ABSTRACT

Title of Document: DEPRESSION IN ONE OR BOTH PARTNERS AND THE EFFICACY OF COUPLE THERAPY

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Although considerable research has been conducted on common factors affecting individual therapy, little research has investigated common factors in couple therapy. The present study examines depression in one or both partners as one of the potential common client factors affecting couple therapy. The study uses data from 55 couples who sought therapy for relationship issues at a large university-based family therapy clinic that serves an ethnically diverse population. The results suggest that, at least within the range of depression represented in this couple and family therapy clinic sample, there is no difference in therapy outcome between couples experiencing mild depression and those with minimal to no depression. However, there was some evidence that therapy was less effective when the *male* partner suffered from depression. This study is important in redirecting the attention of couple therapists to males' depression as opposed to the traditional focus on females' depression.

DEPRESSION IN ONE OR BOTH PARTNERS AND THE EFFICACY OF COUPLE THERAPY

BY

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Statement of the Problem

There is a strong correlation between distress within couples' relationships and partners' experiences of depression, and Riso, Blandino, Hendricks, Grant, and Duin (2002) report that depression is found to be 25 times more common in individuals with distressed versus non-distressed marriages. Although it is unclear from correlational studies whether low relationship satisfaction plays a causal role in the development of depression symptoms or whether depression leads to relationship distress, it is clear that many couples who seek therapy for problems in their relationships may have one or both partners suffering from depression. More recent studies that have more directly tested the causal direction between depression and relationship distress have provided evidence that the influence can go in either direction (Beach, Dreifuss, Franklin, Kamen, & Gabriel, 2008). In either case, because of their mutual influence, once relationship distress and depression co-occur in a couple's relationship, therapists must take both into account.

In addition, there is reason to believe that the characteristics of depression (e.g., loss of interest, hopelessness, helplessness, fatigue, social withdrawal) (American Psychiatric Association, 1994) may have a negative impact on the progress of couple therapy and need to be taken into account when clinicians are working with couples who experience both depression and relationship problems. Depression consists of a variety of cognitive, emotional, physiological, and behavioral symptoms that seem likely to impede couples' engagement and progress in therapy. For example, the pessimism or hopelessness that commonly is associated with depression may cause clients to believe

that their problems are unsolvable, prevent them from believing that therapy can be beneficial, and lead them to put little effort into therapy. The related depression symptom of helplessness, an expectancy that one's efforts to solve problems will be ineffective, can manifest in a lack of motivation, either preventing clients from seeking therapy or interfering with their active participation with therapeutic recommendations and assignments. The global negative perceptions of life events that are typical of depressed individuals also may interfere with couple therapy if a depressed individual focuses on a partner's negative characteristics or behavior and systematically overlooks the partner's positives (Beach et al., 2008). Physical symptoms such as diminished energy, insomnia, and low sex drive, as well as the common depression behavioral symptom of social withdrawal, also may interfere with partners' motivation and ability to take part in the work involved in couple therapy.

Much research on depression has addressed how the qualities of depression affect individuals' interpersonal relationships as well as their functioning in other roles in life such as their occupations. However, there is a gap in the literature, in that prior studies have not examined how depression may serve as a barrier to the efficacy of couple therapy. This is a significant gap in knowledge about therapy with distressed couples, because the success of couple therapy depends on engaging both members of a couple in treatment, and any factor that interferes with one or both partners' participation will limit the effectiveness of the therapist's efforts. Therefore, this study examines the extent to which, in a sample of couples who have sought therapy for relationship problems, one or both partners' levels of depression at the initiation of treatment predict the degree of progress in therapy. The study will investigate whether progress in couple therapy varies

depending on whether one or both partners experience symptoms of depression, in spite of the fact that both members of the couple were sufficiently motivated to attend therapy. The results of this study will have implications for couple therapists' approaches to addressing the characteristics of depression while working on relationship issues.

Purpose

The purpose of this study is to examine the degree to which partners' levels of depression when they enter couple therapy influence the effectiveness of the therapy. Because 16% of Americans will suffer from depression at some point in their lives (www.depression.com), and there is considerable evidence that forms of individual and couple therapy can help many of these individuals overcome their depression, it is critical to examine how the characteristics of depression (e.g., loss of interest, hopelessness, helplessness, fatigue, social withdrawal) (American Psychiatric Association, 1994) can serve as barriers to therapy. A negative correlation consistently has been found between level of depression and relationship satisfaction (Beach et al., 2008). Therefore, a large percentage of individuals who present with relationship problems also are likely to be experiencing some degree of depression. Although there is evidence that couple therapy has the potential to alleviate partners' depression among couples in which the two problems co-occur (Beach et al., 2008), little is known about the degree to which depression interferes with partners' engagement in the work of couple therapy and ultimately with its effectiveness. The aim of the present study is to examine the extent to which depression in one or both partners is a risk factor for lower efficacy of couple therapy. The results of the study may help clinicians who work with couples in which one or both partners are depressed to take the depression into account so that treatment of

couple issues can occur without therapy being negatively impacted by the characteristics of depression. If a negative association between depression and efficacy of therapy is found, it would be important to integrate aspects of treatment that would address these depression-related barriers to effective couple therapy. Thus, the findings will have important implications for treatment plans, which may need to include integration of interventions for depression with those for couple interaction patterns.

Literature Review

The following review covers literature regarding both depression and couple relationship distress. The sample for the present study includes both married and unmarried couples, but the studies cited in the literature review vary regarding the marital status of the samples. Consequently, the marital statuses within each study's sample will be described, and the relevance of the findings for the current study's sample can be considered. A second factor regarding the generalizability of prior studies and the present one involves the sexual orientations of the sample participants. Studies identified through my review of prior research on depression in the couple context have used heterosexual samples, and the present sample also is restricted to heterosexual couples, due to the small percentage of gay and lesbian couples who seek therapy at the clinic where the data were collected. Although it would be easy to assume that depression and relationship distress are related similarly in homosexual and heterosexual couples, there is a lack of prior research findings to support that assumption, so the findings from this study cannot be generalized to homosexual couples.

Finally, the review of literature incorporates terms such as "satisfaction/distress," and "adjustment/maladjustment," to connote the quality of couple or marital functioning.

This diversity of terms is associated with a lack of consensus about the characteristics of relationships that are measured by widely used instruments such as the Dyadic Adjustment Scale (DAS; Spanier, 1976). This study will use the term "couple relationship distress" to incorporate the subjective thoughts and emotions involved in an individual's overall level of relationship satisfaction. Although measures such as the DAS include items that assess individuals' cognitions and behavior as well as their emotional responses to their relationships, total scores on the measures tend to tap global positive versus negative feelings about the relationship. Consequently, the terms "satisfaction" and "distress," which are widely used in the literature, will be used in the current study as well to describe the ends of a continuum for individuals' overall positive or negative feelings about their couple relationship.

Depression. Depression is highly prevalent in contemporary society. As previously stated, 16% of Americans suffer from depression at some point in their lives (www.depression.com). According to Sandberg, Miller, and Harper (2002), depression represents a major national public health problem, ranking among the top ten most costly disorders in the U.S. Depression is considered to be as physically and mentally disabling as the most severe chronic medical disorders (Sandberg et al., 2002). In addition, the occurrence of episodes of depression in individuals' lives are predictive of further episodes. For example, O'Connor (2003) found that individuals who have one episode of diagnosed major depression have a 50% likelihood of having another; those who have three episodes are 90% more likely to have repeated incidents. Angst (1986) estimated that once depressed individuals enter outpatient treatment, they are likely to spend 20% of their lives depressed. A 12-year prospective study of over 400 patients seeking

treatment for depression in psychiatric settings found that they spent 15% of this time meeting full criteria for major depression (Judd et al., 1998). Therefore, depression is extremely common and chronic, and once an individual has an episode of depression he or she has a high probability of having to continue dealing with issues of depression in the future.

It is important to differentiate between depression as discrete diagnostic categories of disorders such as major depressive disorder or dysthymic disorder (in which an individual either has a disorder or does not) and depression as a set of symptoms that vary along a continuum of severity. According to the DSM IV-TR (1994), major depressive disorder is characterized by five or more of the following symptoms present within the same two week period, representing a change from the individual's prior functioning:

> (1) Depressed mood most of the day, nearly every day (in children and adolescents, can be irritable mood); (2) markedly diminished interest or pleasure in almost or all activities; (3) significant weight loss when not dieting or weight gain; (4) insomnia or hypersomnia nearly every day; (5) psychomotor agitation or retardation; (6) fatigue or loss of energy nearly every day; (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional); (8) diminished ability to think or concentrate or indecisiveness; and (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan, or a suicide attempt or a specific plan for committing suicide. (p. 169)

At least five of these symptoms must cause significant distress in social and occupational areas of the individual's functioning, and the symptoms cannot be explained by the loss of a loved one or bereavement. Dysthymia is a form of depression that is less severe and debilitating than major depressive disorder but is more chronic. It is defined as depressed

mood for most of the day, as indicated either by the individual's own subjective account or the observation of others, for at least two years (American Psychiatric Association, 1994). Along with the dysthymic depressed mood, there must be two or more of the following symptoms:

> (1) Poor appetite or overeating; (2) insomnia or hypersomnia; (3) low energy or fatigue; (4) low self-esteem; (5) poor concentration or difficulty making decisions; and (6) feeling hopeless. (American Psychiatric Association, 1994, p. 177)

Some studies that have examined the association between relationship distress and depression have focused on individuals with versus without such discrete diagnoses, whereas other studies have tested the correlation between degree of relationship distress and severity of depression symptoms along a continuum ranging from none to severe. Often, individuals experience symptoms of depression that can be represented along a continuum based on severity and frequency. Although for some individuals these symptoms may reach a level of severity that qualify the person for a clinical diagnosis of a depressive disorder, many other individuals experience lower levels of symptom frequency and severity that fail to reach diagnostic criteria but still are problematic and can impair interpersonal as well as occupational functioning. These characteristics include a variety of cognitive (e.g., hopelessness, low self-esteem, suicidal thoughts), affective (e.g., low mood, loss pleasure in activities, feelings of guilt), physiological (e.g., fatigue, loss of appetite, insomnia, diminished sex drive), and behavioral (e.g., social withdrawal, clinging, procrastination) symptoms (American Psychiatric Association, 1994).

