

Marital and Family Processes in *Depression:*

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Couples Therapy for Depression: Using Healthy Relationships to Treat Depression

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The concordance rates between depression and marital distress have been reported to be as high as 50% (Beach, Jouriles, & O'Leary, 1985). Evidence has suggested that relationship distress frequently precedes the development of depressive symptoms (Beach & O'Leary, 1993; Markman, Duncan, Storaasli, & Howes, 1987; Schaefer & Burnett, 1987) and increases an individual's vulnerability to depression (e.g., Beach, Whisman, & O'Leary, 1994). Although not all depressive episodes are preceded by relationship distress, depression invariably has a negative effect on the quality of a couple's intimate relationship (Billings, Cronkite, & Moos, 1983; Birtchnell, 1988; Horwitz & White, 1991; Schuster, Kessler, & Aseltine, 1990; Weiss & Aved, 1978; Weissman, 1987). Given the reliable association between depression and marital distress, treating an individual's depression within the context of his or her marital relationship often may be a logical choice (Beach, Sandeen, & O'Leary, 1990). The individual is embedded within his or her marital relationship, and the depression inevitably both affects and is affected by the couple's ongoing day-to-day interactions (see Coyne and Benazon, chapter 2; Davila, chapter 4; and Katz, chapter 6). That partnership, therefore, can either be a source of strength and an asset to the individual's recovery or a source of further suffering and a hindrance to the health of both partners (see Whisman, chapter 1, for more detail).

Although several state-of-the-art treatments for unipolar depression have demonstrated some degree of effectiveness, there is certainly room for improvement. The National Institute of Mental Health Collaborative Depression Study reported recovery rates of 57% for imipramine plus clinical management, 55% for interpersonal psychotherapy (IPT), and 51% for cognitive-behavior therapy (Elkin et al., 1989). Similarly, in a component analysis of cognitive therapy (CT) for depression, Jacobson et al. (1996) reported a 58.3% recovery rate for a complete CT package and 50% and 56.4% recovery rates for the behavioral activation and automatic thoughts components, respectively. In addition, such treatments appear to result in long-term recovery for only about one half of treated individuals (e.g., Gortner, Gollan, Dobson, & Jacobson, 1998).

One possible reason that many individuals do not recover or relapse over time is that current treatments focus on treating the individual and do not attempt to directly affect his or her ongoing relationships. These treatments do not place a strong emphasis on factors such as having a supportive and responsive home environment. Indeed, some evidence has suggested that simply being married, in and of itself, increases the effectiveness of treatments for depression (Elkin et al., 1989; Jarrett, Eaves, Grannemann, & Rush, 1991; Thase & Simons, 1992). Furthermore, there also is evidence that the supportiveness of a spouse decreases the incidence of depression following stressful life events (Brown & Harris, 1978) and that marital distress increases the incidence rate of depression even above the rate for single individuals (Ross, 1995). Therefore, it appears reasonable to hypothesize

that treating depression in couples therapy, regardless of the presence or absence of co-occurring relationship distress, may result in faster recovery rates and lower relapse rates by fostering and maintaining a supportive marital relationship that responds effectively to the symptoms of depression.

Given such a likely benefit, couples treatments for depression have been explored several times. To date, however, systematized couples treatments for depression have focused exclusively on treating the depression by focusing on the marital distress (see Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). In this chapter, we explore the possibility of designing a couples therapy that addresses depression directly and that may therefore be equally applicable to couples who are not maritally distressed as well as to couples reporting significant marital distress. Specifically, we provide a detailed description of a treatment adapting couples therapy techniques for promoting acceptance, intimacy, and collaboration to the goals of a behavioral treatment for depression. We discuss methods for uniting the couple with a common perspective toward the depression and fostering a sense of "we-ness" and collaboration against the depression. We also discuss fostering partners' ability to respond flexibly to situations that might exacerbate the depression as well as their ability to effectively handle day-to-day challenges. In addition, we discuss building tolerance, preparing for relapse, and participating in active self-care. Finally, we discuss the importance of continual active engagement as partners both within the relationship and outside of the relationship. First, however, we present a brief review of the existing literature regarding marital therapy as a treatment for depression.

Previous Studies

Behavioral Marital Therapy

Behavioral marital therapy (BMT) as a treatment for depression has been the subject of several studies. Beach and O'Leary conducted one of the few well-controlled studies (Beach & O'Leary, 1992; O'Leary & Beach, 1990). In their study, maritally distressed couples in which the wife met the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III;* American Psychiatric Association, 1980) criteria for major depression or dysthymia were randomly assigned to BMT, Beck's (Beck, Rush, Shaw, & Emery, 1979) CT, or a wait-list control condition. The BMT procedures used are described in Beach, Sandeen, and O'Leary (1990) and consisted of the instigation of positive behavior, communication training, problem-solving training, and relapse prevention procedures (see also Jacobson & Margolin, 1979). The following results were found: (a) BMT and CT were equally effective at reducing depressive symptoms in comparison to the wait-list condition, and (b) BMT significantly outperformed CT in the alleviation of wives' marital distress. Interestingly, Beach and O'Leary (1992) found that for husbands, BMT and CT resulted in equal improvement in marital satisfaction. Beach and O'Leary noted, however, that the positive effects of CT on husbands' marital satisfaction may hold only for the mildly discordant subset as a result of attrition of the more discordant husbands in the CT sample.

