Unipolar depression in adults: Family and couples therapy

AUTHOR: Gabor Keitner, MD
SECTION EDITOR: Peter P Roy-Byrne, MD
DEPUTY EDITOR: David Solomon, MD

All topics are updated as new evidence becomes available and our peer review process is complete.

Literature review current through: **Oct 2023.**
This topic last updated: **Sep 20, 2023.**

INTRODUCTION

Depression occurs in a social context and usually affects the patient's significant others. The way in which family members and significant others respond to the depressed patient, in turn, influences the course and outcome of the depressive episode [1]. While many family members cope well when a member becomes depressed [2,3], others experience significant distress themselves and inadvertently exacerbate the patient's depression, decrease the likelihood of recovery, and increase the probability of recurrence [2-5]. It therefore makes good clinical sense to include the family as part of evaluating and treating depressed patients.

There are psychoeducation, systems, emotion focused, and cognitive-behavioral therapy family therapies. They all share the twofold aim of modifying negative interactional patterns and promoting supportive aspects of dyadic relationships, to change the interpersonal context linked to depression [6].

This topic reviews the use of family assessments and family therapy for treating depression in adult patients. An overview of all options available for treating depression is discussed separately. (See "Unipolar major depression in adults: Choosing initial treatment".)

INDICATIONS

Nearly all depressed patients can benefit from an assessment with their significant others during which the clinician evaluates the:

- Patient's social situation
- Presence of life changes
- Nature of the family's relationships
- Family's understanding of depression
- Family's awareness of what treatment involves
- Family's expectations of the patient and the clinician

A family assessment can facilitate treatment in several ways. The clinician can gain collateral information that patients may be withholding intentionally or not. In addition, some patients resist treatment, and clinicians can recruit family members as allies to help overcome this. Family members themselves may be resistant to certain aspects of treatment and encourage noncompliance on the part of the patient (eg, family members may believe that antidepressant medication is addictive).

Family therapy is most appropriate for families who have pronounced difficulty in dealing with depression in their loved one. Family therapy is particularly indicated in families where marital/family problems predate the onset of the depression, because these families generally have greater difficulties in managing depression in a family member [7]. Family therapy can address both the preceding problems and the difficulties that a family has in dealing with the depression.

Family therapy is usually an adjunct to pharmacotherapy and/or individual psychotherapy for treating depression. However, family therapy may be indicated as a stand-alone treatment if the depressive syndrome is not severe and occurs in the context of marital or family distress [7,8].

There are no contraindications to a family assessment or family therapy for adult patients with depression. However, patients must be able to tolerate elicitation of strong affects such as sadness and anxiety, which may occur during treatment.

THEORETICAL FOUNDATION

Family dysfunction and/or marital discord are highly prevalent in families with a depressed member [9]. One study found that marital distress occurred more often in depressed inpatients (n = 35) than community controls (n = 42) (47 versus 17 percent) [10]. Another study that prospectively followed depressed patients (n = 50) and healthy controls matched by age and sex

(n = 50) for up to 10 years found that marital relationships were worse in the patient group [11]. Depression is associated with impaired family functioning in different cultures [12].

Relationship distress and depression interact such that each exacerbates the other. Both depression and family dysfunction tend to be chronic, creating a vicious cycle lasting for many years [13]. As an example, depressed patients may behave in ways that irritate and alienate family members, eventually leading to rejection of the depressed patient [14]. In addition, individuals with depression may also selectively seek negative feedback consistent with their poor self-image [15].

Couple distress can lead to depression through loss of intimacy and emotional connection, combined with tension and interpersonal hostility [16]. One study found that marital distress was associated with a 10-fold increase in depressive symptoms, and another study found that the risk of major depression was 25 times greater in unhappy marriages compared with untroubled marriages [17,18]. Conversely, support from a spouse has been shown to decrease the frequency of depression following stressful life events [19].

