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Marital Problems and Treatment Outcome in Depressed Women
A Clinical Trial of Social Work Intervention

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In a clinical trial investigating the effectiveness of social work intervention with depressed women patients in general practice, 80 women were randomly allocated to an experimental group for referral to attached social workers or to a control group for routine treatment by their GPs. They were reassessed at 6 and 12 months. The results indicated that women who had major marital problems were more likely to be depressed at follow-up than those with good relationships. However, patients with marital difficulties in the experimental group made more improvement than the controls. Women initially assessed as suffering from 'acute on chronic' depression and having major marital difficulties were found to benefit most from social work intervention.

Marital disharmony and breakdown have a number of damaging ramifications both for the adults concerned and the children. It brings with it a higher risk of suicide, behavioural problems in children, and deterioration in physical health (Home Office, 1979; Dominian, 1980).

Depression and marital problems are also closely linked, although there is controversy as to their sequence (Briscoe & Smith, 1973; Brown & Harris, 1978). Paykel *et al* (1969) found that increases in marital difficulties and disputes were the most frequent 'life events' reported by depressed women in the 6 months prior to seeking treatment. In another study, Weissman & Paykel (1974) assessed the social adjustment of depressed female outpatients and compared them with a normal female population. They found that the depressed women had much more marital dysfunctioning than the normal women, characterised by poor communication, friction, disengagement, and sexual problems. In addition, these marked impairments persisted long after the women recovered clinically (Bothwell & Weissman, 1977). Other studies have suggested that women who lack close confiding relationships with their husbands or cohabitees are particularly vulnerable to episodes of depression (Miller & Ingham, 1976; Brown & Harris, 1978).

Research has indicated that more people approach their general practitioners with their marital difficulties than any other professional (Chester, 1971; Home Office, 1979; Mitchell, 1981; Brannen & Collard, 1982), presenting their problems either overtly or covertly, with symptoms of physical or mental ill-health. It has been advocated that general practitioners and the primary care team should be strengthened by the attachments of other professionals to deal specifically with problems such as these (WHO, 1973; Shepherd, 1974), and in recent years an increasing number of different professions have been attached, including social workers, clinical psychologists, community psychiatric nurses, and counsellors (Kincey, 1974; Hicks, 1976).

While there has been a considerable number of reports and subjective accounts on the advantages that these various schemes confer (e.g. Clare & Corney, 1982), there has been a lack of independent objective assessments of whether these schemes actually benefit the patients referred.

The aim of the clinical trial described in this paper is to investigate whether the attachment of a social worker to general practice can benefit depressed women of child-bearing age. As previous studies have found that clinical improvement is often directly related to marital improvement, this suggests that the treatment of depression should also include social intervention aimed at reducing marital difficulties and strife (Rounsaville *et al*, 1980). This paper, therefore, specifically focuses on the subgroup of women with marital difficulties, investigating their clinical outcome after 6 months and one year, and the effects of treatment.

Method

Following a pilot study to test feasibility, the main study was initiated involving the participation of six doctors. Five of these were based in a health centre with a social work attachment scheme involving four part-time social workers. This scheme had been in operation for 2 years when the study started and was well established. The sixth doctor was from a single-handed practice and had been involved in previous studies with this unit.

The doctors were asked to refer women aged 18–45 years presenting with 'acute' or 'acute on chronic' depression, whose symptoms of depression had appeared (in the case of the former group) or intensified (in the case of the latter group) in the previous 3 months. Women suffering from major physical ill health and those already seeing a social worker were excluded.

All referrals were initially interviewed by a psychiatrist, using the Clinical Interview Schedule (CIS; Goldberg *et al*, 1970). This schedule was developed specifically for use in community surveys and has been found to be acceptable to individuals who do not see themselves as psychiatrically disturbed. It includes a detailed enquiry into the severity and frequency of ten common symptoms (e.g. irritability, depression, anxiety) which are each rated on a five-point scale. The total symptom score is a composite rating obtained by adding these ten scores together. At the end of the interview, the psychiatrist rates the patient on the presence of 12 'manifest abnormalities' observed during the interview. These are each rated on a five-point scale and the scores are added together to form a composite 'manifest abnormality score'. A total score for the interview is obtained by adding the symptom score to twice the manifest abnormality rating. This method of scoring has been found to have the best agreement with clinical judgement. A rating of overall severity is also made. A score of 0 is not a case, 1 is subclinical, 2 a psychiatric case of mild degree (disturbance is just clinically significant), 3 a case of moderate degree, and 4 a case of severe degree.