According to Blazer (2003), although there is a lower prevalence of diagnosable depressive disorders among older adults than among younger individuals, rates of clinically significant yet non-diagnosable depression symptoms in samples of older adults range from 8-16%. The experience of sub-diagnosable depression symptoms also increases the risk for subsequent diagnosable depressive syndromes (Blazer, 2003). Assessment instruments that measure level of depression typically measure the severity of symptoms. For example, the widely used Beck Depression Inventory (BDI; Beck, Rush, Shaw & Emery, 1979) measures depression symptoms on a continuum of severity. The present study uses severity of depression symptoms representing varying levels of depression, based on prior research evidence that depression severity is associated with the degree of relationship distress in samples of couples who have sought therapy, similarly to the current study's sample. Given that the current sample of couples sought relationship therapy rather than individual treatment for depression, focusing on depression as a continuum rather than as a diagnosable disorder is more relevant.

Depression and Relationship Satisfaction. Depression and subjective relationship distress tend to coexist (Beach et al., 2008). Although correlational studies leave it unclear whether depression contributes to low relationship satisfaction or vice versa, or causality operates in both directions, it is clear that the two are related. Mead (2002) found that individuals with a history of major depression had a 70% greater chance of separation or divorce in the next year than individuals without major depression. In a study by Riso et al. (2002), depression was found to be 25 times more common in individuals with distressed versus non-distressed marriages. In a meta-analysis conducted by Whisman (2001) of 26 studies involving 3,700 women and 2,700

men, marital dissatisfaction was shown to account for approximately 18% of the variance in wives' and 14% of the variance in husbands' depression symptoms. Riso et al. (2002) also found that marital stressors were the most frequently reported precursors to hospitalization for depressed individuals.

Further evidence that there is an association between relationship distress and depression comes from treatment studies in which interventions that are designed to increase partners' levels of relationship satisfaction also decrease their depression. Treatment outcome research with depressed maritally discordant individuals indicates that behavioral marital therapy results in increased marital satisfaction and decreased levels of depression (Riso et al., 2002). Jacobson et al. (1993) found that when husbands became less distressed and more supportive toward their wives during the course of therapy, their wives were more likely to be non-depressed subsequent to therapy and more likely to maintain their lack of depression for at least a year. According to Beach et al., (2008), many distressed couples who were depressed became less depressed as their relationship improved during couple therapy. Therefore, both the quality of the couple relationship and the degree of improvement in the relationship during therapy are strong predictors of subsequent decreases in partners' depression.

Although increasing relationship satisfaction through couple therapy has been found to alleviate depression symptoms, researchers have also found that depression can have a negative effect on therapy. It is important to understand the characteristics of depression that pose risks for lower degrees of improvement in relationship functioning during couple therapy.

The effect of depression on relationships. Depression can lead both partners in distressed couples to feel isolated and distant from each other, to perceive that their relationship has lower cohesion than it once did, and in some cases, to suspect that their relationship never had closeness and intimacy (Beach et al., 2008). According to Beach et al., (2008), some of the supportive processes that are lost when couples experience depression in the context of low couple satisfaction include:

> (1) Couple cohesion and shared pleasant activities; (2) acceptance of emotional expression and disclosure of personal feelings; (3) actual and perceived coping assistance in dealing with environmental and relationship stressors; (4) self-esteem support and positive, non-critical feedback; (5) perceived spousal dependability, availability, and commitment; and (6) intimacy and confiding in the spouse. (p. 550)

Whisman (2001) found that marital dissatisfaction is likely to contribute to increased risk of depression by increasing levels of stress and hostility between the partners (e.g., through verbal and physical aggression and threats of separation and divorce). In turn, depression tends to predict greater negative behavior toward the partner, which in turn, creates greater relationship distress. In a study by Beckerman (2001), couple therapists reported that the most common presenting problem among couples with depression was emotional distance in the relationship. This emotional distance is usually perceived by the partners as alienation and is frequently characterized by lack of communication and physical intimacy. Coyne and Benazon (2001) found that depression may come to dominate the marital interactions of some couples so that it becomes an overwhelming barrier to communication and use of problem-solving skills.

Communication in couples experiencing depression. An association between depression and quality of couple communication has been demonstrated. Researchers

have observed that in couples in which one spouse is depressed there are more negative communication behaviors such as blaming and criticism than in couples where there is no depression (Hops et al., 1987, Schmaling & Jacobson, 1990). According to Davila (2001), depressed spouses display self-denigration and physical and psychological complaints when interacting with their partners. In Hops et al.'s (1987) study, both depressed wives and their non-depressed husbands were less likely to self-disclose than partners in relationships lacking depression. Furthermore, Hops et al. found that during couple discussions depressed women exhibited higher rates of depressive behavior (e.g., self-focus communication of sadness and despondency) and lower rates of problem-solving behavior than either their non-depressed spouses or partners in non-depressed couples. Davila (2001) found that dysphoric spouses (those with depressed mood) expect less support from their partners and show diminished capacity to provide support to and receive support from their partners.

Depression appears to play a role in the way that couples with depression are able to solve problems and deal with conflict. Compared to non-depressed partners, depressed individuals make more negative attributions about causes of each other's negative actions and exhibit higher levels of conflict, tension, negativity, ambivalence, hostility, and criticism when attempting to resolve problems with their partners (Gotlib & Whiffen, 1989.) In a study of depressed and non-depressed couples by Schmaling and Jacobson (1990), couples in which there was a depressed wife and who were not distressed in their marriage showed patterns that were different from what is typically found in non-distressed marriages. Specifically, Schmaling and Jacobson (1990) found the expression of depressed behavior (e.g., aggression, negative solution, disagreement, and criticism)

by the wife in high-conflict tasks to be the main pattern of interaction that was unique to depressed couples.

Sandberg, Miller, and Harper (2002) interviewed 26 older couples to understand how older couples' experiences with depression affected their communication. Sandberg et al. (2002) compared couples with depression to a control group of non-depressed couples. They found that depressed couples exhibited far fewer positive exchanges in communication. Specifically, non-depressed couples were able to communicate with greater intensity and clarity than did the couples with a depressed partner. In depressed couples' communication, even though there were a few successful discussions, a much less positive tone was apparent. Comments by the depressed couples revealed antagonistic patterns of communication in which ongoing criticism and outbursts were common. Frequent themes among depressed couples' communication and problem-solving were isolation, hopelessness, and frustration.

There are also studies that reveal nonverbal differences in communication between depressed and non-depressed couples. Gotlib and Whiffen (1989) compared male and female depressed psychiatric inpatients, non-depressed medical inpatients, and non-depressed, non-patient control subjects and their spouses. Compared with the non-patient controls, both the depressed and the medical couples rated their marriages as less satisfactory, smiled less frequently during the interactions with their spouses, engaged in less eye contact, and were characterized by less pleasant and less aroused facial expressions.

Psychological abuse, relationship satisfaction, and depression. In distressed relationships, there is a higher chance of emotional abuse between partners. According to

O'Leary (2001), definitions of psychological abuse include acts of recurring criticism and/ or verbal aggression toward a partner, and/ or acts of isolation and domination of a partner. In a study by O'Leary (2001), 72% of women rated emotional abuse as having a more negative effect on their emotional well-being than physical abuse. O'Leary (2001) also found that psychological abuse has a negative effect on recipients' relationship satisfaction. Additionally, there is a correlation between emotional abuse and depression (Arias, & Pape, 2001; Marshall, 2001; O'Leary, 2001; Sackett & Saunders, 2001), and threats of separation or divorce (considered to be a form of psychological abuse) place women at a higher risk for a major depressive episode (O'Leary, 2001). Arias and Pape (2001) found that in a community sample of 232 married women, psychological abuse was a significant predictor of depression symptoms and problem drinking. Also, women who experienced emotional abuse more negatively reported more fear of the partner, shame, loss of self-esteem, depression, and anxiety. Marshall (2001) notes that an individual who is enacting behaviors that are discounting of his or her partner could make the partner feel unimportant. If a partner feels insignificant, especially in their primary relationship, it could be very difficult for this person to believe that they are important in other aspects of their life or in the lives of others (Marshall, 2001). In a study by Sackett and Saunders (2001), depression was found to be related to receiving criticism, ignoring, and ridicule from significant others. Therefore, distressed relationships are more likely to be characterized by forms of emotional abuse between partners, which can elicit depression.

Effects of depression on the non-depressed partner. There also is evidence that an individual's depression is related to their non-depressed partner's experience of the

couple's relationship. One must be cautious about making causal inferences about the association between an individual's depression and their partner's relationship satisfaction, because many of the studies looking at this relationship are strictly correlational, and directional causalities cannot be deduced. However, spouses living with a depressed partner report significantly more relationship distress and unhappiness than comparable community couple population norms. For example, wives' level of depression symptoms has been shown to be correlated with husbands' level of marital dissatisfaction (Whisman, 2001). According to Mead (2002), factors that can lead to stress for other family members and non-depressed partners include:

> Excessive and frequent reassurance seeking; seeking self-verifying or self-confirming feedback, which for many depressed individuals is seeking negative feedback; expressing a negative view of themselves, the world, and the future, which produces a pervasive sense of hopelessness; feelings of a lack of social support from significant others; and a tendency towards shyness, which makes them more vulnerable for depression. (p. 304)

Depressed individuals often seek interpersonal soothing (reassurance from others) to satisfy their emotional needs and insecurities. However, at the same time they may seek negative feedback to attempt to substantiate their negative self-image. The result is that the depressed individual's frequent attempts to get either positive or negative feedback may become confusing and aversive to others (Mead, 2002). Benazon (2000) looked at a sample of participants from two outpatient clinics receiving treatment for depression and gave couples a series of assessment instruments measuring interpersonal affect, communication, and level of expressed emotion (an individual's expressed negative attitude toward a significant other). Benazon found a correlation between the depressed spouse's reassurance seeking and mood and their partner's negative attitude.