Family functioning also predicts the course of illness in depressed patients. Interpersonal support, greater intimacy, and help from a partner to improve coping may buffer the effect of depressive symptoms and facilitate recovery [20]. Conversely, family dysfunction may interfere with recovery from depression. In one study of patients with chronic depression, remission occurred in fewer depressed patients with discord in their intimate relationships (n = 91), compared to depressed patients without discord (n = 80; 34 versus 61 percent) [21]. Other studies have found that family dysfunction is associated with a slower rate of recovery from depressive episodes [22,23]. As an example, one study found that duration of major depressive episodes was longer in patients from families with unhealthy functioning (n = 25) than patients from families with healthy functioning (n = 38; 8 versus 6 months) [24]. In addition, excessive criticism and/or emotional over-involvement within the family increases the likelihood of recurrence following recovery from depression [25].

Depression interferes with parenting skills and adversely affects children [26]:

- Young children of depressed parents have more difficult temperaments, more problems with aggression and mood, more insecure attachments, more difficult interpersonal functioning, poor self-esteem, and lower academic performance.
- Children of parents with depression have higher rates of internalizing (eg, anxiety and depression) and externalizing (eg, substance use) symptoms and disorders.

- The quality of parenting may not improve significantly despite recovery from the depressive episode.

Although many authorities distinguish couples therapy from family therapy because of theoretical and organizational reasons, we maintain that the principles of treatment are similar [27]. Both couples and family therapy focus upon the depressed patient and their social connections, as opposed to simply focusing upon the individual patient. The clinician may need to make some technical adjustments depending upon whether the clinician meets with two, three, four or more family members, but the principles of treatment are the same. The main determinate for couple or family approaches is the comfort level of the clinician with smaller or larger numbers of significant others.

ASSESSMENT

The first step in treating depressed patients with family therapy is to evaluate the patient and the family together.

We assess the nature and quality of the family's relationships to determine whether family therapy is appropriate. Most families do not need family therapy, but all families can benefit from an assessment and opportunity to meet with the treating clinician in order to discuss their concerns, learn more about the illness and available treatments, and to receive support and guidance in how they can help the patient.

We suggest that all members of the family should be seen at least for the initial evaluation. "Family" means anyone who has a meaningful, emotionally important relationship with the patient. A meaningful relationship is one in which people live together or see and talk with each other for 10 or more hours per week. After the initial evaluation, decisions can be made about the composition of subsequent meetings for family therapy.

This initial meeting should be viewed as an evaluation and not a treatment session. The clinician has to be particularly careful to be open to all participants' perspectives of the presenting problems and not to imply blame.

Patient assessment — The clinician should assess the patient's depression, personality, and social life. This part of the interview overlaps with information collected during the initial interview of the patient alone without the family and may thus be truncated. However, family members often reveal new or contrasting information.

The patient's specific type of depression should be characterized:

- Is this the first episode or is it a recurrence?
- Are there symptoms of psychosis?
- Is it chronic?
- Are there any comorbid psychiatric or nonpsychiatric illnesses?
- Is there a family history of mood disorders?
- What treatments have been tried?
- What has been helpful and what has not?

The patient's personality should be characterized:

- What is the person with the depression like?
- What is their temperament?
- How is the patient coping with the depression?
- What is the meaning of the depression to the patient?
- What are the depressed patient's conflicts?

The patient's social life should be characterized:

- What recent changes occurred in the patient's social situation?
- What is the patient's work situation?
- Who are the significant people in this person's life?
- What is the quality of this person's social and family relationships?

The clinical features and diagnosis of patients with depression is discussed in greater detail separately. (See "Unipolar depression in adults: Assessment and diagnosis".)

Family assessment — The essential task in meeting with family members for the first time is to evaluate their functioning. The family assessment determines both the need for family therapy and the specific areas of family life that might need to be addressed.