Patients ascertained as obtaining a rating of overall severity of 2 or more who also fulfilled the age and chronicity criteria were referred to a social research worker using the Social Maladjustment Schedule (Clare & Cairns, 1978). This instrument includes a detailed marital assessment in which married and cohabiting women were rated on four items: shared interests and activities, sources of conflict, responsibilities and decision-making, and sexual compatibility. For women on their own the rating concerned the woman's relationship with her boyfriend or her attitudes towards the opposite sex and her opportunities for meeting men.

Patients were then randomly allocated to the experimental or control group by a research assistant who was not involved in the assessments. In order that the two groups were matched in certain characteristics, patients were allocated into one of eight sets according to two categories of age, married or single status, and whether they were suffering from an 'acute' or 'acute on chronic' depression. The first patient in any of these sets was assigned to the experimental or control group by the toss of a coin, the second patient was automatically assigned to the alternative group, the third patient randomly allocated and so on. Those allocated to the experimental group were referred to one of four attached social workers for treatment, while the controls were referred back to their doctors for routine treatment.

After 6 months, the women were reassessed by means of the same instruments. The research staff involved in these assessments were unaware of any intervening treatment. Additional information was obtained by placing a card in the general practitioner's notes. The date of any clinical improvement or deterioration, from the initial psychiatric assessment to one year later, was recorded, as well as the number of visits the patient made to the doctor and any psychotropic drug prescription. Details were also collected from the attached social workers, who completed specially designed forms regarding each client referred to them. These forms recorded the initial assessment of the social worker and the problems presented, and also details of the social worker's contacts with the client, the types of intervention given, and the reason for closure.

The results were analysed by means of univariate and multivariate analyses of covariance, taking into account the three matching variables and also the initial scores as covariates.

Results

Characteristics of cohort

There were 116 women referred to the study, of whom 104 attended for the first interview. Of these, 91 were assessed as suitable for inclusion in the study. Of the 13 women who were ineligible, nine were considered to be chronically depressed, two had depressions of insufficient severity, and two were already seeing a social worker.

Of the 91 eligible women, four refused the social interview and seven were unwilling to participate in the follow-up

TABLE I
Summary of initial characteristics of experimental and control groups

	Experimental group (n = 41)	*Control group (n = 39)*
Marriage		
Married women and cohabiting women: %	76	69
Women with major problems in their marital or sexual relationships: %	63	59
Work		
In paid employment: %	61	64
Social class		
Social class I & II: %	17	10
Social class III: %	68	79
Social class IV & V: %	15	10
Ethnic origin		
British by birth: %	88	90
Duration of illness		
'Acutely' depressed: %	39	49
'Acute on chronic': %	61	51
Age		
Mean age: years	31.0	28.6

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TABLE II
Presence or absence of major 'marital' problems: patients improved 6 and 12 months after referral

	No or minor problems		*Marked problems*	
	6 months (n = 31)	*12 months (n = 29)*	*6 months (n = 49)*	*12 months (n = 40)*
Percentage of patients improved (severity rating 0 or 1)	87	72	51	47.5
Percentage of patients not improved (severity rating 2 or 3)	13	28	49	52.5

TABLE III
Presence or absence of major 'marital' problems: patients improved in the experimental and control groups

	No or minor problems				*Marked problems*			
	Experimental		*Control*		*Experimental*		*Control*	
	Number	*%*	*Number*	*%*	*Number*	*%*	*Number*	*%*
Patients improved	11	73	16	100	17	65	8	35
Patients not improved	4	27	0	0	9	35	15	65
Total	15	100	16	100	26	100	23	100

interviews or had moved out of the area. Therefore, 80 patients were included in the study, 41 being allocated to the experimental group (existing services plus allocation to the social worker) and 39 to the control group (existing services only).