At 1-year follow-up, Beach and O'Leary (1992) found that BMT wives continued to report significantly greater marital satisfaction than CT wives. Moreover, the effect of BMT on depression appeared to be mediated by marital satisfaction. That is, wives' depressive symptoms improved because their marital satisfaction improved. Furthermore, the evidence suggested a differential response to CT based on pretreatment levels of marital discord and cognitive distortion. Specifically, higher levels of pretreatment marital discord (and fewer cognitive distortions) were significantly more predictive of remaining depressive symptoms

for CT wives than for BMT wives. CT, however, did perform as well as BMT when wives reported lower levels of marital discord (and greater cognitive distortions).

Taken together, these two studies suggest that, for distressed couples, improving marital functioning is as effective as modifying individuals' cognitive distortions in the treatment of depression. In fact, the studies suggest that BMT may be more effective than CT at alleviating the symptoms of depression when relationship distress is high. Thus, if the goal is to treat depression, it appears that the clinician can target either the relationship between the individual and his or her partner or the individual's cognitions. However, if the goal is to treat marital distress, it appears that the clinician must target the relationship directly. One implication of these results is that marital therapy may be a more broadly applicable treatment for distressed couples, as it is capable of treating both relationship distress and individual depression.

To address the efficacy of BMT for depression when the couple is not maritally distressed, Jacobson and colleagues (Jacobson, Dobson, Fruzzetti, Schmalings, & Salusky, 1991) studied both distressed and nondistressed couples with a depressed wife. Couples were randomly assigned to BMT, CT, or a treatment in which individual CT sessions were interspersed with conjoint BMT sessions. Results of this study once again demonstrated a significant reduction in depressive symptoms in all three conditions. Furthermore, this study demonstrated that this symptom reduction occurred regardless of whether couples were distressed or not. As with the Beach and O'Leary (1992) study, only BMT resulted in significant gains in marital satisfaction. However, whereas Beach and O'Leary demonstrated that BMT and CT were equally effective as treatments for depression in a maritally distressed sample, the Jacobson et al. (1991) study demonstrated that the two treatments were not equivalent in a maritally nondistressed sample. Specifically, CT significantly outperformed BMT as a treatment for depression with nondistressed couples, whereas the two treatments were equivalently effective with distressed couples. It should be noted, however, that nondistressed couples' depressive symptoms did significantly improve (effect size = 1.67); they simply demonstrated less improvement than the couples in the CT group (effect size = 3.98).

Six- and 12-month follow-up of these couples revealed no differential relapse rates between the three conditions (Jacobson, Fruzzetti, Dobson, Whisman, & Hops, 1993). In fact, relapse rates were low in all conditions at 12 months (10%–15%). At 6-month follow-up, wives of nondistressed couples treated with BMT were more depressed than those treated with CT or with the combined treatment. However, at 12-month follow-up, there were no significant differences in wives' depression scores among the treatment conditions.

In summary, these studies suggest that treatments directed at improving the quality of the marital relationship effectively reduce the symptoms of depression and increase reported levels of marital satisfaction. Furthermore, treating the relationship appears to be as effective as treating an individual's dysfunctional thoughts for alleviating depressive symptoms and more effective for increasing marital satisfaction over the long run. However, the major caveat appears to be that, when a couple is not maritally distressed, individual CT is initially more effective for depression than marital therapy. In contrast, it appears that depressed individuals who also are maritally distressed are best served by marital therapy.

Cognitive Marital Therapy

Teichman, Bar-El, Shor, Sirota, and Elizur (1995) investigated the efficacy of cognitive marital therapy (CMT) as a treatment for depression. The primary aim of CMT "is to increase the insight of the spouses regarding their respective part in maintaining the

depression and then to motivate the search for alternative reciprocal patterns'' (p. 138). Three categories of depression-maintaining patterns were described: (a) overprotection (e.g., the depressed spouse's depression is maintained by the caretaking of his or her spouse); (b) hostility or ambivalence (e.g., the nondepressed partner both positively reinforces depressive behavior by caretaking and punishes the depressed partner by communicating irritation and contempt); and (c) complementary dysfunctional needs (e.g., self-enhancement, mutual dependency, irrational role assignments). This structured therapy is limited to 15 sessions and focuses on the cognitive, affective, behavioral, and interactive components of these depression-maintaining patterns (see Teichman & Teichman, 1990, for more detail).

Couples in which one spouse met *DSM-III-R* (American Psychiatric Association, 1987) criteria for major depression or dysthymia were randomly assigned to CMT, CT, or a wait-list control condition. Participants were not assessed for marital distress. Results indicated that the CMT group's depressive symptoms decreased significantly from pre- to posttherapy, whereas the CT group did not change significantly. Posttherapy, the CMT group reported significantly lower depression scores than the other groups, and CMT resulted in the fewest unrecovered patients compared with the CT and wait-list groups (33%, 87%, and 93%, respectively). Finally, the spouses of the depressed patients in the CMT group also reported significantly lower posttreatment depression scores than did the spouses of CT patients. In short, CMT outperformed CT as a treatment for depressive symptoms from pre- to posttherapy for both depressed patients and their spouses.

However, at 6-month follow-up, the CMT and CT groups both showed significant decreases in depressive symptoms, with no significant differences between the groups. In addition, both CMT and CT demonstrated equivalent rates of unrecovered patients (41.6% and 54.5%, respectively). Results were similarly equivalent for patients' spouses.

