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### || The Depressed Mother and Her || Rebellious Adolescent

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Depression in a mother can have a serious impact on the entire family and particularly on the adolescent children. Moreover, maternal depression is relatively common. A review of the epidemiologic literature finds few exceptions to the observation that clinical depression is more common in women (Weissman & Klerman, 1977). Its incidence may be increasing, and it is no longer a disorder predominantly of the older woman or the hospitalized. Today, the typically depressed patient is apt to be a woman in her most productive years, married, living at home, and rearing children—often adolescent children. Depression affects the capacity to enjoy life and to carry out the vital tasks of being a parent; however, insufficient attention has been paid to the family dynamics of depressed patients in general or to the relationships with their children in particular. Even less has been written about the relationship between the adolescent children and depressed mothers.

During the course of studying various treatment approaches to depression, we became aware of the social and interpersonal problems of the depressed woman (Weissman & Paykel, 1974). Following these observations we undertook a systematic comparison study of the social adjustment of a group of depressed women, both at the height of illness and at the point of their recovery, and compared them with a group of women who had never been depressed (the controls). All the acutely depressed women's relationships were found to be impaired, but their most intimate relationships, particularly those with their children, were the most impaired when compared with the matched control group. We concluded that an acute depressive illness significantly affected the depressed woman's capacity as a mother. A more intensive clinical study of the de-

pressed mothers and their children at different stages of the family life cycle was then undertaken. This study indicated that a substantial amount of deviant behavior was found in the adolescent children of depressed mothers.

This chapter describes the impact of a depressed mother on her adolescent children and the implication of these findings for treatment intervention. The focus is on the mother because we have studied these problems only among women. Further work is urgently needed in understanding the impact of paternal depression on children.

## || DEPRESSED PATIENTS AND "NORMAL" NEIGHBORS

The observations were derived from a study of the social functioning of 40 depressed women who were compared with a group of 40 controls in their neighborhood ("normal" neighbors). All the subjects were women between the ages of 25 and 60 years who lived in the greater New Haven (Connecticut) area. The depressed women were the first 40 consecutive patients admitted to a research clinic for the study and treatment of depression. These patients were judged by the treating psychiatrist to have moderate to severe depressive illnesses and no other prominent psychiatric syndromes. The symptoms of depression included feelings of sadness, worthlessness, a tendency to cry, guilt, suicidal feelings, weight loss, and sleep disturbance and were present for at least 2 weeks prior to the interview. The large majority of the depressions met the DSM-II criteria for depressive neurosis. If these patients were to be classified according to the more recent DSM-III, they would receive a diagnosis of nonbipolar, nonpsychotic major primary depression.

The normal-neighbor group was selected from the city directory and resided on streets adjacent to those where the patients lived. They were matched for sociodemographic variables with the patient group. Also, those included were without overt psychiatric disturbance or previous psychiatric history or treatment or serious medical illness.

Clinical data on the mother-child interaction were obtained in the course of the psychiatric treatment of the mothers and during research assessments. Some clinical interviews were obtained with the adolescents of the depressed sample in the course of the mothers' treatment. Information on the adolescents of the control group was obtained during the mothers' research assessments.

Parental role performance of all 80 women was assessed by the Social Adjustment Scale (SAS), which contains 42 questions that measure either instrumental or expressive role performance over the past 2 weeks in six

**Table 6-1**  
**Relationship Between**  
**Depressed Women**  
**and Their Adolescents**

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Less involved
Impaired communication
Increased friction
Loss of affection
<u>Overall more impaired as parents</u>

major areas of functioning: work as a worker, housewife, or student; social and leisure activities; relationship with extended family; and role as a spouse, a parent, and a member of the family unit. This report focuses on the parental role.

In general, the questions in each area fall into four major categories: the subject's performance at expected tasks, the amount of friction with others, finer aspects of interpersonal relations, and inner feelings and satisfaction. Each question is rated on a 5-point scale with a higher score indicating impairment.

Details of the sampling method, structure, reliability, and scoring of the rating scale can be found elsewhere (Weissman & Paykel, 1974). The depressed and normal women were similar in age, sex, social class, religion, race, marital status, and numbers and ages of children. They were predominantly middle-aged (mean age 42 years), white, Catholic, married, living with their spouse, and from the middle and lower-middle social classes. The average number of children per family was 2.5.