Although one needs to be cautious because this is a correlational study and it is possible that the partner's negative mood leads to the depressed individual's symptoms, it is also possible that the depressed individual's negative behaviors and constant reassurance-seeking contribute to their partner's negative attitude and mood toward them. A depressed individual's negative behaviors may lead others to respond with negative emotions, behavioral counterattacks, or avoidance of the depressed individual. According to Mead (2002), the depressed individual is likely to interpret their partner's counterattack or withdrawal as the withdrawing of support. This negative behavior by the non-depressed individual may reinforce the depressed person's negative views of the self, relationship, and world. In turn, the tendency of the depressed spouse to see a variety of aspects of life as negative and hopeless may overwhelm the partner's more healthy thoughts related to life causes and consequences of negative events.

Men's and women's responses to their partner's depression-related behaviors seem to be ambivalent or cyclical. Sometimes the depressed partner's behavior elicits empathy and attempts to help from the non-depressed partner, and at other times it elicits anger and blaming. In Beckerman's (2001) study of couple therapists, therapists report that the non-depressed partner often reacts by becoming overcontrolling and overprotective, trying to compensate for the partner's functional and emotional limitations caused by the depression. In the same study, the most common observation of therapists regarding couples with depression was that the non-depressed partner expressed frustration, anger, and emotional withdrawal in response to their partner's symptoms of depression. Therefore, depression has the potential to increase distress and unhappiness in the non-depressed partner and affect the couple relationship.

Depression and gender. Gender tends to be associated with both the prevalence and experience of depression. Women are twice as likely to suffer from unipolar depression as are men (Mead, 2002). In a study of 170 freshmen from the University of Bordeaux, France, Husky, Mazure, Maciejewski, and Swendsen (2009) found that compared to men, women demonstrated higher depressed mood averages, rated events as being more negative, and experienced greater depressed emotional reactivity following events of equivalent impact. The higher prevalence of depression in women also contributes to their perceptions and satisfaction with their marriages. Depressed women perceive their marriages as significantly more maladjusted than depressed men, and family members of depressed men report better family functioning than those of depressed women (Kornstein et al., 2000).

In a one-year prospective study, Davila, Bradbury, Cohan, and Tochluk (1997) found that wives with higher levels of dysphoria solicited, received, and provided support in a negative manner when interacting with their husbands, and this behavior resulted in further marital stress. In a study by Davila (2001) dysphoric wives expected their husbands to be negative and critical and subsequently were themselves negative and critical when attempting to both receive support and provide support to their husbands. Therefore there seems to be a cycle in which dysphoric women generate dyadic stress and marital conflict. In contrast, Davila et al. (1997) found that for husbands there was no evidence of stress generation; nor were there effects of perceptions or behavior on subsequent marital stress. According to Mead (2002), when depressed husbands express positivity, wives respond with less positivity and increased negativity. When depressed wives express positivity or negativity, the responses from husbands are no different from

those of normal controls. That is, husbands experiencing depression are less negative than wives experiencing depression. In Gotlib and Whiffen's (1989) study, female depressed subjects demonstrated more negative mood than did depressed male subjects following interactions with their spouses. This finding makes it appear that living with a depressed wife is associated with more negativity between partners than living with a depressed husband. However, this negativity appears to be a function of the wife's depression rather than a communication pattern between the partners.

In a study by Danielsson and Johansson (2005), women had a greater variety of words and metaphors to describe their moods than did men, a difference that may be due to differential socialization of females and males. Therefore, when wives are depressed, husbands may need to work on accepting their more expressive negative communication style as a function of their depression. When it is the husband who is depressed, wives may need to be coached on expressing less negativity and more positivity in response to their depressed husbands' positive statements.

Rumination is more common in women than in men and results in longer, more severe episodes of depression (Boughton & Street, 2007). Rumination refers to behaviors and thoughts that focus one's attention on one's depressive symptoms and on the implications of these symptoms (Boughton & Street, 2007). When looking at tendencies to ruminate, males are more likely than females to actively distract themselves from their negative moods, and their coping strategies are more action focused than those of women (Boughton & Street, 2007). These tendencies toward a gender difference in couple communication associated with depression are relevant for examining how depression may affect progress in couple therapy because of the experience of increased negativity

associated with depression in women. The present study adds to knowledge in this area by examining the relative degrees to which depression in female and male partners predict the degree of progress in couple therapy.

Depression as a barrier to engagement and progress in therapy. Many clients struggling with depression express a preference for individual psychotherapy over antidepressant medication. Mohr et al. (2006) found, however, that when referrals for psychotherapy are made, only 20% of individuals follow up, and of these, half drop out of treatment. Thus, there are a considerable number of individuals with depression who either fail to complete psychotherapeutic treatment or who find therapy unhelpful. In a study by Dozois and Boardman (2002), an attrition rate of 32% was found for individual cognitive behavioral therapy (CBT) in the National Institute of Health Treatment of Depression Collaborative Research Program. Additionally, the researchers reported a post-CBT remission rate of 51%; suggesting that about one-half of the sample who did receive treatment remained symptomatic (Dozois & Boardman, 2002). Across numerous studies, one of the most powerful predictors of whether or not therapy has a positive outcome is one's baseline level of depression (Dozois & Boardman, 2002). Thus, it appears from studies on individual therapy that the level of depression may act as a roadblock to successful therapeutic outcomes. In fact, Mohr et al. (2006) found that depression was associated with increased frequency with which treated individuals perceived barriers to improvement in their presenting problems, with 74.0% of depressed patients reporting one or more barriers, versus 51.4% of non-depressed patients citing barriers. The common factors theory of therapy efficacy may explain this correlation between level of depression and therapeutic outcome.

The common factors theory of therapy efficacy. The common factors theory of therapy efficacy, as applied by Drisko (2004) and Thomas (2006) with various approaches to individual psychotherapy, and by Sprenkle and Blow (2004) with approaches to couple therapy, proposes that certain general variables shared by various theoretical approaches or models as opposed to characteristics of specific theoretical approaches or models, contribute to change in psychotherapy. Although most of the studies on the common factors theory of therapy efficacy focus on individual therapy, it seems probable that these same common factors would have a similar if not equal effect in couple therapy. According to a meta-analysis of common factors in individual therapy by Drisko (2004), the most general conclusion was that common factors shared by all psychotherapies are the most important "active ingredients" of psychotherapy. These common factors appear to be more important to client improvement than are differences in specific psychotherapeutic models or techniques. One of the most significant contributions of the common factors movement is highlighting the truth that the client, rather than the model or the therapist, is probably the major factor in change (Sprenkle, Davis, & Lebow, 2009). According to Drisko (2004), the common factors are broken down into four subgroups, and studies by Lambert (1994) identified the percentage of influence that each type of factor had on therapy outcome. Lambert (1994) identified the four subgroups as: (a) client and extra-therapeutic factors such as the client' level of motivation and commitment to change, inner strength, religious faith, social support, community involvement, and stressful events (accounting for 40% of therapeutic change), (b) relationship factors such as the relationship that the therapist and client form while focusing together on the work involved in therapy (30%), (c) model/technique

factors (15%), and (d) placebo, hope, and expectancy factors (15%). There have been many studies exploring these common factors and their relations to therapy outcome.

Thomas (2006) studied the difference between clients' and therapists' perceptions about the degree to which each of the four common factors in therapy -- extra-therapeutic factors, model/techniques, therapeutic alliance, and hope/ expectancy -- contribute to change in the individual therapeutic process. Thomas (2006) also looked at the differences between the percentage of variance in change attributed to client factors versus the percentage of change attributed to therapist factors. The study was based on perceptions of therapy of ten doctoral level therapists and 30 clients. According to the therapist sample, the mean percentages for the common factors contributing to therapeutic outcome were: 22% for client extra-therapeutic factors; 16% for models/techniques; 35% for the therapeutic relationship, and 27% for client's hope/expectancy (Thomas, 2006). For clients, the mean percentages for the common factors were: 13% for client extra-therapeutic factors; 28% for models/techniques; 29% for therapeutic relationship; and 30% for client's hope/expectancy (Thomas, 2006). Findings for perceptions of the overall mean percentages of the client's and therapist's contributions to change revealed that therapists gave more weight to the client (61%) than to the therapist (39%). Clients also placed more value on the client (60%) than the therapist (40%) when examining the contributions to change within the therapeutic process. Although based on individual therapy, Thomas' (2006) study offers couple and family therapists the perspectives on common factors from the therapists and clients, the people who are most involved in the therapeutic process.

Client factors. According to a review of the literature, there are several key client/ extratherapeutic factors that affect the outcome of psychotherapy. It is clear that client factors are one of, if not the most important factor of change in both individual and couple therapy (Drisko, 2004; Lambert, 1992; Sprenkle & Blow, 2004; Thomas, 2006). Client factors include the number of problems and symptoms that a client identifies, the severity of these problems, the client's ability to identify a focal problem and the severity of this problem, level of motivation, capacity to relate, capacity to tolerate and manage affect (both in changes in types and intensity), comorbid physical conditions, commitment to change, and religious faith (Drisko, 2004). Extratherapeutic factors include factors such as changing jobs, life events that are occurring, existence and strength of social support outside of therapy, and community involvement (Sprenkle, Davis, & Lebow, 2009). It is important to consider how depression may affect these client common factors that have such significance in therapeutic outcome.

Another one of the client factors that has been identified as affecting therapeutic outcome and that seems likely to be affected by depression, is hope/expectancy. Hope or expectancy refers to the client's degree of belief that progress in resolving personal problems is tangible and plausible. In a review of the literature on common factors in individual therapy, Grencavage and Norcross (1990) found that the most influential factor in individual therapy was positive expectancies and hope for improvement, proposed by 26% of all authors. In the same study, the second most frequent factor among therapist qualities, advanced by 20% of the authors, was the therapist's ability to cultivate hope and enhance positive expectancies within the client (Grencavage & Norcross, 1990). It

appears that client hopelessness and pessimism can be a barrier to therapy. It is likely that this hope and expectancy in individual therapy is equally as important in couple therapy.