In a follow-up report, Teichman (1997) compared the three groups to a pharmacotherapy group (PT) treated primarily with amitriptyline. Results of the posttreatment comparisons demonstrated that the CMT group reported a marginally significant lower mean depression score than the other groups, with no significant differences emerging among the other groups. At 6-month follow-up, the CMT and CT groups reported significantly lower depression scores than the PT group, although the CMT and CT groups did not differ from each other. The results of these studies supported the results of the previous studies in demonstrating that marital therapy and CT appear to be equally effective treatments for depression in the long run (i.e., 6–12 months). Additionally, this study also suggested that a marital therapy designed to address marital interactions that maintain depression may result in faster symptom reduction for both depressed patients and their spouses than individual therapy. Addition of the PT group allowed these investigators to demonstrate that, although PT resulted in significant reductions in reported depressive symptoms, it performed poorly compared to CMT in the short run and poorly compared to both CMT and CT in the long run.

Unfortunately, because this study did not include a measure of marital satisfaction, it did not address questions regarding (a) the efficacy of CMT as a treatment for marital distress, (b) the potential mediating role of marital satisfaction in the relationship between CMT and depressive symptoms, or (c) the potential differential effects of CMT on maritally distressed versus nondistressed couples. It is highly likely that a substantial number of study couples were also maritally distressed, and a comparison of these two groups would have added substantially to the previous research.

Conjoint Marital Interpersonal Psychotherapy

Foley, Rounsaville, Weissman, Sholomaskas, and Chevron (1989) conducted a pilot study investigating the efficacy of conjoint marital interpersonal psychotherapy (IPT-CM) as a treatment for depression. The premise of IPT-CM is that depression develops within interpersonal contexts and that a treatment directed at interpersonal marital issues can be an effective treatment for depression. IPT-CM is described as focusing on five marital areas: communication, intimacy, boundary management, leadership, and attainment of socially appropriate goals. Specific problems in these areas are targeted for improvement, primarily by focusing on dysfunctional communication between spouses. Details of the IPT approach can be found in Klerman, Weissman, Rounsaville, and Chevron (1984).

Eighteen couples who attributed the presence of depression to discord within their marriage were randomly assigned to 16 weeks of either IPT-CM or individual IPT. Patients in both groups reported significant improvement in depressive symptoms and social adjustment from pre- to posttreatment; however, no significant differences were found between the two treatments. On the other hand, assessments of marital functioning revealed that IPT-CM patients were significantly better adjusted following treatment than IPT patients. In addition, patients' spouses also improved significantly in marital functioning from pre- to posttreatment regardless of treatment condition.

Consistent with the above studies, conjoint and individual treatments for depression appeared to be equally effective at reducing depressive symptoms. Differences between the two treatments emerged when level of marital adjustment was measured, with the individual treatment having had little effect on marital quality compared to the marital treatment.

Enhancing Marital Intimacy Therapy

Waring, Chamberlaine, Carver, Stalker, and Schaefer (1995) conducted a pilot study comparing enhancing marital intimacy therapy (EMIT) to a wait-list control group. EMIT is described as a therapy designed to "facilitate self-disclosure of personal constructs" (p. 4) as a means of building intimacy in the relationship. Waring et al. described the techniques of EMIT as involving self-disclosure of (a) each partner's explanation for the depression, (b) each partner's observations and experiences of their parents' marriages, (c) each partner's perspective on the early history of the relationship, and (d) each partner's relating of the current relationship to past relationships.

Participants were 17 couples with a depressed wife randomly assigned to either EMIT or a 10-week wait-list. Although both the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the Hamilton Depression Inventory (HDI; Hamilton, 1960) were used, depressed wives in the EMIT group showed improvement over the wait-list group only on the HDI. Following the treatment of some wait-list couples, analyses were conducted again on the somewhat larger sample ($n = 23$). This reanalysis revealed significant reductions on both measures of depressive symptoms. Thus, although it reflected the results of a pilot study with a small sample, this report demonstrated the robust nature of the effect of marital therapy on depression.

Replication From Outside the United States

These results also have been supported by research conducted in The Netherlands. Emanuels-Zuurveen and Emmelkamp (1996) compared the efficacy of a cognitive-behavioral individual treatment to a communication skills-based marital therapy in the

treatment of unipolar depression. Marital therapy procedures were based on those described by Beach et al. (1990) and on the communication-skills training techniques described by Emmelkamp and colleagues (Emmelkamp, Van Linden van der Heuvel, & Ruphan, 1988). This therapy consisted of 5 initial sessions devoted to examining any problems stemming from the depression that might have hindered marital therapy, such as complicated grief or low activity level, followed by 10 sessions focusing on communications-skills training, including active listening, assertiveness, and problem-solving training.

Thirty-six participants reporting depressive symptoms and significant marital distress were randomly assigned to one of the two treatment conditions. As with the above studies, the individual cognitive-behavioral treatment and the marital treatment were equally effective treatments for depression. Again, as with the above studies, marital treatment resulted in significantly greater improvements in marital satisfaction than individual treatment. The authors noted, however, that the marital treatment condition experienced more dropouts than the individual treatment condition and that many of the couples were disappointed that depression was not addressed specifically in the marital treatment.

Summary

Results are remarkably consistent across a variety of marital therapies. Marital therapy as a treatment for depression is significantly better than no treatment at all. Furthermore, marital therapy is as good or better than standard CT when applied in cases in which the depressed individual is also significantly maritally distressed. However, marital therapy has not been shown to be as effective a treatment for depression as CT when partners are not also maritally distressed. This, of course, makes perfect sense when one considers that these marital treatments were not intended to be direct treatments for depression, but instead were intended to have an effect on depression by alleviating marital distress. Without the presence of marital distress, traditional marital therapies may be limited in their effectiveness. However, a couples therapy designed to address depression as well as increase marital support and cohesion may be effective regardless of the presence or absence of marital distress.