## || DEPRESSED AND NORMAL WOMEN AS PARENTS

Sixteen of the 40 depressed women and 17 of the 40 normal women had at least one adolescent child living at home. The typically depressed person is sad, apathetic, and listless. Juxtapose these symptoms with the demands of parenthood that require energy, interest, emotional involvement, and affection. As one might expect, acutely depressed parents had considerable difficulties with their children. Compared with the normal neighbors, the depressed women were quite impaired as parents. They were only moderately involved in their children's lives, had difficulty in communicating with the children, reported considerable friction, and expressed a loss of affection toward their adolescents (Table 6-1). The mothers were guilty about their inadequacy but were unable to control these

feelings or to change their behavior, and there was anger and resentment at the entire family for making what was interpreted as unfair demands.

In contrast, the normal women usually reported relatively harmonious, involved, and affectionate relationships with the adolescents. We have identified at least four areas of parental dysfunctioning in depression: emotional involvement, communication, affection, and hostility.

### **|| Involvement and Interest**

Acute depression impaired the parents' ability to be involved in their children's lives. For adolescents, this included interest and involvement in school progress, social activities, friends, and the dispensing of discipline.

Irritability, self-preoccupation, and anergia prevented the parents from meeting their children's normal demands for attention. Involvement was limited by the emotional or physical distancing of the parent or by overcontrol; for example, one mother retired to her room when the children came home from school; another regimented household activities, and any deviation from the schedule was met by her harsh reprisal.

### **|| Communication**

Adolescents became less inclined to discuss events or deeper feelings and problems with the depressed parent whose troubled affect and self-preoccupation conveyed disinterest and an unwillingness and inability to listen.

Parent-child relationships became disengaged, and the children either took their problems elsewhere or allowed them to build up. One 14-year-old youngster abruptly stopped attending school during the height of her mother's illness. She had been having academic difficulties, felt that her teacher was unsympathetic to her, and was embarrassed by her own poor performance in the class. She had not discussed the problem at home as she did not wish to overburden her mother and felt that she would not understand. The mother was totally perplexed at the girl's sudden refusal to attend school.

### **|| Affection**

Depressed parents reported a lack of affection for their children that produced feelings of guilt and inadequacy. The mothers worried about these feelings of not being able to love their children or to feel spontaneously warm emotions. Some mothers became frightened about their own hostile feelings toward all the children or, at times, toward one child who was singled out.

## II Hostility

Contrary to older writings on depression, we have found that acutely depressed patients show increased rather than decreased hostility. This hostility is directed toward intimate family members, spouse, and especially children, and less so toward casual acquaintances or the professionals who are carrying out their treatment. The compliant and obsequious patient in the office can be quite hostile at home. The discrepancy in the patient's affect at home and with strangers may account for the discrepancy in the literature regarding hostility and depression.

Most of the hostility toward the children took the form of irritability; however, at times overt and intense conflicts and physical violence were reported. The conflicts could become quite serious with the adolescent child, especially if the child exploited the parent's helpless state and became rebellious and demanding. As is described later, a substantial minority of adolescents developed problems in school, with friends, or with the law or had an intensification of ongoing problems that predated the parent's depression.

We also observed children who became withdrawn and sad, such as one 14-year-old boy who was afraid to make any comments or requests that would disturb his mother. She had spoken so openly of the helplessness of her life that he was afraid she might kill herself.

At times, the depressed parent's intense rage toward the children was frightening to both the parent and the child. When Mrs. W. came for her weekly appointment, she could barely speak. With a trembling voice she described an incident the evening before. Her daughter had been deliberately defiant and challenging, and the mother couldn't take it any longer. In a fit of rage she held a knife to her daughter's throat, and when she considered the impact of what she had done, the mother felt weak, terrified, and full of remorse.

In general terms, the acute symptoms of depression conflicted with the demands of being a parent. Depression has been described as a signal for nurturance, assistance, and succor. These are the very demands made on parents by their children. At the simplest level, apathetic, sad, and anergic depressed parents are placed in an untenable position of having demands made on them by their children for the help, care, and affection that they themselves require.

## II ADOLESCENT CHILDREN

What meaning do the parental depressive symptoms have for the child? The writings of Bowlby (1951, 1958, 1960, 1961, 1968, 1969, 1970, 1973, 1977) provide the best conceptual framework for understanding

**Table 6-2**  
 Women Reporting Problems  
 with at Least One of Their  
 Adolescent Children

Depressed women	81%
Normal women	12%

both the short-term impact and the long-term consequences of parental depression on children. Many forms of psychiatric disorders result from the malfunctioning of a person's capacity to make and maintain affectional bonds. The pattern on which personal affectional bonds are modeled is determined to a significant degree by events within the family, especially—but not exclusively—during childhood. Many of the intense human emotions arise during the formation, disruption, and renewal of affectional bonds.

