		3-Month Follow-up	
	M	SD	M	SD	M	SD
Dimensions of Spousal Support Scale ^a						
Wife						
Treatment	17.83	6.88	20.63	5.26	19.39	7.20
Waitlist Control	17.10	6.32	17.59	7.93	17.31	7.19
Husband						
Treatment	45.50	10.34	51.06	12.29	50.23	13.40
Waitlist Control	42.13	11.49	46.17	10.33	44.65	10.85

^a Discrepancies in wife and husband scores reflect different gender-versions of the DSS

Table 9

Perceived Negative Spousal Behaviors and Self-Esteem Support Scale Scores at Pre, Post, and Follow-up for Wives in Treatment Compared to Waitlist Control

Measure	Pre-treatment		Post-treatment		3-Month Follow-up	
	M	SD	M	SD	M	SD
Perceived Negative Spousal Behaviors Scale						
Treatment	18.60	6.13	16.08	5.74	14.44	5.64
Control	21.80	8.72	25.43	7.11	27.57	5.68
Self-Esteem Support Scale						
Treatment	51.77	14.88	55.58	15.32	57.83	16.26
Control	40.80	15.53	40.86	13.75	31.43	11.01

Table 10

Test of Hypothesized Mediators of Wives' Treatment Outcomes

Criteria	β	t	p
1. Effect of treatment (BCT) ^a on the outcome (Path c):			
BCT \rightarrow Δ BDI	-0.42	-2.33	.03
BCT \rightarrow Δ DAS	0.37	2.02	.05
2. Effect of treatment on the mediator (Path a):			
BCT \rightarrow Δ IRBAS (W)	0.41	2.24	.04
BCT \rightarrow Δ IRBAS (H)	0.37	1.98	.05
BCT \rightarrow Δ DSS (W)	0.38	2.03	.05
BCT \rightarrow Δ DSS (H) ^b	0.21	1.08	<i>ns</i>
BCT \rightarrow Δ PNSB	-0.61	-3.14	.01
BCT \rightarrow Δ SESS	0.45	2.09	.05
3. Effect of change in mediator on outcome (Path b):			
Δ IRBAS (W) \rightarrow Δ BDI	-0.55	-3.32	.01
Δ IRBAS (W) \rightarrow Δ DAS	0.51	2.88	.01
Δ IRBAS (H) \rightarrow Δ BDI	-0.40	-2.05	.05
Δ IRBAS (H) \rightarrow Δ DAS	0.43	2.16	.04
Δ DSS (W) \rightarrow Δ BDI	-0.38	-2.04	.05
Δ DSS (W) \rightarrow Δ DAS	0.77	6.02	.00
Δ PNSB \rightarrow Δ BDI	-0.06	-0.23	<i>ns</i>
Δ PNSB \rightarrow Δ DAS	-0.73	-3.38	.00

Δ SESS \rightarrow Δ BDI	-0.15	-0.62	<i>ns</i>
Δ SESS \rightarrow Δ DAS	0.56	2.65	.02

4. Effect of treatment on outcome controlling for

change in mediator (Path c'):

BCT \rightarrow Δ BDI / IRBAS (W) ^c	-0.24	-1.44	<i>ns</i>
BCT \rightarrow Δ BDI / IRBAS (H)	-0.27	-1.38	<i>ns</i>
BCT \rightarrow Δ BDI / DSS (W)	-0.32	-1.74	<i>ns</i>
BCT \rightarrow Δ BDI / PNSB	-0.54	-1.97	.07
BCT \rightarrow Δ BDI / SESS	-0.43	-1.80	.09
BCT \rightarrow Δ DAS / IRBAS (W)	0.22	1.22	<i>ns</i>
BCT \rightarrow Δ DAS / IRBAS (H)	0.22	1.09	<i>ns</i>
BCT \rightarrow Δ DAS / DSS (W)	0.13	0.98	<i>ns</i>
BCT \rightarrow Δ DAS / PNSB	0.01	0.01	<i>ns</i>
BCT \rightarrow Δ DAS / SESS	0.19	2.65	<i>ns</i>

^a BCT = Brief Couples Therapy for depression.

^b Due to the non-significant effect of treatment on the mediator DSS (H), we did not further examine criteria 3 and 4 for this mediating mechanism.

^c / = controlling for.

Table 11

Test of Hypothesized Mediators of Husbands' Treatment Outcomes

Criteria	β	t	p
1. Effect of treatment (BCT) ^a on the outcome (Path c):			
BCT → Δ BDI	-0.41	-2.26	.03
BCT → Δ DAS	0.38	2.04	.05
2. Effect of treatment on the mediator (Path a):			
BCT → Δ IRBAS (W)	0.41	2.24	.04
BCT → Δ IRBAS (H)	0.37	1.98	.05
BCT → Δ DSS (W)	0.38	2.03	.05
BCT → Δ DSS (H) ^b	0.21	1.08	<i>ns</i>
3. Effect of change in mediator on outcome (Path b):			
Δ IRBAS (W) → Δ BDI	-0.09	-0.46	<i>ns</i>
Δ IRBAS (W) → Δ DAS	0.34	1.71	<i>ns</i>
Δ IRBAS (H) → Δ BDI	-0.28	-1.40	<i>ns</i>
Δ IRBAS (H) → Δ DAS	0.41	2.05	.05
Δ DSS (W) → Δ BDI	-0.30	-1.52	<i>ns</i>
Δ DSS (W) → Δ DAS	0.74	5.17	.00
4. Effect of treatment on outcome controlling for change in mediator (Path c'):			
BCT → Δ BDI / IRBAS (W) ^c	-0.39	-1.89	.07
BCT → Δ BDI / IRBAS (H)	-0.31	-1.51	<i>ns</i>

BCT → Δ BDI / DSS (W)	-0.31	-1.60	<i>ns</i>
BCT → Δ DAS / IRBAS (W)	0.23	1.16	<i>ns</i>
BCT → Δ DAS / IRBAS (H)	0.20	0.99	<i>ns</i>
BCT → Δ DAS / DSS (W)	0.08	0.57	<i>ns</i>

^a BCT = Brief Couples Therapy for depression

^b Due to the non-significant effect of treatment on the mediator DSS (H), we did not further examine criteria 3 and 4 for this mediating mechanism.

^c / = controlling for

Figures

Figure 1. Hypothesized mediating mechanisms of Brief Couples Therapy (BCT) for Depression.

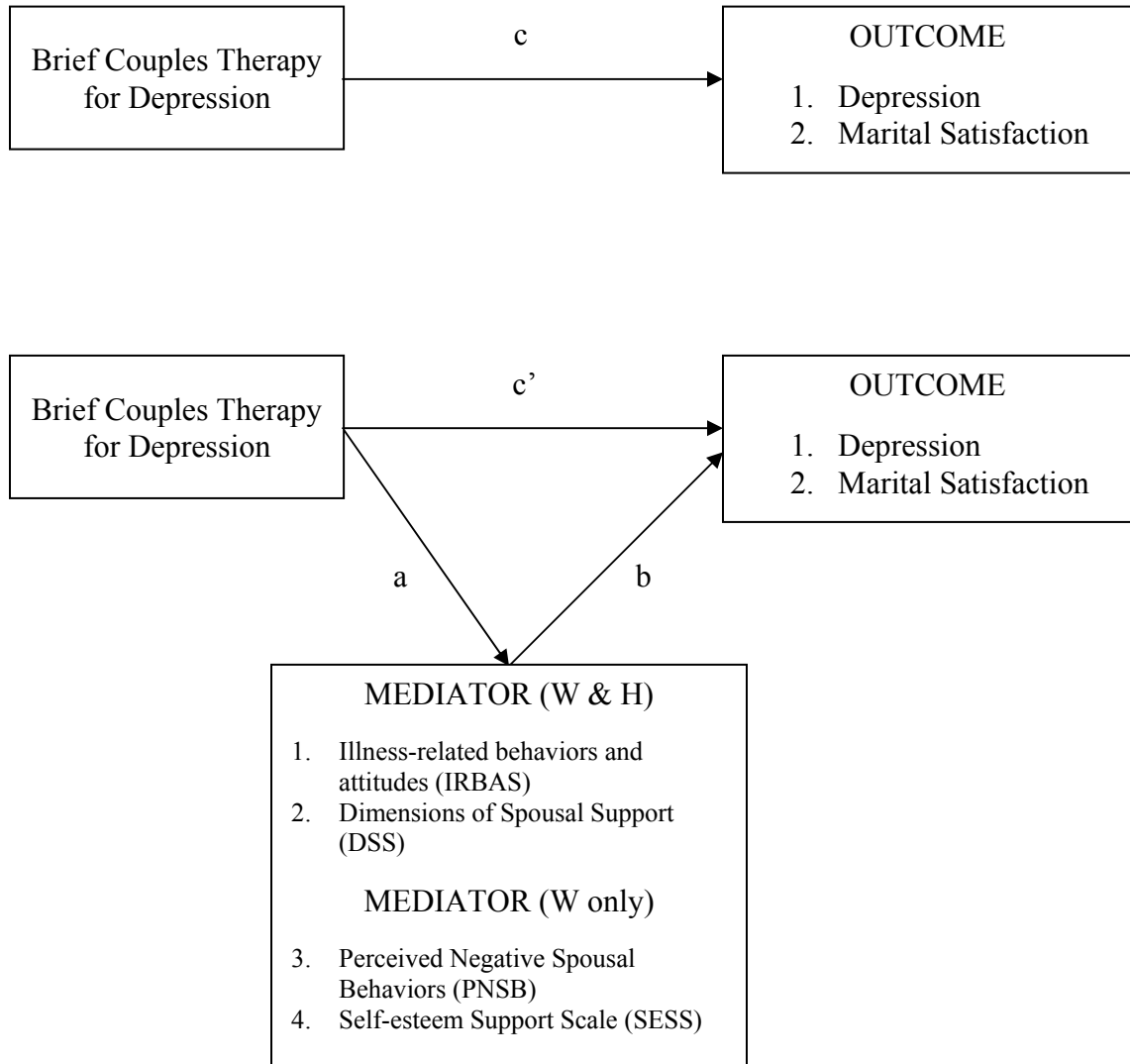


Figure 2. Predicted Hamilton Rating Scale for Depression (HAM-D) scores over time for women in treatment versus waitlist control.

