

Emotion-Focused Therapy for Couples in the Treatment of Depression: A Pilot Study

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Emotion-focused therapy (EFT) for couples was compared to pharmacotherapy in the treatment of major depressive disorder. Eighteen distressed couples in which the female partner met diagnostic criteria for major depressive disorder were randomly assigned to 16 weekly sessions of emotion-focused therapy or pharmacotherapy with desipramine, trimipramine, or trazadone. Twelve couples completed the study. Both interventions were equally effective in symptom reduction. There was some evidence that females receiving EFT made greater improvement after the conclusion of treatment than those receiving pharmacotherapy. The results suggest EFT might be useful in the treatment of comorbid major depressive disorder and relational distress.

A substantial body of literature now documents a reliable association between marital discord and the presence of depression. Whisman (2001) conducted a meta-analysis on 26 studies where both depressive symptoms and marital satisfaction were assessed and found that “. . . the weighted mean effect size (correlation) between depressive symptoms and marital satisfaction across the 26 studies . . . was $-.42$ for women and $-.37$ for men. Both of these mean effect sizes were significantly different from 0 ($ps < .001$)” (p. 4). Noting Cohen’s (1988) discussion of small ($r = .10$), medium ($r = .30$), and large ($r = .50$) effect sizes Whisman (2001) concludes “. . . the association between depressive symptoms and marital dissatisfaction falls in Cohen’s medium-to-large size range” (p. 4).

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Whisman (2001) further identified ten studies in which marital satisfaction was assessed in both samples of individuals formally diagnosed in some manner with depression (rather than simply having depressive symptoms) and a control group of nondepressed individuals. Meta-analysis indicated that "... the presence of diagnostic depression was associated with greater marital dissatisfaction" (Whisman, 2001, p. 5). The weighted mean effect size (d) was 1.75. In interpreting these results, attention was again drawn to Cohen's (1988) discussion of small ($d = .20$), medium ($d = .50$), and large ($d = .80$) effect sizes. It was concluded that "...the mean effect size for the association between diagnostic depression and marital dissatisfaction clearly falls in the large effect size range" (Whisman, 2001, p. 5).

Whisman (2001) notes that similar results have been noted in three community samples of people not seeking treatment. Weissman (1987) found that individuals with marital discord were 25 times more likely to have a diagnosis of major depression than people without marital unhappiness. Goering and colleagues (1996) found that individuals in a troubled marriage were four times more likely to have an affective disorder than those in non-troubled marriages. Finally, Whisman and Bruce (1999) compared marital dissatisfaction in individuals with and without major depression and found an effect size of .70 for women and .36 for men. Whisman (2001) concludes by stating that "... diagnostic depression is associated with marital dissatisfaction in both treatment-seeking and population-based samples" (p. 10).

The association of marital discord and depression has led to attempts to treat depression with couple therapy. Both Emanuels-Zuurveen and Emmelkamp (1997) and Foley and colleagues (1989) used a "partner-assisted approach" to the treatment of depression by having the spouses of depressed patients attend individual therapy sessions. In both studies the two treatment groups were equally effective in improving depression ratings although only the couple intervention resulted in improved marital functioning.

O'Leary and Beach (1990) assigned 36 maritally distressed couples in which the wife met the criteria for major depressive disorder or dysthymia to either standard behavioral marital therapy (BMT), individual cognitive therapy for the wife, or a waiting list condition. At posttest, each of the two treatment conditions was more efficacious than the wait list condition in improving depression ratings although neither was more effective than the other. The women given marital therapy, however, showed greater increases in marital satisfaction than did those given cognitive therapy or no therapy. These differences continued at one-year follow up (Beach & O'Leary, 1992).

Jacobson and colleagues (1991) compared standard BMT, individual cognitive therapy, and a combination of BMT and individual cognitive therapy in 60 couples in which the wife had been diagnosed with major depressive disorder. Individual cognitive therapy was superior to BMT in treating depression where there was no marital distress. In maritally distressed couples,

however, BMT and individual cognitive therapy were equally effective in treating depression. BMT was the only treatment that had a significant positive impact on relationship satisfaction in distressed couples.