Therefore, the remainder of this chapter describes a couples therapy designed for the treatment of depression regardless of the presence or absence of self-reported marital distress. The therapy described integrates the acceptance- and change-promoting approach of integrative behavioral couples therapy (IBCT; Christensen & Jacobson, 1991, 2000; Christensen, Jacobson, & Babcock, 1995; Cordova & Jacobson, 1993; Jacobson & Christensen, 1996) with a behavioral approach to the treatment of depression (Cordova & Jacobson, 1997).

Acceptance in Couples Therapy

IBCT rose from the desire to help those couples not benefiting from traditional BMT. Studies have suggested that the one third of couples least likely to benefit from BMT (Jacobson, Schmalings, & Holtzworth-Munroe, 1987) have tended to be severely distressed, older, emotionally disengaged (Baucom & Hoffman, 1986; Hahlweg, Schindler, Revenstorf, & Brengelmann, 1984), and polarized on basic issues (Jacobson, Follette, & Pagel, 1986). BMT was designed to teach couples new relationship skills and requires that partners work together to learn those skills. Partners who are too distressed and polarized simply cannot work together well enough to learn what BMT has to teach. IBCT was designed to repair the

collaborative capacity of these couples by fostering intimacy and closeness through acceptance.

Acceptance can be understood as a graceful coming to terms with those things about a relationship that are unlikely to change while at the same time working efficiently toward changing those things that can be changed (Cordova & Jacobson, 1993; Cordova & Kohlenberg, 1994). Acceptance techniques function to increase closeness and intimacy within a relationship despite the presence of specific irreconcilable differences. In therapeutic terms, couples are encouraged to "give up the struggle" to change the unchangeable and, therefore, to free up the time and energy previously lost to destructive change efforts for more healthy relationship behavior. It should be noted, however, that the type of acceptance proposed does not promote hopeless resignation or subjugation to unhealthy power differences. Therapy is not intended to promote depressive withdrawal from relationship engagement but instead to promote the ability to differentiate between what can be changed with hard work and what cannot. In essence, IBCT is intended to produce an active and effective couple by emphasizing both emotional acceptance and relationship change skills.

For example, when skill deficits are contributing to a couple's distress, fostering acceptance can promote the collaboration necessary to learn those skills. Alternatively, distressed couples may not have skill deficits, but may simply be too embattled to use the skills they do have effectively. In such cases, fostering acceptance can move the couple past destructive and unwinnable conflicts and allow them to use their skills more effectively. An approach designed to foster both emotional closeness and relationship skillfulness provides the appropriate blend of compassion and action necessary for effectively addressing unipolar depression regardless of the presence or absence of relationship distress (Cordova & Jacobson, 1997). If the couple is concurrently distressed, then the already empirically supported indirect approach to the treatment of depression is an immediate option. If, on the other hand, the couple is happily married, then that happy marriage can become the context in which the partners learn about and address the depression as a team.

We are emphasizing an acceptance-based approach to the treatment of depression for several reasons. First, it has been theorized that such an approach may simply be more generally effective than an exclusively change-oriented approach (Christensen & Jacobson, 1991, 2000; Christensen et al., 1995; Cordova & Jacobson, 1993; Jacobson & Christensen, 1996), and preliminary evidence has been presented to support this supposition (Cordova, Jacobson, & Christensen, 1998; Jacobson, Christensen, Prince, Cordova, & Eldridge, *in press*). In short, we believe this is a uniquely powerful form of couples therapy. Second, because depression may be a recurring condition (*cf.* Shea et al., 1992), the use of acceptance-based techniques for coping with recurrences seems appropriate. Coming to terms with depression as a potentially chronically recurring condition may aid couples in becoming effective agents of primary and secondary prevention as well as facilitators of tertiary intervention. Third, many of the ways in which depressed individuals and their partners respond to depression do more harm than good, and it is the unique goal of acceptance interventions to decrease the frequency and destructiveness of a couple's dysfunctional change attempts.

Couples Therapy for Depression

Couples therapy for depression (CTD) uses the techniques of IBCT to achieve the goals of a behavioral therapy for depression (*i.e.*, increased effective action). CTD is intended to be effective regardless of the depression's etiology and is intended to address both depression and marital distress simultaneously. It also is intended to be an effective treatment for

depression in the absence of significant marital distress. Working with nondistressed couples presents the challenge of fully integrating the nondepressed spouse and the relationship itself into a treatment for what is most commonly considered an individual problem. However, it also presents the advantage of a couple with an easily established collaborative set. In other words, although both partners may be affected by the depression, they are not also struggling directly with each other and are therefore in a better position to take advantage of the strengths inherent within their partnership. On the other hand, working with couples who are also significantly maritally distressed provides multiple targets for intervention. The relationship distress itself can be targeted as a means of both improving relationship satisfaction and alleviating depressive symptoms. Alternatively, the depression can be targeted as a means of not only treating the depression, but also as an issue through which the couple can reestablish intimacy, collaboration, and trust in their relationship. In other words, establishing a partnership in relation to the depression can serve as a vehicle for establishing relationship satisfaction. In summary, couples therapy can serve as a treatment context for depression, for relationship distress, or for both simultaneously, with the main difference being the range of possible intervention targets.

