CHAPTER 17

AN INTERACTIONAL PERSPECTIVE ON DEPRESSION

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Konrad Lorenz (1952) has recounted how he once unwittingly attracted a group of tourists during one of his imprinting experiments in a vacant lot in London. Observing him waddling through the high grass in a figure-eight pattern and quacking, the tourists had no way of knowing that he was conducting a scientific experiment and would later win a Nobel prize for his work. Given Lorenz's scraggly appearance, there seemed to be little reason to consider explanations for his odd behavior other than that it was simply an expression of some kind of psychopathology.

Like these tourists, many theorists and researchers have been so impressed with depressed persons' self-derogation, pessimism, and apparent reluctance to take even minimal initiative to remedy obviously upsetting situations that they have not bothered to consider how this behavior might be intelligible in a more inclusive context. The bulk of the literature focuses on the nature of depression and more specifically on the thinking of depressed people without even passing consideration of their predicament, their effects on others, or how others react to them. Watzlawick, Beavin, and Jackson (1967) have anticipated how such a narrowing of the range of inquiry can result in confusion and misattribution to individuals of what is more appropriately to be viewed as features of their exchanges with their environments.

One can find ample examples of this in the depression literature. That a third of women academic physicians are clinically depressed has been discussed in terms of how some women, who are especially vulnerable to depression might be attracted to academic medicine as a career (Welner et al., 1979). Alternatively, efforts to understand the characteristic complaints of depressed people have been focused not on how their everyday lives might provide them with something about which to complain, but rather on how the thinking processes of depressed and nondepressed people differ when their success or failure on a task has been rigged by an experimenter. Undaunted by contradictory findings and past demonstrations of the inherent limitations of their methods (see Gage & Cronbach, 1955; Coyne & Gotlib, 1983), researchers continue their futile struggle for the definitive
answer to the question of whether it's depressed or nondepressed people who are "realistic" (Dykman, Abramson, Alloy, & Hartlage, 1989). Of course, we cannot adequately specify subjects' thinking processes without reference to what information is generally available to them, and who appears realistic in a given experiment may largely depend on the match between the answers sustained by the subjects' everyday experiences and what the experimenter has made "realistic" by design.

Expanding the boundaries on what is considered relevant in the study of depression, an interactional perspective starts with the assumption that an understanding of depressed people requires that we know something about their ecological niches—that is, the conditions of their everyday lives, the problems they face, and how these problems may resist or even be exacerbated by how they and key people around them cope. Furthermore, whereas what depressed people think is important to how they lead their lives, it is not the only and it is often not the primary determinant of the adjustment that they achieve. Thinking and even what a person does can have only limited causal efficacy in many situations. Indeed, the apparent ineptness of depressed people's coping and intractability of their problems may well depend on unyielding features of their circumstances and the characteristic responses that they receive from others, responses that may not entirely be determined by what the depressed people do.

Adopting such a perspective entails setting a new research agenda. There is less interest in depressed people's attributions for hypothetical events or how they struggle with insolvable anagrams or bogus feedback on a laboratory task. Instead, attention is focused on how depressed people get along with key people in their lives as well as how they affect and get affected by people who do not have a history with them.

In this chapter, we will review a wide range of evidence as to the nature of the rich and reciprocal links between depressed people and their interpersonal environments. At the onset, a few cautions are in order. First, provocative though some of this evidence may be, much of it is circumstantial and suggestive, rather than indicative of the complex processes by which depressed people and those around them are influencing each other. Second, the delineation of a formal model has been limited, progressing little beyond a preliminary statement more than a decade old (Coyne, 1976a). At this point, the interactional perspective involves a broadening of the range of factors to be considered in attempts to explain depression and some tentative suggestions as to how they might be relevant, rather than a set of formal, well-delineated theoretical propositions. Nonetheless, it will be seen that existing data provide a strong impetus for further development of an interactional perspective on depression and highlight the futility of continuing to attempt to build models of depression that do not adequately take into account its interpersonal context.

In an early paper, Coyne (1976a) outlined how the behavior of depressed people and those around them might come to fit into an emergent interpersonal system—how all involved might inadvertently contribute to the perpetuation of an unsatisfactory situation. The distressed behavior of depressed people was viewed as reflecting involvement in a set of circumstances where the usual sources of security, meaning, and validation have been disrupted or have otherwise proven to be insufficient. Such circumstances are likely to be the result of stressful life changes or chronic difficulties, but they also can coevolve with depression.

Regardless of the precipitants for depression, it can be anticipated that depressed people will make demands and depend on their relationships in ways that leave others feeling depressed or annoyed themselves, pressured, or that their needs are not being met. Depressed people are thereby likely to provoke reactions that leave them feeling further insecure and even rejected. Undoubtedly, relationships differ in their ability to accommodate the distress and dysfunctional behavior characteristic of depression, as well as the overt disagreement, direct expression of negative affect, and efforts to renegotiate expectations that are likely to accompany it (Coyne, 1988a). Relationships that otherwise appear satisfactory may prove brittle when faced with such challenges.

Thus, while it is assumed that depression is likely to be preceded by stressful life circumstances and overtly problematic relationships, greater emphasis is placed on how the behavior of depressed people and those around them becomes interwoven or concatenated over time. It is conceivable, for instance, that even without the provocation of major life changes, some people are going to be chronically or intermittently needy and will test the supportiveness and patience of
those around them. The outcome of this behavior may depend on how it is handled by key people and the patterning of the relationship that results. Also, some people may be inclined to be particularly obtuse, indifferent, or unfulfilling in their response to the needs of others, and whether this proves depressing to a partner may depend on the ability of the partner to cope with such behavior and how the relationship evolves. An interactional perspective does not deny the individuality of either depressed people or those who are involved with them or how each may contribute to problematic situations, but it does look to the emergent characteristics of interactions and relationships for how this individuality will be shaped and how these problems unfold.

One common feature of depressed people's interactions with others is that the obvious distress of the depressed person has the effect of engaging others, making them feel responsible, and thereby shifting the interactional burden onto them. Their distress proves aversive to others and is capable of inducing a negative mood in them. Yet, at the same time, it is also guilt inducing and inhibiting. People around depressed people may attempt to control their aversiveness by seemingly providing what is being asked, even while communicating impatience, hostility, and rejection. The subtle and overt hostility and rejection that depressed people receive validates their sense of insecurity and elicits further expression of distress, strengthening the pattern. Thus, others may become involved with depressed people in ways that unwittingly perpetuate or aggravate their problems. An interactional stalemate may be the result. Aside from the direct effects of getting caught up in such a pattern, everyone involved may find it more generally difficult to be pleasant and responsive to each other, maintain a household, deal with other problems that they face, and/or simply have the discussions necessary to renegotiate their relationship (Coyne, 1990).

More recent statements of this perspective also have acknowledged the salience of overt anger and negative outbursts in the interactions of depressed people and how these features might be related to inhibited communication at other times (Coyne, 1984; Kahn, Coyne, & Margolin, 1985). Contrary to psychoanalytic formulations of depression, depressed people have not turned all their anger inward. Particularly in their close relationships, they may at times express or receive considerable hostility. Depressed people's obvious distress and the possibility of their becoming even more distressed may serve generally to inhibit others' attempts at direct confrontation. For their part, depressed people tend to be avoidant of conflict and interpersonally sensitive, and they may therefore struggle to head off situations that could involve more criticism and rejection from others. However, despite and even because of such strategies, problems arise that cannot be so readily avoided. When it becomes necessary to face them, the interaction is burdened by the accumulation of unresolved issues and negative feelings and attitudes toward each other. The resulting exchanges are likely to be highly emotional and unproductive, strengthening the sense that problems cannot be discussed and therefore the likelihood that they will again accumulate without resolution. Thus, inhibition may beget hostile exchanges which beget more inhibition. Related to this, the Oregon Research Institute (Biglan, Hops, & Sherman, 1988) has utilized Patterson and Reid's (1970) coercion theory in conceptualizing depressive behavior as a form of aversive control. This group emphasizes how displays of depressive behavior may in the short run inhibit hostile behavior and elicit compliance from others, even though it also serves to suppress caring behavior and increase the likelihood of subsequent hostility.