Applying these concepts to the depressed mother-child interaction, the eruption of a clinical depression in a parent can be experienced by the child as a disruption of affectional bonds. A number of children developed symptoms in association with the parental depression. For the older child, the parent's withdrawal was felt as a loss of guidance and boundaries and a loss of a model of behavior. Depending on the pervasiveness, severity, and recurring nature of these symptoms and the availability of alternate caretakers, the impact on the child's development could be short-term, subsiding with the parental recovery, or it could be long-term and resistant to change.

Thirteen of the 16 depressed women with adolescents (81 percent) had problems with one or more of their adolescent children; however, only two of the 17 normal women (12 percent) reported having problems with their adolescents. The differences were highly significant (Table 6-2).

The depressed women had 23 adolescent children, 17 (74 percent) of whom had problems (Table 6-3). By contrast, the normal women had 31 adolescents, 3 (10 percent) of whom had problems. The difference between the number of the depressed women's adolescent children and the normal women's adolescent children who had problems was also highly significant ( $p < .001$ ).

**Table 6-3**  
 Adolescent Children  
 Reported to Have Problems

Depressed women	74%
Normal women	10%

**Table 6-4**  
Problems in Adolescent Children  
of Depressed Mothers

Problem	Number of Adolescents Involved* ( <i>N</i> = 17)
School difficulties	8
Parental conflicts	8
Involvement with law	5
Drug use	3
Sexual involvement	3
Total	27

\*The number of adolescents involved in various problems exceeds the number of adolescents since some adolescents were involved in more than one problem.

In summary, substantially more depressed than normal women had problems with at least one of their adolescents, and substantially more adolescents of the depressed women as compared to the normal women had problems. The kind of problems reported by the mothers varied. In the normal group, one adolescent was illegitimately pregnant, and two were involved frequently in severe verbal clashes with the mother.

The normal women were not without problem children, and some of them discussed how they averted potential difficulties with their adolescents. A 44-year-old woman, the wife of a factory worker, with five children aged 11–18 years living at home, described how she and her husband had dealt with the problems presented by their oldest child. The youth had befriended a group who had prison records and were jobless. He claimed that his parents did not understand him. The parents responded with genuine concern, indicated their strong interest in understanding him, and suggested that they sit down and talk. Several lengthly and emotion-laden discussions ensued. During that time and subsequently, the parents reported an outstanding improvement in his appearance, attitude, and choice of friends.

By contrast, a substantial number of serious behavior problems was found among the adolescents of depressed mothers during the height of the mother's illness (Table 6-4). Some adolescents were involved in multiple problems. School problems and conflict with parents occurred frequently. Eight adolescents were having serious school problems such as truancy, sudden failing grades, and dropping out of school.

Some parent-child conflict might be expected in association with an adolescent's increasing independence; however, extreme conflict was reported for eight of the depressed mothers' adolescents. This conflict included physical or persistent verbal clashes that resulted in three adoles-

cents leaving the home temporarily and one 13-year-old running away for 1 month after an argument with her mother. Five adolescents were involved in legal problems. One, a 15-year-old boy, was put on probation for stealing a bicycle, and four other adolescents were arrested for various difficulties including possession of drugs or weapons and glue sniffing. Three adolescents were involved with drugs, including heroin, LSD, and frequent marijuana use. Three adolescents were involved in sexual difficulties that included promiscuity and homosexuality. A 16-year-old girl became involved in a homosexual relationship during the height of her mother's illness, leaving home to live with an older single woman. Despite all these problems, only two adolescents were receiving psychiatric treatment.