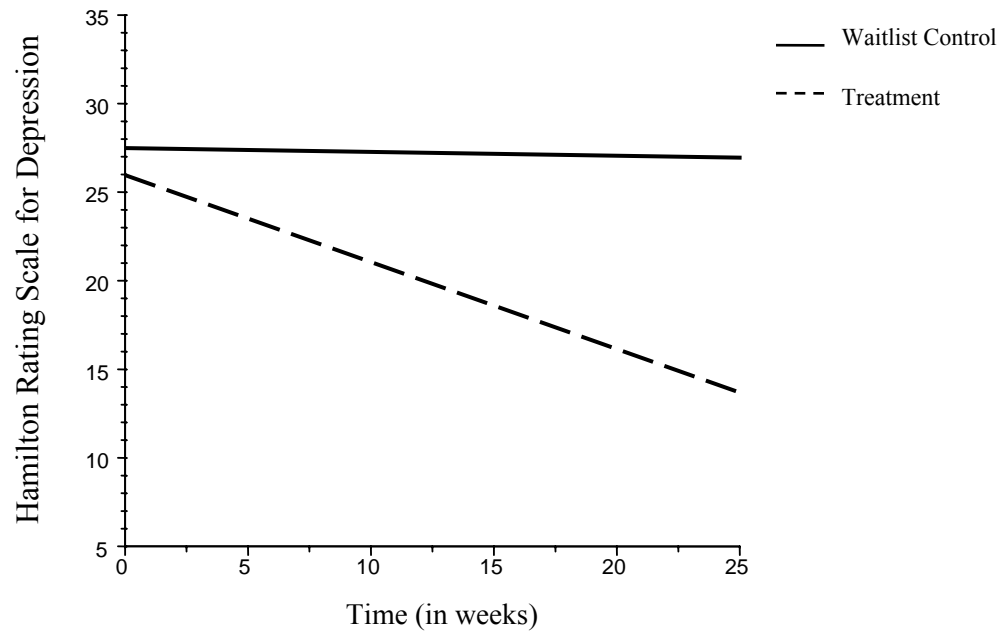


Figure 3. Trajectories of Beck Depression Inventory (BDI) scores for wives and husbands in treatment versus waitlist control.

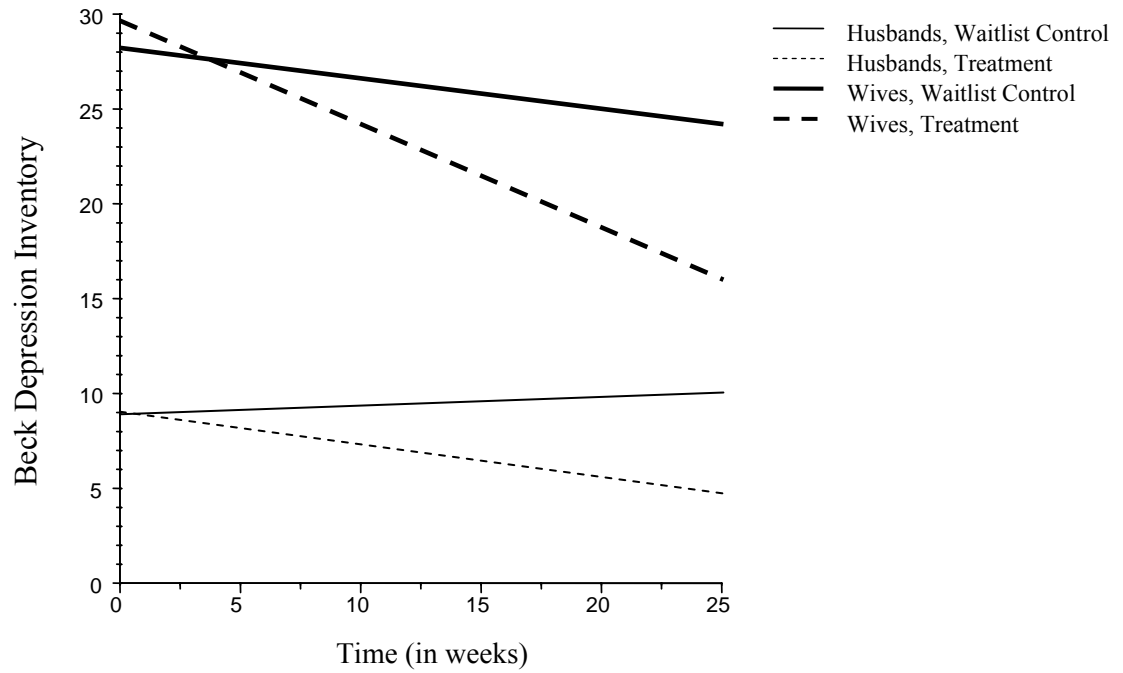


Figure 4. Trajectories of Dyadic Adjustment Scale (DAS) scores for wives and husbands in treatment versus waitlist control.

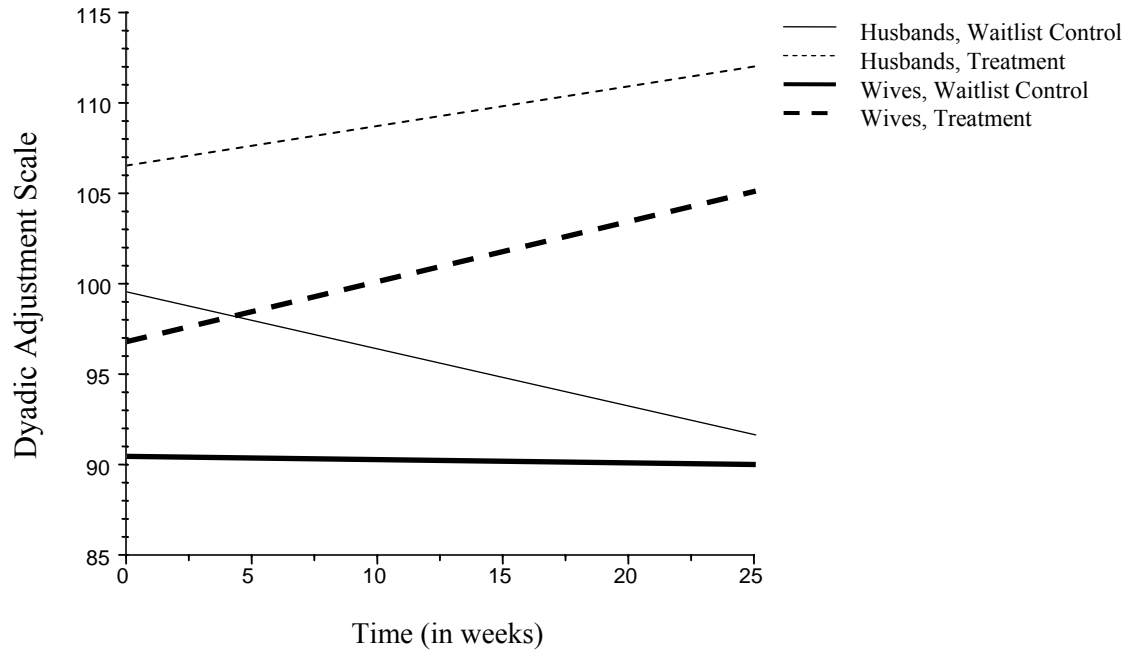
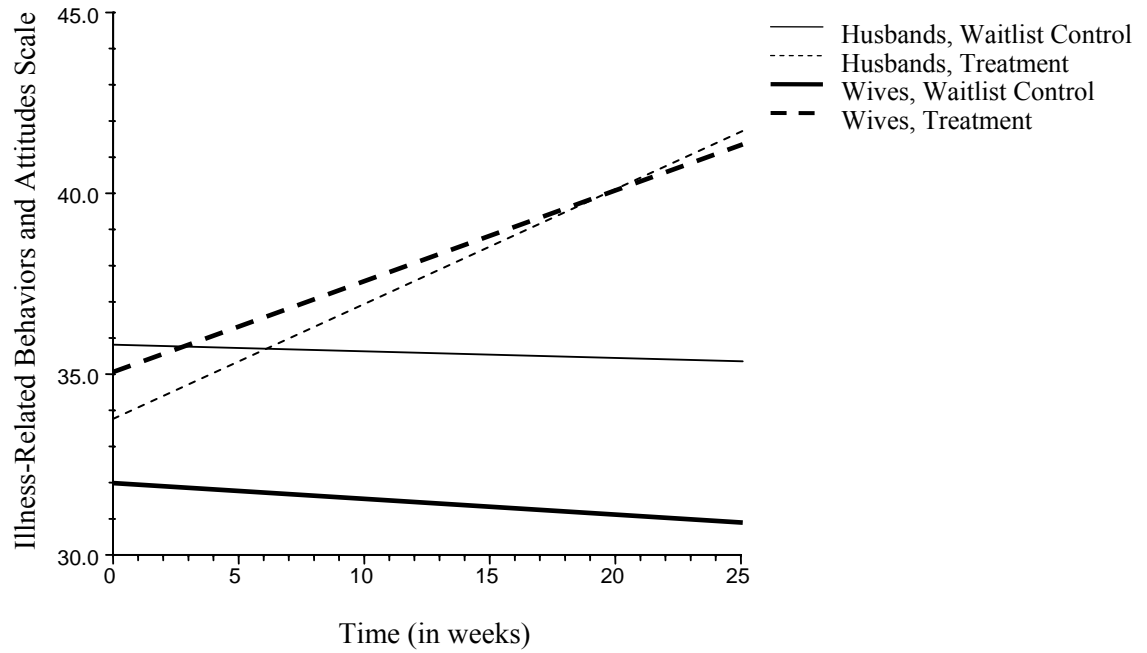


Figure 5. Trajectories of Illness-Related Behaviors and Attitudes Scale (IRBAS) scores for wives and husbands in treatment versus waitlist control.



Appendix: Treatment Manual and Protocol

Brief Couples Therapy for Depression: Overview

What is Brief Couples Therapy for Depression?

Psychoeducational and brief, problem-focused interventions are typically relatively brief and focused on increasing individuals' knowledge and understanding of a psychiatric problem/disorder. As such, a couples psychoeducational treatment for depression is focused on helping couples better understand how depression affects the individual functioning of each partner within the relationship, as well as the functioning of the marital relationship overall. The treatment entails five weekly sessions, each lasting two hours. Sessions will be structured and will incorporate both conjoint and individual, split-session formats. The therapist using couples psychoeducational therapy will apply a combination of didactic and cognitive-behavioral strategies to help couples adjust to the negative impact of depression on their lives, reduce the extreme negativity that is common in these couples due to the burden associated with the depression, and foster greater acceptance and support within the relationship.

When is Brief Couples Therapy for Depression Appropriate?