Those who have little hope for improvement or expect things to go badly are less successful in therapy than those who are optimistic and hopeful. Dozois and Boardman (2002) found that, compared to individuals who completed cognitive group therapy, persons who dropped out of the therapy reported substantially greater pessimism about the possibility of symptom control and endorsed beliefs that their problems were unsolvable. In the same study, even when clients who had high negative treatment expectancies persisted with therapy, a pessimistic orientation toward their ability to control their symptoms was associated with achieving less benefit from therapy (Dozois & Boardman, 2002). Using data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP) Meyer, Pilkonis, Krupnick, Egan, Simmens, and Sotsky (2002) found that patients' pretreatment expectations of therapeutic effectiveness predicted their active engagement in therapy, which then led to greater relative improvement. Overall, it appears that individuals who are low in hope generate fewer solutions to their problems when they perceive obstacles and have lower expectations of attaining their goals than clients with high levels of hope (Dozois & Boardman, 2002).

Depressed clients are likely to be pessimistic about therapy because symptoms of depression include having a greater certainty in anticipating both negative future outcomes and an absence of positive future outcomes. Beck et al. (2006) examined varying levels of hopelessness between depressed outpatients, outpatients with generalized anxiety disorder, and outpatients with other psychiatric disorders. They found

that depressed outpatients rated worst outcomes as being more likely and best outcomes as being less likely than outpatients in the other two groups. Kagan et al. (2004) found that depressed adolescents showed differences from non-depressed controls in their pattern of accessible explanations for both negative and positive life events. Compared with non-depressed adolescents, adolescents high in depression produced more reasons to explain why bad things would happen relative to why they would not happen. They also produced fewer reasons for why good things would happen relative to why they would not.

Additionally, the explanations that people make for past events are important in influencing their predictions of the likelihood that similar experiences will occur in the future. Cropley and MacLeod (2003) found that depressed individuals attribute the causes of negative events to internal factors (characteristics of the person as opposed to factors outside the individual), stable factors (continuous, long-lasting, and recurring), and global factors (those that occur across a variety of situations as opposed to single actions or mistakes). Those who explain the causes of negative past events as internal, stable, and global are likely to remain pessimistic over time about future situations and events. Based on such findings, it seems likely that clients' negative expectancies regarding therapeutic progress may be a significant factor associated with lack of engagement in and attrition from therapy.

As described earlier, another common factor that has been found to be related to therapeutic outcome is the relationship that the client forms with their therapist. The literature demonstrates that the relationship between the client and the therapist has a significant impact on the progress of therapy. Bordin (1979) suggested that the alliance

between client and therapist is composed of three elements: the bond between the parties (the emotional quality of the relationship, which includes aspects such as trust, caring, and involvement); the tasks involved in therapy (the extent to which both the client and therapist are comfortable with engaging in the activities of therapy, and the extent to which the client finds the tasks credible things to do); and the goals (the extent to which the client and therapist are working toward compatible goals). The alliance is also the extent to which clients and therapists feel connected and engaged with one another (Sprenkle, Davis, & Lebow, 2009). Research findings indicate that the alliance between the client and therapist is one of the most consistent predictors of treatment outcome, across different types of problems and across types of therapy (Comninos & Grenyer, 2007; Klein et al., 2003; Shirk, Gudmundsen, Kaplinski, & McMakin, 2008). In a study of 54 adolescents with depression, Shirk et al. (2008) found that adolescent-reported therapeutic alliance predicted reductions in depression even after controlling for the number of therapy sessions. Similarly, Klein et al. (2003) found that early therapeutic alliance perceived by patients was a strong predictor of subsequent decreases in depression symptoms in chronically depressed outpatients receiving cognitive behavioral therapy.

Because it is the client's own perceptions of the therapeutic alliance that predict outcome, client factors may influence their perceptions of therapeutic alliance as well as their ability to join with the therapist. Thus, clients' interpersonal problems may inhibit the formation of a helping therapeutic alliance. Comninos and Grenyer (2007) found that preexisting interpersonal problems such as a fear of intimacy, an overly domineering style, and interpersonal withdrawal and helplessness, may inhibit a client's ability to

make use of a positive working alliance with a therapist, preventing the reduction of depression symptoms. Whereas prior research has focused on depression as a barrier to therapeutic alliance and outcome of individual therapy, the present study investigates clients' levels of depression as a potential barrier to the development of a positive client-therapeutic alliance and the effectiveness of couple therapy.

Depression also is strongly associated with perceived social isolation and social withdrawal (American Psychiatric Association, 1994). The American Psychiatric Association lists "the loss of pleasure or interest in almost all activities and interests" which includes interpersonal relationships, as one of the discrete characteristics of major depressive disorder (1994, p.168). Sandberg et al. (2002) found that some depressed partners may withdraw from interaction with their spouse, and this may result in a heightened sense of frustration for the non-depressed partners as they try to engage their spouses. It seems probable that this social withdrawal would make it difficult for partners dealing with depression to seek therapy, create a therapeutic alliance with the couple therapist, and engage and participate in therapy sessions and activities.

In summary, a review of the literature demonstrates that there is a strong negative correlation between levels of depression and relationship satisfaction, and there is some evidence of a bi-directional causal process between the two. This means that many couples presenting for couple therapy may have one if not both members suffering from some level of depression symptoms. The literature also suggests that clients with depression may have difficulty engaging in therapy, have low expectancies that therapy will solve their personal problems, drop out of therapy, or find therapy unhelpful. The common factors theory of therapy efficacy proposes that general variables such as client

characteristics and qualities of the therapeutic relationship are the most active ingredients for change in clients' presenting problems. Because depression seems likely to affect these client-related factors, it is important to examine how depression affects progress in couple therapy.

Hypotheses

The common factors framework describes how client factors are crucial in determining the course and outcome of psychotherapeutic treatment (Sprenkle, & Blow, 2004). Therefore, based on the notion that client characteristics can affect the course of therapy, it is hypothesized that depression in one or both partners will negatively affect progress in couple therapy. The literature shows that the barriers associated with depression strongly affect medical treatment for health conditions (Morrow-Howell, 2008). It is expected that these same barriers from depression would apply to mental health treatment as well. This study tested three main hypotheses:

1. The higher the level of depression in either partner, the less effective couple therapy will be.
2. If both partners experience higher levels of depression, the progress of therapy will be affected more than if only one partner experiences depression.
3. Based on prior research findings in the literature that gender is a factor in the prevalence and experience of depression, and due to the fact that in couples with a depressed female there may be more mutual criticism, blaming, and hostility than in couples with a depressed male, it is expected that the degree of depression in the female partner serves as a greater barrier to couple therapy than the level of depression in the male partner. Thus, it is

hypothesized that the female partner's depression will have a stronger negative association with progress in therapy than will the male partner's depression.

Chapter 2: Method

Sample

The sample was heterosexual couples who had sought couple therapy at the Center for Healthy Families at the University of Maryland, College Park. This study involved secondary analyses of data that were collected previously through standard pre-therapy assessments of couples who attended therapy at the Center for Healthy Families. College Park is a suburb of the greater Washington D.C. area and is located in Prince George's County, Maryland, which is diverse in race, ethnicity, and socioeconomic status. The client population at the Center for Healthy Families reflects the diversity of the surrounding community. The female sample for the present study was 57.4% Caucasian, 18.5% African American, 11.1 % Hispanic, 5.6% Asian/ Pacific Islander, and 5.6% other. The male sample for the present study was 66.7% Caucasian, 16.7% African American, 3.7% Hispanic, 1.9% Native American, and 9.3% other. The sample for this study also had diverse levels of education ranging from the completion of high school to the acquisition of master's and higher-level degrees, as well as diverse socioeconomic statuses ranging from low income to moderate income. Couples who seek services at the clinic tend to be within the age range of 25-35 years. Table 2.1 summarizes the demographic characteristics of the sample. There is diversity in the problems that bring couples for therapy at the Center for Healthy Families. Problems include concerns such as unemployment and financial stress, conflicts regarding relationships with extended family members, psychological and physical aggression, parenting conflicts, infidelity, and psychological disorders in one or both partners. Referral sources include other mental health clinics, courts, former clients, self-referral through the Yellow Pages, and

advertisements. The Center for Healthy Families is one of only a few low-cost resources for therapy services in Prince George's County, Maryland.

Table 2.1 Demographic Characteristics of the Sample

Variables	**Males (*n*=55)**		**Females (*n*= 55)**	
Mean age of partner (*SD*)	33 (7.6)		31.3 (7.8)	
Average length of relationship (*SD*)	5.8 (4.4)		5.8 (4.6)	
Average personal yearly gross income	$46, 476		$26, 524	
Relationship status	*n*	%	*n*	%
Married, living together	31	56.4	31	56.4
Married, separated	1	1.8	1	1.8
Living together, not married	13	23.6	13	23.6
Dating, not living together	8	14.6	8	14.6
Other	2	3.6	2	3.6
Race	*n*	%	*n*	%
Native American	1	1.9	0	0
African American	9	16.7	10	18.2
Asian/ Pacific Islander	0	0	3	5.5
Hispanic	2	3.7	6	10.9
White	36	66.7	31	56.4
Other	7	11.0	5	9.1
Level of Education	*n*	%	*n*	%
High school diploma	11	20.0	5	9.1
Some college	8	14.6	13	23.6
Bachelors degree	10	18.2	9	16.4
Masters degree	9	16.4	9	16.4
Other	17	30.9	19	34.6

Measures

The measures selected to assess the variables of the present study are a subset of the pre-therapy assessment instruments used at the Center for Healthy Families. In this study, the independent variable is each partner's level of depression symptoms and was measured using the Beck Depression Inventory (BDI). Higher scores on the BDI indicate higher levels of depression.

The dependent variables on the measures described below were indices of therapy outcome, in which pre- to post- therapy change scores were examined. Each of the outcome variables is measured by a self-report instrument that is administered to each member of a couple before beginning couple therapy at the Center for Healthy Families and again after they have completed 10 double-length sessions (90 minutes) of couple therapy. The details of the couple therapy are described in the Couple Therapy section of this proposal. There are four dependent/ outcome variables:

1. Relationship satisfaction was measured using scores on the Dyadic Adjustment Scale.
2. The amount of partners' positive affectional and instrumental behaviors toward each other was measured by the Positive Partner Behavior scale.
3. The amount of partners' psychologically abusive behavior toward each other was measured with the Multidimensional Measure of Emotional Abuse.
4. Partners' negative attributions about each other were measured with the Marital Attitude Survey.