Finally, Coyne (1989) has provided some hypotheses about the nature of the characteristic complaints of depressed people and the various ways in which they may be intelligible in their interactional context. He emphasized that before assuming that these complaints are prima facie evidence of cognitive distortion, it is important to explore them both as reflections of the negative experiences that depressed people accumulate and as active attempts to manage such experiences. More than simply expressing negative thoughts, depressed people's complaints may be seen as instrumental or illocutionary speech acts (Austin, 1965). Namely, they may be a means of reducing demands, and eliciting support from others or of inhibiting them and leaving them feeling guilty. They also may be a self-manipulative or self-handicapping strategy (Snyder & Smith, 1982) in that they allow depressed people to reduce their expectations of themselves, avoid the implications of potential failures, and otherwise guard against disappointment.

Over the past decade, there have been these refinements of the interactional perspective on depression. Yet, even with such elaborations and qualifications, it still provides a rather sketchy
picture of interpersonal processes in depression. Nonetheless, it can serve to organize our review of the literature, highlighting some patterns of findings that may then provide the basis for defining a research agenda for the future and the continued development of the perspective. Refinement of theory is obviously important, but we also should be sensitive to the pitfalls of its premature ossification. As well as tying together facts that might otherwise seem unrelated, theory can serve to keep crucial facts from being given the consideration that they are due. We look only at the data that fit and look only in places where we will find that kind of data. For instance, provocative findings that there is a more than 25-fold increase in the risk for depression when one is not able to talk to one's spouse (Weissman, 1987) or that spousal criticism is one of the most powerful predictors of subsequent relapse (Hooley, Orley, & Teasdale, 1986; Vaughn & Leff, 1976) warrant more attention than they are accorded by most current theories of depression. These findings are quite compatible with an interpersonal perspective and can be an important impetus to its refinement. Yet, we also should remain alert to findings whose explanation remains more elusive; for instance, that being married is associated with poorer response to antidepressant medication (Keller et al., 1984). Such findings need to be replicated, but they should not be lost from view simply because their theoretical relevance has not been established.

We will begin with survey and interview studies of life events, social support, intimacy, and depression, identifying how such research is relevant to an interactional perspective and the kinds of questions it leaves unanswered. We will next consider the unique contribution of studies of interactions between depressed people and people with whom they are not previously acquainted. Then we will consider studies of the relationships between depressed people and family members, first their spouses and then their children.

STRESS, SUPPORT, INTIMACY, AND DEPRESSION

A large body of survey research now relates measures of life events, social support, and intimacy to depressive symptoms and diagnosis. The generally accepted interpretation of this literature is that it demonstrates a role for stressful life events in the onset of depression and for positive or intimate social relationships in protecting the individual from depression both directly and by buffering the effects of stress. Yet considerable ambiguity and controversy remain. Questions have been raised as to the extent to which occurrence of life events may be the result of chronic and intermittent depressive symptoms rather than invariably the cause or precipitant; whether stress-support accounts of depression are most appropriately limited to milder forms of the disorder; and whether the referents for "life events" and "support" in the circumstances of survey respondents are distinct and what researchers have assumed them to be.

Stress

Rather consistently, measures of life events and chronic strains or difficulties have been found to be associated with depressive symptoms. Yet, it appears that some of the conditions associated with depressive symptoms are insufficient to precipitate an episode of clinical depression (Coyne & Downey, in press). Marital difficulties are associated both with depressive symptoms and clinical depression (Lewinsohn, Hoberman, & Rosenbaum, 1988), but poverty (Weissman, 1987) or having a handicapped child (Breslau & Davis, 1986) are associated with symptoms, but not an increased risk for clinical depression. Focusing on clinical depression, Paykel (1979) calculated that the risk of depression is increased by a factor of 5.6 in the 6 months following any major event he considered and a factor of 6.5 following an exit from a major social role.

Because most studies of life events and depression are retrospective in design, it is often difficult or impossible to disentangle confounds between measures of life events and depression or to identify instances in which depression brought on the events, rather than vice versa (Dohrenwend, 1974; Monroe, in press). Thus, the apparent precipitation of an episode of depression by a breakup of a relationship or the loss of a job may actually be a matter of the dysfunction associated with being depressed bringing about such events. To resolve this issue, it is necessary to go beyond the usual retrospective, checklist approach to the assessment of life events. For instance, Brown and Harris (1978) excluded chronic cases of depression and utilized in-depth analysis of extensive interview data to ensure that events did indeed precede the onset of depression and that the events were unlikely to be a consequence of depression. Even with such stringent procedures, they found that the relationship between severe life events and de-
pression held across four different samples. For instance, in one sample of community-residing women, 53% of the new cases of diagnosable depression involved women who had had such an event of causal importance in the previous 9 months versus 19% of the women who were not cases. Yet, not all stressful life events were found to have the potential for precipitating depression, only those that had long-term threatening implications for a woman’s well-being.

The distinctive feature of the great majority of the provoking events is the experience of loss or disappointment, if this is defined broadly to include threat of or actual separation from a key figure, an unpleasant revelation about someone else, a life-threatening illness to a close relative, a major material loss of general disappointment or threat of them, and miscellaneous crises such as being made redundant after a long period of steady employment. (pp. 274–275)

Brown and Harris' (1978) strategy of focusing on events that are patently independent of any existing depression circumstances many of the criticisms of the typical study of life events and depression, and it provides a demonstration that the stress-depression link be reduced to a matter of confounds or depression-causing life events. However, it also provides an incomplete picture of the role of life events in depression, excluding many cases of depression and many instances in which life events might contribute to depression. About 40% of clinically depressed people suffer from a “double depression,” with an acute depressive episode superimposed on a preexisting dysthymia (Keller & Shapiro, 1982). Whereas Brown and Harris' (1978) approach might exclude these depressed people from study, there is the possibility that the onset of the acute episode may result from the interplay of dysthymia and life events, as when a spouse threatens separation because of a person’s chronic low-grade depressed mood and behavior, and this precipitates an acute episode, which leads to an actual separation. Also, an earlier study had found the single most frequent event reported by depressed women is an increase in arguments with their spouses (Paykel et al., 1969), but most recent studies exclude this event from consideration because of the difficulty in assuming its independence from depression. While allowing a stricter test of the contribution of life events to depression, this exclusion closes the question of whether such increased turmoil in close relationships may play an important role in explaining the occurrence of depression. Thus, having established that life events that require long-term adjustment may precipitate depression, it is time that theorists and researchers explore other, more complex ways in which life events and depression may be linked. Efforts to provide a strict test of a causal role for life events may inadvertently lead to a distortion of the basic phenomena under consideration.