As mentioned previously, there are many available treatments for depression that have been shown to be effective and that differ in focus, format, and structure. Accordingly, the therapist must decide if a couples-based psychoeducational approach to depression is an appropriate form of treatment for the couple given a number of factors such as their circumstances, the symptom picture, and the state of their marital

relationship. The psychoeducational approach is viewed to be an appropriate intervention modality for couples when the following considerations have been satisfied:

- The risk of suicide has been carefully assessed and risk of precipitous suicidal gestures has been determined to be low.
- The depressed patient has received a thorough diagnostic assessment and has been accurately diagnosed as non-bipolar (i.e., receives a diagnosis of either unipolar major depression or dysthymia) and is not suffering from a disorder other than depression that prohibits her from being diagnosed as depressed.
- The partner of the depressed patient does not meet DSM-IV diagnostic criteria for major depression and/or dysthymic disorder himself, as this intervention is designed for couples in which only one of the partners is depressed. [Note: This criterion is necessary to ensure that husbands are not sufficiently depressed themselves to be considered the “primary” patient within the marriage—that is, they are not experiencing depression of equal or greater severity than their wives].
- The presence of marital discord is determined not to be so severe as to warrant a longer-term, more in-depth marital treatment such as marital therapy for depression. To meet this criterion, both spouses should score a 75 or higher on the Dyadic Adjustment Scale (DAS), as this is well below the mean DAS score of 94.7 ($SD = 15.47$) in a discordant, treatment-seeking population (Crane, Allgood, Larson, & Griffin, 1990). [Note: This criterion is necessary to ensure that couples who are significantly discordant and who perceive the

discord as the cause of the depression can be appropriately referred for more intensive marital therapy].

- The depressed patient is not suffering from a chronic physical illness to which her depression is attributed. It is felt that couples in which the wife's depression is secondary to and largely caused by her having a comorbid chronic physical illness are qualitatively different, in terms of their specific clinical needs, from those couples in which the depression is viewed as the primary problem.
- Both spouses have been seen individually and assessed for factors that would contra-indicate such an intervention, namely the presence of recent acts of infidelity and/or aggression within the relationship. Given the potentially detrimental impact of recently experiencing or learning of a partner's infidelity, e.g., Cano & O'Leary, 2000, it is felt that such couples would presumably need and benefit from more intensive marital therapy that would specifically focus on the underlying marital problems and dynamics. Similarly, if the couple is determined to be frequently or severely physically aggressive, or if fear of one's partner is determined to be too great, then a conjoint intervention may not be appropriate given the potential risks of involving them in a treatment that may induce or exacerbate the aggression, as well as the assumption that the proposed intervention is not designed to address the specific clinical issues involved in treating aggressive couples.

Preparing the Couple for Treatment

Assessing Motivation for & the Benefits of Change

It should be expected that couples entering treatment will be somewhat skeptical about the therapy and resistant to coming, especially the male partners of depressed women. It is commonly known that females are two to three times more likely to be depressed than males (American Psychiatric Association, 1994) and are more likely to seek treatment for their depression from medical and/or mental health professionals. Given that depression is relatively much less common in men and men are far less open to seeking treatment in general, you will likely encounter resistance from some of the male partners, who may express feelings of frustration at being “dragged” into treatment and questioning as to why they need to participate in treatment when they are “not the sick ones.” Such resistance can be reflective of the degree to which the non-depressed person is hostile, critical, and blaming of their depressed partner, which can be informative to you in focusing the treatment on reducing such negativity within the relationship (discussed in further detail in later sections). However, such resistance can also hinder or compromise the potential success of the treatment and therefore needs to be addressed within the first session of treatment. First, each partner’s level of motivation for change should be assessed. That is, find out what each partner hopes to get out of treatment and areas in which they would like to see change. Second, talk with each partner about the role they can play in making those changes. That is, what does each partner see as his/her contribution to the difficulties in the marriage/relationship.

After assessing these motivational factors, discuss with both partners the potential benefits of being in the treatment. For the non-depressed partners (i.e., husbands/male partners), being in treatment can have the following benefits: (1) better understanding of depression; (2) better understanding of how depression is impacting them and normalization of what they are going through; (3) learning ways to cope with the burdens that they may be facing; and (4) most importantly, recognizing the important role they can play in helping to reduce or alleviate their partner's depression, which will then benefit them in terms of removing psychological distress, improving their social and sexual life, improving their relationship, and helping their kids.

Affirming the Couple's Strengths

Couples entering treatment may be struggling with doubts about the quality and strength of their relationship and their ability to endure the hardships they are facing. Thus, it is extremely important to instill in the clients a sense of optimism, hope, and confidence in their ability to make change and benefit from treatment. One method of providing such encouragement is by affirming their strengths as a couple. This can be done by pointing out to the clients the positive aspects of their relationship, as determined from your tailored assessment in session one, and their commitment to the relationship, as evidenced by their coming to treatment. You should also seek opportunities to affirm, compliment, and reinforce the couple sincerely throughout the course of treatment. Some examples:

- I appreciate your hanging in there through this feedback, which must be pretty tough for you.

- I think it's great that you're strong enough to recognize the risk here and that you want to do something before it gets more serious.
- You've been through a lot together, and I admire the kind of love and commitment you've had in staying together through all this.
- You really have some good ideas for how you might change.
- Thanks for listening so carefully today.
- You've taken a big step today, and I really respect you for it.

Orienting the Couple to Treatment

Couples entering treatment may have preconceived notions and expectations of therapy based on common stereotypes or on past treatment experiences. For example, the couple may assume that treatment is predominantly characterized by “talk therapy,” in which individuals talk about their problems in a self-directed, freely associating, and unstructured manner. Thus, the couple must be oriented to the didactic, structured, and directive nature of the present treatment. More specifically, inform the couple that sessions will be structured according to agendas set by the therapist, while still allowing enough flexibility to address pertinent issues raised by the clients. Furthermore, sessions will regularly involve the use of psychoeducational materials (e.g., handout about depression) and participation in specific behavioral activities (e.g., communication training), as well as tasks to be conducted for “homework” in between sessions (e.g., communication logs). It must be stressed to the couple that completing these homework tasks and participating in the activities in session will significantly enhance treatment success, and any non-compliance must be dealt with promptly. Explaining the role of the

therapist as that of a teacher or coach will also help the couple to better understand the nature of the treatment. Finally, the therapist should provide the couple with a rationale for the treatment and a brief description of what it entails. For example:

We know that depression can place a lot of stress on a marriage and on the individual partners. We know that partners of depressed persons often do not understand depression or how difficult it can be for the person suffering from depression. This lack of understanding can lead these partners to become hostile, critical, and blaming, and they tend to withdraw and provide less emotional support to the depressed individual. When there is a lot of negativity and not much support in a marriage, the depressed partner is more likely to either stay depressed or to have a relapse in the future. So we will be focusing here on working directly to reduce such negative interactions and [to the wife] to increase your husband's support and positivity toward you. We also know that one partner's depression can also negatively affect the other partner, who will often experience a great deal of psychological distress and burden themselves as a result of living with a depressed person. So we will also be working here on helping you [the husband] better cope with and adjust to living with your wife's depression.

Psychoeducation

Understanding Depression: The Basic Facts

Myths Surrounding Depression

Unlike chronic medical illnesses such as heart disease or arthritis, depression carries with it a stigma of shame that adds to its intensity, which is perpetuated by a lack of understanding about the disorder. The myths that abound concerning depression may make it even harder for a depressed person and her loved one to cope with the illness, and may also have negative consequences for the relationship. Thus, an important focus of this treatment is to help couples better understand depression and to alter any misperceptions or misinformation they may have about the disorder. Here are some common myths surrounding depression that you should be familiar with in working with these couples.

Myth 1: With enough willpower, anyone can overcome depression. Partners of depressed individuals often hold the belief that depression is something that can be willed away or controlled. In fact, a study by Jacob, Frank, Kupfer, and Carpenter (1987) found that significant others' beliefs about the etiology of depressive disorder were not comprehensive or well integrated and were characterized by misunderstanding. More specifically, significant others only partially recognized the biological nature of the disorder and tended to place heavy emphasis on external or situational causes, which may contribute to blaming and criticizing of the patient for not being able to better control environmental influences. Partners who hold such a belief are likely to make such statements to their depressed partners as "If he would only try harder..." or "If only she

would be reasonable...” or “If she would only snap out of it!” Expressing such sentiments to a person who is depressed is as unfair and futile as telling a heart-disease patient, “With enough willpower, you can control your heart functioning.” Moreover, the belief that one’s partner lacks the fortitude and character to overcome her problem can reinforce the negative thoughts a depressed person already has about herself, and can cause her to label herself as weak or a failure. This may further deepen the self-criticism and despair that is already so strong and pervasive within depressed individuals’ thinking. It is easy to understand how a non-depressed partner might hold such a view. A non-depressed person may have self-critical thoughts, but is able to manage such thoughts. Unfortunately, a depressed person is unable to do so. Given the automatic, negative styles of thinking that are so pronounced in depressed individuals, controlling such negative thoughts does not seem feasible to them. Similarly, a non-depressed person may experience negative emotions, but is able to cope with these emotions and knows that the emotions will pass. Unfortunately, depressed individuals may feel gripped by their emotions and unable to control or change them. Thus, when a person is depressed, the skills that seem employable or even intuitive to others are not available.

It is important to help the partners of depressed individuals understand that depression is a complex illness, and like many psychological/psychiatric problems, it has biological, social, psychological, and genetic components and is affected by all of these factors. Furthermore, like many medical illnesses, depression must be treated. Likening depression to a medical illness may help partners reframe their attitudes about depression and be more understanding. Moreover, partners should be informed that depression can often be a chronic condition that comes and goes, with times of relapse and remission.

Thus, the message to convey to partners is that willpower often has very little to do with the course of depression, but that support and understanding from a loved one may have far more of a positive impact on the depression than the depressed person's level of willpower.

Myth 2: Depression is something to be ashamed of. Shame is a symptom that often accompanies depression. Depressed individuals often feel stigmatized in their own minds and by others. They may fear that their loved ones will leave them because they are "crazy." Thus, it is very important for depressed individuals to receive reassurance from their partners that they are not defined by their emotional illness. It may also be helpful for partners to be open with one another about the depression, and perhaps even with close family members and friends, so that the depressed person does not feel that their struggle is so shameful that it needs to be kept a secret and not be talked about.