The indices of progress in therapy were increases in relationship satisfaction, positive partner behavior, as well as decreases in forms of psychological abuse and negative attributions. All measures are described in detail below.

The *Beck Depression Inventory* (Beck, Rush, Shaw, & Emery, 1979) was used to measure the level of depression symptoms in each partner. The BDI is one of the most widely used instruments for assessing severity of depression symptoms. The BDI items cover 21 cognitive, affective, physiological, and behavioral symptoms, using a multiple choice response format and 0 – 3 scoring values for levels of severity (Beck et al., 1988). The 21 symptoms are: (a) mood, (b) pessimism, (c) sense of failure, (d) lack of satisfaction, (e) feelings of guilt, (f) sense of punishment, (g) self-dislike, (h) self-accusation, (i) suicidal wishes, (j) crying, (k) irritability, (l) social withdrawal, (m) indecisiveness, (n) distortion of body image, (o) work inhibition, (p) sleep disturbance, (q) fatigability, (r) loss of appetite, (s) weight loss, (t) somatic preoccupation, and (u) loss of libido (Beck et el., 1988). A meta-analysis of the BDI's internal consistency estimates produced a mean coefficient alpha of .86 for psychiatric patients and 0.81 for non-psychiatric subjects, respectively (Beck et al., 1988). The mean correlations of BDI total scores with clinician ratings with the Hamilton Psychiatric Rating Scale for Depression were .72 and .73 for psychiatric and non-psychiatric patients, respectively (Beck et al., 1988). Beck et al. (1988) uses the cutoff point of 9 on the BDI to indicate at least a low level of depression. In the literature, the BDI has also consistently differentiated between individuals with subtypes of depression and discriminates between anxiety and depression.

The *Dyadic Adjustment Scale* (DAS; Spanier, 1976) was used to measure partners' levels of relationship satisfaction. The DAS measures overall adjustment in couple relationships and has four subscales: (a) dyadic consensus, (b) dyadic satisfaction, (c) dyadic cohesion, and (d) affectional expression (Spanier, 1989). Spanier administered the DAS to 218 married persons and 94 divorced couples. A small sample of never-married cohabiting couples was given the questionnaire to determine potential problems in question wording and applicability of the scale for nonmarital dyads. The test-retest correlation for the total DAS was .96 (Spanier, 1989). Spanier (1976) reported total scale internal consistency reliability (Cronbach alpha) of .96. The subscale internal consistency reliabilities range from .73 to .92 (Spanier, 1989), but due to the high internal consistency of the total DAS most often researchers and clinicians use individuals' total scores on the set of 32 items, and the present study followed that procedure. Spanier (1989) uses a cut-off score of 97 to indicate a relationship in distress.

The *Positive Partner Behaviors* (PPB) scale was used to measure the frequency of positive affectional and instrumental behaviors occurring between members of a couple. A study by Wills, Weiss, and Patterson (1974) tested two hypotheses concerning the relationship between the day-to-day interaction of marriage partners and their global reports of how satisfied they were with that interaction. The study called for marriage partners independently to make two types of measurements for each of 14 days: (a) observations of the frequencies of specific spouse behaviors and (b) global ratings of the pleasantness of their interaction. These behavioral data were then related to the global ratings of pleasantness through multiple regression analysis to determine which types of spouse behavior were related to judgments concerning pleasantness of interaction. Data

from the study by Wills, Weiss, and Patterson (1974) were the basis for the creation of the Positive Partner Behavior scale.

The PPB assesses two types of behavior: instrumental behaviors and affectional behaviors. Instrumental behaviors are defined as those necessary for the marriage to survive as a social and economic unit (e.g., "spouse cooked a good meal" or "spouse did household repairs") (Wills, Weiss, & Patterson, 1974). Affectional behaviors are those that serve to maintain the interpersonal attraction between husband and wife by conveying acceptance, affection, and approval (e.g., "spouse asked about my feelings" or "spouse touched me pleasantly") (Wills, Weiss, & Patterson, 1974). The PPB asks the respondent to report whether or not each behavior has been exhibited by one's partner during a specified period of time (e.g., the past week) and how "pleasurable" the recipient found each type of behavior that occurred. For each item on the PPB there are two scores: whether or not the behavior happened, and on a scale of 1-9, how pleasant or unpleasant the behavior was. The PPB was used in this study to assess the number of positive partner behaviors occurring in the couple relationship before and after therapy. Specifically, "after therapy" refers to after the tenth couple session, when the therapeutic requirement of CAPP is complete. Although some couples decide to continue couple therapy, the post data were collected after the tenth session of couple therapy.

The *Multidimensional Measure of Emotional Abuse* (MMEA; Murphy & Hoover, 2001) measures the amount of partners' psychologically abusive behavior toward each other. In this study, decreasing levels of emotional abuse between partners was used as an indication of relationship improvement. According to Murphy and Hoover (2001), psychological abuse behaviors are directed at the target's emotional well-being or sense

of self and are intended to produce emotional harm or threat of harm. The MMEA measures four categories of emotional abuse: dominance/ intimidation, restrictive engulfment, denigration, and hostile withdrawal. Murphy and Hoover (2001) define dominance/ intimidation behaviors as threats, property violence, and other nonverbal acts intended to produce fear or submission through the display of aggression. Murphy and Hoover (2001) describe restrictive engulfment as behaviors intended to isolate the partner and restrict the partner's activities and social contacts, along with intense displays of jealousy and possessiveness. The intended effect of restrictive engulfment behaviors is to increase the partner's dependency and availability. Denigrating behaviors include humiliating and critical verbal behaviors intended to reduce the partner's self esteem (Murphy & Hoover, 2001). Hostile withdrawal behaviors are those through which the individual withholds emotional contact and withdraws from the partner in a hostile fashion. According to Murphy and Hoover (2001), the main intent of these hostile withdrawal behaviors is to punish the partner and increase the partner's anxiety or insecurity about the relationship.

For each item on the MMEA the respondent is asked to report separately the frequencies with which the type of behavior was enacted by the self and by the partner during the past four months. The response scale for each item is on a scale from 0 (never in the past 4 months) to 6 (more than 20 times in the past 4 months). There is also an option of circling a "9" which means the behavior has never happened in the relationship. For each question, the client marks an answer for both how often they themselves engaged in the specific behavior as well as how often their partner engaged in the behavior. The internal consistencies (coefficient alpha) of these four MMEA derived

subscales for reports of abusive behavior by self and partner were found to be .84 and .85 for restrictive engulfment (13 items), .88 and .91 for hostile withdrawal (9 items), .89 and .92 for denigration (17 items), and .83 and .91 for domination/ intimidation (15 items) (Murphy & Hoover, 2001). For the purpose of this study, the index of a persons' abusive behavior was their partner's rating of behavior on these four scales. There is a tendency for individuals to bias their answers and underreport their own aggressive behavior. One way that people in the field deal with this potential bias is to use the partners' rating of an individual's aggressive behavior, and this study adheres to this recommendation.

The *Marital Attitude Survey* (Pretzer, Epstein, & Fleming, 1991) was designed to assess the degrees to which individuals hold potentially dysfunctional attributions and expectancies regarding problems in their couple relationships. The 39 MAS items comprise eight subscales, six for attributions and two for expectancies regarding improvement in the relationship. The six subscales assessing attributions are (1) Attribution of Causality to Own Behavior, (2) Attribution of Causality to Own Personality, (3) Attribution of Causality to Spouse's Behavior, (4) Attribution of Causality to Spouse's Personality, (5) Attribution of Malicious Intent to Spouse, and (6) Attribution of Lack of Love to Spouse. The two subscales assessing expectancies are (a) Perceived Ability of Couple to Change Relationship and (b) Expectancy of Improvement in the Relationship. Only the attribution subscales are included in the set of assessment questionnaires at the Center for Healthy Families where the data for this study were collected. Respondents rate the extent to which they agree with each MAS statement on a 5-point Likert scale, ranging from "strongly agree" to "strongly disagree."

In a sample of 156 subjects seeking marital therapy, most of the MAS subscales were found to have moderate to high internal consistency, as assessed by Cronbach's coefficient alpha (Pretzer, Epstein, & Fleming, 1991). In the same sample, individuals attributing their relationship problems to their partner's personality, behavior, lack of love and malicious intent reported greater dissatisfaction with the relationship, perceived greater communication problems, and held more unrealistic relationship beliefs (Pretzer, Epstein, & Fleming, 1991). In the present study, a composite of individuals' scores on those four subscales (Attributions of Causality to Partner Behavior, Attributions of Causality to Partner Personality, Attribution of Malicious Intent to Spouse, and Attribution of Lack of Love of Spouse) served as the index of negative attributions about the partner.

Procedure

A secondary analysis was conducted of data that previously were collected during standard therapy assessments at the Center for Healthy Families in conjunction with an outcome study on domestic violence in couple relationships. The outcome study is called the Couples Abuse Prevention Program (CAPP). The data used for this study were drawn from the pre-therapy and post-therapy assessment data provided by the couples who have participated in CAPP. The CAPP study is designed to compare two forms of couple therapy, both of which are meant to decrease couples' anger and verbal or physical aggressive behavior. The CAPP study compares a structured cognitive-behavioral therapy (CBT) approach with the usual treatment (UT) approach, which is comprised of a variety of systems-oriented approaches to couple therapy (e.g., solution-focused, emotional-focused, structural, narrative, experiential). There are several criteria required in order for

couples to be included in the CAPP study. In order to qualify, couples must (a) have been in an intimate couple relationship for at least six months, (b) have experienced verbal or physical aggression in the relationship during the past four months, (c) have no physical abuse resulting in physical injury requiring a hospital or doctor visit, or that involved use of a weapon to threaten, coerce or harm a partner during the past 4 months, (d) both want to improve the relationship, (e) see each other at least once a week, and (f) do not have an untreated drug or alcohol problem (La Taillade, Epstein, & Werlinich, 2006). Participation in CAPP consists of both partners completing an assessment before beginning couple therapy, participating in 10 double-length (i.e., 90-minute) couple therapy sessions, completing a post-therapy assessment, and a follow-up assessment four months after completion of therapy at the Center for Healthy Families. Couples who qualify for the study and agree to participate in CAPP are randomly assigned to receive either the CBT or the UT condition. Both treatment conditions are designed to help couples increase their relationship satisfaction by improving communication and decreasing forms of aggressive or abusive behavior.