Over the years, there has been the persistent notion that while stress may be upsetting and de-moralizing, clinical depression is an illness that cannot be explained by stress. In one version of this argument, Bebbington, Tennant, and Hurley (1981) have suggested that episodes of depression identified in people residing in the community may “have a ready explication as understandable and unimpressive responses to adversity” (p. 346), but that this would not hold for depression in psychiatric patients. Replying to this argument, Brown and Harris (1982) reviewed seven studies of depressed people in treatment and found that an average of 56% of these patients had an important or severely threatening event in the 6 months prior to the onset of their depression. They further noted that these studies did not assess the chronic life difficulties that also have been shown to be associated with depression, and suggested that this figure was therefore a low estimate of the magnitude of the stress-depression relationship in clinical populations. On the basis of these data, Brown and Harris concluded that when appropriate section criteria are employed, depression in community and treatment samples are in fact comparable with regard to the role of stress.

An argument related to that of Bebbington et al. (1981) is that within a clinically depressed population there are two kinds of depression, one related to stress (reactive) and the other biological (endogenous), and for the latter we can afford to ignore the role of interpersonal factors. This argument is based on a misunderstanding of the nature and correlates of endogenous depression. A set of symptoms such as sleep and appetite disturbance predict a better response to antidepressant medication and electroconvulsive therapy, and endogenous depression is now defined on this basis. However, whether a precipitating stress can be identified is not relevant to diagnosing a depression as endogenous. Reactivity to changes in the environment during a depressive episode, rather than the absence of precipitating stress, has been found to predict response to biologically oriented
treatment (Fowles & Gersh, 1979) and it has now replaced the lack of antecedent stress as an additional criterion for endogeneity. Further, there is evidence that endogenously depressed patients tend to have preexisting problems in their close relationships (Birchnell & Kennard, 1983), and among depressed patients the overall association between endogenous features and the presence or absence of recent life events is weak at best (Dolan, Calloway, Fonagy, De Souza, & Wakeling, 1985).

In yet another version of this argument, it also has been suggested that current diagnostic criteria for depression are overinclusive. If a sample of depressed people is selected on the basis of a demonstrable biological abnormality, then stress will be irrelevant to their depression. Some episodes of depression are associated with identifiable biological features such as nonsuppression of cortisol secretion in response to dexamethasone. Yet, among depressed persons such features are not related to whether a precipitating stress can be identified (Dolan et al., 1985). Thus, whether we consider depression in clinical populations, endogenous depression, or depression with an associated neuroendocrine abnormality, we are not precluding the importance of stressful life events for someone becoming depressed. The key question is not whether depression is to be explained in terms of the interactional context or biology, but how interactional and biological factors fit together. As yet, this question has not received the attention it deserves.

**Social Support, Intimacy, and Depression**

The hypothesis that having good social relationships protects against depression has been given considerable attention. Having a smaller social network, fewer close relationships, and less supportive relationships have all been shown to be related to depression (Billings & Moos, 1984; Schaefer, Coyne, & Lazarus, 1981). It also has been suggested that it is the quality of one’s closest relationships that is most crucial and that the support available from other relationships does not compensate for the deficiencies of one’s intimate relationships (Coyne & DeLongis, 1986).

As in the case of life events and depression, Brown and Harris’ (1978) classic study gives what is perhaps the richest picture of the importance of quality of one’s relationships in depression. They found that whether a woman had a confiding rela-

tionship with her spouse was a powerful mediator of the association between life events and depression. Women who lacked a confiding relationship with an intimate were three times more likely to become depressed in the face of a life event. Further, having a good intimate relationship appeared to eliminate the effects of other risk factors such as having three young children at home, being unemployed, and having lost one’s mother in childhood. In subsequent analyses, Brown, Bifulco, Harris, and Bridge (1986) examined whether the difficulties in the marital relationships of depressed women could have been brought about by their affective state if they had been suffering from an insidious form of disorder. They utilized a rating based on a commonsense judgment as to whether these difficulties could be construed as contingent or probably contingent on the woman’s affective state, and found that only a third of the marital difficulties were rated as contingent. Two thirds of the marital difficulties involved husbands judged to be “grossly dependable.”

Brown and Harris (1978) distinguished between life events as provoking agents in depression and a lack of intimacy as a vulnerability factor, with the effects of a lack of intimacy occurring in the presence of a life event. It is this aspect of their work that has been subject to the greatest criticism. Other investigators have reanalyzed the Brown and Harris (1978) data using alternative statistical techniques, and they have been able to show that the effects of lack of intimacy are independent of whether there has been a serious life event (Cleary & Kessler, 1982; Tennant & Bebbington, 1978; but see Oatley & Bolton, 1985). This reinterpretation is consistent with the robust conclusion of community surveys that a lack of social support has a direct effect on depressive symptoms and diagnosis (e.g., Andrews, Tennant, Hewson, & Vaillant, 1978; Aneshensel & Stone, 1982; Costello, 1982).

Further questions have been raised as to the meaning of intimacy and social support scores and their referents in the everyday lives of survey respondents. The general assumption has been that a high score on social support or intimacy indicates that respondents have something in their lives (i.e., social support or intimacy) that low scorers lack. However, it could be that rather than indicating the presence of something positive, a high score most importantly indicates that respondents are relatively free from interactions or conditions in their relationships that might prove
depressing (Coyne, Ellard, & Smith, 1990). Consistent with this notion, Roy (1978) found that women reporting an inability to confide in their husbands were but a subset of those reporting a “bad marriage,” and that it was having a bad marriage that leaves women at risk for depression, and not the lack of a confiding relationship per se.

However, the most relevant and provocative data come from the Yale Epidemiologic Catchment Area Study (ECA; Weissman, 1987). In a sample of over 3,000 adults, being married and being able to talk to one’s spouse apparently provided a modest reduction in the risk for depression over that associated with being single, separated, or divorced. These may be viewed as the benefits of intimacy. However, this effect was overshadowed by the negative effects of being married and indicating that one could not talk to one’s spouse. The odds ratio for depression associated with being married and not being able to talk to one’s spouse (i.e., the odds associated with not being able to talk to one’s spouse versus the odds associated with all other conditions) was a striking 25.8 for men and 28.1 for women. Taken together, results of this study strongly suggest that most of the apparent protection from depression afforded by having a good relationship with one’s spouse (i.e., spousal support or intimacy) found in other studies might better be seen as a reflection of the detrimental effects of being married but not getting along with a spouse. These findings give added credibility to arguments that not having to deal with problematic features of bad relationships may be more powerful than the purported salutary effects of good relationships.

Taken together, the kinds of studies that we have reviewed might be interpreted as suggesting that regardless of whether it is endogenous or has an associated biological abnormality, depression frequently arises in a context in which there have been losses or disappointments such that personal goals, plans, and expectations have been seriously disrupted, and more specifically when there is turmoil in close relationships. This latter association has sometimes been obscured by researchers’ tendencies both to exclude relevant items from life event inventories and to interpret social support and intimacy scores primarily in terms of what good relationships provide rather than the costs of being in an unsatisfactory relationship. Being in an unsatisfactory close relationship is a powerful risk factor for depression, perhaps more so than most major life events, and is independent of the effects of life events.

Survey studies of life events, social support, and intimacy are thus consistent with an interactional perspective on depression and can lead to a sharpening of focus on the specific kinds of conditions associated with the onset of depression. Yet, these studies tell us little about why particular events befall particular people in particular contexts or the importance of how events unfold. Depression typically does not occur in single episodes, but it is a recurrent, episodic condition (Coyne & Downey, in press). At the present time, we know little about how this course reflects enduring risks or vulnerabilities of the interpersonal contexts in which depressed persons live or how recurrent depressive episodes shape these contexts. Further, as Brown and Harris (1978) noted, their study left open the question of how depressed people “get caught up in a crisis or difficulty, try to cope with it, and the resources that they have for it” (p. 293).