At the time of the initial assessment, the experimental and control groups were closely similar in respect of their demographic characteristics, and psychiatric, physical ill health and social ratings, and there were no statistically significant differences between them (Table I). Over two-thirds of both groups were married or cohabiting, and high proportions had major problems in their relationships with their husbands, cohabitees, or boyfriends (hereinafter called major 'marital' problems). Approximately 80% of each group were taking psychotropic drugs. Table I shows some of the initial characteristics of both groups.

Follow-up scores

When the women were re-interviewed 6 months later, approximately two-thirds were assessed by the psychiatrist as improved (i.e. given a severity rating of 0 or 1 on the CIS). However, the majority of women who had no major 'marital' problems had improved at follow-up, in comparison to only half of those with major problems in this area (Table II).

This difference was statistically significant at below the 1% level for the four follow-up composite clinical ratings (symptom score, manifest abnormality score, severity rating, and total score) using univariate analyses of covariance. The medical notes also revealed that women with no or minor 'marital' problems improved in health much quicker than those with 'marital' difficulties ($P<0.01$). The former were also less likely to be depressed one year after referral (Table II). However, this information was only available for 69 women, as 11 patients had moved and changed practices.

Although the quality of the patient's relationship with her sexual partner affected the clinical outcome, it was found to have no statistically significant influence on the improvement of social scores, on psychotropic drug prescription by the doctor, or on the patient's attendances at the surgery, as recorded by the general practitioner.

Effects of treatment

There was very little difference in outcome between the experimental and control groups after 6 months or one year according to the clinical data collected or the social or medical criteria.

Over 80% of both groups had taken psychotropic drugs between the two assessments, and there were no major differences between groups on the length of time patients were taking these drugs. Although at the time of follow-up assessment 22% of the experimental group were taking a psychotropic drug in comparison with 31% of the controls, this difference was not statistically significant.

Women with major 'marital' problems who received social work help made much more improvement than the controls (Table III). This interaction between treatment and quality of the patients' 'marital' relationship was found to be significant when a multivariate analysis of variance was performed on all the follow-up clinical scores ($P<0.05$), and for three out of four of the follow-up composite clinical ratings using univariate analysis of covariance ($P<0.05$; Corney, 1981*a*, 1985). However, there were no significant interactions on the social scores indicating improvement, or on psychotropic drug prescription or patients' attendances at the surgery.

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TABLE IV

Proportion of patients improved after 6 and 12 months for 'acute' and 'acute on chronic' patients according to quality of 'marital' relationship

	Group 1 (acute on chronic; no or minor problems)		*Group 2 (acute on chronic; marked problems)*		*Group 3 (acute; no or minor problems)*		*Group 4 (acute; marked problems)*	
	Proportion	*(n)*[1]	*Proportion*	*(n)*	*Proportion*	*(n)*	*Proportion*	*(n)*
Proportion improved at 6 months (severity rating 0 or 1)								
Group E[2]	0.6	(10)	0.8	(15)	1.0	(5)	0.5	(11)
Group C[3]	1.0	(4)	0.3	(16)	1.0	(12)	0.4	(7)
Proportion improved at 12 months (according to medical notes)								
Group E	0.6	(9)	0.6	(14)	0.6	(5)	0.6	(10)
Group C	0.5	(4)	0.2	(11)	1.0	(11)	0.6	(5)

1. Numbers in brackets represent total in each subgroup.
2. Group E = experimental group.
3. Group C = control group.

Further analysis of the data indicated that the chronicity of the patient's depression was another important variable in determining outcome. An important distinction between the patients included in the study is that some were 'acutely' depressed, having had symptoms of depression for 3 months or less, while others were assessed as 'acute on chronic', having had symptoms for a longer period. The results indicated that a much higher proportion of 'acute on chronic' patients improved if they were referred to a social worker. For 'acute' patients the reverse was true, fewer patients improving when referred to the social work service. This interaction between treatment and chronicity was also found to be statistically significant in a multivariate analysis of covariance ($P<0.05$), and in the univariate analyses of three out of four of the composite clinical scores ($P<0.05$).