Given that several sources of information already exist describing acceptance in the treatment of marital distress (Christensen & Jacobson, 1991, 2000; Christensen et al., 1995; Cordova & Jacobson, 1993; Jacobson & Christensen, 1996), this chapter addresses treatment in the absence of significant marital distress. The absence of significant marital distress allows the therapist to target the depression directly. The following sections describe how a partnership that deals effectively with unipolar depression can be established.

The following are the basic therapeutic goals of CTD: (a) uniting the couple with a common perspective toward the depression, (b) increasing the partners' behavioral flexibility, (c) increasing the effective handling of aversive situations, and (d) promoting active exploration of the relationship and the environment. These treatment goals address the symptoms of depression by strengthening the couple's relationship and their capacity to work together to solve problems and pursue both common and individual goals. The following sections describe the pursuit of each goal in the treatment of depression.

Uniting the Couple With a Common Perspective

Uniting the couple with a common perspective from which to address the depression is initially the key goal of CTD. The idea of uniting a couple in relation to problems that may be difficult or impossible to solve is an adaptation of IBCT's unified detachment (e.g., Christensen et al., 1995; Jacobson & Christensen, 1996). Fostering a united perspective is the first goal of CTD because the remainder of therapy depends on the partners having adopted a position from which they are addressing the depression as a team. The goal is to actively involve both partners in treatment and to develop the relationship as a dependable source of social support. A unified perspective allows partners to regard the depression more accurately as a joint problem and not the sole responsibility or fault of either partner individually. Developing a somewhat detached perspective also allows partners to stay close to each other despite the depression rather than allowing the depression to drive them apart. The key to developing a unified detachment is to depict depression as an entity or process that is in a sense separable from the individual partners. In essence, depression is framed not as something residing inside the individual, but as a third party present within the relationship with its own agenda and effects.

Developing a Sense of "We-ness"

In the pursuit of a unified detachment, we talk of the couple developing a sense of "we-ness" similar to that described by Gottman (1994), in which the couple feels united in the struggle with depression rather than divided by it. As noted, this sense of we-ness is essential to CTD in that it is the context from which depression can be addressed by the couple as partners. We-ness undermines blame and criticism by allowing the couple to blame the depression rather than each other. We-ness provides a sense of being able to work together effectively and facilitates both partners taking an active role in addressing their common enemy. Once this sense is developed, the depressed partner no longer has to cope with the depression alone, but is joined by his or her partner, thus tapping into a powerful source of support. In addition, the nondepressed partner is included in treatment as a genuinely essential component, thus avoiding any sense of being excluded from a fundamentally important part of his or her partner's life and fostering a sense of effectiveness and agency to counteract feelings of helplessness in the face of the other's depression.

The first step to developing a sense of we-ness is to provide the couple with a thorough and objective education about depression. The rationale is to begin to objectify depression as a thing, to educate the partners about their common enemy, and to clarify any misinformation about depression that the partners might have brought with them into therapy. The therapist should explain how depression is conceptualized in the DSM, discuss the possible causes debated in the literature, and outline what is known about the effects of depression on intimate relationships. Partners are encouraged to take personal responsibility for learning as much as they can about the condition they are dealing with. The goal is to promote a sense of agency through which the couple begins to face their problem as fully integrated partners.

We-ness also can be promoted through an adaptation of the empty-chair method. The empty-chair method simply involves talking about the depression as though it were seated in an empty chair in the therapy room. The idea is to use a physical prop to facilitate the partners' conceptualization of the depression as a third party in their relationship, with its own causes, its own effects, its own agenda, and its own existence apart from either partner. Essentially, depression is formulated as an unwelcome guest in the couple's relationship. Furthermore, it is discussed as something for which neither partner is to blame, but something for which both partners ultimately are responsible. In other words, once the depression is placed in the chair, it is acknowledged that neither partner is to blame for it but that both partners are responsible for actively addressing it, monitoring it, coping with it, and working to prevent its recurrence.

Promoting Self-Observation

Unified detachment also can be promoted through assisting couples in objective, non-judgmental self-observation. Self-observation is an important component of treatment because depressed individuals frequently use destructive strategies (e.g., substance abuse, excessive distraction, and suicide) to escape from their own feelings of despair. However, escape from one's own thoughts and feelings is practically impossible, and attempts to do so are ultimately fruitless and self-destructive. Self-observation facilitates acceptance of distressing thoughts and feelings because the act of observing oneself is incompatible with the avoidance, withdrawal, and aggression that often interfere with more appropriate responses (Cordova, 1998). The goal of CTD is to foster acceptance of private experiences exactly because those experiences cannot be effectively addressed in any other way. Self-observation provides the perspective from which the depressed individual can simply attend

to the ebb and flow of his or her thoughts and feelings without attempting to control them. In addition, the shared outlook that the partners construct allows them to observe their own private experiences, get to know them, become comfortable with them, and begin to accept them without the disheartening work of trying to deny, denigrate or destroy them. In particular, the depressed individual is provided a perspective from which he or she can watch the thoughts and feelings associated with the depression without "buying into" them, without struggling with them, and without evaluating them as necessarily good, bad, foolish, or shameful. The depressed individual is allowed the perspective from which to simply watch these thoughts and feelings come and go of their own accord. The short-term goal of promoting a repertoire of active self-observation is to undermine the depression about the depression and establish a sense of nurturance and acceptance toward the depressed individual's own experience. The long-term goal is to free up the time and energy wasted on ineffective attempts to destroy undeniable feelings for the pursuit of other more attainable goals.