More basically, a social support score or an endorsement of a life event tells us little about a complex set of circumstances, and while they suggest the relevance of interactional processes to depression, they only hint at what these processes may be. In the terminology of Geerwitz (1973), an item on a life events scale such as “birth of a child” is a rather thin description. A thicker description or a closer look at the situations of two women giving birth may reveal features that make it more understandable why one gets depressed and the other does not. Addressing this question in their interview study, Brown and Harris (1978) found that for the women who became depressed, the pregnancy had given added significance to already existing problems: “pregnancy and birth . . . can bring home to a woman the disappointment and hopelessness of her position—her aspirations are made more distant or she becomes even more dependent on an uncertain relationship” (p. 141).

Although an important first step, survey studies have inherent limitations in efforts to understand interactional processes associated with depression. A richer sampling of the particulars of the lives of depressed people is needed. Brown and Harris’ (1978) contextual method of interviewing represents one such solution to this problem. It involves gathering extensive background information about circumstances of respondents and then having this information rated on various dimensions by people other than the interviewers. Structured daily diaries completed by depressed people
and their significant others is another. Actual sampling of interactions of depressed people and others in the home and laboratory is the method most identified with an interactional perspective, but we should be realistic about the difficulties in obtaining an adequate and representative sampling of behavior and making the fullest use of it. No single method is going to prove sufficient to generate a comprehensive view of depression.

Although encouraging of an interactional perspective on depression, the kinds of data just considered raise an important challenge as to how one can decisively test interactional hypotheses about depression. If depression often arises in the context of turmoil in close relationships, how might the emergent patterns of interaction that have been postulated be separated from the effects of such preexisting difficulties? To understand better the interactions between depressed people and the key people in their lives, it thus becomes necessary to sample interactions in which the participants do not have such a history together.

DEPRESSED PEOPLE IN INTERACTION

Studies of depressed people's interactions with strangers allow one to investigate the effects of their current behavior without the confounding effects of past interactions and background that color marital and familial interactions. Any interpersonal difficulties observed in studies of interactions with strangers cannot be attributed to the mate selection, preexisting conflict, or long-term negative attitudes of depressed people and their spouses that might explain the patterning of their enduring close relationships. Yet in the Popperian sense, the notion that depression has identifiable impact in a fleeting contact with a stranger is a "risks hypothesis"; that is, it is the kind of hypothesis that could so easily be wrong and for that very reason increases our confidence in its validity when it stands up to empirical test. Despite the intuitive notion that strangers would be less tolerant of depressed people's difficulties than would family members, several studies (e.g., Hinchliffe, Hopper, & Roberts, 1978; Weissman & Paykel, 1974) have noted that interpersonal disturbances are more pronounced within intimate relationships. A 20-minute conversation in which strangers are asked to become acquainted is socially constraining and places minimal demands on participants, and so it is quite possible that the usual difficulties of depressed people will not have the opportunity to develop. Depressed people may be more inclined to withdraw from strangers and hide their distress than with intimates (Meyer & Hokanson, 1985). Studies of interactions with strangers can therefore serve to inform our interpretation of studies of interactions with intimates, but a lack of predicted findings should not prematurely discourage us from pursuing a potentially fruitful line of inquiry concerning the intimate relationships of depressed people. Fortunately, however, results of studies of depressed people in fleeting contacts with strangers do indeed give encouragement to development of an interactional perspective on depression.

Do Depressed People Create Negative Affect in Others?

One hypothesis that has received much attention in the literature has been that interacting with a depressed person, even for a brief period of time, can create negative mood in others. Most tests of this hypothesis have used paradigm developed by Coyne (1976b), in which college students interacted with either depressed psychiatric patients, nondepressed psychiatric patients, or nondepressed nonpsychiatric controls over the telephone. Subjects completed self-report mood checklists following the interactions. Those interacting with the depressed group experienced significantly greater negative affect themselves: anxiety and hostility, as well as depression.

Several studies have replicated Coyne's (1976b) findings, despite methodological variations. Winer, Bonner, Blaney, and Murray (1981) had subjects read transcripts describing either depressed or nondepressed persons. Strack and Coyne (1983) had subjects interact face to face with either depressed or nondepressed college students. Hammen and Peters (1978) had subjects talk over an intercom system with confederates enacting either a depressed or nondepressed role. Boswell and Murray (1981) had subjects listen to tape-recorded interviews of depressed or schizophrenic patients or staff at a psychiatric hospital and then imagine themselves interacting with these target individuals. All of these studies used self-report mood checklists and found that depressed people aroused more dysphoric emotions in others than nondepressed controls, although Boswell and Murray (1981) reported that the negative mood induction by depressed individuals was no greater than that by schizophrenic controls. However, a number of the above studies used either confeder-
ates enacting depressed roles or subjects imagining interactions with depressed people, so the ecological validity of the effect is still subject to challenge. The use of confederates helps to standardize the behavior of the “depressed” people, but it carries the risk that confederates will not accurately portray the behavior of a depressed person or that they will not accommodate the flow of interaction in a way that is similar to someone who is not enacting a role. At this point we do not know enough about the typical behavior of a depressed person in an initial encounter to assert with confidence that a script for a “depressed” confederate captures the crucial verbal and nonverbal behaviors and reactivity to the partner’s response. The use of videotaped stimuli also provides some standardization of conditions, but carries the liability that the stimulus person’s behavior is not contingent on the subject’s behavior, and therefore there are limits to the extent to which the encounter can be construed as an interaction.

Not all of the literature has confirmed Coyne’s idea about mood induction. Howes and Hokanson (1979) had subjects interact on a problem-solving task with a confederate playing a depressed, nondepressed, or physically ill role. Gotlib and Robinson (1982) studied subjects interacting with either depressed or nondepressed college students, and King and Heller (1984) utilized Coyne’s original (1976a) methodology with outpatients. None of these studies found group differences in self-reported mood, although Gotlib and Robinson (1982) did find nonverbal indications of mood change, as will be discussed later. These studies highlight the remaining need to determine whether a mood induction can be obtained reliably in a fleeting encounter between a depressed person and a stranger, and if so, what the requisite conditions are for it to be observed.

How Do Others Respond to Depressed People?

Coyne (1976a) suggested that the aversive nature of interactions with depressed people often leads others to respond negatively or to avoid future interactions with these individuals. Using a questionnaire on which subjects indicated how willing they would be to interact with a target individual in the future, Coyne (1976b) found that subjects were more rejecting of depressed patients than nondepressed patients or controls. Hammen and Peters (1977, 1978), Strack and Coyne (1983), Howes and Hokanson (1979), Winer et al. (1981), and Boswell and Murray (1981) all used essentially the same measure and found similar results, although the latter study demonstrated this trend only for male subjects. Convergently, Robbins, Strack, and Coyne (1979) found that subjects indicated that they were less willing to give positive reactions to depressed individuals, and Younghren and Lewinsohn’s (1980) depressed subjects reported receiving fewer positively reinforcing responses from others. Hokanson, Sacco, Blumberg, and Landrum (1980) likewise reported that subjects communicated more extrapunitive comments (e.g., feelings of irritation) to depressed individuals than to controls. However, two studies (Gotlib & Robinson, 1982; King & Heller, 1984) used Coyne’s (1976a) rejection questionnaire and found no differences in the extent to which depressed people were rejected.

In everyday situations, as opposed to laboratory analogs, rejection of depressed people may take the form of actual avoidance. Yarkin, Harvey, and Bloxom (1981) found that simply being told that someone is depressed leads to others sitting farther away before an interaction begins. Weissman and Paykel’s (1974) discovery that depressed people had relatively few social contacts and limited support systems is consistent with this idea. In addition, several studies have found that depressed people are devalued and perceived as less well adjusted (e.g., Boswell & Murray, 1981; Burchill & Stiles, 1988).