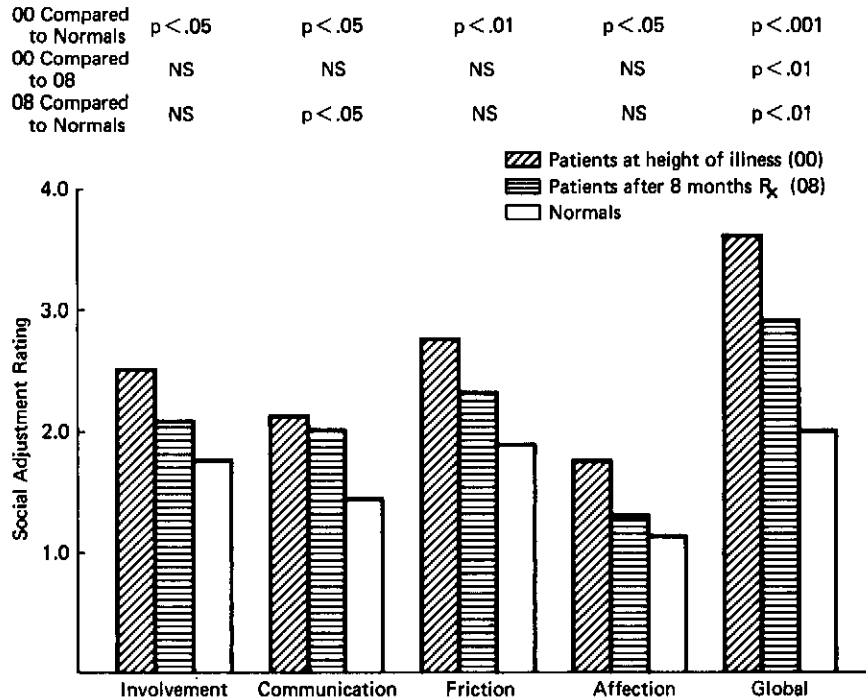
The depressed women displayed little resilience and had difficulty in controlling their own hostility and aggression. They alternated between episodic explosive outbursts and withdrawal. They frequently directed their hostility toward the child. They were unable to define or set limits for their adolescents and either overcontrolled or undercontrolled them. Some mothers were envious of their teenage daughters' developing sexuality and were even competitive with the girl for the attention of the spouse. Rather than providing stability and nurturance to the children, the mothers, when ill, made demands for themselves.

### || THE DEPRESSED WOMAN AS A PARENT DURING RECOVERY

Clinical data indicated that the adolescent's deviant behavior in most cases was highly related to the mother's acute depression. Statistical assessment of the changes in the behavior of the adolescents as the mothers improved was not available; therefore, we examined the depressed mothers after 8 months of treatment for depression when they were asymptomatic. Comparisons of the parental role performance of the depressed women at the height of symptomatic illness, after treatment when asymptomatic, and with the normal women are shown in Figure 6-1. Only 13 of the 16 depressed patients were assessed at the end of the 8 months since 3 patients had been withdrawn from the study because of clinical relapse.

As shown in Figure 6-1 and described in Table 6-1, the patients at the height of illness (00) were significantly more impaired parents than normal women on all variables. The changes in the parental role performance of the depressed patients from the height of illness (00) to the recovery phase after treatment (08) were not significant on any variables other than the raters' global judgment. When the recovered patients (08) were compared with the normal group, the differences were not significant on any varia-





**Figure 6-1.** Social Adjustment Scale scores at height of illness and after 8 months of treatment: a comparison with normals. (Reprinted with permission from Weissman, M., & Siegel, R. *The depressed woman and her rebellious adolescent. Social Case Work*, 1972, 18, 563-570. Published by *Family Service Association of America*.)

bles except communication with the adolescent and the raters' global judgment, where the patients were still rated as more impaired.

Figure 6-1 offers a presentation of these results and shows that the depressed patients were somewhat less impaired as parents after 8 months of treatment than they were at the height of their illness but were still more impaired than the normal mothers, especially in communication with their children. After treatment, the depressed women were intermediate in parental performance between their acute illness and the normal state.

After 8 months of treatment for depression, when most of the women were symptomatically recovered, their parental performance had improved considerably in all areas. However, they were still somewhat more impaired than the normal women, especially in their ability to communicate with the children. The adolescents in many cases did respond to the mother's recovery with some decrease in acting out.

### ||| Adolescents' Response to Mothers' Improvement

As the depressed mothers recovered, many, but not all, of the problems with their adolescents improved, and many of the children's problems diminished. The ability of the mother to pull herself together, to set limits, to negotiate with the adolescents, and to show genuine interest usually had a salutary effect on the child. Obviously, the youth on heroin did not stop the habit when the mother recovered but did curtail physical abusiveness toward the mother when she had enough energy and self-confidence to make it clear that she would not tolerate it. One 14-year-old had refused to return to school during her mother's illness. When the mother felt better, she began to listen to what was disturbing the daughter in school. The mother was then able to discuss the problem with school officials and worked out a more satisfactory school placement for her daughter.