Data from the family assessment are used to develop a biopsychosocial formulation that addresses both the patient's problems and the social context in which they present. All three

factors (biological, psychological, and social) should be considered together in developing a formulation and corresponding treatment plan.

Assessing and clarifying the family's difficulties can be of significant therapeutic value in and of itself, as it may provide an opportunity for the family to hear each other's concerns in a safe environment in a way that was perhaps not possible up to that point. Families may have been reluctant to express their perspectives to each other for fear of hurting each other's feelings or because of the anger that each may have felt about the burden they have been dealing with.

A family assessment does not necessarily lead to family therapy. If the family assessment reveals a well-functioning family, then reassurance, support, and education can be offered.

The clinician and family members may be most interested in focusing on the depression, its impact on the family, and what the family should do to be helpful. While these issues are central to working with families of a depressed patient, it is also important to do a more comprehensive family assessment in order to better understand the full range of problems and concerns a family may have, because these concerns may influence the depression even if the family is not aware of these issues. As an example, a depressed woman may have a husband and son who often argue with each other, and their conflict may contribute heavily to her depression.

There are different ways to assess a family and many kinds of information that can be gathered. Some family therapists begin with a long history of the family's life, connections, and evolution as a unit. Other therapists are more interested in a here and now view of how the family functions and current problems with which they are dealing. Still other therapists are focused primarily on the process issues in the family session. All three approaches have merit, are not mutually exclusive, and there is no evidence that one approach is superior to the others.

It is important for the clinician to establish a connection with the family when meeting with the family for the first time. The family needs to feel understood, respected, and validated. They should not be blamed for their loved one's problems or judged for their perceived deficiencies. Families are more likely to participate openly in the assessment process if they feel comfortable with it.

One effective way of putting a family at ease is to orient them to the evaluation process at the beginning of the meeting. The orientation explains the purpose of the evaluation, establishes goals for the process, and develops consensus about the agenda. It is important to clarify what the family expects will happen and what they would like to get out of the meeting. The clinician explains that the goal of the meeting is to provide an opportunity for all family members to

identify what they see as problems and to bring up any areas of concern. The clinician can then outline their expectations from the assessment and map out the process ahead.

It is most useful to start by asking each family member to identify what they see as the problems in the family. Every person should be given the opportunity to express their concerns without being interrupted by others. The challenge for the clinician is to not get sidetracked by beginning therapy to deal with problems before everybody has had an opportunity to present their perspectives. The clinician also has to make sure the problems are not described in such detail as to not leave time for exploration of problems and concerns of other family members.

Family functioning — After the concerns of each family member have been delineated, the clinician should evaluate the family's overall functioning. The goal is to understand how the family's specific ways of functioning in different spheres of family life contribute to the patient's depression. The clinician should identify potentially dysfunctional transactional patterns, which are repetitive interactional processes that prevent effective resolution of ongoing interpersonal problems.

There is no "typical" pattern of family dysfunction. Each family attempts to cope with the reality of its depressed member in ways that are unique to the individuals and circumstances that make up that family constellation.

Several models of family functioning have been described, each focusing on different aspects of family life. At the same time, there is considerable overlap between these approaches.

One model that provides structure and breadth to the family assessment is the McMaster Model of Family Functioning [28]. In this model, clinicians systematically assess the following dimensions of family functioning:

- Problem solving – The family's ability to resolve problems to a level that maintains effective family functioning.
- Communication – The exchange of information within the family.
- Roles – The repetitive patterns of behavior by which family members fulfill family functions (eg, household chores, child care responsibilities, finances).
- Affective responsiveness – Whether family members are able to respond to the full spectrum of feelings experienced in the emotional life of each member and whether the emotion experienced is consistent or appropriate with the stimulus or situation.

- Affective involvement – The extent to which the family shows interest in and values the activities of individual family members.

- Behavior control – The ways in which a family establishes rules about acceptable behavior relating to physically dangerous situations, psychobiological needs and drives, and social behavior between family members and people outside the family.