Others’ responses to depressed people also have been assessed through behavioral observations, including verbal codings with positive/negative evaluations of each utterance and nonverbal codings of posture, eye contact, gestures, and facial expression. Two studies suggested that others give fewer total responses, fewer positive responses, and more negative responses when interacting with depressed people (Gotlib & Robinson, 1982; Howes & Hokanson, 1979). This nonverbal indication of mood change and rejection in the Gotlib and Robinson (1982) study occurred after only 3 minutes, despite subjects not subsequently reporting less willingness to interact with depressed persons in the future. The discrepancy between self-report and behavioral measures in this study may reflect subjects’ ambivalence about actually feeling annoyed when they believe they should be helpful. This interpretation is also consistent with Coyne’s (1976a) contention that others respond with non genuine support toward depressed peo-
ple. Further, it could indicate that others’ nonverbal reactions to depressed people are automatic and not mediated by the same kinds of conscious recognition and interpretation that would be registered in questionnaire responses.

In most of the research concerning others’ reactions to depressed people, the focus has been primarily on the responses that are elicited by depressed people, and any variability or contribution by the others has been slighted. One exception is Ellard, Coyne, Showers, and Ruvulo’s (1987) study of the role of others’ expectancies in determining the experiences of both parties in dyadic interactions involving a depressed person. As in other research, people who expected that they were going to interact with a depressed person were negative in their evaluation of the actual interaction. Likewise, subjects who were told that the person with whom they would interact was warm and outgoing responded negatively when that person was actually depressed. Apparently, subjects reacted to the disconfirmation of their expectations. However, when subjects were told that their partner was nurturant and high in self-esteem, but uncomfortable in initial encounters, both subjects and their naive depressed partners evaluated themselves and each other positively. Ellard et al. (1987) interpreted these results in terms of this manipulation of expectations, both preparing subjects for what would follow but at the same time reducing their self-imposed responsibility for managing the interaction. Ellard et al. (1987) suggest that more emphasis be placed on what others bring to an interaction with a depressed person and the demands this puts on both parties, and we agree.

What Do Depressed People Do?

Despite some intriguing findings, it remains unclear what depressed people do in these interactions to elicit negative reactions. Depressed people’s speech content and speech processes, as well as nonverbal behavior, have been assessed. It has been suggested that their negative self-statements and self-devaluations (Blumberg & Hokanson, 1983; Hokanson et al., 1980; Jacobson & Anderson, 1982), negative affective content (Gotlib & Robinson, 1982), higher level of self-disclosure (Coyne, 1976b; Jacobson & Anderson, 1982), negative facial expression and body language (Gotlib & Robinson, 1982), and nonreciprocal involvement and greater focus on self (Pyszczynski & Greenberg, 1987; Ziomek, Coyne, & Heist, 1983) contribute to the aversive nature of the interactions. However, findings concerning specific behaviors are much less consistent than the findings of the negative impact itself, and Coyne, Kahn, and Gotlib (1987) suggest that the critical behaviors of depressed people in their interactions are not yet being assessed.

Although it has been seldom done, it is important that researchers sample a wider range of interactions besides those initiated by the instructions that the participants become acquainted. Two studies creatively utilized the Prisoner’s Dilemma Game for this purpose. Hokanson et al. (1980) found that in a high-power role, depressed people tend to be exploitative and uncooperative, and they communicated more self-devaluation and helplessness. This elicited uncooperativeness, extrapunitiveness, and expressions of helplessness from their partners. Low-power depressed people tended to blame their partners for their role, eliciting more friendliness and ingratiating behavior from them. In an extension of this study, Blumberg and Hokanson (1983) varied the roles played by confederates interacting with depressed and nondepressed college students. Confederates playing a critical-competitive role elicited more extrapunitiveness from depressed than from nondepressed subjects, and helpless-dependent confederates elicited more negative self-statements from depressed than from nondepressed subjects. Across confederate roles, depressed people communicated high levels of self-devaluation, sadness, helplessness, and general negative content. The interactions occurring in a Prisoners Dilemma Game are highly constrained and limited in their goal. Nonetheless, these studies provide some further insights into the behavior of depressed people and the response of others, including the observation that as well as being sad, depressed people have a capacity for being hostile, uncooperative, and extrapunitive.

Summary of Findings and Possible Hypotheses

The research surveyed earlier indicates depressed people often precipitate negative moods in others. However, there are not enough face-to-face interaction studies in the literature to consider this an established effect. The measurement of mood by checklist after imagined interactions with depressed people or interactions with confederates may not accurately reflect subtle mood induction effects that occur in actual interactions with de-
pressed people. Gurman (1986) also noted that the lack of significant positive correlations between mood and social rejection suggests that mood is not a crucial factor leading to rejection of depressed people. This is quite plausible, but more data are needed before accepting such an interpretation. By a similar logic, one might conclude that if a person does not contract rash after being in the woods, he was not avoiding the poison ivy. It could be that subjects reject depressed persons because of a sense that they could cause a bad mood, but subjects are still able to avoid a mood induction within the confines of brief interaction.

Overall, the accumulated research has established that strangers interact differently with depressed people than with nondepressed people and are themselves differentially affected. Furthermore, these differences are generally aversive and lead to a desire to not interact with the depressed person in the future. The rejection effects described above are quite consistent and have been found both with self-report measures and behavioral observation. Undoubtedly a number of processes are triggered in an encounter with a depressed person. Some of these may be verbally mediated and others not. One possible process is suggested by the Gottlib and Robinson (1982) study, which used face-to-face interactions of college students. As we noted, the negative behavioral responses of those interacting with depressed people occurred quickly, within the first 3 minutes of the interaction. Others' negative reactions may thus occur as an automatic emotional response that is not mediated by verbal processes. Perhaps others respond aversively with a negative "gut reaction" to the emotional cues or signals that are presented by the depressed person. It has been demonstrated that people are responsive to cues indicating anger, such that they more readily pick out an angry face in a group picture in which everybody else is happy than a happy face where everybody else is angry (Hansen & Hansen, 1988), and similar processes may be evoked by a sad or sullen face or posture. Consistent with this notion, it has been found that the severity of a patient's depression is readily reflected in an interviewing physician's nonverbal behavior (Frey, Jorns, & Daw, 1980) and that mothers briefly enacting a depressed role has a pronounced effect even on infant behavior (Cohn & Tronick, 1983).

Of course, the factors responsible for inducing a negative response in strangers might be different from those that create relationship problems over time for marriages and families. For example, the depressed person's increased self-disclosure or disclosure of intimate material may be inappropriate with strangers and lead to their being disliked by them, but the same effect might not be obtained with spouses. Or, a depressed person's display of suffering might create sympathy in strangers but be seen as yet another attempt to enact a dependent role and get others to assume responsibility when put in the context of long-term marital relationships.

Many of the effects found in the stranger studies may be exacerbated when they occur over an extended period of time. The general negativity of the depressed person's speech content, outlook, and self-absorption may create small effects in brief interactions with strangers, but they likely would be considerably more aversive when experienced daily. Convergent with this idea, Weissman and Paykel (1974) found that depressed women's greatest interpersonal disturbances were in their roles as wives and mothers.

The relationships and interactions of depressed college students and their roommates offer an intermediate position between those with strangers and those with spouses or family members. College roommates have much more extensive contact than strangers and negotiate an ongoing relationship with typical interactional styles. However, selection factors are much less important, as students are frequently assigned roommates by lottery, and their involvement is generally less intimate and interdependent than married couples'.