Self-observation is also beneficial to the nondepressed partner. The nondepressed partner may seem to experience two competing inclinations in response to the other's depressive behavior. One inclination is to respond solicitously (e.g., offering help and comfort), whereas the other is to be irritated and frustrated (which precipitates verbal aggression and withdrawal; e.g., Biglan, 1991; Coyne, 1976; Lovejoy & Busch, 1993). The nondepressed partner may initially act on his or her first inclination and engage in a great deal of caretaking behavior intended to alleviate the depressed partner's suffering. However, that behavior often carries undertones of irritation, providing the depressed individual with a mixed message of both loving support and critical anger. Over time, the nondepressed partner often becomes more openly angry as solicitous responses become increasingly fruitless. Furthermore, the nondistressed partner may find himself or herself actively avoiding his or her partner or physically withdrawing when depressive symptoms are present. As with the depressed partner, self-observation from a shared perspective allows the nondepressed partner to begin the process of coming to terms with his or her own undeniable private experiences. Because it appears that these mixed emotions are unavoidable, fostering their acceptance allows both partners to recognize that these feelings are normal, nonmalicious, and inescapable and that they need not be denied or eliminated to respond well as partners. Although self-observation is sometimes difficult to learn, it is made easier when it initially requires that the individual simply describe out loud the thoughts and feelings he or she is observing.

In addition, self-observation can help the couple recognize the interaction patterns that may be common within relationships with a depressed partner. For example, there is evidence that depressed individuals engage in excessive reassurance and negative feedback seeking (see Joiner, chapter 7), which may, in turn, lead their partners to respond with solicitousness, then irritation, and eventually withdrawal. By observing the interaction pattern, the couple can learn to tolerate these occasional aversive interactions without completely withdrawing from interacting altogether. The couple can see that they sometimes get stuck in this pattern and that they are able to move through it without damaging their relationship, so long as they do not wholly withdraw from each other to avoid this type of interaction.

Increasing Partners' Behavioral Flexibility

A second goal of CTD is to increase both partners' behavioral flexibility. Behavioral flexibility is an important objective of treatment because rigidity and passivity predispose

individuals to depression by limiting their ability to actively adapt to changing environments (Cordova & Jacobson, 1997). In other words, the absence or suppression of responses that enable adaptation to changing contingencies results in a shrinking repertoire of effective behavior and a subsequent increase in contact with aversive relational stimuli (i.e., arguments and unresolved problems). As an individual's ability to behave effectively diminishes, he or she becomes increasingly vulnerable to depression. The depressed individual is gradually left with little he or she can do to effect positive change, resulting in depressed mood, irritability, loss of motivation, anhedonia, and the host of other symptoms commonly associated with clinical depression.

For example, the transition to parenthood is a predictably stressful time for couples and has been associated with deterioration in marital satisfaction (Belsky, 1990). Such a transition requires a great deal of adaptive coping from both partners. Partners who attempt to carry on exactly as they did before parenthood are likely to find that a great deal of that behavior is no longer functional and that much of the behavior necessary for parenting is missing. Intimacy between partners may begin to deteriorate as the demands of parenthood increase. Failure to adapt increases vulnerability to depression by decreasing positive interactions within and outside of the relationship and increasing negative interactions. CTD aims to foster the emergence of flexible repertoires capable of adapting to changing circumstances, rebuilding depleted resources, and preparing for future transitions.

Another type of rigidity that couples are susceptible to involves becoming stuck in emotionally negative ways of thinking about and responding to specific problems in the relationship. Specific topics or issues in the relationship can set the stage for repetitive patterns characterized by negative assumptions about each other and heated, angry exchanges. These patterns, because they are practically guaranteed to be exceptionally aversive and ultimately ineffective, are classically depressogenic because they require an enormous amount of time and energy with absolutely no positive payoff. In such cases, promoting greater mutual empathic understanding of each partner's role in the pattern fosters partners' behavioral flexibility. Promoting empathy increases flexibility by changing the emotional context within which the problematic interaction has characteristically occurred. It is often the case that affecting the emotional climate surrounding a particular issue can have a dramatic effect on the interaction itself. Sometimes an emotional shift from blaming accusation to empathic understanding eradicates the problematic interaction pattern altogether. Other times it aids in easing the partners in and out of the pattern, therefore limiting the amount of damage that pattern does to the relationship.

These rigid patterns are also likely to develop in relation to the depression itself. Therefore, partners are encouraged to talk about their experiences of the depression and the feelings involved in the struggle to overcome it. The nondepressed partner is encouraged to share the softer, more vulnerable feelings (e.g., fear, desperation, hurt, or loneliness) that may be motivating the harder expressions of anger, criticism, and withdrawal in response to the depression. This effort is necessary because it is important for the depressed spouse to experience genuine empathy for the struggles of the nondepressed spouse in relation to the depression. In addition, reestablishing empathy from the nondepressed spouse to the depressed spouse is necessary because of the previously mentioned evidence that the behavior of depressed individuals tends to erode empathy over time and elicit feelings of irritation and withdrawal (e.g., Biglan, 1991; Coyne, 1976; Lovejoy & Busch, 1993).

Reestablishing empathy provides other benefits as well. First, couple cohesion increases when each partner feels equally supported by the other. Second, the elicitation of empathy from the depressed spouse toward the nondepressed spouse, if done in a way that does not feed into already established feelings of guilt, provides the depressed partner with a

focus outside of the self. Because the salience of positive environmental stimuli is diminished by a preoccupation with private thoughts and feelings, drawing the depressed individual out of himself or herself and back into the relationship is theorized to begin the process of reestablishing environmental control over positively reinforced behavior. Third, reestablishing empathy not only increases understanding about the effects of depression on the partners, but also creates the emotional closeness necessary to collaborate in its treatment and monitoring. Finally, and perhaps most important, building intimacy in the relationship and the competence with which the partners facilitate and engage in intimate interactions is exactly the type of effective interpersonal behavior that is theorized to alleviate depression.