We suggest using the self-report General Functioning Scale of the Family Assessment Device (table 1) to help assess these areas of family functioning [29,30]. Alternatively, a three-item version of this scale takes less than one minute to complete and has been validated [31]:

- We can express feelings to each other
- We do not get along well together
- We confide in each other

Families can review either scale prior to the initial family meeting to establish a baseline, and before each treatment session as an outcome measure to track their progress. The items can be discussed as part of each family session.

Other models of family functioning include the:

- Beavers Systems Model, which identifies family competence and family style as major constructs of how the family is organized and functions [32]

- Circumflex Model of Marital and Family Systems focuses on family cohesion, flexibility, and communications [33]

- Family focused therapy, which prioritizes problem-solving, family organization, and emotional climate [34]

Tools for family assessment — A variety of instruments allow clinicians to evaluate and quantify family functioning systematically in order to track change over time, compare families, and conduct research.

- Self-report (internal) instruments include the: Family Assessment Device [29,30,35,36] (table 1), Dyadic Adjustment Scale [37], Self-report Family Inventory [38], Family Environment Scale [39], and Family Adaptability and Cohesion Evaluation Scales III [33]. (See 'Family functioning' above.)

- Interviewer-rated (external) instruments include the: McMaster Clinical Rating Scale [40], Global Assessment of Relational Functioning [41], Beavers Interactional Styles Scale [37],

and Camberwell Family Interview [42].

There is no absolute advantage to either interviewer-rated or self-report perspectives on family functioning because each may be more useful to answer different kinds of questions. Self-report instruments provide information about each family member's view of their family functioning. This can be used to help members see and understand differences in each other's point of view. Interviewer-rated assessments are more comprehensive because the rater can include observed family processes. In addition, interviewer-rated assessments provide information about how the family is seen by others, which the clinician can use when giving feedback to the family and helping them decide which problems to address. Thus, each type of assessment complements the other. Interviewer-rated assessments may yield more valid information but require time from someone on the treatment team.

TREATMENT

General treatment principles — Family therapy is defined as any psychotherapeutic endeavor that explicitly focuses on altering interactions between family members and seeks to improve the functioning of the family as a unit, or its subsystems, and the functioning of the individual members of the family [43].

The different types of family therapy include systems, psychoeducation, emotion focused, and cognitive-behavioral therapy [44]. They all aim to modify negative interactional patterns and promote supportive aspects of dyadic relationships, in order to change the interpersonal context linked to depression [6]. These specific therapies are described below, with greater attention given to a specific form of systems therapy. (See 'Systems therapy' below and 'Psychoeducation' below and 'Emotion focused therapy' below and 'Cognitive-behavioral therapy' below.)

The different types of family therapy have all been shown to be effective in the treatment of families with a depressed member [6,45-48]. There is no empirical evidence indicating one family therapy is more effective than another. This leads to a dilemma for clinicians trying to determine which family approach to learn and use in particular clinical situations. It makes most sense for a clinician to become competent in one major school of family therapy rather than try to mix ingredients from different models. The selected model of family therapy should be broadly based and well defined so as to allow it to be applied to a wide range of family problems, including families with a depressed patient [27,49].

Common problems that occur in families of depressed patients and can be treated with family therapy include:

- Poor communication
- Lack of support between family members
- Not fulfilling parental roles
- Poor understanding about the nature of depression, the patient's limited capabilities, available treatments, and likely course of illness
- Blame, criticism, and hostility in response to the depressed patient's social withdrawal, negativity, hopelessness, helplessness, regression, and dependence

A common challenge is to find a balance between encouraging the patient to take on new responsibilities without discounting the patient's incapacity due to the depression. The clinician, patient, and family members should set goals that are realistic in terms of what functions the depressed patient can manage and what family members can do to support the patient. A better understanding of depression can help the patient and family members determine the patient's realistic capabilities.