Couple therapy. The CBT condition focuses on communication, problem-solving skills, anger management skills, relationship recovery from prior aggressive behavior, and enhancement of relationship strengths and satisfaction (La Taillade, Epstein, & Werlinich, 2006). The UT condition is broadly based on family systems theory and includes a variety of prominent theoretical approaches to couple therapy. Therapists and supervisors at the Center for Health Families vary in their preferred models of therapy (as described above); thus, the specific procedures used during the usual treatment condition will vary.

Data Collection. Data were collected when one or both partners of the couple called the Center for Healthy families to request couple therapy. A 15-minute phone intake is completed with the member of the couple who called to inquire about services. The phone intake gathers information regarding the presenting problems that the couple is experiencing, and the interviewer also asks initial questions about the occurrence of levels of violence and substance abuse. During a subsequent staffing meeting, the couple is assigned a co-therapist team. The assigned therapists call the couple in order to schedule an assessment session for the following week. During the couple assessment session, the partners are placed in different rooms to assure the confidentiality of all answers and a safe environment to conduct individual assessments for violence, substance abuse, and personal safety. Each partner completes a set of questionnaires, including those to be used for the present study. At the conclusion of ten couple therapy sessions, the minimum CAPP requirement, the therapists give both partners, separately, a closing assessment comprised of the same questionnaires as those used in the pre-therapy assessment. All of these data are entered into the Center for Healthy Family's assessment database by graduate students who are the clinic staff members. This study involved secondary analyses of the Center's CAPP database.

Chapter 3: Results

Overview of Data Analysis

The data were analyzed in two ways to test the relation between level of client depression symptoms and progress in couple therapy. First, four discrete conditions regarding presence or absence of depression in members of clinic couples were compared:

1. both partners in the couple having no to minimal levels of depression (a score of 9 or lower on the BDI)
2. the female partner only having at least a low level of depression
3. the male partner only having at least a low level of depression
4. both partners having at least a low level of depression

The criterion used regarding the presence of at least a low level of depression in a member of a couple was a BDI total score of 9 or above (the cutoff recommended by Beck, Steer and Garbin, 1988). The amounts of change in partners' DAS, PPB, MMEA, and MAS scores (post-minus pre-therapy change scores) in the four conditions were compared using one-way analysis of variance (ANOVA), with planned contrasts used to test for the specific group differences that are predicted by the hypotheses. The analyses were run separately for females' outcome indices and males' outcome indices (e.g., females' DAS change scores and males' DAS change scores).

A second approach to the analyses involved a set of multiple regression analyses in order to take advantage of the fact that depression scores exist on a continuum, and the above ANOVAs force levels of depression into discrete categories similar to diagnoses. The BDI scores of the female and male partners were used as predictor variables in each

multiple regression analysis, predicting one of the outcome measures (change in DAS scores, change in PPB scores, change in MAS scores, or change in MMEA scores). Again, the analyses were run separately for females' outcome indices and males' outcome indices. The multiple regression analyses allowed a test of the relative associations of female and male depression with the outcome indices.

Table 3.1. Variables

Dependent Variables

Dependent Variable	*Measure*	*Method*	*Cut-off Criteria*
Relationship satisfaction	Total self-report score on the DAS	Score change on total Post-pretest self-report scores	Although a specific "cut-off" score for relationship satisfaction is not used, a score of 97 or below indicates a distressed relationship
Positive partner behaviors	Total scores on the PPB (as reported by partner)	Score change on total Post-pretest scores (as reported by partner)	No specific cut-off, higher scores are indicative of higher frequency of positive partner behavior and used as an indication of higher relationship satisfaction
Levels of emotional abuse	Total scores on the MMEA (as reported by partner)	Score change on total Post-pretest scores (as reported by partner)	No specific cut-off score but lower scores indicate less emotional abuse in relationship and suggest higher relationship satisfaction
Negative attributions toward spouse	MAS composite self-report scores on 4 subscales: attributions of causality to partner's behavior, attributions of causality to partner's personality, attribution of malicious intent to spouse, and attribution of lack of love of spouse	Self-report score change on four subscales total post-pretest scores	No specific cut-off scores but lower scores suggest less negative attributions about partner and are indicative of higher relationship satisfaction

Independent Variable

Independent variable	*Measure*	*Cut-off Criteria*
Levels of depression	Self-report total score on the BDI	A score of 9 is used as the cut-off point for at least a low level of depression. Higher scores indicate higher levels of depression

Data Analyses

In a preliminary analysis intended to identify the degrees of females' and males' depression in the current sample, the distributions of females' and males' BDI scores were examined. The results indicated a sample that for the most part is only mildly depressed. For females, only 13% of the sample had BDI scores that would be classified as clinically significant depression (scores of 20 and above). Similarly, for males, only 6.7% of the sample had BDI depression scores that would be classified as clinically significant depression (scores of 20 and above). This relatively mild level of depression must be taken into account when interpreting the results of the study.

Analyses of Variance Testing the Hypotheses Regarding Group Differences

Analysis of variance for change in psychological abuse. In the following analyses of variance, the degrees of freedom vary slightly due to missing data on variables. A one-way analysis of variance was computed comparing the four types of couples defined by the presence or absence of at least a mild degree of depression (both partners having no depression (type 1), only the male having at least mild depression (type 2), only the female having at least mild depression (type 3), or both partners having at least mild depression (type 4) on females' reports of change in their male partners'

amount of psychological abuse. The number of couples in each category was 5 for type 1, 7 for type 2, 17 for type 3, and 23 for type 4, respectively. Thus, there were notably fewer couples in which both partners had no depression, and the *n* of 5 in that group just barely reached the minimum size needed to conduct the ANOVA. The results of the ANOVA are summarized in Table 3.2. There was no significant couple type effect; F (3, 48) = 1.96, p = .13. The means for the groups (both partners having no depression, only the male having at least mild depression, only the female having at least mild depression, and both partners having at least mild depression were -11.60, -4.71, -21.29, and -22.00, respectively (see Table 3.6). Similarly, the one-way ANOVA comparing the four types of couples on males' reports of change in their female partners' psychological abuse also was not significant for the difference among the four couple types; F (3, 48) = 1.81, p = .12. The means for the groups (both partners having no depression, only the male having at least mild depression, only the female having at least mild depression, and both partners having at least mild depression) were -0.60, -8.86, -22.00, and -15.48, respectively (see Table 3.6). Thus the results did not support the hypothesis regarding an association between partners' pre-therapy depression being associated with less decrease in psychologically abusive behavior over the course of couple therapy.

Table 3.2. Analyses of Variance for Change in Psychological Abuse

Source		Sum of Squares	Degrees of Freedom	Mean Square	*F*	*p*
Males' change in psychological abuse (as reported by female partner)	Couple Type	2134.88	3	711.63	1.96	.13
	Error	17457.80	48	363.70		
	Total	19592.67	51			
Females' change in psychological abuse (as reported by male partner)	Couple Type	1982.67	3	660.89	1.81	.14
	Error	17514.16	48	364.88		
	Total	19496.83	51			

Analysis of variance for change in positive partner behavior. As summarized in Table 3.3, the one-way analysis of variance comparing the four types of couples on change in males' positive partner behaviors as reported by their female partners was not significant; F (3, 48) = 1.25, p = .30. The means for the groups (both partners having no depression, only the male having at least mild depression, only the female having at least mild depression, and both partners having at least mild depression) were 1.40, -2.00, 1.00, and 5.38, respectively (see Table 3.6). The one-way ANOVA comparing the four types of couples on amount of change in females' positive partner behaviors as reported by their male partners also was not significant; F (3, 49) = 0.68, p = .57. The means for the groups (both partners having no depression, only the male having at least mild depression, only the female having at least mild depression, and both partners having at least mild depression) were -1.00, 6.86, 3.24, and 3.42, respectively (see Table 3.6).

Table 3.3. Analyses of Variance for Change in Positive Partner Behavior

Source		Sum of Squares	Degrees of Freedom	Mean Square	*F*	*p*
Males' change in positive partner behaviors (as reported by female partner)	Couple Type	363.85	3	120.62	1.25	.30
	Error	4632.83	48	96.52		
	Total	4994.67	51			
Females' change in positive partner behaviors (as reported by male partner)	Couple Type	180.93	3	60.31	0.68	.57
	Error	4377.75	49	89.34		
	Total	4558.68	52			

Analysis of variance for change in negative attributions about partner. As summarized in Table 3.4, the one-way ANOVA comparing the four types of couples on change in males' negative attributions about their female partner was not significant; F (3, 48) = 0.22, p = .88. The means for the groups (both partners having no depression, only the male having at least mild depression, only the female having at least mild depression, and both partners having at least mild depression) were -2.60, -9.86, -7.56, and -8.42, respectively (see Table 3.6). However, the one-way ANOVA for change in females' negative attributions about their male partner just reached the .05 level of significance; F (3, 49) = 2.79, p = 0.05. The means were -22.60 for couples with neither partner having at least mild symptoms of depression, 0.43 for couples in which the male only had at least a low level of depression, -6.88 for couples in which the female only had at least a low level of depression, and -7.79 for couples in which both partners had some

depression (see Table 3.6). Scheffe post-hoc pair-wise comparisons of the four groups indicated that the only two groups that differed in amount of change in females' negative attributions were the couples in which neither partner was depressed and the couples with only the male partner being depressed, with the former group showing a larger decrease in negative attributions. Thus, change in females' negative attributions was less when her male partner was depressed than when neither partner was depressed. This finding was not consistent with the hypothesis that females' own depression would impede progress in couple therapy but did indicate that males' pre-therapy depression predicted less progress in females' decreasing their negative attributions about the males.