Roommate Studies

Two studies have indicated that the relationships of depressed college students with their roommates were more conflictual and negative than those of nondepressed students and suggested that more prolonged contact between depressed people and others does not ameliorate the effects found in interactions with strangers. Bur- chill and Stiles (1988) found that depressed students were rejected and disliked more, were perceived as functioning less well, and spent less time with their roommates. In addition, the roommates of depressed students came to an experimental setting in worse moods than did roommates of non-depressed students, highlighting the aversive nature of an anticipated interaction with a depressed person. However, after an interaction in which they discussed relational concerns, the moods of
depressed students and their roommates actually improved, whereas the moods of nondepressed students and their roommates did not change. The positive effects of this particular interaction (likely an atypical one for depressed student-roommate dyads) may represent finally having an opportunity to directly address their relational conflicts. These students frequently remarked to the experimenter that although they recognized that the relational concerns discussed in the experiment were genuine problems, they had never attempted to address them directly. Perhaps outside of the experimental situation, these students and their roommates had avoided discussions that might have reduced their discontent with each other because of a lack of confidence that it would have been productive. By contrast, the nondepressed students and their roommates appeared to have fewer problems to tackle, and the experimental interaction was thus an innocuous one that did not affect their moods.

Hokanson and his colleagues (Howes, Hokanson, & Lowenstein, 1985; Hokanson, Lowenstein, Hedeen, & Howes, 1986) followed college roommates in a 3-month longitudinal study. Like Burchill and Stiles (1988), Howes et al. (1985) found that the roommates of depressed students were more depressed than the roommates of nondepressed students, but they also were able to show that there was an increase in depression from the first to the fifth and again to the eleventh week of rooming together. The roommates of depressed students reported that they increased their caretaking of the depressed students over time, but the depressed students themselves came to see their roommates as more distrustful and competitive (Hokanson et al., 1986). This apparent contradiction may perhaps be explained by the roommates' attempts to be supportive while simultaneously resenting the burden placed on them. Such frustration with the depressed students' inability to be helped or taken care of could lead to both members becoming angry and unhappy. Hokanson et al. (1986) also found that the depressed students were more dependent, distrustful, and self-devaluing and that the dependent behavior increased over time.

These roommate studies offer an opportunity to study more chronic effects of depressed people's relationships while still providing a control for the possible selection bias seen in marital relationships. They find that the mood induction that has been found inconsistently in studies of brief interactions occurs with students rooming with a depressed person. They also suggest that these relationships come to be characterized in negative terms and that roommates come to dislike and reject depressed people, perhaps because they resent their impossible position of trying to alleviate the depressed person's suffering. This frustration and anger may lead to blaming the depressed person, who in turn is angered by the rejection and lack of support. Both partners become stuck in a pattern of ineffective coping (see Coyne, Wortman, & Lehman [1988] for an extended account of such miscarried helping).

Effects of Intimacy on a Depressed Person's Relationships

As discussed in the preceding section, the effects of interacting with a depressed person may vary with the degree of intimacy found in the relationship. The stranger studies have shown that others respond negatively to depressed people immediately in first-time encounters. The roommate studies indicated that more extensive and long-term interactions led to the development of negative moods in roommates and relationships that were negative, rejecting, and that contained greater conflict. These findings suggest that the effects noted above likely will be more intense in marital and familial interactions, as well as being systematically more complicated. For example, the depressed student-roommate pairs in the Burchill and Stiles (1988) study developed more positive moods after only an interaction in which they discussed problematic aspects of the relationship. Marital partners placed in a similar interaction, however, would likely have unsuccessfully attempted such resolution many times previously. Their conflicts are likely to be more entrenched, complex, and less amenable to one positive interaction.

MARRIAGES AND FAMILIES
OF DEPRESSED PEOPLE

A number of studies suggest that spouses corroborate depressed people's negative reports about their marriages (Coleman & Miller, 1975; Kahn et al., 1985), and so these complaints cannot be dismissed as a reflection of depressed people's general negativity or cognitive distortions as prevailing cognitive theories of depression might suggest. Yet the picture that is emerging of the marital relationships of depressed people is much more complex than can be conveyed by such global sum-
mary statements. It is becoming clear that the spouses of depressed people bring their own vulnerabilities and difficulties to the marriage, that marital interactions are quite negative during a depressive episode in ways that could be construed as depressing, and that the quality of the marriage impacts on the course of depression and the response to treatment (Coyne, 1988b).

**Spouses of Depressed People**

There is evidence that the spouses of depressed people have personal and family histories of psychopathology themselves and that they have heightened psychological and physical complaints during their partner’s depressive episode. Furthermore, there is even evidence that some women vulnerable to depression are more likely to marry men who contribute to their becoming depressed (Quinton, Rutter, & Liddle, 1984).

Studies of assortative mating have examined the extent to which the spouses of depressed people are married to people with diagnosable psychopathology, and in one of the better designed studies, Merikangas and Spiker (1982) found that over half of spouses of affectively disturbed patients met the Research Diagnostic Criteria for a lifetime diagnosis of psychiatric illness. Most of these spouses met the criteria for affective disorder, and both the patients’ and spouses’ affective disturbances tend to have developed after marriage. Sex differences have been noted: women may be considerably more vulnerable to becoming depressed when living with a depressed partner than men, but this may be due in part to these women being more likely to have family histories of affective disturbance themselves. In contrast, depressed women are more likely than controls to be married to a man with an alcohol or substance abuse problem or personality disorder (see Coyne & DeLongis, 1989, for a more extensive review).

About 40% of spouses of patients currently in a depressive episode have enough symptoms to be classified as probable cases or are suitable for referral, and this contrasts with 17% of the spouses of depressed patients who are not currently in an episode (Coyne et al., 1987). Tracking the spouses of depressed patients seen in family practice, Widmar, Cadoret, and North (1980) found that they made more office visits than controls. The spouses showed a pattern of significant increases in somatic complaints leading up to the patient’s diagnosis, and a decrease subsequent to it.

Several studies suggest that women’s relation-

ships with their spouses may be important mediators of the association between childhood adversity and depression in adulthood. Birchell (1980) studied women whose mothers had died in childhood and who had a poor relationship with subsequent maternal figures and found that a good relationship with the spouse went far in compensating for this risk. Those women who had good relationships with their spouses and still became depressed did so almost a decade later than those with bad relationships. Parker and Hadzi-Pavlovic (1984) found that not only did an affectionate relationship with the spouse largely eliminate the influence of this negative childhood experience, but an unaffectionate relationship with the spouse undid the influence of a positive relationship with the father and stepmother. The spouses of women vulnerable to depression may have their own contribution to problems in the marital relationship. Quinton et al. (1984) found that poor adjustment in women raised in an institution was associated with their spouses currently having alcohol or drug problems or difficulties with the law. Furthermore, spouses’ reports of their own deviance in adolescence were predictive of their wives’ current adjustment.

Taken together, these studies suggest that the effects of early adverse experiences may be largely indirect and in part through the selection of the spouse. Also, taken together with the previously discussed findings of increased personality disturbance among the husbands of depressed women, it may be inferred that women whose vulnerability to depression is such that it is more critical that they maintain a positive intimate relationship also may marry men who are less able to provide it. Consistent with this, recall that Brown et al. (1986) found that depressed women with marital difficulties tended to be married to husbands who were “grossly undependable.”