Family therapy meetings generally last from 30 to 60 minutes depending on the stage of treatment. Meetings should initially be held weekly and then with decreasing frequency as the patient and family improve. The number of family meetings range from 1 to more than 20, depending on the type and severity of presenting problems and the specific type of family therapy used.

The usual format is for a single clinician to treat a single family. However, family therapy can be delivered within a group format, in which one or two clinicians treat up to five depressed patients and their respective families. Multifamily group therapy is effective for providing psychoeducation and decreasing feelings of isolation and hopelessness by sharing information, support, and coping strategies [50].

Depression is often a chronic and recurring disorder. Thus, patients and other family members need to learn skills to help manage the depressive illness over the patient's lifetime [7].

Family interventions may create problems if the clinician implies that family members and processes caused the patient's depression. Family interventions may also negatively impact well-functioning families if a clinician assumes a causal relationship between normal family

problems and the patient's depression, or if a clinician breaches confidentiality by revealing a secret that the depressed patient did not want revealed to other family members.

Focusing upon emotion laden issues may help some patients but can also lead to discontinuation of treatment and to marital separations.

Family therapy can be terminated when the family and clinician agree that the family is dealing with their problems effectively. Family therapy should also be terminated if the patient's and the family's situation is deteriorating or if the family is not committed to the treatment process.

Treatment goals — Common processes and goals in the different effective family therapies are probably more important for treatment outcome than the specific maneuvers of a given school of therapy or of a particular clinician. All of these therapies attempt to:

- Increase knowledge about depression
- Decrease guilt about the illness
- Redefine problems between family members
- Increase use of adaptive coping mechanisms
- Encourage appropriate emotional expression and responses
- Improve communication skills
- Improve problem-solving skills and parenting skills
- Clarify boundaries between family members
- Set appropriate boundaries between the familial subsystems and family of origin
- Promote insight into current transactions and historical factors
- Decrease conflict
- Resolve family-of-origin issues

The primary challenge for the clinician is to determine the particular needs and goals of any given family and the obstacles that prevent them from achieving those goals. This is most likely to occur by meeting with all available family members to elicit different perspectives of the problem and determine how the family has tried to deal with the problem. Examples of specific goals that the patient and family may desire include:

- Direct and clear communication of concerns
- Gradually increasing and fuller involvement in necessary family roles
- Gradually increasing participation in activities outside of the home
- Greater levels of physical activity

Noncompliance — Noncompliance is common in family therapy, similar to other psychosocial and somatic treatments. Various factors need to be evaluated to deal effectively with lack of

follow through in completing homework assignments:

- Were the tasks clearly outlined?
- Were the tasks appropriate to the person's capabilities and schedule?
- Was there agreement by all family members about their assignments?
- Did the tasks address identified family problems?
- Was the family motivated and committed to the treatment process?

The tasks should be renegotiated if noncompliance is related mainly to task assignment and allocation issues. It is this process of negotiating tasks, and evaluating whether patients follow through and the reasons for success and failure, which is the core of the therapeutic work.

The family should be given the choice of reengaging in or terminating treatment if noncompliance is related to lack of motivation to change, provided the depressed patient is not at acute risk. Families that terminate treatment should be allowed to return when they are ready to participate more actively.

Booster sessions — Families should be given the option of "booster," follow-up sessions once they have completed a successful course of treatment. An initial booster session can be scheduled one to three months later and if they report they are doing well, another one six-months after that. The focus should be on reinforcing gains and helping to solve new problems.

Systems therapy — Systems is a type of family therapy that views the family as a single system or entity. Systemic models view dysfunctional family relationships as causing or reinforcing symptoms. Systems therapists attempt to restructure maladaptive patterns of family interactions.