Chronicity of illness, presence of marital problems, and treatment

As the analyses revealed that chronicity of the patient's depression and the quality of her 'marital' relationship were both important, further analyses of three-way interactions of these two variables and treatment were performed. These were statistically significant for univariate analyses of three out of four of the follow-up composite clinical scores ($P<0.05$).

These findings suggested that one subgroup of patients benefited more from the social workers' interventions than the three other groups (Table IV). These were women who were assessed initially as having major 'marital' problems and who were suffering from 'acute on chronic' depression (group 2). With this particular group of women, 80% of the experimental group were assessed as clinically improved at follow-up in comparison with only 31% of the controls. This difference still held one year after referral when the medical notes were examined. Of the experimental group, 57% were judged by the doctor to be well, in comparison with 18% of the controls. In contrast, women assessed as acute on chronic who had no or minor 'marital' problems (group 1) fared less well in the experimental group than the controls, but there was no difference in outcome one year after the initial assessment.

For the acutely ill patients, there were fewer differences in outcome between the experimental and control groups. All those with no or minor 'marital' problems improved (group 3), while over half of those with a poor relationship failed to get better.

The majority of women who had improved clinically also made some improvement in their social adjustment; thus 'acute on chronic' depressed patients with major 'marital' difficulties who were referred to a social worker made more improvement in their social adjustment than the controls in this category. However, the three-way interactions for social work intervention were not statistically significant, either for social scores in general or for those scores measuring marital adjustment (Corney, 1981*a*).

Social contacts

The women were also asked about the number of social contacts they had. The women with major 'marital' problems also tended to have poorer social contacts. Over 40% of the women with 'marital' problems were rated as having poor social contacts in comparison with only 16% of the women who had no or minor problems. The results suggest that those women with poor social contacts benefited more from the additional help from a social worker, as more clinical improvement was made by patients with poor social contacts in the experimental group than those allocated to the control group. This interaction was significant, however, for only two of the four composite clinical ratings made at follow-up, and a multivariate analysis of variance was not possible. However, all five subjects in group 2 ('acute on chronic', major 'marital' problems) with poor social contacts improved in the experimental group, by contrast with only two out of eight of the controls.

TABLE V
Who helped most: numbers improved at 6 months for the four groups of patients studied

	Group 1 (acute on chronic; no or minor problems)		*Group 2 (acute on chronic; marked problems)*		*Group 3 (acute; no or minor problems)*		*Group 4 (acute; marked problems)*	
Who helped	*Number improved*	*(n)*[1]	*Number improved*	*(n)*	*Number improved*	*(n)*	*Number improved*	*(n)*
Experimental group								
No one	3	(6)	3	(4)	1	(1)	4	(6)
Social worker	2	(3)	7	(8)	3	(3)	0	(2)
Other	1	(1)	2	(3)	1	(1)	1	(3)
Total	6	(10)	12	(15)	5	(5)	5	(11)
Control group								
No one	2	(2)	3	(11)	6	(6)	1	(3)
Other	2	(2)	2	(5)	6	(6)	2	(2)
Total	4	(4)	5	(16)	12	(12)	3	(7)

1. Numbers in brackets represent total in each subgroup.

Initial and follow-up social scores

When the initial scores of the four categories of patients outlined in Table IV were examined, there was no evidence to suggest that the differences in outcome between the patients in the experimental and control groups for these categories were due to the initial social scores (Corney, 1981*a*).

The social workers' contacts with their patients and the nature of the intervention

As the previous results suggest that social work intervention was more beneficial to patients suffering from 'acute on chronic' depression, especially those with marked 'marital' problems, the social workers' activities were analysed, taking into account the four groups of patients outlined in Table IV.