Increasing the Effective Handling of Aversive Situations

Increasing the effective handling of aversive situations is another goal of CTD. A great deal of depressogenic behavior consists of passive or passive-aggressive responses to problems that are genuinely solvable. Similarly, depressogenic behavior often consists of struggles to avoid or destroy problems that cannot be changed. In such cases, learning to distinguish those things that can be changed from those that cannot helps partners manage their efforts more effectively and avoid unproductive struggles. In general, problems that are amenable to active problem-solving strategies are overt, operantly shaped, or otherwise changeable through direct action. Problems that are not amenable to problem-solving strategies tend to be private (e.g., thoughts, feelings), unconditionally respondent, or simply unavailable for manipulation. For solvable problems, therapy promotes collaborative problem solving and active social support. On the other hand, for unsolvable problems (e.g., partner or relationship characteristic that cannot be changed constructively), acceptance is promoted as the most effective type of response (Cordova & Jacobson, 1997). Struggling to change the unchangeable is depressogenic, and freeing up the time and energy devoted to that struggle should be a central aspect of effective therapy.

Relinquishing the struggle to change the unchangeable is often best accomplished through strategies that foster tolerance. Tolerance-promoting techniques include providing understandable reasons for the depression and the behaviors associated with it, highlighting the positive features of the relationship despite the depression, and preparing in advance for relapse.

Providing understandable reasons for the depression and the behaviors associated with it was discussed earlier as a means of uniting couples with a shared perspective. Understandable reasons also promote tolerance by emphasizing that neither partner is to blame for the depression. For example, if a couple considers the depression to be caused by an environmental insufficiency, rather than personal inadequacy, then they are much less likely to feel shame and self-loathing and more likely to actively address those environmental deficiencies. In addition, if partners come to understand that learning to genuinely tolerate occasional feelings of depression is the surest means of getting on with an active and meaningful life, then they are less likely to become completely distracted by misguided attempts to control day-to-day variations in mood.

Highlighting the positive features of the relationship places the depression within its proper context as simply one aspect of a much larger life together. Tolerance develops as a result of recognizing that the symptoms of depression coexist with many other enjoyable and meaningful experiences. CTD involves redirecting partners toward those meaningful activities that remain available to them in living a quality life. The message conveyed is that an individual can value himself or herself, his or her life, his or her partner, and his or her

relationship as vital components of a life that also sometimes includes the symptoms of depression. It is assumed that a depressed mood cannot simply be willed away and that vulnerability to depression may be a chronic condition. Depressive moods may come and go as a function of the transactions between an individual and his or her environment, and a meaningful life can be pursued despite moment-to-moment variations in mood.

Tolerance is also built by preparing couples for depressive relapse. Such preparation accomplishes two things. First, it prepares partners emotionally for the possibility that depression may recur. Preparing a couple for relapse decreases the probability that they will be emotionally devastated by future episodes. Second, discussing the possibility of relapse allows partners to prepare effective responses to reemergent symptoms and depressogenic life events (e.g., a death in the family or relocation). Again, the assumption is that a vulnerability to depression may be chronic and that additional depressive episodes may occur. Given this, it seems prudent to prepare depressed individuals and their spouses for possible recurrences. This discussion with the couple evolves naturally from previous discussions of the depression as an unwelcome guest for which neither partner is to blame. Such unwelcome guests, much like the flu or misfortune, at times cannot be avoided, but can still be dealt with successfully. CTD discusses the concept of living with and despite the occasional period of depressive mood, rather than living in fear of it or in response to it.

Preparation for relapse involves working with the couple to identify foreseeable events that might set the stage for subsequent depressive episodes. Identifying such events in advance allows the couple to be prepared by allowing them the opportunity to discuss active coping strategies and means of broadening their available repertoires as an inoculation against depression. Preparation for relapse also involves preparing the couple to recognize and respond to early signs of relapse. Recognition of the early signs of relapse requires becoming familiar with depressive symptoms as they might manifest themselves in overt behavior (or the lack of it), in mood, and in thinking processes. It also requires understanding the partners' vulnerabilities and the types of environmental changes that might interact with those vulnerabilities. For example, if one partner recognizes that he is often strongly affected by criticism at work, then he and his partner are better able to recognize when that might be affecting his mood. Recognizing such events allows the couple to tap directly into their skills for dealing with such events, such as discussing what can be done to address the criticisms or the critic, recognizing that the mood will pass, or focusing on other areas of life that are sources of effective activity.

Communication and Problem-Solving Training

Another means of promoting the effective handling of aversive circumstances is through training in effective communication and problem-solving skills. The implementation of communication and problem-solving training is described only briefly, as detailed descriptions of these techniques can be found in numerous other sources (e.g., Cordova & Jacobson, 1993).

Communication training consists primarily of teaching couples simple, concrete steps to ease communication and decrease the probability of misunderstandings. These steps include (a) keeping the message short, (b) focusing on the speaker's perspective, (c) avoiding blame and criticism, and (d) paraphrasing the speaker's message. Although treatment does not require couples to adhere to a particular style of communication, for those couples experiencing severe communication difficulties, communication training provides a useful structure within which other therapy goals can be pursued. A tool such as communica-

tion training may be necessary only with those couples whose communication skills are inadequate for dealing effectively with the presence of depression in their relationship. However, for those couples, communication training may be an essential step toward tapping into their capacity to support each other and work together collaboratively in the treatment of the depression. In addition, improving their communication skills may, in and of itself, contribute to improvement as it adds to their repertoire of effective interpersonal behaviors.