Emanuel-Zuurveen and Emmelkamp (1996) compared individual cognitive/behavioral therapy to a general communication-focused couple therapy. Both groups experienced significant improvement and there was no difference between the two groups in the reduction of depressive symptoms. Only the conjoint therapy, however, resulted in an improvement in marital adjustment scores. Teichman, Bar-El, Shor, Sirota, and Elizur (1995) compared a conjoint cognitive/family systems orientations to individual cognitive therapy and a no-treatment, waiting list group. The couple intervention was more effective than individual cognitive therapy in the treatment of depression in this sample. Couple satisfaction was not assessed.

A recent randomized study conducted in the United Kingdom compared antidepressant medication to couple therapy (Leff et al., 2000) in 77 depressed individuals. The antidepressant medication arm consisted of desipramine with trazadone and fluvoxamine as back ups where needed. Couple therapy consisted of 12–20 sessions intended “. . . to help the patient and partner to gain new perspectives on the presenting problems, to attach different meanings to the depressive types of behaviour and to experiment with new ways of relating to each other” (Leff et al., 2000, p. 96). Patients receiving medication only were three times more likely to drop out of the study. Both groups produced an improvement in scores on the Beck Depression Inventory (Beck et al., 1961) but the couple therapy group made significantly greater gains. The advantage of couple therapy over pharmacotherapy remained statistically significant at 2 year follow up.

Thus, preliminary research has generally found that couple therapy is as effective in the treatment of depression as individual therapy if the couple has relationship distress but that only the couple therapy improves relationship functioning. Further, Leff and colleagues (2000) study suggests that couple therapy may be more beneficial than antidepressant medication (a result that needs replication).

Most of the previous studies using couple therapy in the treatment of depression have utilized a behavioral or cognitive/behavioral model of couple therapy. Beach (2001) believes that “. . . it seems likely that all efficacious approaches to marital therapy may have something to offer in the treatment of co-occurring marital discord and depression” (p. 210). Baucom and colleagues (1998) concluded that behavioral marital therapy and emotion focused therapy (EFT) for couples are the only models of couples therapy with demonstrated efficaciousness in the treatment of relationship distress. Beach (2001) notes “Given the grounding of EFT in attachment theory, and the links between disrupted attachment and depression . . . EFT also should be considered a potentially viable form of treatment for discordant couples with a depressed partner” (p. 210).

EFT is an integration of an interactional/family systems approach (e.g., Fisch, Weakland, & Segal, 1983) with an affective/experiential approach (e.g., Perls, Hefferline, & Goodman, 1951; Rogers, 1951) that also draws upon attachment theory. Johnson and Denton (2002) summarize the experiential-systemic synthesis by stating that in EFT “. . . there is a focus on the circular cycles of interaction between people, as well as on the emotional experiences of each partner during the different steps of the cycle” (pp. 223–224).

EFT is carried out in nine steps: (1) delineate the conflict issues between the partners, (2) identify the negative interaction cycle, (3) access unacknowledged feelings underlying interactional positions, (4) reframe the problem(s) in terms of underlying feelings, (5) promote identification with disowned needs and aspects of self, (6) promote acceptance by each partner of the other partner's experience, (7) facilitate the expression of needs and wants to restructure the interaction based on the new understandings, (8) establish the emergence of new solutions (cycles), and (9) consolidate new positions (Johnson & Denton, 2002, p. 230).

Published randomized studies of EFT include four assessing the efficacy of EFT in the treatment of marital distress (Denton et al., 2000; Goldman & Greenberg, 1992; James, 1991; Johnson & Greenberg, 1985a) and one examining the treatment of marital distress for couples with a chronically ill child (Walker, Johnson, Manion, & Cloutier, 1996). There have been two studies in which participants served as their own controls (Johnson & Greenberg, 1985b; Johnson & Talitman, 1997). In all of these, EFT was more effective than a waiting list control group or produced significant improvements in relationship adjustment relative to pretreatment levels. A recent meta-analysis (Johnson, Hunsley, Greenberg, & Schindler, 1999) found a statistically significant mean effect size of 1.43 for EFT in changing Dyadic Adjustment Scale (DAS; Spanier, 1976) scores, which compares favorably with effect size estimates of .95 for BMT (Hahlweg & Markman, 1988; Shadish, et al., 1993). It also appears there is a tendency for marital quality to continue to improve after the termination of EFT. For example, two-year follow up of couples from the Walker and colleagues (1996) study found that treatment effects were maintained at two years (cited in Johnson, Hunsley, Greenberg, & Schindler, 1999).