The social workers also recorded in detail their activities performed either with the client or on behalf of the client. The social workers worked in a number of ways with these clients and were not given any specific guidelines. This was because the needs of the clients were remarkably varied: some women had few social problems while others had many. The social workers were asked, however, to try to see their clients on a regular basis, to make a contract with the client specifying frequency of interviews, and to agree on a plan of action regarding their work in the following months. They were also asked to limit their time of contact to the 6 months between assessments.

Communications with the clients were classified by the social workers according to the typology developed by Hollis (1964), which the social workers were familiar with using. The social workers used sustaining and exploring techniques with all the clients they interviewed, investigating the reasons why the patient was depressed as well as offering support and reassurance. The social workers also considered that in 90% of the cases they tried to develop their client's awareness and understanding of the dynamics of her personal situation, behaviour, and attitudes. In addition, the social workers tried to help some of their clients using behavioural techniques; for example, helping the client manage her depression by setting her a number of tasks to perform each day or devising a contract between husband and wife to increase co-operation between them.

In addition to the interventions, the social workers also gave some form of help concerning practical matters to over 40% of their clients. Of the 35 patients they saw, they gave information on practical issues to 15, they acted as an advocate or referred to other agencies for 8, and they gave substantial help to 2 women in the form of financial aid, holidays, day nursery placements, and council accommodation.

Although similar proportions of patients in all four groups received the different kinds of counselling identified, a higher proportion of patients in groups 2 and 3 received practical help.

Number of interviews

There was no general relationship between clinical improvement and the number of interviews given, but in many cases only a few interviews were given as the patient improved and further interviews were considered unnecessary.

Just over 60% of the patients seen by the social workers were interviewed alone. This was not usually due to decisions made by the social worker but due to the spouses of the patients often resisting involvement, or the patients' reluctance for their spouses to be interviewed. However, clients who were seen with their spouses did not improve more on ratings measuring marital adjustment or on clinical scores that those clients seen alone.

Motivation

At the end of their involvement with each client, the social workers were asked to rate the clients' motivation to be helped by them. The social workers assessed nearly 60% of the women in group 2 (Table IV) as highly motivated, in comparison with only 15% of the women in the other groups. This term was used by social workers when clients were willing not only to accept help but also to alter their behaviour or situation accordingly. The highest rate of improvement was found among the clients who were highly motivated; over 80% of this group had improved at follow-up.

Clients' assessment of help obtained

At the end of the second social assessment, the patients were asked if anyone had helped them, and they were given time to spontaneously mention one or more individuals. They were then asked who had helped most (Table V), and were questioned in further detail about whether they received help from their general practitioner or from a social worker.

Nearly 70% of the experimental group spontaneously mentioned one or more people as helpful (including spouse, friends) in comparison with only 45% of the controls. Two-thirds of those who saw a social worker spontaneously mentioned that she had helped them, especially those in groups 2 and 3.

When asked who had helped most, over 45% of the 35 patients who saw a social worker indicated that she had, particularly patients in groups 2 and 3 (Table V). The doctor, husband, friends, and relatives were mentioned by the control group as being the most helpful more often than by patients in the experimental group.

When the patients were asked specifically whether they had seen a social worker and whether it had been helpful, a further six patients thought she had been helpful. All but one of the 35 patients who saw a social worker had considered that the social worker had been understanding, and only two patients had found difficulty in talking to her. Generally, patients appreciated the help they received, with 80% mentioning the support given by the social worker. A third mentioned practical help or information, and the same proportion indicated that the social worker had helped them either "manage their depression" or increased "their understanding of themselves" or "helped in their relationships" (Corney, 1981*a*).

Discussion

The results suggest that the quality of the patient's marital relationship is a crucial factor affecting clinical outcome: women with marital difficulties were much more likely to be still depressed 6 months or one year after referral than women without these problems. These findings are in accordance with those found by Weissman and her colleagues in their study of depressed female out-patients (Rounsaville *et al*, 1980).