Table 3.4. Analysis of Variance for Change in Negative Attributions about Partner

Source		**Sum of Squares**	**Degrees of Freedom**	**Mean Square**	***F***	***p***
Males' change in negative attributions about their female partner	Couple Type	174.845	3	58.282	0.22	.88
	Error	12751.828	48	265.663		
	Total	12926.673	51			
Females' change in negative attributions about their male partner	Couple Type	1583.476	3	527.825	2.78	.05
	Error	9280.637	49	189.401		
	Total	10864.113	52			

Analysis of variance for relationship satisfaction. As summarized in Table 3.5, the one-way ANOVA comparing the four groups of couples on change in females' relationship satisfaction was not significant; F (3, 49) = 0.90, p = .45. The means for the groups (both partners having no depression, only the male having at least mild

depression, only the female having at least mild depression, and both partners having at least mild depression) were 14, 0.71, 13.06 and 14.96, respectively (see Table 3.6). Similarly, the one-way ANOVA comparing the four groups of couples on change in males' relationship satisfaction was also not significant, F (3, 49), = 0.34, p = .80. The means for the groups (both partners having no depression, only the male having at least mild depression, only the female having at least mild depression, and both partners having at least mild depression) were 4.8, 7.71, 12.47, and 10.33, respectively (see Table 3.6). These findings did not support the hypothesis that partners' pre-therapy depression would be associated with less increase in relationship satisfaction over the course of couple therapy.

Table 3.5. Analysis of Variance for Relationship Satisfaction

Source		**Sum of Squares**	**Degrees of Freedom**	**Mean Square**	***F***	***p***
Change in females' relationship satisfaction	Couple Type	1133.12	3	377.71	0.90	.45
	Error	20625.33	49	420.92		
	Total	21758.45	52			
Change in males' relationship satisfaction	Couple Type	277.00	3	92.33	0.34	.80
	Error	13485.80	49	275.22		
	Total	13762.79	52			

Table 3.6. Mean Change Scores for each Couple Type

	Couple Type 1	**Couple Type 2**	**Couple Type 3**	**Couple Type 4**
Means for females' reports of change in their male partners' amount of psychological abuse	-11.60	-4.71	-21.29	-22.00
Means for males' reports of change in their female partners' amount of psychological abuse	-0.60	-8.86	-22.00	-15.48
Means for female reports of change in males' positive partner behaviors	1.40	-2.00	1.00	5.38
Means for male reports of change in females' positive partner behaviors	-1.00	6.86	3.24	3.42
Means for change in males' negative attributions about their female partners	-2.60	-9.86	-7.56	-8.42
Means for change in females' negative attributions about their partners	-22.60	0.43	-6.88	-7.79
Means for change in males' relationship satisfaction	4.8	7.71	12.47	10.33
Means for change in females' relationship satisfaction	14	0.71	13.06	14.96

Multiple Regression Analyses Testing Partners' Depression as Predictors of Changes during Therapy

Multiple regression analyses for change in level of psychological abuse. In the following multiple regression analyses, the degrees of freedom vary slightly due to missing data. In the multiple regression analysis predicting males' change in males' levels of psychological abuse (as reported by their female partners on the MMEA) from females' and males' pre-therapy BDI depression scores, the multiple correlation *R* was .23 and R^2 = .06; F (2, 49) = 1.42, p = .25. Similarly, in the analysis predicting change in females' MMEA psychological abuse (as reported by their male partners) from females' and males' pre-therapy BDI scores, the multiple correlation *R* was .18 and R^2= .03; F (2, 49) = 0.77, p = .47. These results did not support the hypothesis that partners' pre-therapy levels of depression would be associated with less decrease in their psychologically abusive behavior over the course of couple therapy.

Multiple regression analyses for change in positive partner behaviors. In the multiple regression analysis predicting change in males' positive partner behaviors (as rated by their female partner), the multiple correlation *R* was .29 and R^2= .09; F (2, 49) = 2.26, p = .12. Within this analysis there was a trend for females' depression scores to be positively associated with their reports of increases in males' positive partner behavior (β = 0.23, p = .096). In the multiple regression analysis predicting change in females' positive partner behaviors (as rated by their male partner), the multiple correlation *R* was .15 and R^2= .02; F (2, 50) = .60, p = 0.55. These results did not support the hypothesis that partners' pre-therapy levels of depression would be associated with less increase in their positive behavior over the course of couple therapy. The trend toward females'

greater depression being associated with an *increase* in their report of their partner's positive behavior was counter to the hypothesis.

Multiple regression analyses for change in negative attributions about partner. In the multiple regression analysis predicting change in females' negative attributions about their male partner from females' and males' pre-therapy depression scores, the multiple correlation *R* was .16 and R^2= .03; *F* (2, 50) = 0.65, *p* = .53. Similarly, in the multiple regression analysis predicting change in males' negative attributions about their female partner from the males' and females' pre-therapy BDI scores, the multiple correlation *R* was .18 and R^2 = .03; *F* (2, 49), = 0.81, *p* = .45. These results did not support the hypothesis that partners' pre-therapy depression would be associated with less decrease in their negative attributions over the course of therapy.

Multiple regression analyses for change in overall relationship satisfaction. In the multiple regression analysis predicting change in males' DAS relationship satisfaction from males' and females' pre-therapy BDI depression scores, the multiple correlation *R* was .13 and R^2 = .02; *F* (2, 50) = 0.43, *p* = .66. Similarly, in the multiple regression analysis predicting change in females' relationship satisfaction scores from males' and females' pre-therapy depression scores, the multiple correlation *R* was .11 and R^2 = .01; *F* (2,50) = 0.29, *p* = .75. These results did not support the hypothesis that partners' pre-therapy depression would be associated with less increase in their relationship satisfaction over the course of therapy

Chapter 4: Discussion

Discussion, Limitations, and Implications

This study tested three hypotheses:

1. The higher the level of depression in either partner, the less effective couple therapy will be.
2. If both partners experienced higher levels of depression, the progress of therapy will be affected more than if only one partner experienced depression.
3. The female partner's depression will have a stronger negative association with progress in therapy than the male partner's depression will.

Although couple therapy was demonstrated previously to be effective overall within this sample in improving relationship satisfaction and reducing negative behavior within the couples (LaTaillade, Epstein, & Werlinich, 2006), the results of the present study, for the most part, did not confirm the three hypotheses regarding depression being a barrier to therapy progress. Rather, the results of the study suggest that, at least within the range of depression represented in this couple and family therapy clinic sample, there is no difference in therapy outcome between couples experiencing some depression and those with minimal depression symptoms, and having two depressed partners did not result in a worse outcome than having only one.

The only significant finding regarding the relation between depression and treatment outcome was that in couples in which only the male suffered from depression, the female partners' levels of negative attributions about their depressed male partners did not improve from pre-therapy levels. This is in contrast to couples in which neither partner entered therapy with depression symptoms and in which females' negative

attributions about their male partners did improve over the course of therapy. Additionally, there was a trend for females' pre-therapy depression scores to be positively associated with their reports of increased positive behaviors by their male partners over the course of therapy. Thus, it appears that through the course of therapy, in couples in which only the female experienced at least a low level of depression, there was a trend toward an increase in the frequency with which male partners enacted positive behaviors toward the women. These results suggest that, in contrast to the hypothesis that the progress of therapy would be impeded more if the female partner entered therapy with depression, there was some evidence that therapy was less effective when the *male* partner suffered from depression because the female partners' negative attributions about them did not change significantly from pre-therapy levels, and that therapy was *more* effective in encouraging positive partner behavior when the female was depressed. The following are possible explanations that may account for these results that did not confirm the study's hypotheses.

The sample. In looking back at the literature review, which was the foundation for the hypotheses, there is a fundamental difference between the samples in the studies reviewed and the sample used for this study. The results of the preliminary analysis involving the distributions of depression scores by gender in the present sample indicated that for females, only 13% of the sample had BDI scores that would be classified as clinically significant depression (scores of 20 or above). Similarly for males in the study, only 6.7% of the sample had BDI scores that would be classified as clinically significant depression (scores of 20 or above). The remainder of the sample reported no symptoms of depression or mild levels. In contrast, the studies included in the literature review

included samples of individuals who were either in the clinically depressed range on depression scales or had been given a formal clinical diagnosis of major depression. For example, Dozois and Boardman (2002) conducted a study of cognitive-behavioral therapy for depression with 48 individuals and found that there was a post-CBT remission rate of 51%, such that about one-half of the sample in the study receiving treatment returned to being clinically depressed. Clients' pre-therapy depression predicted poorer therapy outcome. However, Dozois and Boardman used a sample whose level of depression was much higher than the level of depression found within the sample used for the present study, such that the majority of their sample had received a pre-therapy diagnosis of major depression, and all were concurrently on at least one antidepressant medication.

Similarly, in Riso et al.'s (2002) study in which depression was found to be 25 times more common in individuals with distressed versus non-distressed marriages, the sample consisted of 61 individuals with chronic depression. The criteria for chronic depression in the Riso et al. (2002) study was a DSM-IV diagnosis of chronic major depressive disorder or dysthymic disorder, with both diagnoses requiring a duration of depression of two years or longer. Other studies in the literature review included samples that scored at least a 20 on the 24-item Hamilton Rating Scale for depression (a clinically significant level) for a period of two years (Klein et al., 2003), clinically depressed individuals who had BDI scores of 18 or greater and were currently in treatment for depression (Hops et al., 1987), and psychiatric patients who were currently hospitalized for treatment of depression (Gotlib & Whiffen, 1989). This is vastly different from the sample for the present study, in which only small percentages of the members of the

treated couples had depression scores generally considered to reflect clinically significant depression.

Therefore, one possible reason why the results did not show that depression was a barrier to couple therapy could be that the couples seeking therapy at the clinic where the data were collected were simply not depressed enough to interfere with their engagement and progress in therapy. This is not all that surprising, given that the clinic is known specifically as a center for treatment of relationship problems, not depression. Even though there is a well-established association between relationship distress and depression, individuals who are experiencing debilitating levels of depression may be more likely to seek help from clinicians who specialize in and are known for their focus on individual treatment for depression. If the sample for the present study had higher levels of depression, perhaps the efficacy of therapy would be significantly affected.