Myth 3: You can't be productive if you are depressed. It is a common belief that depressed people cannot function. While this may indeed be true for some, it may also be the case that a depressed person is sabotaging herself by holding such a false belief, or her partner is enabling her to be non-productive by holding and acting on such a belief. It is important to point out to both partners that an individual can be depressed and still function. In fact, most people who are depressed and are receiving treatment live productive lives. People in treatment who are depressed can work at their jobs or carry out family responsibilities in a similar manner as a professional athlete who competes with pain or injury. They simply push through it. Thus, the idea behind this treatment is to help both partners learn to cope with their daily lives *despite* the depression.

Myth 4: Therapy does not work. You may encounter resistance from couples in the form of doubts about the helpfulness and potential success of therapy. Thus, it is important to inform these couples that depression can indeed be successfully treated. In fact, therapy for depression is effective in 80% of cases (Antonuccio et al., 2000). In a comprehensive evaluation of available treatment outcome data, Antonuccio and his colleagues found that psychotherapy is equally, if not more, effective than pharmacotherapy in the treatment of mild, moderate, and even severe depression. Such research findings can be provided to the couples to help build their confidence in the treatment and other therapies in general.

Prevalence and Course

Of all problems that are mentioned by patients at psychological/psychiatric and primary care clinics, some form of depression is most common. Lifetime prevalence rates for depression in the general population range from 9% to 21% among women and 4% to 13% among men (Kessler et al., 1994; Weissman et al., 1991). Women experience depression approximately twice as frequently as men (Nolen-Hoeksema, 1987), and depression is most commonly diagnosed among 25- to 44-year-olds (Robins et al., 1984). Depression is also a significant problem within the primary medical care population. Depression is one of the most common disorders (not just mental disorders) found in primary care (Katon, 1982), and depression is treated by primary care professionals as often, if not more, than by mental health specialists (Narrow, Regier, Rae, Manderscheid, & Locke, 1993).

As a result of increasingly sophisticated clinical and community studies, depression is now seen as less of an acute, single-episode phenomenon and more of a chronic, episodic condition (e.g., Coyne, Pepper, & Flynn, 1999; Judd et al., 1998). A 12-year prospective study of over 400 patients seeking treatment in psychiatric settings found that they spent, on average, 15% of this time meeting full criteria for major depression (Judd et al., 1998), suggesting that over a long period of time depression is characterized by intermittent symptoms with full-blown relapses and recurrences. In a study of primary medical care patients, Coyne et al. (1999) obtained a relative risk of 8.0 for past depression predicting current depression. Their findings also showed that 85% of currently depressed primary care and 78% of currently depressed psychiatric outpatients were experiencing recurrences. These two groups of patients, who had a mean age in their late 30's, had an average of over eight past episodes, with no differences between the groups. Taken together, these rich findings indicate that in clinical and primary medical care samples, individuals experiencing an episode of depression are very likely either to have experienced an episode in the past or to experience a recurrent episode in the future. Given the recurrent nature of depression, helping couples to recognize the signs of depression, as well as develop coping skills to utilize when the depression reappears, is a crucial focus of the treatment.

Symptoms of Depression

The most prominent affective symptom in depression is dysphoric mood. *Dysphoria* refers to a generalized feeling of lack of well-being, especially an abnormal feeling of discontent, anxiety, or physical discomfort. As reflected in this definition,

feelings of anxiousness and fearfulness are often seen in major depression and dysthymia. As Hamilton (1982) noted, the three most common symptoms seen in depression are depressed mood, loss of interest, and anxiety (*note*: at least one of the first two symptoms must be present in order to make a diagnosis of major depression). Difficulty falling asleep, loss of appetite, lack of energy and fatigue, and suicidal thoughts come next in order of frequency. Hamilton (1982) further indicated that less educated or psychologically sophisticated patients tend to emphasize physical symptoms and underplay their feelings of depression and anxiety. Upon questioning, however, they will admit to a feeling of “flatness” or “loss of feeling,” reflecting their depressed mood and loss of interest or pleasure. At the outset of major depression, individuals will often weep and cry for no apparent reason. After several months, they may report that they feel like crying but it no longer seems feasible. They will avoid company and group activities, though the depression may not be apparent to many outsiders.

Educating the Couple

Being able to identify and understand the nature and symptoms of depression will help couples to better adjust to its impact. For the depressed partner, better understanding her own symptoms will help her to attribute her difficulties to the disorder rather than to global defects in her personality, thereby lessening the harsh criticism and judgments she may make of herself. For the non-depressed partner, better understanding the symptoms and course of depression will also help him to attribute his partner’s difficulties to the disorder, as well as help him to be prepared for the impact of the depression on their lives. Accordingly, an early goal of treatment is to educate couples about the disorder,

generally in the first or second session. The couple is provided with bibliotherapy on the nature of depression and on anti-depressant medications (adapted from the NIH website), which should be distributed to the clients for their review. In addition, the therapist should devote time in session to reviewing the relevant information about depression discussed previously.

The therapist should also inform the couple about the prevalence and course of depression, particularly the research findings on the likelihood of recurrence/relapse, while being careful not to make the future appear bleak. The therapist can reassure the couple that change is attainable and that as both partners learn better ways of coping with the depression, its negative impact will lessen over time. The hope for long-term improvements should also help to increase both partners' motivation for making change.

Models of Depression: Understanding its Causes

Equally as important as understanding the symptoms and nature of depression is understanding its causes. The material that follows provides an overview of the interpersonal models of depression that provide much of the rationale for delivering a brief intervention for depression in a couples-based rather than individual format. That is, the present treatment aims to target many of the interpersonal/relational factors that maintain depression and affect its course. Accordingly, several interpersonal models and their role in depression will be covered here briefly. These models are as follows: (1) anger turned inward, (2) social support, (3) marital discord, (4) coercion, and (5) family systems. The therapist should be familiar with these models when educating the couple

about the etiology of depression, as they provide much of the theoretical underpinnings of how and why depression can be effectively treated with a brief, couples-based psychoeducational intervention. The final section on *Educating the Couple* also provides the therapist with a guide as to informing the couple about the various interpersonal causes of depression.

Anger Turned Inward

Psychoanalytic views of depression have typically emphasized loss of love and emotional security as a key variable in depression (Klein, 1940), as postulated by Freud in his classic paper “Mourning and Melancholia.” The essence of Freud’s view was that a loss produces self-criticism and that, in turn, the individual becomes angry at him/herself. This process was said to occur because the individual becomes angry with the lost person, but because hostility or anger toward the lost person would produce guilt, the individual directs the anger toward him/herself. The individual is largely unaware of his/her hatred toward the lost object, and this anger remains outside one’s consciousness.

Partial support for the psychodynamic view of anger and depression is the research indicating that depressives often display intense overt anger with family members (Weissman, Klerman, & Paykel, 1971). Recent analyses by behavioral researchers also provide some support for the notion that depressed individuals display overt anger with their spouses (Biglan et al., 1985; Beach & Nelson, 1989). Both found that depressed discordant wives were more negative toward their spouses than were nondepressed, nondiscordant wives. However, the anger observed in these studies was overt rather than introspective anger. While the psychodynamic view of anger in

depression has been seriously questioned, it has influenced the interpersonal treatment (IPT) research of Klerman and Weissman, a successful treatment approach that emphasizes interpersonal disputes, role transitions, loss and interpersonal deficits, as well as social and familial factors in depression.

Social Support

Social support generally refers either to the concrete aspects of social networks, such as size, density, and intensity, or to the provisions offered by social contacts, such as expressive and instrumental support (Lin, 1986). Further, the positivity or negativity of an individual's contacts with members of the social network is also considered a very important characteristic of social support.

There is considerable evidence of relationships among various aspects of social support and depression (Barnett & Gotlib, 1988). For example, depressed persons are less likely than nondepressed persons to have a large or dense friendship network (House, Landis, & Umberson, 1988). Despite such associations, the mechanism underlying these relationships is not always clear. General behavioral or affective abnormalities may impede the development of close interpersonal relationships (Kessler, Price, & Wortman, 1985), or perhaps the relationship between social support and depression results from the fact that depressed persons do not seek social support (Kuiper & Olinger, 1989). Another interpretation is that depressed persons have an aversive interpersonal style that prompts others to reject or dislike them (Gotlib & Colby, 1987). These views regarding the lack of an affiliative tendency and an aversive interpersonal style need not be conflicting. Indeed, they all can be partly true. Importantly, however, it appears that social network size and

density may not be the most powerful aspect of social support; rather, it appears that the provisions of close relationships, such as emotional support and perceived availability of support, may be more powerful in buffering the effect of stress (Lin, Dean, & Ensel, 1986; Kessler & McLeod, 1985).

In the area of depression, several studies indicate the relevance of social support. For example, Lin, Dean, and Ensel (1986) examined the effects of general social support and strong ties with an intimate confidant. Using a longitudinal design, the authors assessed the independent roles of social support via relationships in general (weak tie support) and via close relationships (strong tie support) on the formation of depressive symptomatology. Social support was found to have a strong direct and independent effect on depression and its change over time. It was also found that social support buffered the effect of stress on symptom formation. Of particular interest, it was found that a close relationship with a confidant (typically a spouse) who was providing instrumental and expressive support was the strongest indicator of social support and the best predictor of subsequent depressive symptomatology. In an earlier study, Brown et al. (1993) examined the critical role that a husband plays in protecting women from psychiatric disorder. They found that for married women experiencing a provoking agent (i.e., a severe life event generally involving a significant loss or disappointment), the lack of a general close relationship was unassociated with risk of depression; instead, the quality of the link with husband was of overwhelming significance in providing protection against the onset of depression.

Thus, there is a considerable amount of good prospective evidence linking lack of social support with the formation or maintenance of depressive symptomatology and

suggesting a role of social support in buffering life stress. While there is some evidence that general social integration and certain structural features (e.g., size) of the social network are helpful in maintaining positive mental health, stronger evidence links the absence of the provisions of close relationships with the development of depressive symptoms. Accordingly, the work on general social support and depression can be seen as pointing in the direction of direct consideration of intimate relationships and their role in depression. Since the strongest family ties are usually in dyads such as the marital relationship, it is natural to look to the marital relationship for particularly powerful opportunities to provide social support (Burgess, 1981; Weiss, 1974). Clinical applications of this, specifically in terms of helping non-depressed partners to provide the type of support that is needed and desired by the depressed partner, are discussed in more detail in the section on *Understanding Types of Partner Support*.