Clinical experience has suggested that EFT is useful in the treatment of depression (Johnson & Denton, 2002). This study, however, is the first formal test of EFT in the treatment of depression.

METHOD

Participants were heterosexual couples who cohabited at least two years and who had no immediate plans for divorce or separation. At least one member of each couple had to score less than 95 on the Dyadic Adjustment Scale (DAS; Spanier, 1976) as indication of relationship distress. The female part-

ner had to meet the criteria for a major depressive episode on a computerized version of the Diagnostic Interview Schedule (CDIS; Blouin et al., 1986). She had to endorse depressive symptomatology of at least moderate intensity by scoring 25 or greater on the Inventory to Diagnose Depression (IDD; Zimmerman et al., 1986). Couples were excluded from the study if either partner met diagnostic criteria for a psychiatric disorder in addition to major depressive disorder, if the male partner was diagnosed with major depressive disorder, active suicidality, active chemical dependency, a primary sexual dysfunction, violence between the partners, or if either partner was involved in another form of mental health treatment.

Depressed individuals referred to the Centre for Psychological Services at the University of Ottawa or recruited through newspaper advertisements were pre-screened by telephone. Subjects who satisfied the initial criteria for participation completed written consent, a demographic questionnaire, the CDIS, IDD, and DAS. Subjects were then randomly assigned to receive either EFT or pharmacotherapy.

Female participants assigned to the pharmacotherapy condition received either desipramine or trimipramine (125 mg–225 mg daily) or trazadone (250 mg–450 mg daily) prescribed by a psychiatrist based on presenting symptomatology. Dosage levels were monitored (where indicated) and adjusted over the 16-week treatment period in accordance with patient response. Participants in the pharmacotherapy group were seen solely for the purpose of drug maintenance and clinical management. There was no maintenance pharmacotherapy beyond the 16-week treatment period.

The EFT intervention consisted of 14 conjoint sessions of EFT and one individual session for each partner for a total of 16 sessions. Therapy sessions typically lasted one and one quarter hours, and were conducted on a weekly basis.

Couple therapy was conducted by six doctoral interns (3 males, 3 females) in clinical psychology. All therapists had a minimum of one year of supervised training in EFT supplemented by specialized clinical training (10 hours) on the use of EFT with a depressed population. In addition to the pretest, couples repeated the IDD and the DAS during the seventh week (Time 2), post-treatment (Time 3), and at three (Time 4) and six months (Time 5) follow up.

RESULTS

Eighteen out of 54 couples screened met the inclusion criteria and were randomized to treatment. Six couples dropped out (four from pharmacotherapy and two from EFT). The final sample consisted of seven couples in the EFT group and five couples in the pharmacotherapy group. Of the 7 couples who completed treatment with EFT, 2 couples were unavailable for the six-month follow-up assessment.

The mean participant age was 36 for females, and 38 for males. On average couples had been cohabiting for 11 years, had 2 children, and had a mean income of \$45,000. No differences were found between treatment groups in terms of age, years of cohabitation, number of children, income, years of education, or pretest IDD or DAS scores.

Two trained judges using an EFT implementation checklist achieved an inter-rater correlation of $r = .92$ ($p < .001$) in rating 146 therapist statements. The raters then coded 664 therapist statements and found that 551 (83%) fell within the categories contained in the EFT implementation checklist. It was concluded that the EFT intervention was faithfully implemented.

One-way analyses of variance (ANOVA) with repeated measures were performed for each dependent measure with treatment condition as the between-groups factor and the five assessments as the within-groups factor. Only results for the females' IDD scores are reported here (Figure 1). Repeated measures ANOVA revealed that the main effect for treatment on IDD scores was not significant.