**Depression and Marital Interaction**

Not surprisingly, studies of the marital interactions of depressed people have found them to be tense, hostile, and conflictual. Kahn et al. (1985) found that there was no difference between depressed outpatients and their spouses in sadness or anger following a brief laboratory discussion, but both differed greatly from controls. The depressed people and their spouses experienced each other in the interactions as more negative, hostile, mistrusting, and detached, and less agreeable, nurturant, and affiliating. Arkowitz, Holliday,
and Hutter (1982) found that husbands of outpa-
tient depressed women did not report more gen-
eral feelings of hostility than did husbands of non-
depressed outpatient women or normal controls. 
However, following a brief laboratory interaction 
with their wives, they were more hostile than the 
control husbands who had similarly interacted with 
their wives. Kahn et al. (1985) also found that de-
pressed outpatients and their spouses did not differ 
from each other in how they generally coped with 
marital conflict, but that they both differed from 
control couples. Depressed people and their 
spouses were in agreement that each was high in 
aggressive behavior and withdrawal and low in con-
structive problem-solving.

Hinchliffe, Hopper, and Roberts (1978) found 
that, compared with surgical controls and their 
spouses, interactions between depressed persons 
and their spouses were characterized by greater 
tension and negative expressiveness, more emo-
tional outbursts, and considerable incongruence 
between verbal and nonverbal behavior. Interac-
tions between depressed patients and strangers 
were much less negative than their interactions 
with their spouses, with the depressed people 
showing more adaptive and reciprocal behavior. 
The Frii Universitat Berlin group (Hautzinger, 
Linden, & Hoffman, 1982; Linden, Hautzinger, 
& Hoffmann, 1983) studied maritally distressed 
couples with and without a depressed partner as 
these couples discussed a variety of issues. Com-
pared with the spouses in couples without a de-
pressed partner, the partners of depressed people 
evaluated their partners and their relationships 
more negatively, and although they spoke nega-
tively of their own well-being, they evaluated 
themselves more positively. They cried more often 
than spouses of nondepressed people. They also 
agreed less with their partner's statements, but 
they also offered more help to their partners. De-
pressed people made more negative self-evalu-
atisons and statements about the future, while mak-
ing more positive statements about the partner 
and the relationship. They also agreed more often 
with their partners. Other studies suggest that de-
pressed women concede more in disagreements 
with their husbands (Merikangas, Ranelli, & Kup-
fer, 1979), and that they are more likely than non-
depressed women to be dominated by their hus-
bands in decision-making (Hoover & Fitzgerald, 

Researchers at the Oregon Research Institute 
(Biglan et al., 1985; Hops et al., 1987) have pub-
lished the only studies of marital interactions of 
depressed people that employed sequential analy-
sis as an analytic tool. In a problem-solving dis-
cussion, couples with a depressed woman engaged 
in less disclosure (excluding complaints about 
well-being). Further, the husbands of depressed 
women proposed more solutions than their wives 
did. In the control couples, the wives proposed 
more solutions. In couples with a depressed wife, 
the husband's facilitative behavior reduced wives' 
depressive behavior. In couples in which there was 
both marital distress and a depressed wife, the 
wives' depressive behavior had the effect of de-
creasing the husbands' subsequent aggression (ex-
pressions of sarcasm and irritation), while the 
husbands' aggression decreased the wives' subse-
quent depressive behavior. Thus, each was able to 
exert aversive control over the other's behavior 
and was able to obtain brief, though immediate 
respite from the other's averseness. In home ob-
servations, depressed wives' dysphoric behavior 
also suppressed their husbands' aggressive be-
havior, but it suppressed expressions of caring as 
well (Hops et al., 1987). Husbands' caring be-
havior reduced their wives' dysphoric behavior 
more than in couples without depression or mari-
tal distress.

Leff and Vaughn (1985) found that the majority 
of the spouses of depressed people were critical of 
them. While some of this criticism centered on 
their depressed partner's current symptomatic be-
havior, a considerable proportion of it was aimed 
at traits and behavior evident before the onset of 
the patient's depression. Such a hostile, critical 
environment can be the origin of a depressed per-
son's self-complaints and hopelessness, a means 
of validating and expanding on existing self-criti-
cism, and a buffer against change. Consistent 
with this latter possibility, experimental studies 
suggest that intimates who agree with a person's 
negative self-view can effectively insulate that per-
son from positive experiences that might other-
wise challenge this view of themselves (Swann & 
Predmore, 1985). Leff and Vaughn (1985) further 
found that the majority of depressed patients, 
particularly women, were fearful of loss and rejec-
tion and desirous of continual comfort and 
support. Yet, contextualizing this observation, 
Leff and Vaughn (1985) showed how depressed 
persons may be maintained in such fears and per-
ceptions. Namely, "few depressed patients de-
scribed as chronically insecure or lacking in self-
confidence were living with supportive or sym-
pathetic spouses... When this was the case, the patients were well at followup" (p. 95).

Overview

Overall, the pessimism, hopelessness, feelings of insecurity, self-complaints and lack of a sense of self-efficacy of depressed people may be more congruent with the nature of their relationships with their spouses than has generally been supposed. As can be seen, depressed people's distress and problems such as dependency, inhibition, and difficulties dealing with hostility do not occur in a vacuum, and the fit of these difficulties with the patterning of their close relationships warrants more attention. The marriages of depressed people tend to be distressing and insecure and not conducive to renegotiating expectations, to overt disagreement, or to the direct expression of negative affect. Further, rather than simply being passive and withdrawn, depressed people are often caught up in miscarried efforts to resolve their difficulties with intimates in which they are unsuccessfully confrontative as well. As Kahn et al. (1985) suggested, depressed people and their spouses may be involved in a cycle in which their unsuccessful efforts to resolve differences lead to withdrawal and avoidance and to negative affect, mistrust, and misgivings about each other. The accumulated effect of such interactions is to overwhelm the couple when they again attempt to settle specific differences, increasing their hopelessness about the possibility of improving their relationship.

Marriage, Marital Quality, and the Course and Outcome of Depression

Studies of the quality of the marriages and marital interactions of depressed people suggest the need to consider further not only how interactional factors trigger an episode of depression, but how they shape its expression, management, and consequences for both depressed people and the people around them. These influences are reflected in studies of the treatment and outcome of depression.

The finding that married patients respond less well to antidepressant medication (Keller et al., 1984) might be dismissed as an anomaly, except as that it has been found that people who have recently ended a relationship improve more than those in enduring relationships whether they receive psychotherapy for depression (Parker, Tennant, & Blignault, 1985) or were identified as depressed cases among general practice patients (Parker, Holmes, & Manicavagar, 1986) or in a community sample (Parker & Blignault, 1985). In the absence of further data, we can speculate that it may be easier to recover from the ending of a relationship than for some depressed people to renegotiate their chronically distressing relationships.

Other studies have found that marital problems predict poorer treatment outcomes. The Yale group has found that the marital problems faced by many depressed people are a negative prognostic indicator in treatment with antidepressant medication (Rounsaville, Weissman, Prusoff, & Herceg-Baron, 1979). Those patients whose marriages improve show satisfactory response to medication, but the evidence is that medication has little direct effect on the quality of depressed people's involvement in their marriages (Weissman et al., 1979). Further, 4-year follow-up assessments of depressed people with marital problems who have been treated with antidepressants suggest that they tend to continue to be vulnerable to depression and to have marital problems (Rounsaville, Prusoff, & Weissman, 1980). Courney (1984) found that depressed women with marital problems were less likely to improve in individual psychotherapy than those without problems. Although cognitive therapy has proven to be effective with depressed outpatients, Jacobson, Schmeling, Salsalisky, Follette, and Dobson (1987) found that depressed people with marital problems benefited little from it.