Marital Discord

There is considerable support for an association between marital discord and depression (e.g., Beach, Arias, & O'Leary, 1987). Weissman (1987) reports that in a representative sample drawn from the New Haven area, the risk of having a major depressive episode was approximately 25 times higher for both males and females if they were in a discordant marital relationship than if they were in a nondiscordant marriage. This association holds true in clinical samples as well. There appears to be about a 50% overlap of the association between marital discord and depression in samples selected for marital problems or in samples selected for depression (Beach et al., 1985; Rounsaville et al., 1979). While the present treatment is not designed for depressed couples that are

severely discordant (i.e., DAS score of 75 or lower) or couples in which marital problems are determined to be the primary cause for the depression, it is assumed that marital/relationship problems do play a critical role in the maintenance or exacerbation of depressive symptoms and therefore should be addressed in the context of the depression. Clinical applications of this are discussed in more detail in the section on *Recognizing and Understanding the Impact of Depression*.

Coercion

The coercion model was first developed in relation to children who would employ behaviors such as whining and tantrums in a coercive way, as to prompt their parents to stop them by placating rather than punishing. This model has been generalized to many other family interactions, including marital interactions. In marriages, a depressed woman may often engage in aversive behavior, such as complaining about her life, and the husband may console her or stop making critical comments to her. This aversive behavior on the part of depressed individuals has been thought to be functional in reducing others' attacks and in obtaining positive social consequences (Biglan, Hops, & Sherman, 1988). In fact, Biglan and colleagues (1985) provided initial data supporting this functional role of depressive behavior. While the research findings are limited, they do suggest that the reduction of spousal hostility represents a plausible reinforcer of depressive behavior.

Depressive behavior in general is not simply a function of operant contingencies in a dyadic relationship. It is possible, however, that in certain situations an angry yet concerned husband may become much less critical of his wife if she complains about her depressive symptomatology. Since the coercive power of depressive behavior to suppress

critical comments by the spouse is negatively correlated with the duration of marital discord (Nelson & Beach, 1991), it is possible that a discordant spouse may become increasingly depressed as higher levels of depressive behavior are required to continue to suppress his/her partner's critical behavior. In addition, it has been shown that significant others can exert a direct effect on depressive behaviors via straightforward reinforcement and extinction procedures (Brannon & Nelson, 1987). Although the coercion model has not been extensively tested or empirically confirmed, it does provide a powerful framework for intervention, implying that targeting a reduction in spouses' critical behavior may remove the need for depressed persons to use their depressive behavior as a defense against their partners.

Family Systems

Systems views of depression have been presented by a number of individuals, but Coyne (1976) has articulated one of the most frequently cited presentations of the systematic view of depression. Similar to the coercive model presented above, Coyne maintains that the depressed person's behavior is maintained or increased in part by his/her social environment. It is suggested that the depressed person demands attentions through complaints about the depression. A sympathetic spouse may initially react with concern about the depressed person's feelings. However, according to Gotlib and Colby (1987), "If the depressed person's symptomatic behavior continues...others with whom they interact themselves begin to feel depressed, anxious, and frustrated or hostile, feelings that are communicated subtly to the depressed person. When the depressed individual observes these negative or discrepant messages, she or he becomes

increasingly symptomatic in an attempt to regain the initial support (p. 17).” It is hypothesized that as this process continues, the depressed person puts others off, and he/she is eventually seen as a whiner or a complainer. In the extreme, these depressed individuals are simply alienated and avoided by others.

A good deal of data has been generated in an attempt to support Coyne’s (1976) basic assertions. Using primarily stranger dyads, considerable evidence has been found that depressed patients prompt rejection, devaluation, and some sort of negative mood in the target of the interaction (e.g., Biglan, Rothlind, Hops, & Sherman, 1989). In addition, it is clear that spouses of depressed patients are themselves more depressed than persons in the general community (Coyne et al., 1987). The mediating mechanism of the rejection and devaluation of the depressed person by the nondepressed person does not seem to be induction of negative mood in the nondepressed person, as originally proposed by Coyne. Instead, it seems that perceived dissimilarity of the depressed person to the nondepressed person may account for the rejection of and negative reactions to the depressed person (Rosenblatt & Greenberg, 1988). Interestingly, depressed individuals do not reject or devalue other depressed persons as much as nondepressed individuals reject depressed individuals (Rosenblatt & Greenberg, 1988). Thus, if a husband and a wife are both depressed, they might not reject each other as much as would be the case if one member of the dyad were depressed and the other were not.

Couple-based intervention for depression has been proposed by systematically oriented theorists (e.g., Coyne, 1988, 1989). Similar to the present therapeutic approach, Coyne suggested a structured, goal-oriented, relatively brief intervention that includes homework, an awareness of depression-related symptoms and causes, and attention to

depression-related processes that can complicate therapy. Also similar to the present therapeutic approach, Coyne emphasized the importance of improved communication and intimacy in the marital/romantic dyad.

Educating the Couple

As mentioned previously in the section on *Myths Surrounding Depression*, significant others' beliefs about the etiology of depressive disorder often are not comprehensive or well integrated and are characterized by misunderstanding (Jacob et al., 1987). Depressed individuals may themselves not understand the cause(s) of their depression, leading them to question how and why they came to struggle with depression. Furthermore, both partners may hold the belief that depression is something that can be willed away or controlled, when in fact, depression is a complex problem often rooted in multiple etiological factors. Thus, an early component of the treatment is to educate couples about the various possible causes of depression with the goal of increasing partners' awareness of and sensitivity to the complex nature of the disorder. This will also help couples to understand the principles underlying the rationale for and mechanisms of the treatment.

Recognizing and Understanding the Impact of Depression

When a first or even recurrent episode of depression strikes, the couple may have difficulty recognizing and understanding the impact that it can have on both partners and on their relationship. A large part of being able to cope with the depression is dependent

on being aware of the ways in which the couple is negatively impacted. Thus, your role as the therapist is to help both partners become more informed and aware of how their lives have been changed, hindered, and interfered due to the depression.

Burdens Faced by Partners of Depressed Individuals

Depression can take a terrible toll on the individual afflicted with the illness, but it can also have an intense impact on the partner. Several studies have investigated the burdens that significant others of depressed individuals bear, and their findings are consistent—the depression of a loved one can influence their work life and financial status, their emotions, their relationship with their loved one, and their sense of control over life. In a study of recurrent depression and its effects on family burden, Jacob et al. (1987) found that nearly 70% of the significant others of depressed individuals reportedly experienced both emotional strain (e.g., neglect, depression, hopelessness, worry, and frustration) and practical problems in various aspects of day-to-day living (e.g., difficulty planning for future, lack of cooperation from depressed partner, daily inconveniences). These significant others found it most upsetting to hear their depressed partners express feelings of worthlessness, inadequacy, and low self-esteem. Apathy and disinterest in usual activities were also distressing to significant others, as were the depressed individuals' constant ruminations, worrying, and low moods (Jacob et al., 1987). The burden and distress experienced by a significant other are likely to affect the quality and degree of acceptance and support that they provide to their depressed partner. Thus, it is important to help the partners of depressed individuals understand how they are being impacted, so that they can begin to help both themselves and their depressed partners.

When conducting your tailored assessment of the couple, it is crucial to focus on the specific ways in which the partner of the depressed individual has been burdened and the family life strained. This will give you a sense of the degree to which the couple has been negatively impacted by the depression. The following questions may help to guide you in your assessment of such strain/burdens, and are also meant to increase awareness of the impact that the depression is having on the non-depressed partner and how he may be feeling. These questions should be asked of the non-depressed partner when meeting with him individually, so as not to make the depressed partner feel guilty and overly responsible for causing such burdens:

- Have you had to make any adjustments in your life (such as changing your work schedule or cutting back on social activities) in order to cope with the depression? If so, what kind of changes?
- Have household routines such as mealtimes or bedtimes been upset?
- Have you suffered financial pressures or strain because of the illness?
- How did you feel when you first discovered that your loved one was suffering from depression? Sad, frightened, upset, guilty, embarrassed?
- How do you feel about it right now?
- Do you feel that your loved one is a different person since the onset of the illness?
- Do you behave differently now around your loved one?
- Has the depression created friction in your relationship with your partner? If so, how?
- Does anyone else know how you are feeling?

- Do you feel you have neglected other family members because of the depression?
- Has your productivity at work been affected?
- Have your co-workers noticed any changes in your own mood?
- Do you feel trapped or resentful?
- Do you resent that your loved one has become more dependent on you?
- Do you fear that your behavior might worsen the situation?
- Do you find yourself worrying about the future a lot?
- Do you feel angry? Do you sometimes feel hopeless and depressed yourself?

It is very important to normalize what these individuals might be feeling and experiencing as a result of their partner's depression. It is normal and to be expected for them to experience various difficulties, and most people in their situation struggle with similar issues. Research has linked many emotions with having a depressed loved one, including fear, anxiety and worry, frustration and anger, grief, a sense of burden or being overwhelmed, shame, guilt, annoyance, resentment, embarrassment, entrapment, feeling neglected, hopelessness and discouragement, and even depression (Benazon & Coyne, 2000; Coyne et al., 1987; Fadden et al., 1987; Jacob et al., 1987). Normalizing that such emotional reactions are common, and that they can be treated in therapy, can provide the partners of depressed individuals with a sense of hope and optimism about positive change and the future.

Skills Training: Targeting Change in the Relationship Dynamics

Reducing Blame, Criticism, and Hostility

A major focus of the treatment is to reduce negative exchanges between partners that are common among couples in which one partner is depressed. Research indicates that there are two distinct problematic patterns of interaction between depressed individuals and their spouses. The first pattern involves the tendency for depressed individuals to seek both reassurance and negative feedback from their spouses (due to conflicting needs of self-enhancement and self-verification), and the second pattern involves negative communications between spouses (blaming, criticism, etc.). Both of these interaction patterns have received a great deal of attention from clinical researchers and have been shown to play a significant role in the co-existence of depression and marital distress.

There is evidence that depression is characterized by a difficult interaction between reassurance seeking and negative feedback seeking—over time, the two patterns become enmeshed or paired. Swann and colleagues have shown that dysphoric individuals with negative self-views appear to have conflicting needs for positive reassurance as well as negative self-verifying feedback (Swann, Wenzlaff, Krull, & Pelham, 1992). Depressed individuals seek interpersonal soothing (reassurance) to satisfy emotional needs; at the same time, they seek negative feedback (verification) to substantiate their negative self-image and to satisfy cognitive needs (Joiner, Alfano, & Metalsky, 1993; Joiner & Metalsky, 1995). The result is that depressed individuals' frequent attempts to get both reassurance and negative feedback may become confusing,

stressful, and aversive to their partners. These aversive interpersonal behaviors may lead spouses to respond emotionally, to counterattack, or to escape from and avoid the depressed individual. It may also be that this paired reassurance and negative feedback seeking is intermittently rewarded and punished by the depressed individual's spouse, thereby perpetuating the pattern and making it resistant to change. Clearly, this pattern of interaction has a negative impact on both partners, particularly on the non-depressed spouse who is repeatedly burdened by his/her partner's conflicting interpersonal demands. This treatment specifically addresses this problem by helping spouses cope with and respond more effectively to their depressed partners' conflicting needs.