There was, however, a significant main effect for assessments over time with $F(4,32) = 6.68$, $p < .01$. For females receiving EFT the within-group contrast set revealed that levels of depression decreased from pre- to post-treatment, $F(1,32) = 7.82$, $p < .05$, $r = .44$, and from post-treatment to 6-month follow up, $F(1,32) = 9.42$, $p < .05$. Thus, depressive symptomatology continued to improve during the 6 months after treatment. Similarly, females receiving pharmacotherapy showed a significant reduction in depression from pre- to posttreatment [$F(1,32) = 4.23$, $p < .05$, $r = .34$]. Six-month follow-up levels of depression, however, did not differ significantly from the treatment phase ($F(1,32) = 2.58$, $p > .05$). Females receiving pharmaco-

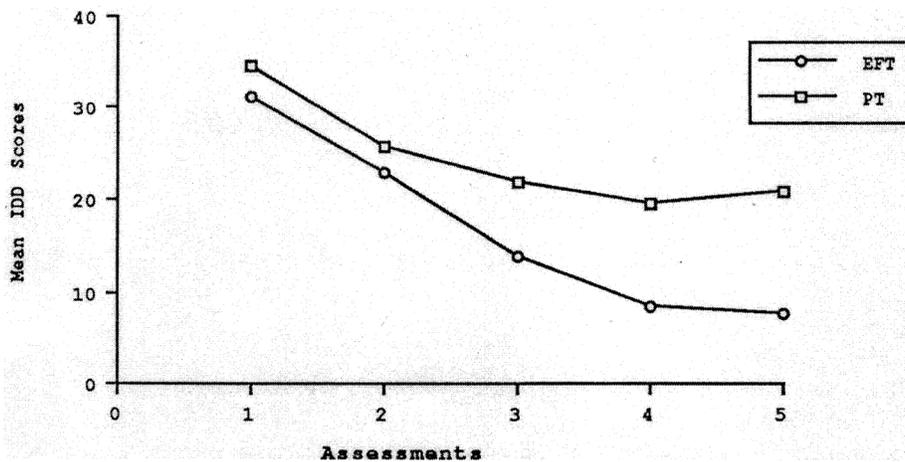


FIGURE 1. Mean IDD Score Across Assessment Periods for Females in EFT and Pharmacotherapy Groups

therapy did not continue to make gains beyond the treatment period. A between-group contrast set revealed no significant differences between groups at either post-test or follow up.

DISCUSSION

These preliminary results support the potential usefulness of EFT as a treatment for depression occurring in the context of couple distress. EFT appears to have been effective in the treatment of depression in females. This was true not only in terms of statistically significant symptom reduction, but also in terms of clinically significant gains. The effect size (calculated as per the recommendations of Smith & Glass, 1977) obtained by females in EFT on the IDD (1.56) compares very favorably with those presented in meta-analyses of the treatment of depression where the average effect size for psychotherapy is 1.22 (Steinbrueck, Maxwell, & Howard, 1983) and suggests moderate to large treatment effects. Indeed, by follow up there were no women in EFT who satisfied diagnostic criteria for depression. Additionally, the majority of females in EFT also showed significant gains in marital adjustment over the assessment periods. As a group, the marital adjustment of females in EFT increased over the follow-up period, mirroring the trend in the reduction of depressive symptomatology.

One limitation of the present design is that there was no maintenance pharmacotherapy beyond 16 weeks. This could possibly account for the lack of gains at follow up for the pharmacotherapy group. Another limitation is the small sample size. While the resulting low power inhibited the ability to detect statistically significant differences between groups the within-group patterns of response to treatment suggest that there might be potentially important differences between the treatment groups. Notably, the EFT intervention performed at least as well as pharmacotherapy.

These preliminary results represent the first test of EFT in the treatment of depression and one of the first outcome studies using any type of non-behavioral couple therapy for this purpose. The overall assessment of the effectiveness of the two interventions suggests that EFT is a promising intervention in the treatment of depression comorbid with relationship distress and that further investigation is warranted. Future clinical trials will benefit from a larger sample size to increase power and take into account the effect of couples who drop out of treatment.

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