We suggest the Problem Centered Systems Therapy of the Family. This therapy is based upon the McMaster Model of Family Functioning [27,28]. Treatment emphasizes changing behavior to resolve problems in family functioning identified during the family assessment. The General Functioning Scale from the Family Assessment Device can be used to assess family functioning (table 1). (See 'Family functioning' above.)

The clinician focuses upon stages of treatment rather than on specific intervention skills:

- Assessment of the patient and family functioning
- Contracting and setting goals for treatment
- Treatment

- Termination of treatment and closure

The patient, family, and clinician determine the goals of treatment by discussing which problems in family functioning should be addressed. These problems are identified in the family assessment, which includes use of the General Functioning Scale from the Family Assessment Device (table 1). (See 'Family functioning' above.)

The basic principles of treatment are:

- Including as many family members as possible
- Treating current problems and developing the family's problem-solving skills
- Active collaboration between the clinician and family
- Modeling of open and direct communication by the clinician
- Focusing on the family's strengths
- Family's responsibility for changing their behavior
- Emphasizing behavioral change and concrete tasks that are easily evaluated
- Emphasizing positive feelings for emotionally oriented tasks

Improving the family's problem-solving skills starts by eliciting how the family identifies and resolves problems that occur, the difficulties and dissatisfactions that arise during this process, and what changes the family wants to make so that problems are resolved in a reasonable manner that is satisfactory to all. As an example, the family may need to reduce its expenses because the depressed patient is no longer providing an income. Treatment involves examining how the family identifies, discusses, and negotiates this problem; who decides what expenses will be reduced or how new income will be generated; who is responsible for carrying out the necessary steps; and who is responsible for ensuring the necessary steps have been taken. The family decides which aspects of this process to change in order to better its skills at addressing issues as they arise and practices its skills with other problems.

Improvements in family functioning should focus upon specific behaviors that are easily verified. As an example, if the family identifies a dirty kitchen as a problem and decides who is responsible for keeping it clean, the next step is to determine what concrete changes need to be made. Do the dishes need to be washed? How frequently? Does the floor need to be swept or washed? How frequently? Does the trash need to be removed? How frequently?

Emotionally oriented tasks may involve changing how family members respond to each other's feelings. As an example, family members may need to consciously work to respond with empathy to the patient's depressed feelings, rather than impatience or frustration.

Problem Centered Systems Therapy of the Family is a short-term, time-limited treatment. A typical course of treatment is 6 to 12 weekly sessions, each lasting one hour. A practical guide for couples/family therapy for depression is shown (table 2). In addition, a manual is available for problem centered systems therapy, which permits easier learning and consistent application [28].

Psychoeducation — Psychoeducational family therapy focuses upon altering negative attributions about the patient's depression, teaching coping skills, providing support, and teaching the family about the signs and symptoms of depression, available treatments, and course of illness [51].

Emotion focused therapy — Emotion focused therapy is the integration of a family systems approach, an affective and experiential approach, and attachment theory. It delineates conflicts between partners, identifies negative interactional cycles, accesses unacknowledged feelings, reframes problems in terms of underlying feelings, promotes identification with disowned needs and aspects of self, promotes acceptance by each partner of the other partner's experience, facilitates the expression of needs and wants, and establishes the emergence of new solutions [52].

Cognitive-behavioral therapy — Cognitive-behavioral marital therapy is a time-limited and structured treatment which emphasizes changes in attitude, behavior, and affect [53]. Treatment initially focuses on outlining problems, modifying negative expectations about individual and relationship change, and changing explanatory style. Treatment emphasizes restoring pleasant interactions and shared activities for the couple, and improving communication and problem-solving skills [54].

CONTINUING CARE

Through a course of family therapy, it is important to continue to monitor the patient's depression and also the possibility of the emergence or presence of mood disorders in other family members.

There is some controversy about who should provide family interventions and how to integrate family therapy with individual psychotherapy and pharmacotherapy for the depressed patient. Many psychiatrists choose to meet with family members solely for gathering historical information, and delegate family interventions to social workers or family therapists.