The second interaction pattern that is particularly problematic among depressed individuals and their spouses is negative communication. Researchers have observed that in couples in which one spouse is depressed, there are more negative communications (e.g., blaming, criticism, etc.) than in couples where there is no depression (Biglan et al., 1985; Lewinsohn & Shaffer, 1971; Nelson & Beach, 1990; Schmaling & Jacobson, 1990). Research has shown that criticism is especially problematic in these couples. Spouses of depressed individuals often have negative, critical attitudes toward their partners (Hooley, 1986), which has been found to be highly predictive of patient relapse. Hooley and colleagues have shown that the frequency of criticisms from the non-depressed spouse predicts relapse as well as or better than any variable in the depression literature (Hooley, Orley, & Teasdale, 1986). Similarly, Hooley and Teasdale (1989) found that expressed negative emotion and wives' perceptions of criticism from their spouses were the best predictors of relapse into depression. Thus, the attitudes and behaviors of spouses toward their depressed partners, namely their criticism and

underlying feelings of intolerance, are key areas of therapeutic intervention. More specifically, the treatment aims to reduce common negative spousal behaviors such as avoidance of the depressed person, complaints about the depressed person and her requests for help/support, communication of frustration and resentment, impatience, criticism, shouting/yelling, and displays of resistance to or uncomfortability with talking about the depression.

Such negative attitudes and behaviors may stem in part from partners' misperceptions and lack of information about the causes of depression and the disorder in general. Thus, providing the couple with psychoeducation about depression should help to reduce some of the non-depressed partner's hostility and criticism. However, cognitive-behavioral approaches to skills training (i.e., communication training and problem-solving training) must also be employed to help these couples reduce their negative interactions. The following paragraphs provide the therapist with an introduction to targeting such negative interactions among couples.

It is common for partners to respond to their depressed loved one's complaints and fears with defensiveness, frustration, and denial. This is natural, for these complaints can be frightening and upsetting, if not wounding. If the depressed partner cries, "Nobody cares," her partner's initial response might be, "That's not true! I care," or "Your friends care," or "Your parents care," and so on. Answering in such a way, however, makes the depressed person's complaint literal and focuses on the specific content, while overlooking the underlying vulnerability and fear of abandonment. The depressed person may hear defensiveness behind her partner's reassurances and may retort angrily with statements such as "You don't understand." She may then point out to her partner all the

ways in which he has demonstrated that he does not care. She has slighted her partner's attempts to be caring, which then hurts him. What ensues is an argument in which each partner unproductively tries to accuse and blame the other partner of being unsupportive and insensitive. This results in the depressed person feeling isolated in her pain and her partner feeling criticized and unappreciated, even angry. Other well-intended but ultimately counter-productive communications include:

“Snap out of it!”

“You’ll be fine.”

“It’s not that bad.”

“Just try a little harder.”

“Don’t worry. Things will get better.”

“Why don’t you try thinking more positively?”

These statements can make the depressed person feel distanced, patronized, or judged. Although spoken by her partner in an attempt to reassure, a depressed individual may experience them as placating remarks that push her away and leave her feeling emotionally alone. There is a better way for partners to respond to their depressed loved ones, one that requires a more empathic stance and a willingness to withhold their initial impulses and consider other approaches to the situation. The next section focuses on building empathy and acceptance so that partners can become more able to comfort their depressed loved ones, and depressed individuals can become more open to hearing and receiving their partners’ support.

*Increasing Couple Cohesion: Caring and Companionship**

Couples dealing with one partner's depression, particularly those couples presenting with the joint problem of marital discord, are likely to show low levels of couple cohesion (Beach, Nelson, & O'Leary, 1988). Thus, these couples tend to be low in the type of shared positive activity that one might expect to have antidepressant properties (Lewinsohn & Arconad, 1981). This is especially true of couples in which the depressed partner is dealing with extreme anhedonia and a drastic reduction in pleasurable activities overall. By addressing cohesion early in therapy, the therapist is attempting to bring about a rapid shift in the amount of positive, enjoyable time spent together by the couple and increase the rate of positive exchanges and ongoing displays of affection. The techniques most appropriate for this goal are drawn from the pool of support-understanding strategies currently available to marital therapists (Weiss, 1978). These strategies are particularly useful for the depressed and discordant couples, because they are designed to reverse the cycle of coercion and withdrawal exhibited prominently by these couples and to reintroduce fun and mutual involvement.

One of the most valuable techniques for enhancing cohesion is the prescription of increased caring gestures (Stuart, 1980; Weiss & Birchler, 1978), or companionship activities (Jacobson & Margolin, 1979). Caring gestures focus on mutual relationship pleasures that the spouses agree on. Caring gestures are any behaviors that are designed to please the partner and, in so doing, indicate love and caring. The behaviors to be increased should already be within the response repertoire of the spouses; that is, no new learning should be required. Also, they are typically rather small actions that could be repeated often. The goal of a caring-gestures focus is to increase the frequency of already

learned responses that are readily available but currently underused. Similarly, companionship activities are joint activities that are enjoyable or have been enjoyable for the couple in the past. Companionship activities are typically somewhat larger actions than caring gestures, possibly involving such activities as going on a date or talking about each other's day. Once again, however, they should be relatively simple and not require new learning.

The therapist typically introduces the topic of caring and companionship by noting the evidence that spouses care for each other and want to resolve problems and have a more satisfying relationship. This can be challenging at times, but the therapist who cannot make this case at all plausible probably should not be doing couples therapy for depression. Having made the case that at times the spouses exhibit genuine caring impulses and positive feelings toward each other, we then note that many of the day-to-day things that help convey these feelings have disappeared from the relationship, especially when one of the partner's is feeling so down and hopeless about her situation and perhaps the future of her relationship. Often one of the partners has commented on this point or reported the lack of cohesion, and it is helpful to mention their desire to increase these aspects of the relationship. For couples in which this is the case, it is important for the therapist to quickly set the stage for putting such caring gestures on the agenda in the first session of treatment. If this intervention is faced with resistance by one of both partners, it may be necessary for the therapist to provide additional rationales for caring items, making sure the rationales make sense to each partner as they begin work in this area. Rationales such as the following may be helpful: "Engaging in reassuring and pleasant interactions is an important first step toward resolving problems. Showing caring

for one's spouse/partner also feels food once it is reestablished and feels spontaneous and natural again." A rationale of this type helps depressed and discordant couples feel more hopeful about their situation and relationship.

There are many ways to implement the strategy of increasing caring and companionship behaviors (Jacobson & Margolin, 1979; Liberman et al., 1980; Stuart, 1980), and the therapist should decide which of the approaches seems most appropriate or fitted for the individual couple. All approaches, however, provide guidance to help the couples better identify, prompt, recognize, and reinforce potentially positive couple behavior. At the very outset, correct identification of pleasing behavior is necessary. It is quite common for couples to have poor skills in recognizing concrete events that are pleasing or displeasing to one another. Because of the potential for a "positive" gesture's not having the impact intended, the therapist can have each spouse individually generate a written list or verbal exchange of small gestures he/she would like to have the partner perform, while stressing to the couple that in compiling such lists, they are not creating a series of demands for their partners. This is important because it prevents the caring list from becoming yet another annoyance or perceived stressor in the relationship. Instead, the lists are to be viewed as menus from which the partner can choose when he/she desires to perform a caring gesture for his/her mate. It is also important that the gestures involve *small* behaviors that require no new learning, that are specific, and that involve increases in positive behavior rather than decreases in negative behavior. "Being more sociable at parties," for example, would be rejected both because it is too vague and because it may call for a new behavior to be learned that is not already within the partner's repertoire. "Stop bothering me when I get home from work" might be included

if reworked into “Give me 10 minutes when I get home from work before discussing anything.” This reworking from a request for an absence of a negative behavior to a request for an increase of a positive behavior is important, because the absence of behavior is not usually a salient event. Caring gestures must be salient to both the giver and the receiver in order to be effective. Especially encouraged on caring-gesture menus are gestures that can be performed frequently, that call for minimal monetary expenditure, and that are under the giver’s total control.

After identification of positive events is accomplished, some type of prompting for increased exchange of caring behavior is typically necessary. In this regard, three aspects of the caring assignment are essential for depressed couples: (1) emphasizing that the caring gestures should be performed *at least* weekly and ideally on a *daily* basis; (2) emphasizing that each partner is responsible for performing caring gestures for their partner *independently* of the partner’s success in performing such caring gestures; and (3) emphasizing the importance of giving recognition when caring gestures have been performed. First, the rationale given to the couples for making the assignment a weekly/daily one is that caring gestures are supposed to be small indications of underlying feeling and, as such, need to be given generously in order to effectively demonstrate positive feeling. It is also the case that depressed persons show a very consistent tendency to underestimate the rate of positives they experience and to have some difficulty recalling positive experiences. Accordingly, for the depressed partner, anything below a frequency of several gestures a week may be too infrequent to be observed and recalled. Secondly, the independence of the assignments given to husband and wife is designed to help couples out of the common pattern of “tit for tat.” The third

aspect of caring gestures is that their performance be recognized. It is important that spouses be taught ways of recognizing and reinforcing the caring behavior of their partner. It is not at all uncommon in depressed couples for the spouses to respond “blankly” to a partner’s caring behavior. Thus, the therapist can discuss with the couple the importance of letting their partner know that he/she is on track and doing well when performing caring items, as well as ways for each partner to honestly and directly inform the other that a caring gesture has been noticed and its intent appreciated, and to communicate the feelings it evoked.

Depressed (and discordant) couples often function as married isolates, living separately under one roof. Thus, the therapist should stress the importance of increasing companionship and shared positive activities, such as dating, joint recreational activities, and activities with other couples. This can be surprisingly difficult, especially if the couple reports that there are absolutely no activities they would both enjoy doing. In such situations, the therapist can gently probe for activities they used to do together while they were dating and during the early years of their marriage. This may help the couple to overcome their initial reluctance at the thought of reintroducing such activities into the relationship. Once again, the therapist should be alert to any suggestions for joint activities that have a high likelihood of failure. If one partner sounds unenthusiastic, or if the activity is too burdensome for the depressed partner, the suggestion should be further examined until both partners can agree on an activity that they would both enjoy and feel comfortable with.