Another 17-year-old girl responded to her mother's recovery by mobilizing herself to look for employment. The depressed mother's pessimism about the girl's future and chances of ever finding employment had deterred the girl from making any plans for herself. The boy on probation for stealing a bicycle took a paper route to buy his own bicycle and joined a boy's club. The girl involved in a homosexual relationship returned home when the mother was well enough to encourage her to return. Although the girl continued the homosexual relationship, she ceased to live with the woman and began involving herself in heterosexual relationships as well.

A small number of the adolescents who were not involved in deviant behavior did, in fact, become nurturing and maternal to the mother in her illness. The adolescent took over the housework and care of siblings and sometimes intervened between the mother and the more rebellious siblings. Most of the adolescents, however, did not respond to the mother's request for help but were threatened by this request; they tended to exploit her helplessness by further rebellion. A considerable amount of deviant behavior, including problems with school and law, drug abuse, sexual acting out, and hostile clashes with the mothers, was observed in the majority of the adolescent children of the depressed mothers. The extent of this behavior was in sharp contrast to that of the adolescent children of the normal women, where few problems were observed.

Questions can be raised about the temporal relationship between the mother's illness and the adolescent's deviance. Would any mother not become depressed with such problems? In this sample, many of the women had been treated previously for depressive episodes, when the children

were younger and without observable problems. Although many of the adolescent problems may not have occurred directly in conjunction with the mother's illness, many of the children had not had a previous history of behavior problems. Much of the children's acting-out behavior increased with the mother's acute illness, and the major part of it decreased with her improvement.

The depressed woman's spouse should be mentioned, as his role was crucial in the perpetuation of a conflictual mother-child relationship. If the spouse aligned himself with the adolescent against the mother, the child's abusive behavior toward the mother increased and was difficult to control even when the mother recovered.

### || Is the Adolescent Deviance a Masked Depression?

The frequent association of adolescent deviant behavior with adolescent depression has been described by a number of investigators. It has been suggested that acting out and sociopathic manifestations in adolescents are likely to mask underlying depression and take the form of temper tantrums, school drop-outs, truancy, running away, drug use, disobedience, underachievement in school, and promiscuity. Delinquency, especially gang contacts, may combat feelings of helplessness and prevent these feelings from becoming overt. The adolescent's antisocial behavior may be a deliberate attempt by the child to provoke parental condemnation. It allows the parent to focus on such behavior while ignoring long-standing hostilities and allows the child to ward off feelings of loss. Aggressive behavior may be used to ward off depressive feelings and may be considered justified by the adolescent for past grievances toward the parent.

The loss of a parent through death has been observed to interfere with the development of an effective superego since the identification process is considered critical in preventing delinquency among adolescents. Although the depressed mother may be physically present, her withdrawal and detachment may be experienced as a loss by the vulnerable adolescent, a loss not only of her nurturing and interest, but of her direction and control as well. Indeed, she is not psychologically available to guide, lend interest, or comfort. Her pessimism is conveyed and can be assumed by the adolescent, suggesting that the adolescent problems described here may be a form of masked depression.

Because contacts were primarily with the mother, it is beyond the scope of this study to determine the degree of covert depression in the adolescents; however, certain trends are suggestive. The adolescents did

experience an object loss previously and might be vulnerable to depression themselves. A number of the adolescents did appear to have a quality of hopelessness characteristic of depression. Although it was suggested that the deviance was a form of masked depression in many of the adolescents, more intensive clinical studies are necessary to confirm this.

## || CLINICAL IMPLICATIONS

There is substantial evidence in this research and in others that maternal depression can have a detrimental effect on children of any age and especially on the developing adolescent. The depressed mother's withdrawal, disinterest, and hostility can exacerbate serious adolescent behavior problems that may not be easily reversible. Therefore, early detection of the maternal depression as well as prompt and appropriate treatment can have an important preventive impact.

### || Detecting Depression in the Parent

Who can detect depression, and how is depression detected? Early detection usually occurs directly with the parent, often by a nonpsychiatric physician or a professional who is not a physician. A case of depression that reaches the psychiatrist is usually not in its earliest stages. Physicians other than psychiatrists, mental health personnel of all disciplines, and those professionals not involved in mental health clinics per se, therefore, are in excellent positions to do early detection. There are many clues to help in the detection of depression. The parent who seems apathetic or listless, has multiple complaints, or is extremely irritable may be harboring depressive symptoms. Direct inquiries such as "Have you felt sad, moody?" or "Have you had difficulty in sleeping?" or "How has your appetite been?" or "Have you felt life is worth living?" are all useful.