Another factor regarding the present sample that could contribute to the results of the study not confirming the hypotheses is the small sample size of the couple type in which neither partner had any depression ($n = 5$). The small sample size of this couple type limited the statistical power for detecting group differences in the one-way analyses of variance. In fact, five is considered the minimum size for groups for conducting ANOVAs. Therefore, this subsample size barely made the requirement to run the analyses of variance. If there was a larger sample of that type of couple (neither partner experiencing depression), the analyses may have detected more significant group differences.

In addition, all of the couples in this study's sample had sufficiently overcome any reluctance that they may have had about couple therapy in order to make the effort to

contact the clinic, complete an extensive pre-therapy assessment, participate in ten 90-minute treatment sessions, and complete an extensive post-therapy assessment. This factor may contribute to why levels of depression did not significantly influence the progress and efficacy of therapy in the present study. Although low motivation is a common characteristic of depression, the fact that these couples fulfilled their ten-session requirement says something about their level of motivation for treatment, in that their depression levels did not inhibit them from consistently attending couple therapy. Perhaps people whose therapy would be significantly affected by depression levels would not have the motivation to attend couple therapy at all. Or, perhaps people with high levels of depression dropped out of couple therapy before the ten-session requirement and thus did not qualify for participation in the present study due to not completing both pre- and post-therapy assessment materials.

The effect that one partner's depression has on the other partner. The three hypotheses for the present study focused on how one or both individuals' depression would affect their *own* responses to therapy, but the results suggest that part of what was occurring in couple therapy was that an individual's depression influenced their non-depressed partner's response to therapy. For example, in couples in which only the male partner was depressed, therapy failed to improve the females' negative attributions about their depressed partner. In couples in which neither partner was depressed, only the female was depressed, and both partners were depressed, the female did demonstrate a decrease in negative attributions about her male partner. Therefore, the male's depression was associated with the non-depressed female's lack of decrease in negative attributions.

Similarly, in couples in which only the female was depressed, over the course of therapy the male partners increased their frequency of positive partner behaviors. Thus, it is likely that the females' level of depression was affecting the male partners' increase in positive partner behavior. This finding can be viewed in the context of the literature on the effect of depression on non-depressed partners. Beckerman (2001) found that men's and women's responses to their partner's depression-related behaviors seem to be ambivalent and cyclical. Beckerman (2001) found that sometimes the depressed partner's behavior elicits empathy and attempts to help from the non-depressed partner, and at other times it elicits anger and blaming. Therefore, non-depressed partners often are ambivalent, in that they can be quite supportive and behave positively, but at some point they can become frustrated and respond negatively. In the case of the present study, when women were depressed their male partners apparently worked harder to enact positive behavior for them, perhaps to make them feel less depressed. Thus, maybe because this was a sample of couples who sought therapy together the male partners were focusing on how to be supportive to their depressed partners. Although the hypotheses were not confirmed, the present study establishes that depression can influence the non-depressed partner's response to therapy.

Limitations

The present study had a few limitations that should be considered when interpreting the findings. The sample of the couple type in which neither partner experienced depression ($n = 5$) was so small that it barely met the requirement needed (minimum group size of 5) to compute the one-way analyses of variance. The small sample size of this couple type limited the statistical power for detecting group

differences in the ANOVA. If there was a larger and more equal sized sample in each of the four couple types, perhaps the ANOVA results would have detected more group differences.

This study did not control for other possibly confounding variables such as socioeconomic status, education, and race. These potential confounding variables may affect the efficacy of couple therapy more so than depression. The lack of control for these variables may function as a limitation to the present study.

The fact that the data for this study were derived from the sample in the Couples Abuse Prevention Program (CAPP) may limit the degree to which the results of this study can be generalized. Couples in CAPP qualified for participation based on the existence of some level of psychological or physical abuse in their interactions. The presence of some history of abusive behavior in these couples sets them apart somewhat from the broader population of couples who seek couple therapy. For example, perhaps the degree of abuse in the relationship is more salient than partners' levels of depression in influencing progress in therapy. It would be important to conduct additional studies on the efficacy of couple therapy with samples of couples suffering from depression who are not also experiencing any notable level of emotional or physical abuse.

Another characteristic of the sample that limits generalization of the findings is its restriction to only heterosexual couples. In future studies it would be important to include gay and lesbian couples to determine if depression in one or both partners of a homosexual relationship affects couple therapy in the same way as it does for heterosexual couples.

The length of treatment investigated in this study was limited to ten 90-minute sessions, which is fairly brief treatment. Although couples had the option to continue therapy beyond the ten standard sessions, the assessments that were used to examine pre-post change were restricted to the pre-therapy assessment and a second assessment following the ten sessions. The CAPP study does include a 4-month follow-up assessment as well, but an insufficient number of the couples in the sample had completed the follow-up to allow more long-term evaluation of treatment effects. Perhaps the outcome of the study would be different if the CAPP couples were required to have a longer treatment. It is possible that pre-therapy depression would have a more long-term effect on therapy outcome that would be detected if there was longer treatment.

There are also limitations of this study based on the assessment instruments that were used to measure both relationship functioning and depression. It is possible that the instruments selected to measure relationship functioning in the present study (the Dyadic Adjustment Scale, Positive Partner Behavior scale, Multidimensional Measure of Emotional Abuse, and Marital Attitude Survey) do not tap aspects of relationship quality and adjustment that are likely to be influenced by partners' depression. For example, for some couples, there was a decrease in frequency of positive partner behaviors throughout the course of therapy. Thus, unless couples are becoming less satisfied throughout the course of therapy, perhaps the frequency of positive partner behaviors is not an accurate assessment of positive relationship functioning. Perhaps use of measures of characteristics that might be affected more by depression would result in more evidence of deleterious effects of depression on treatment.

Also, in the present study the BDI was the only measure used to assess depression levels. It would be helpful to use an additional measure to assess depression in order to get an accurate and well-rounded index of depression. Throughout the review of literature regarding gender differences in depression, it was noted that there is a gender difference in the experience of depression. It is possible that assessment instruments such as the BDI predominantly measure the "female" experience of depression and do not accurately measure the ways in which males experience depression. In the review of depression and gender in the literature, several researchers noted that measures of depression tend to capture solely the female experience of depression (Boughton & Street, 2007; Kornstein, 2000). For example, Boughton and Street (2007) state that the questions in their study assessing depression may reflect too narrow a definition of depression that fails to include symptoms associated with depression in men, such as excessive alcohol use, acting out, and anti-social behaviors. It may be important to broaden depression measures to ensure that both genders' experiences of depression are obtained. Therefore, solely using the BDI to measure levels of depression may be a limitation of the present study. Lastly, all the assessments used for the purposes of this study involved self-report, and it is possible that clients presented biased responses to the assessment measures for a variety of reasons, such as wanting to make their therapist feel that therapy was helpful and presenting their relationship levels as more satisfactory and depression levels as less severe. Therefore, a possible limitation to this study is the self-report method of data collection.

Implications

The results of the present study have several important implications. They suggest that perhaps, rather than acting as a barrier to progress in therapy, low levels of depression can serve as motivation for partners' participation and engagement in couple therapy. Because low levels of depression did not serve as a barrier to couple therapy, it is possible that these low levels of depression encouraged couples to seek and actively participate in couple therapy in an attempt to feel less depressed. It will be important to conduct further research on how different levels of depression levels are related to partners' degree of motivation for seeking therapy. Members of couples could be asked questions during therapy intake regarding the factors that led them to seek professional help.

The significance of male partners' pre-therapy levels of depression being related to the outcome of couple therapy in terms of lack of improvement in levels of females' negative attributions about their depressed male partners warrants attention. This is an important finding for couple therapists, because if the male partner experiences depression at some level, it may be important for therapists to explore and work with females' negative attributions about their partner in order to improve relationship satisfaction. More broadly, the results of the present study suggest that there is a pattern associated with males' depression that appears to generally inhibit improvement of relationship satisfaction. This is suggested by the *pattern* of the results (including the non-significant ones) across the set of outcome measures, in which the couples with only the male experiencing some level of depression exhibited the least improvement in females' reports of positive partner behavior, psychological abuse, negative attributions

about their partner and overall relationship satisfaction. Again, it is possible that these effects would have been significant if the sample had been larger, especially with more couples in which both partners were free of depression. This finding is only suggestive but would have important implications for clinical work with distressed couples, so there needs to be more research on the effect that males' depression has on relationship satisfaction and response to couple therapy. To date there has been much more research on treatment of couples in which female partners are depressed, and this imbalance should be addressed.

The literature reviewed indicates that at some level depression does affect relationship satisfaction and the progress of therapy significantly. Because in the present study the percentage of couples that experienced clinically significant levels of depression (BDI scores of 20 or above) was so low, it would be important to do more research including equal percentages of couples who have significant depression, minimal depression, and no depression to see at what level depression does become a barrier to progress in couple therapy. Similarly, it would be beneficial to conduct a study in which multiple groups are established based on different cut-off scores to see the level at which depression does negatively affect the efficacy of therapy. Lastly, it would also be important to examine the sample of clients who did drop out of therapy before meeting their ten-session requirement to see if depression had a role in the termination of couple therapy.

Summary

Overall, this study was relevant for couple and family therapists because the results suggest that low levels of depression do not serve as a barrier to couple therapy.

This is encouraging news for couple therapists working with distressed couples who may have mild levels of depression (a common circumstance, given the high rate of depression among distressed couples) because couple therapists do not seem to have to worry about low levels of depression interfering with couple therapy. This study is also important in redirecting the attention of couple therapists to males' depression as opposed to the traditional focus on females' depression. Although it is important to allocate attention to both partners' depression levels, the results of this study suggest that, at least at lower levels of depression, males' depression may be more harmful for the couple relationship compared to the depression of females. This is a notable finding and should be taken into consideration when working with distressed couples suffering from some level of depression.

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