* This section on increasing couple cohesion adapted from *Depression in Marriage* by Beach, Sandeen, & O’Leary (1990).

Building Empathy and Acceptance

What is important for the therapist and the clients to realize is that underlying these negative interactions is a strong need for both partners to feel loved and secure in the relationship, especially the depressed partners who commonly struggle with a fear of being abandoned. The treatment focuses on two core areas of change that can help couples to become more accepting of one another and respond to one another in more empathic ways: (1) developing an empathic silence (i.e., learning to listen without reacting) and (2) communicating validation for one's partner.

As described earlier, conflict can easily arise when partners respond to the literal content of one another's statements rather than to the underlying feelings. Although such reactions are reflexive, they can be changed, and part of doing so involves helping partners to detach themselves so that they can recognize and understand what their partner is really feeling underneath what they are literally saying. The goal is to help partners recognize what their loved one is feeling without reacting personally. This position requires that both partners simply listen without responding immediately to what the other is saying, that is, that they remain in silence while their partner speaks. While this is not easy to do when feeling provoked or criticized by one's partner, it is essential in order for both partners to feel heard. Such an empathic silence is a crucial step in learning to comfort a loved one without engaging in the often-negative literal content of his/her communications. Here is an example of what can be said to couples to help them achieve such an empathic silence and understand the rationale behind doing so:

In the heat of anger, there can be little or no empathy. And without empathy, you cannot give comfort to one another. Empathy requires enough calm and

receptivity that the signals of what your partner is feeling can be received. This calmness and receptivity during even the most difficult and accusatory conversations can be achieved through empathic silence. By remaining silent even when you are aching or feeling defensive, you are acknowledging what your partner is feeling without reacting in the moment. This silence says to your partner, "I'm here; I'm listening; I care." Later, when the rage or destructiveness has passed and the mood has lifted or simmered down, you and your partner can talk more calmly and rationally about what has been said. At times, your partner may take offense at your silence. It could trigger further rage or annoyance. If this should occur, rather than exacerbate an already heated situation, you can respond by saying, "I just want to listen right now. When you're through talking, I'll be glad to share my feelings. Right now I want to pay attention to you." This will communicate to your partner that your silence is not a hardened but an empathic one.

Another focus of the therapy is to help both partners realize how, in spite of their good intentions, their ways of communicating may negatively impact one another. For the partners of depressed individuals, some of the emotionally draining things that they are forced to endure include unpredictable moods, horrifying threats of suicide, outbursts of anger or rage, surly comments, and being shut out emotionally. Depressed individuals may not realize how deeply their partners are affected by the hurtful content of what is being said. Thus, through empathy-building tasks and communication training exercises, the present treatment aims to build empathy for what each partner is going through as a

result of the depression and its impact on the relationship. As mentioned in the previous section, developing the ability to achieve an empathic silence will allow each person to detach him/her self from feeling personally attacked when his or her partner is criticizing or ranting. From this emotional stance it is easier to take the next steps in comforting a loved one—mirroring and validating one another’s feelings.

The best way to convey caring is to validate a partner’s feelings. This can be done by *mirroring*, reflecting back what one’s partner is expressing on an emotional level, not a content level. For example, if a depressed individual says to her partner, “I feel exhausted,” a reasonable response might be, “Honey, maybe you need to take a nap.” However, this would be responding to the *content* of her complaint by making a concrete suggestion, giving her advice when what she wants is to be heard and understood. Instead, if her partner were to say, “Oh, honey, you sound truly weary,” he would be validating or mirroring her *emotions*. As a result, she would feel understood and more emotionally connected with her partner. There are no words more soothing to a depressed individual than these sorts of validating and empathic statements. It may be of help to model such mirroring for the clients, by contrasting content-focused responses with more emotionally validating responses. Here are some additional examples:

CLIENT: No one cares.

Don’t Say: But I do! Don’t you realize that?

Do Say: I know it feels that way to you right now. But we’ll get through this together.

CLIENT: I’m all alone.

Don’t Say: No you’re not! I’m sitting here with you right now. Doesn’t my caring about you mean anything?

Do Say: I know that you're feeling alone right now. Is there anything I can do to help?
I'm glad to just be with you. Together we'll get through this lonely feeling.

CLIENT: Why bother? Life isn't worth living. There's no point in going on.

Don't Say: How can you think that? You have two beautiful children and a great job. I love you. You have everything to live for.

Do Say: I know it feels that way to you right now, but I want you to know that you matter to me and you matter to the children. We'll get through this hopeless feeling together."

CLIENT: I'm dragging everyone else down with me.

Don't Say: No you're not. You see? I'm fine. I can handle this. And besides, I'm doing everything possible to help you.

Do Say: I know it feels that way to you right now. And yes, at times it is difficult for both of us, but we'll get through this burdened feeling together.

CLIENT: Things would be easier if I wasn't here anymore.

Don't Say: Don't talk crazy! What's wrong with you?

Do Say: I would miss you terribly. You're important to me. I want to grow old with you. We'll get through this together.

CLIENT: I'm expendable.

Don't Say: If you felt better about yourself, you wouldn't say stupid things like that.

Do Say: I know you're feeling worthless right now, but we'll get through this.

CLIENT: Nothing I do is any good. I'll never amount to anything."

Don't Say: What are you saying? You've accomplished plenty in your life. You're a great mother. You have a good job. You're blowing everything out of proportion.

Do Say: I know it's upsetting when things don't work out the way you want them to. It's upsetting for me too. Feeling like a failure is really painful. We'll get through this together.

In all of the above scenarios, the non-depressed partner is coached to end with the statement, "We'll get through this together." This statement serves to reassure the depressed partner that she will not be abandoned. Beyond that, it helps to reassure the depressed person of her partner's constancy, that he will be there for her no matter what. Finally, it reminds the depressed person of her partner's dependability and offers hope. The therapist can use such strategies when conducting communication training with the couple in session.

Resolving Conflict through Better Communication

Communication training is an essential component of couples psychoeducational therapy for depression. It is clear from the previous two sections that negative attitudes towards depression and negative ways of communicating such attitudes are common in these couples and can be very toxic to the relationship. The criticism, blame, and hostility described earlier can lead to intense conflict between partners, feelings of rejection or being shut out from one another, avoidance, and lingering resentment that is never resolved. Thus, in addition to helping these couples reduce their negative interactions and develop more empathic ways of communicating, the therapist should also guide the partners to develop specific communication skills that will help them to deal with and/or resolve conflict when it arises.

Communication training essentially begins from the start of the treatment. Both partners are assigned to fill out a communication log for homework at the end of each session, which focus on increasing each partner's awareness of the communication difficulties they are having. Sessions 3 and 4 of the treatment incorporate use of the logs to focus specifically on communication training. The following suggestions may be useful in helping couples to develop more meaningful and successful ways of communicating:

1. *Really listen.* Listening is an active form of communication. It implies mutual respect, and a person who is listened to feels cared about and valued. Thus, when practicing communication skills both in session and in vivo, partners should remind one another not to interrupt or talk over one another. If after communicating a partner feels misinterpreted, he/she might say, "You're not hearing me," and can then try to explain himself/herself in a different way.

2. *Make eye contact.* Emotions are expressed through eye contact as well as with words. Making eye contact with one's partner conveys attentiveness and consideration. When feelings of hurt or anger are present, partners may have a tendency to divert their eyes. Thus, it can be helpful to remind partners to look at one another when communicating.

3. *Ask questions in a non-threatening way.* Partners often engage in *mind-reading* and make false assumptions about what the other is thinking or feeling. This can lead to conflict or a breakdown in communication. Instead, the therapist should help both partners to ask open-ended questions that convey curiosity and sincere interest. For example, a statement such as, "Help me understand what's going on with you," said in a

clam and non-threatening way, can convey to one's partner a desire to listen and share in what he/she is feeling. If the receiving partner still does not understand, he/she can be prompted to continue to ask in different ways until full understanding is achieved.

4. *Clarify assumptions.* When feeling hurt and defensive, partners can distort one another's words or actions. For example, if a depressed partner's need to remain in bed makes her partner furious, he might blurt out in anger, "You just can't wait to get away from me, can you?" In actuality, her need may have little to do with escaping him, and in fact, just the opposite may be true. She may be trying to calm herself with quiet time in order to reconnect with him later. Such underlying and possibly harmful assumptions can create disruptions in a relationship because they lead partners to ruminate upon and view current situations through the potentially distorting lens of past injuries. An effective method of addressing these unspoken assumptions is by having partners ask one another questions that could bring clarification. In the above situation, the upset husband might ask, "Are you saying that you want to get away from me?" This will allow his wife to clarify her true needs and intentions.

5. *Use mirroring.* As explained in the previous section, mirroring validates a partner's emotional experience by communicating one's own understanding and respect for what his/her partner is feeling. Refer to the section on *Validation* for more detail.

6. *Separate character from actions.* In order for partners to help one another feel good about the relationship and maintain self-esteem, it is important to distinguish upsetting or frustrating behavior from general character. This is particularly true for the depressed partners, who have a tendency to view themselves in a globally negative way and may feel defined as a person by their depressive symptoms. When character is

separated from actions, partners communicate to one another that they continue to value each other, even though they may find particular behaviors difficult to accept. This can be done by having both individuals continually remind themselves of the global positive traits in their partner (this is also done in session one as part of a cohesion-building activity).

7. *Keep attuned to unspoken communication.* Facial expressions, body language, and even silence all communicate feelings that need to be understood and articulated. A partner might say, “Oh, don’t worry about me. I’m just fine,” but his/her slumped shoulders or sighing may convey a different message. The therapist should model for the clients how to tune in to such unspoken messages.

8. *Express love and support.* Despite the angry or hurt feelings that may be aired during discussions between partners, the therapist needs to help them find some way to express their vulnerable underlying feelings of love and caring for one another. This will solidify their commitment to the relationship despite the difficulties they are facing.

Understanding Types of Partner Support

Research shows that social support and social networks can act as buffers against stress and aid the coping abilities of individuals faced with a variety of stressors (Hirsch & Dubois, 1992; Rhodes, Contreras, & Mangelsdorf, 1994). In relation to depression, there is overwhelming evidence that having a supportive social network is associated with more rapid recovery from depressive episodes; that is, patients with supportive social relationships recover from their depression more quickly than those who lack such relationships (Billings & Moos, 1985a, 1985b; G. W. Brown et al., 1988; R. Brown &

Lewinsohn, 1984; Brugha et al., 1987, 1990). More specifically, research has documented the role of supportive responses from one's spouse or partner in recovery from depression. McLeod, Kessler, and Landis (1992) found that positive responses of the partner to a respondent's depression predicted recovery more strongly than did negative responses, and that the general levels of supportiveness and conflict in the relationship were unrelated to recovery. What this suggests is that the more generalized negative atmosphere associated with high expressed emotion and high conflict plays a greater role in predicting when and if depressive episodes begin (Hooley et al., 1986), whereas specific supportive responses to the episode play a greater role in determining its length. Their findings further showed that certain supportive responses from one's partner were of particular importance in alleviating depression. That is, depressed respondents whose spouses reported feeling warmth and compassion for the respondent's condition were significantly more likely to recover in any given time period than were respondents whose spouses did not report those feelings.