Two important studies suggest that the number of critical comments about a depressed patient that the spouse makes in an interview during the patient's hospitalization are predictive of posthospital relapse, independent of the patient's level of symptomatology (Hooley et al., 1986; Vaughn & Leff, 1976). In this work, criticism was defined as "a clear statement of resentment, disapproval, dislike, or rejection" (Leff & Vaughn, 1985, p. 125). In the Vaughn and Leff (1976) study, a cut-off of two critical comments by the spouse provided the best discrimination of those depressed patients who subsequently relapsed, while in the Hooley et al. (1986) study, the best discrimination was with three comments. In the latter study, none of the eight patients whose spouses were low in criticism relapsed, whereas 20 of the 31 patients whose spouses were high in criticism relapsed.

Taken together, these studies highlight the continued effects of interpersonal circumstances and
specifically the marital situation beyond the instigation of a depressive episode. The findings that response to medication may be affected by marital problems point to the need to understand better the links between interpersonal circumstances and the biology of depression. Further, the finding that treatment with antidepressants may not resolve the marital problems associated with depression suggests the need to consider work with the close relationships of depressed people either as a primary treatment or an adjunct to medication. There is no incompatibility between medication and marital intervention, and for more severely depressed patients, a combination may be the approach of choice (Coyne, 1987). However, the same difficulties that suggest the need for marital intervention may limit couples with a depressed partner from seeking or benefiting from conventional conjoint therapy. Interventions may be needed that target the negative interactions and misnamed problem-solving that characterize these couples without assuming that they will be able or motivated to cooperate (Watzlawick & Coyne, 1980; for an interactional model of the treatment of depression, see Coyne, 1988a).

Links Between Parental Depression and Child Problems

It has been widely assumed that the difficulties of these children are a result of being parented by a depressed person, but the association between depression in parents and problems in children is likely to be complex. Depressed parents report that they direct even more hostility toward their children than toward their spouses, that they are less affectionate, more emotionally distant, irritable, and preoccupied, and that they experience guilt and difficulty communicating with their children (Weissman & Paykel, 1974). Observational studies also reveal hostility (Hammen, Gordon, Burge, & Adrian, 1987). Surprisingly, the influence of the sad affect of parents has not received as much attention as their hostility, but Biglan et al. (1988) showed that depressed mothers’ sad affect suppressed displays of hostility from their children. Results of other studies suggest that depressed mothers use less effortful strategies in dealing with their children than nondepressed mothers. Depressed parents show lower rates of behavior, particularly the expression of positive affect, and respond slower and less contingently and consistently (Field et al., 1985; for a review, see Downey & Coyne, in press).

Depressed people thus may show many of the same difficulties with their children that they show with other adults (Libet & Lewinsohn, 1973; Youngren & Lewinsohn, 1980). Further, consistent with an interactional perspective, there is considerable evidence that the negativity and hostility between depressed parents and their older children are reciprocal (Radke-Yarrow, Cummings, Kuczynski, & Chapman, 1985; Hammen et al., 1987). Sequential analysis of interactions between depressed parents and their younger children show that they contribute equally to the maintenance of this pattern (Cohn, Campbell, Matias, & Hopkins, in press).

There is also evidence that the same contextual factors that contribute to the parents becoming depressed may be a source of their problems with their children. The children of depressed parents who score high on measures of support and low on stress have considerably fewer adjustment problems than the children of depressed parents in general (Billings & Moos, 1983). Further, the problems of the children may depend on the adjustment of the depressed person’s spouse and whether there are marital problems or disruption.
Thus, the risk of child disturbance increases when both parents are disturbed (Kuyler, Rosenthal, Igel, Dunner, & Fieve, 1980; Weissman et al., 1984). Emery, Weintraub, and Neale (1982) concluded that in the absence of marital difficulties, the risk of problematic school behavior among the offspring of an affectively disturbed parent was no greater than among the offspring of normal control parents. Other studies have found that families in which there has been a divorce account for a considerable proportion of the psychological disturbance of children of depressed parents (Conners, Himmelhoch, Goyette, Ulrich, & Neil, 1979; Kuyler et al., 1980).

Depression in a parent is associated with major threats to the well-being of children, and these children are particularly at risk for depression themselves. Many of the difficulties of depressed people have with others are reflected in their parenting. Yet, as elsewhere in this review, there are suggestions of complex reciprocal processes; specifically, there are indications of the influence of the depressed parents on their children, some indications of reciprocal influences of children on their depressed parents, but also of the other parent on the relationship between depressed people and their children. We should be cautious about placing the responsibility on the depressed person for what are best seen as difficulties tied to the larger context and that may be contingent on the adjustment, behavior, or availability of the other parent as well.

OVERVIEW AND CONCLUSIONS

It seems to be true that depressed people are facing difficult and depressing circumstances, but even so, this observation is too often lost in contemporary psychological theories and studies of depression. The various literatures that we have reviewed in this chapter suggest that there are ample reasons why depressed people might complain about their circumstances, reasons that cannot be reduced to their purported depressive thinking or behavioral deficits. We started with a consideration of the circumstances in which depression arises, noting that it is often associated with loss or disappointment requiring long-term adjustment. We offered a twist on the usual interpretation of the social support and suggested that the detrimental effects of involvement in a bad close relationship may exceed the benefits of a good one. We returned to this focus on the detrimental effects of bad close relationships when we examined predictors of the course and outcome of depression.

Next, however, we reviewed studies of interactions between depressed people and strangers and then of the relationships between depressed college students and their roommates. We noted that such studies were not a substitute for consideration of what occurs in depressed people’s close relationships, but that they had a unique contribution to make in terms of demonstrating that depression can engender problems between people who do not have a previous history together. Also, the mood induction that is sometimes found with brief laboratory contacts of others with depressed people apparently has its parallels in people rooming with a depressed person.

Turning to the marital relationships of depressed people, we found them to be hostile and conflictful. Living with a depressed family member can be associated with considerable distress, but we attempted to present a more complex view of depressed people’s marriages, suggesting that spouses of depressed people may bring their difficulties to the relationship and that they may even contribute to depressed people’s vulnerability. Data concerning treatment outcome and relapse point to the usefulness of targeting the marital relationship for intervention, whether as a primary treatment or an adjunct to medication.

Our review of the literature concerning the children of depressed people found them to be at considerable risk, particularly for depression. Depressed parents can be hostile toward their children and they use less effortful strategies in dealing with them. Their children also show considerable hostility to them. Further, many of the problems between depressed people and their children may be the result of preexisting conditions that contributed to these parents becoming depressed. The studies of the children of depressed parents highlight the need to contextualize considerations of the close relationships and to be prepared for considerable complexity.

Many of the studies that were most directly relevant to the interactional perspective were not inspired by it. For instance, the studies of children of depressed parents originally came about because of the need for a psychiatric control group in studies of the offspring of schizophrenics (see Downey & Coyne, in press, for a review of this early literature). These studies enrich our understanding of interactional aspects of depression, but it is important that research become more in-
terational in its conceptualization and design. An
interactional perspective on depression is more
than the hypothesis that depressed people are dis-
tressing and get rejected. It is a call for a different
way of thinking about psychopathology, one that
involves an appreciation of the rich and reciprocal
links between people and their environments and
of the significance of close relationships. Finally,
it is important from both a theoretical and ethical
point of view that we not reduce these troubled
close relationships to the pure victimization of
spouses and family members by depressed people
or of depressed people by them, but to appreciate
how everyone involved may have got caught up in
difficult circumstances and how their ways of cop-
ing may perpetuate these circumstances despite in-
tentions to the contrary.

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