Integration of care refers to the coordination of different therapies such as pharmacotherapy and family therapy provided by different clinicians. This is the model that is most frequently

used. It has the advantage of being less time-consuming for the clinician and allows for greater specialization of skills. Its disadvantages are that it requires ongoing communication between the different clinicians and requires that they have a synergistic or complementary approach that suits the patient.

Integrated treatment refers to the provision of the necessary biological, psychological, and/or social components of treatment by one clinician. The benefits include better understanding of the illness and its context, more consistent and better coordinated care, and lower cost. Its shortcomings are the difficulty in acquiring the different skills, it is more time-consuming for the clinician, it has a greater potential for breaching confidentiality, and it is more difficult for the clinician to maintain neutrality. To deliver integrated treatment, psychiatrists have to be comfortable with multiple roles, accepted by the patient and the family, and able to pay special attention to boundaries and confidentiality.

There are currently no studies to compare the effectiveness of the integration of care model with the integrated treatment model. Choosing a model is thus based upon the available resources and patient and family preference.

EVIDENCE OF EFFICACY

Psychotherapy trials, like pharmacotherapy trials, are methodologically variable. Some psychotherapy trials are rigorous and specify a priori hypotheses and analytic tests, use active psychotherapy comparators that control for the nonspecific aspects of psychotherapy, use standardized diagnostic criteria and outcome measures, carefully blind outcome ratings, develop manuals for the psychotherapies that are studied and measure adherence, and stratify patients on predetermined risk variables. Less meticulous studies use open-label designs, less rigorous comparators (eg, treatment as usual or waiting lists), or fail to adequately blind outcome ratings. Although it is commonly believed that blinding of patients in psychotherapy is less successful compared with pharmacotherapy trials, this has never been studied.

Depressed patients — Randomized trials indicate that family therapy and couples therapy are efficacious in treating depression in adults [55]. As an example:

- A systematic review identified 14 randomized trials in 651 couples, and found that couples therapy was efficacious for treating middle-aged adults with unipolar major depression [44]. Couples therapy was generally administered over 10 to 20 sessions; some studies did not permit use of antidepressant medication. Primary findings from the meta-analyses included the following:

- Improvement of depression was greater with couples therapy than no treatment (waiting list control), and the clinical effect was large.

- Improvement of depression with either couples therapy or individual psychotherapy (usually cognitive-behavioral therapy) was comparable, as was all-cause discontinuation of treatment. However, improvement of relationship distress was greater with couples therapy than individual therapy and the clinical effect was moderate.

Some studies suggest that meta-analyses may overestimate the clinical effect for nearly all types of psychotherapy in treating depression [56,57]. These inflated clinical effects seem to be the result of publication bias and study quality.

- A systematic review identified 10 randomized trials that evaluated couple (dyadic) and family-oriented interventions in patients with late-life depression (average age 70 years; total n >1800) [58]. The interventions lasted 2 to 12 months, and included psychoeducation, problem solving therapy, and behavioral activation. Family therapy was superior to control conditions (eg, usual care), and for patients with unipolar major depression, the clinical benefit was moderate.

- A review of 19 randomized trials of couple and family interventions for depression concluded that attachment-based interventions, which focus upon rebuilding trust and improving the parents' ability to care for their children, are probably efficacious [59]. In addition, family psychoeducation may also be efficacious.

Other randomized trials, not included in the meta-analysis or systematic reviews, also support using family therapy to treat depression. These trials have found that family therapy provides additional benefits beyond those provided by pharmacotherapy alone and that the benefits of family therapy are comparable to individual therapy [46,60-62]:

- A trial assigned 121 patients with moderate to severe major depression to pharmacotherapy alone, pharmacotherapy plus family therapy (Problem Centered Systems Therapy of the Family), pharmacotherapy plus individual cognitive therapy, or pharmacotherapy plus family therapy plus individual cognitive therapy [45]. Improvement in depression occurred in significantly more patients who received a family therapy component compared to patients who did not (45 versus 10 percent). In addition, patients treated with family therapy had significantly less suicidal ideation.