Based on such findings, it is clear that certain ways of supporting a depressed partner may be more important than others in affecting the course of a loved one's depression. House (1981) described social support as consisting of four types of behaviors, which include: (1) emotional support in the form of love, caring, trust, listening, and other similar affective behaviors; (2) appraisal support in the form of positive feedback or affirmation; (3) instrumental support in the form of a tangible resource or aid, including money, labor, or time; (4) informational support in the form of advice or suggestions. The first two types, emotional and appraisal support, describe the type of supportive responses that were found by McLeod and colleagues (1992) to

enhance recovery from depression. The latter two types, instrumental and informational support, may be of help under certain circumstances, but they can also serve to make the depressed person feel incompetent and undermined by her partner. Given that depressed individuals struggle with feelings of worthlessness and self-criticism, they are likely to have a heightened sensitivity to others trying to do things for them (instrumental support) or trying to tell them what to do (informational support), perceiving this as intrusive or over-bearing. Although her partner is likely intending to be whole-heartedly helpful and supportive, nonetheless the depressed person may experience her partner's help as him taking over or his advice as unsolicited. And unknowingly, her partner may be conveying such messages by trying to "fix" problems (i.e., stepping in to help his depressed partner before listening to her or asking what she needs from him).

Having a deeper understanding of the different ways in which support can be offered will help both partners to better recognize what types of support they may be searching for in any given situation, which can then be communicated to one another and their needs for support thereby met. Of particular importance is helping the couple to build self-esteem support (see section below), especially toward the depressed partner, which can also be focused on in session 3 in the context of discussing the various forms of partner support.

Building Self-Esteem Support

Another major aspect of the relationship that is in need of attention and repair early in therapy is its function in self-esteem support. While caring behaviors and shared activities convey a sense of valuing the partner, they typically do so indirectly. In

addition to these indirect ways of providing self-esteem support, it is possible to intervene to increase the rate of positive partner references or, more simply, positive communication. “Positive communication,” as we are using it here, is not as difficult and involved as the set of behaviors that are normally the focus of communication training. By positive communication, we mean verbalizations that communicate appreciation or acknowledgement of the other person’s good qualities or behavior and desirable traits. Such verbalizations are particularly important for the depressed partner, as low self-esteem and feelings of worthlessness are especially salient. Moreover, depressogenic behavior across time can make it difficult for the non-depressed partner to feel or convey such positive verbalizations, thereby further contributing to the depressed person’s loss of self-esteem. Thus, increasing self-esteem support, particularly toward the depressed partner, is of great importance.

When introducing positive communication to clients, the therapist should present the concept as “expressing what you normally take for granted.” In other words, the therapist should attempt to get both partners to verbalize thanks for the many tasks that their partner does for them (e.g., “Honey, you always iron my shirts so nicely—I appreciate it”); to acknowledge desired change in their partner (e.g., “I noticed that you’ve been cleaning around the house a lot more lately—thanks a lot”); to give compliments (e.g., “You really look nice in that jacket” or “I love the way you smile at me”); and to express positive beliefs and feelings about their partner (e.g., “One of the things I love about you is your great sense of humor”).

For some couples, the low rate of positive communication is simply a matter of having habituated to the partner. With prompting from the therapist, such clients will

have no problem in increasing the frequency of their acknowledgement and appreciation responses. However, for other couples there may be initial obstacles to implementing the therapist's suggestion to increase positive communication (that may or may not have surfaced earlier in the discussion of implementing caring gestures). One frequently articulated objection to increased positive communication among the nondepressed husbands/male partners is, "She should already *know* that I appreciate her; we got married, didn't we?" Another common objection is the idea that positive change should not be acknowledged because the partner is now only doing what *should* have been done months or years before. For both of these beliefs, the therapist can present the clients with a rationale for compliance that sidesteps any issues of blame or control. For example, it can be suggested to the wife, "If you want your husband to increase a given behavior, you must inform him that you like it. If he is trying to do things you would like, and if you say nothing, he is likely to assume he made a mistake and you didn't like it after all." At the same time, we highlight the importance of each spouse as a source of daily information for the other about what is going well. If they fail to provide each other with positive observations that are accurate, it becomes very easy for these positive observations to be lost altogether. When this happens, their views of themselves are more vulnerable to threats and more likely to become distorted in a negative direction. Thus, the therapist can explain that being able to express positives, compliments, and appreciation is very important both for helping to keep the relationship on the best possible course, as well as providing a more accurate view of themselves and their relationship. In addition, we emphasize the importance of being able to communicate genuine appreciation in a sincere, not rote, manner.

Specific examples of positive communication that foster self-esteem support can be tried out and practiced in session 3. The therapist can start out by asking the clients to give a compliment or verbalize appreciation to one another in session. If the clients are reluctant to do this task, or if they are unsuccessful in verbalizing the positive statement in a truly positive manner, either because of the choice of words or because of concurrent contradictory nonverbal behavior (e.g., voice tone or posture), the therapist should model the desired response. The therapist can then have each spouse repeat the modeled behavior, with the therapist playing the role of the other spouse. Then the therapist can step out of the picture and have the clients give positive statements directly to each other. Not until this has been successfully completed should the clients be sent home with a homework assignment of increasing their positive communication with each other.

Once positive communication has been initiated (as outlined above), it is often appropriate and useful to focus attention on the recipient's response (especially the depressed partner's reactions) to the self-esteem support. Because the recipient's response to a positive statement can either reinforce or punish that statement, this process must also be clarified for clients. The therapist can model a good response to a compliment (e.g., "Oh, I'm really glad you liked that meal—thanks") as well as poor or punishing responses (e.g., "You're just saying that," or a negative nonverbal response such as a disdainful stare). Given the tendency for depressed individuals to be hypersensitive to perceived criticism and lack of support from their partners, and to therefore respond in defensive and critical ways, it is particularly important to work with the depressed person on ways of inviting her partner to be complimentary and appreciative.

Learning to Cope

Another component of couples-based psychoeducation for depression is introducing both partners to coping strategies that can be used to better adjust to difficult situations that will arise as a result of living with the disorder. For the depressed partners, this treatment component focuses on helping them to better deal with their own depression by employing some basic coping strategies when they are feeling sad, upset, overwhelmed, or angry. Being able to utilize her own resources to deal with some of her difficult emotions will help the depressed partner to feel a little more self-reliant, and will reduce the burden experienced by her partner as a result of her perhaps insatiable needs or demands for support and assistance. A list of valuable coping strategies (adapted from Lewinsohn et al.'s (1986) course on *Control Your Depression*), can be distributed and reviewed with the depressed partner when meeting with her in session 5.

For the non-depressed partners, this treatment component focuses on helping them to avoid becoming overwhelmed themselves by the burdens of caregiving for their depressed partners. Research supports that individuals who ignore their own needs and self-care for the sake of an ill loved one will experience compassion fatigue and burnout. Thus, it is extremely important to guide the non-depressed partners to develop strategies that will help them to care for themselves. A list of valuable coping strategies can be distributed and reviewed with the non-depressed partner when meeting with him in session 5. One strategy that warrants more in-depth consideration involves setting reasonable expectations, as described below.

Setting Reasonable Expectations

When a loved one is depressed, her partner may feel torn about how involved to get in her care, wondering when it is appropriate to step in, and when he should allow his loved one to cope by herself. In defining this role, the non-depressed partner should be guided to avoid certain common pitfalls:

1. *Taking too much responsibility.* It can become easy for the non-depressed partner to take undue responsibility or become over-involved in his partner's depression. Such over-involvement may arise from deep frustration and longing for the situation to improve. Anxiety and feelings of helplessness may trigger a need for greater control. Unfortunately, what the non-depressed partner may not realize is that this behavior cheats his depressed partner of retaining and maintaining as much control over her life as possible. Paradoxically, when he takes undue responsibility, it may reinforce his partner's staying "stuck" in her depression. If this pattern is found to be present in the couple being treated, the therapist should devote sufficient time to helping the partners break this unproductive, even dangerous, pattern of relating.

2. *Self-blame.* Taking too much responsibility can also be linked to the non-depressed partner blaming himself in subtle ways for his partner's depression or failure to recover. He may ruminate over mistakes he has made in dealing with his partner's depression, or over ways in which he perceives himself to have failed her. Such sentiments of regret and self-blame, commonly expressed in the form of "I should have" or "I shouldn't have" statements, can be devastating. Such self-blame may reflect a desperate need for the non-depressed partner to retain some semblance of control in the face of an untenable situation. However, the reality is that such situations cannot be fully controlled. The non-depressed partner can only be responsible for his efforts to do the

best that he can in the moment, and realize that he cannot control the outcome, as much as he would like to believe otherwise.

3. *Becoming an enabler.* The term “enabler” is popularly used in reference to the alcoholism/drug literature. It refers to behaving in a way that makes it possible for an individual to continue with his or her addiction or allow it to go untreated. This term can also be applied to the partners of depressed individuals, who may find themselves making excuses for their partner’s absences from social gatherings, family functions, work, etc. In this case, they are protecting their depressed partners from the disapproval of others or from the stigmatizing elements of the illness. Although the primary motivation is to protect the depressed individual, it may serve a secondary function of protecting the partner from the pain of his own disappointment or from the truth of how difficult and painful the situation may be. The danger in this ulterior motive is that it can develop into a form of denial. A better response than lying, even when the depressed person puts pressure to do so, would be to express the truth to others without being hurtful or embarrassing one’s depressed partner. Most important, both partners need to talk to one another about how to best convey the true nature of the depression without being destructive to the relationship. This can be worked on together with the couple in session 3 or 4.

4. *Denial.* In the more extreme cases, partners may be in denial about the severity or intensity of their loved one’s depression. They may tell themselves that the problem isn’t serious or that it is merely transitory, only to discover that their partners are indeed in a dismal state. It is understandably tempting to minimize the seriousness of the

depression in an attempt to feel more optimistic about the future. Unfortunately, this only hinders the process of facing the problem and working toward overcoming it.