The results of this investigation suggest, however, that women with 'acute on chronic' depression who have marital difficulties may benefit from the help of a social worker. Compared with the controls, more patients in this subgroup who saw a social worker were not depressed at follow-up. The findings of other studies in this area are mixed. Weissman and her colleagues found that individual psychotherapy did not bring about any more substantial social, marital, or clinical improvement among individuals assessed as having "initial marital disputes", leading the authors to suggest that conjoint therapy might have been more appropriate (Rounsaville *et al*, 1979). Although some of the women in this present study received help together with their husbands, this was not built into the design of the trial and depended very much on the patient's wishes or those of her husband. There was no evidence to suggest, however, that conjoint therapy brought about additional improvement in clinical ratings or those scores measuring marital adjustment.

A study of task-centred social work conducted on self-poisoners who had recently been admitted into casualty with an overdose found that one of the major areas of improvement in the experimental group was the patient's marital and interpersonal relationships (Gibbons *et al*, 1978). Although no differences were found between the experimental and control groups in respect of repeated self-poisoning or of clinical criteria, the experimental group showed significantly more change than the controls in their social problems when assessed at 4 and 18 months after entry into the study.

Why did the social worker help patients in group 2 more than the others? Further analysis of the data of the present study, including details on the patients' social contacts and who they felt had helped, suggested that many of the patients with a poor marital relationship also had poor social contacts. Thus in many cases the patient not only could not talk to her husband but also had no one else in whom she could confide. This may be why this group of women so readily accepted the emotional support given by a social worker. The reason why the control patients in group 2 did so badly could have been due to their lack of support from others: over 70% felt no-one had helped them. In contrast, only one-quarter of the experimental patients in group 2 felt no-one had helped, and over half felt the social worker had helped most. Possibly, the lack of a difference between the outcome of the experimental and control groups in the other groups could have been due to the support the control patients received from relatives, husbands, and friends.

The results also indicated that the patients who gained most benefit were those who had been depressed for some time. The results, especially when considered in conjunction with a previous study of general practice patients, suggest that doctors should refer to social workers patients with more long-standing depressions and neuroses, as these will be helped more than those whose symptoms have a very recent onset (Cooper *et al*, 1975; Shepherd *et al*, 1979). When the patient's depression becomes acute on chronic, there is less chance of spontaneous recovery (Cooper *et al*, 1969; Kedward, 1969), and help from an outside agency may be necessary to bring about change. The patient may also be more likely to accept such help and act upon it.

Patients with acute depression appear more likely to recover without outside help. The additional help of the social worker may be unnecessary or even harmful, the social worker interfering with the individual's own mechanisms of coping or the support received from others. The patient may also be less motivated to receive the help offered, having become depressed only very recently, and may not be inclined to accept outside help or regard it as necessary. It is possible that very early intervention may therefore be inefficient, inappropriate or even harmful.

In this study the client's motivation to be helped by a social worker appears to be related to the length of time she has been ill and the help she receives from others. However, it is possible that the nature of the patient's social problems is another important factor affecting motivation. Patients in group 2 had more social problems than the others; many of these were practical matters, which may have been why so many of this group were eager for help.

The social workers carried out much more practical help on behalf of the clients in group 2 and contacted more agencies on their behalf. In the earlier study on chronic neurotic patients, where substantial differences were found between the experimental and control groups, the majority of the social work carried out was practical in nature (Shepherd *et al*, 1979). Although many social workers tend to stress their skills in counselling and underrate the practical help they can give (Wootton, 1978), the arrangement or provision of practical assistance by social workers may be of great value to general practice patients, including those who are depressed. Studies obtaining the clients' views of social work support this, clients appreciating most the combination of practical help with emotional support (Butrym, 1968; Mayer & Timms, 1970; Sainsbury, 1975; Corney, 1981*b*). Certainly the social workers' expertise and knowledge of practical resources are what specifically distinguish them from their other colleagues in general practice and can be used to argue their case for inclusion into the primary care term (Clare & Corney, 1982).

From the results of this study it seems reasonable to suggest that a further study should concentrate specifically on depressed women with marital problems using an 'attached' social worker with experience in conjoint marital therapy. The tendency of women with marital problems to become chronically depressed (Rounsaville, 1980) indicates the need for the development of effective treatment measures, resulting in both marital and clinical improvement.

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