- A trial compared family psychoeducation plus treatment as usual with treatment as usual alone in 54 patients partially or fully remitted from a major depressive episode [63]. Only

family members participated in the four family psychoeducation group sessions, which consisted of didactic lectures and group problem-solving. Relapse during the nine-month follow-up occurred in significantly fewer patients in the psychoeducation group, compared with the control group (8 versus 50 percent).

The efficacy of family therapy for treatment-resistant depression has not been well studied. One open-label study included family members in a depression management program that taught patients to cope more effectively with their depressive illness in spite of its persistence [64]. The program consisted of nine sessions (five individual and four family), each lasting 50 minutes, conducted over 16 weeks, which focused upon improving quality of life and psychosocial and family functioning, rather than decreasing depressive symptoms. Nineteen patients enrolled in the study. Psychosocial and family functioning improved significantly in the 14 patients who completed the program. Depressive symptoms also improved significantly, although this was not a primary outcome.

Durability of improvements — There are no long-term studies of family therapy that have evaluated whether treatment gains persist for years. Outcome studies of other psychotherapies suggest that patients who have learned to identify and manage their problems are in a better position to maintain treatment gains and avoid a recurrent depressive episode, or can deal more effectively with a recurrence [65,66].

Preventing perinatal depression — Randomized trials suggest that family therapy may prevent perinatal depression. A meta-analysis of five trials compared different types of family therapy with control conditions in pregnant or postpartum women (n = 723) and their partners [67]. Women who received family therapy were less depressed than controls, and the clinical effect was small to moderate.

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Depressive disorders".)

SUMMARY

- **Indications**
  - Depression – Nearly all depressed patients can benefit from a meeting with their clinician and significant others to evaluate the patient's social situation, the presence of

life changes, nature of the family's relationships, the family's understanding of depression, their awareness of what treatment involves, and the family's expectations of the patient and the clinician. (See 'Indications' above.)

- Difficulty coping with depression in a family member – Family therapy is indicated for families who have pronounced difficulty in dealing with depression in their loved one, particularly when marital/family problems predate the onset of the depression. (See 'Indications' above.)

- Contraindications – There are no contraindications to a family evaluation or therapy, but patients must be able to tolerate elicitation of strong affects such as sadness and anxiety, which may occur during treatment. (See 'Indications' above.)

- **Family assessment** – The essential tasks in meeting with family members for the first time are to establish a connection, evaluate their functioning, and determine whether there are any problems that require family therapy. (See 'Family assessment' above.)

  The self-report General Functioning Scale of the Family Assessment Device (table 1) can be used to help assess the following areas of functioning: problem solving, communication, roles, affective responsiveness, affective involvement, and behavior control. (See 'Family functioning' above.)

- **Treatment**

  - General principles – A common challenge for the clinician and family is to encourage the patient to take on new responsibilities and at the same time, accept the patient's incapacity due to depression. Family interventions can create difficulties if the clinician implies that family members caused the patient's depression. Focusing upon emotion laden issues may help some patients but can also lead to discontinuation of treatment as well as marital separations.

    Family therapy is terminated when the clinician, patient, and other family members agree that the family is managing their problems effectively. Family therapy should also be terminated if the patient or the family's functioning deteriorates, or if the family is not seriously involved in treatment. (See 'General treatment principles' above.)

  - Goals – Many types of family therapy have been found to be effective for helping families with a depressed member. Common features of these therapies include changing maladaptive patterns of family interactions, promoting supportive aspects of relationships, rebuilding pleasant interactions, educating families about depression

and ways of coping with it, improving communication and problem-solving skills, and reducing blame and criticism within the family.

Topic 1710 Version 23.0

→