Problem-solving training teaches couples concrete strategies for dealing with negotiable problems in their relationship. Problem-solving techniques are taught as a means of effectively approaching problems that can be changed through problem identification and concrete solutions. Problem solving begins with problem definition, proceeds through brainstorming solutions to sorting solutions into the feasible and unfeasible, and finally moves to deriving a change agreement. As with communication training, problem-solving training is hypothesized to aid in the treatment of depression by providing partners with more effective relationship skills. This cooperative problem-solving strategy usually is implemented in the context of relationship problems, and it has been found to be remarkably effective. Additionally, within CTD, this cooperative problem-solving strategy is promoted as a means for a couple to jointly address problems they can face together. Cooperative problem solving is also useful even when one partner must ultimately implement the solution independently. In such cases, problem solving works as a social support tool in that both partners can work together to develop a response plan for one of them.

Beyond focusing on how partners can function as a team in the context of depression, individual self-care skills are also promoted. CTD helps each partner identify areas in which his or her individual efforts are required and guides the development of appropriate self-care skills. Thus, although partners work together, neither can afford to delegate ultimate responsibility for his or her own well-being. No relationship can fulfill every individual need and desire completely, and each partner must be willing and able to supplement his or her relationship with outside sources (e.g., outside friendships, activities).

Promoting Active Exploration and Reactivation

A broad, flexible, and active repertoire is believed to be the key to preventing depression as well as a key to recovery (Cordova & Jacobson, 1997). Therefore, the final component of CTD is promoting an active exploration of and engagement in both the interpersonal and external environment. Exploration of the interpersonal environment is aided by the increased emotional closeness and relationship skills promoted during therapy. Active exploration of the external environment is promoted in therapy through exploration of activities that both members of the couple can participate in together as well as activities that each can participate in individually. Partners are encouraged to seek out opportunities to increase the number and variety of activities available to them as a means of building and maintaining large, effective repertoires.

In individual treatments for depression, behavioral activation often takes the form of coaching an individual to brainstorm a list of possible activities and to try each systematically. The downside of this individual approach is that the individual is sent out alone to try to implement those suggestions without any guarantee of social or other environmental support. By including the spouse as an integral aspect of this endeavor, the depressed individual is not alone in his or her efforts but is instead part of a loving team working toward a mutual goal. In individual approaches, even if the depressed partner wants the spouse's

assistance, the spouse must first be convinced of the importance of participating. This often is easier to accomplish in couples therapy where the mutual benefits can be made obvious by the therapist.

The therapist describes the rationale behind actively increasing both joint and individual activity. The rationale is that developing a repertoire of active exploration fosters increased closeness and satisfaction in the relationship and decreases both partners' vulnerability to depression. As in individual therapy, the couple is asked to brainstorm and create a list of possible joint activities, including ideas that might seem silly or unreasonable. The brainstorming process is intended to be enjoyable in and of itself, and couples should be encouraged to take a lighthearted and playful approach to the task. The couple is then directed to talk about the items and choose one they will do together before the next session. Explicit plans are made, including selecting a day and a time and preparing for foreseeable difficulties. Choosing one or more joint activities for the week remains at least a brief part of subsequent sessions. These activities can be new ones or can include activities that become a regular part of the couple's routine (e.g., breakfast out once a week).

Enjoyable or meaningful individual activities are also chosen in the same fashion. Both partners work together to think of things each can do to be active and effective over the course of the next week. Daily schedules like those used in CT are useful in this endeavor, especially for individuals whose activity levels are limited. Again, once a list has been compiled for each partner, a handful of activities can be chosen by each, those activities can be scheduled, and potential obstacles can be prepared for.

The couple also should be engaged in a discussion emphasizing the necessity of being actively exploratory on an ongoing basis. The rationale to be shared with the couple is that continually exploring within and outside of the relationship for new activities and new responses will add to the richness of their lives and will nurture a growing and flexible repertoire more resilient to the vicissitudes of life. Thus, couples should come to understand that actively pursuing novel experiences is essential, and that continually adding to their abilities and experiences is something to be valued and pursued.

Conclusion

To date, marital therapies for depression have treated the symptoms of depression indirectly by directly treating the causes of marital distress. The empirical literature has consistently demonstrated that this indirect approach to the treatment of depression is as effective as individual treatments for depression, with the added benefit of being significantly more effective at improving partners' marital satisfaction. However, it appears that such indirect treatments are of lesser value to depressed individuals whose relationships are not distressed. It has been our contention that a couples treatment designed to treat depression directly rather than indirectly can be a benefit to depressed individuals regardless of the presence or absence of concurrent relationship distress. Furthermore, we have speculated that such a treatment could potentially be more powerful than individual treatments, both in terms of speeding the process of symptom reduction and in terms of decreasing the likelihood of depressive relapse.

CTD is a couples treatment specifically applicable to depression. Based on behavioral theories of depression and relationship distress, and incorporating techniques for fostering acceptance and facilitating change, CTD is intended to be flexible enough to help most couples effectively cope with unipolar depression and relationship distress. This treatment, however, has yet to be tested empirically. Thus, although our hopes for its usefulness are

high and the bases for its success as a treatment appear sound, its efficacy remains to be demonstrated.

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