If a large-scale, systematic approach to screening for depression is required, there are a number of simple paper-pencil tests for depression that have been widely used and can be incorporated routinely into clinics. These screening tests can be quite useful for detecting persons who may be depressed, but they are not diagnostic tests. They are useful for isolating those persons who are likely to have the disorders from those who most likely do not. All screening tests have a certain chance of failing to detect persons who really are depressed and are falsely negative, or of classifying as depressed those who really are not and are falsely positive. All such screening techniques thus require active clinical follow-up for a more intensive, diagnostic assessment of possible cases.

## || DETECTING MATERNAL DEPRESSION THROUGH THE CHILD

Personnel who deal with children should be alert to abrupt changes in the child's behavior. These changes may be indicative of a change in the parent's clinical state. The important indicators for children might be development of academic or social problems, a drop in grades, repeated absences, deviant behavior, promiscuity, truancy, and fighting. Although none of these is necessarily specific to parental depression, their sudden presence in a previously well-functioning child may indicate a change in the emotional state of the parent. These signs should be followed up by inquiry with the parent and the child.

Indirect evidence gained from a study of depressed women has shown that hostility directed toward the children, either verbal or physical, is frequent and pervasive during the parent's acute depressive episode. Inquiry into symptomatic status of parents of abused children should be made. If the parent is depressed, another mode of treatment and possible prevention of future abuse may be available.

## || TREATMENT OF THE PARENT: ACUTE EPISODE

The most promising advance in the treatment of depression has been in the availability of a range of effective antidepressant medications that have demonstrated efficacy (Hollister, 1978). There are now a number of such medications widely available that are relatively safe and can be administered by most physicians, although patients with concurrent medical problems or previous unresponsiveness or who present special diagnostic or management problems should be seen by a psychiatrist. These medications are particularly useful in reducing the acute symptoms of depression, improving mood and sleep, and restoring appetite and energy. Drug-induced remissions take 1-4 weeks, and with symptom reduction comes a resumption of social functioning, although often at a slower pace over the next 2 months.

The antidepressants have by no means replaced psychological treatments (Weissman, 1979). Indeed, there is evidence that one important function of the antidepressant is to sufficiently alter the symptoms so that the patient can begin to engage in psychotherapy, which is the treatment aimed at improving social adaptation. In practice, some form of psychological intervention is usually combined with antidepressants, although either treatment may be used independently. There is a wide range of psychological treatments that differ in aim, intensity, duration, and the professional

training of the therapist. Generally, the purpose is to provide emotional support and the opportunity for ventilation, to help in dealing with the consequences of the disorder, and to provide an understanding of the maladaptive patterns or antecedents that may have predisposed the parent to the depression.

Whether or not formal psychotherapy becomes part of the treatment plan, there are certain practical issues in the patient's daily life and with the family that should be considered with all patients. Two immediate issues with the acutely depressed parent are the care and the involvement of the family. Detailed questioning about the children and their daily care and the other available caretakers is important. The enlistment of the family may be required, especially if small children are also at home. Families of outpatients may not realize the extent of the patient's incapacity and may perceive the apathy or anergia of depression as laziness and irresponsibility. Clarification of the nature of depression, the treatments used, and the time span for recovery may help to involve the family positively in the treatment and help them to assist in the care of the children. Although families of outpatients may be tolerant of the patient's decreased performance and hopeless affect, daily confrontation with these disorders can be a trying experience, and many families require support.

The astute clinician will realize that the compliant obsequious depressed patient can be quite irritable and hostile at home. Discrete questioning such as "Do the children get you down?" or "Do you tend to pick on them?" or "Can you tolerate the children's noise?" can lift the burden of secrecy from the patient, establish the treatment relationship on a firmer ground, and assist the patient and family in arranging the care of the children.

This type of questioning and planning can be handled by any mental health professional responsible for the care of the patient. The term "approach model" frequently employed in clinics is appropriate. In this model the physician provides and supervises the medication; a nurse, social worker, or other nonmedical professional carries out the psychological counseling.

### || TREATMENT OF THE PARENT: CONTINUING CARE AND TERTIARY PREVENTION

There is good evidence now that a 6-8-month course of maintenance treatment is valuable in preventing relapse after recovery from the acute symptoms of depression. There is evidence that depressions tend to reoccur so that most patients who have suffered a depression will require continuing available care even beyond the maintenance phase. The care

required may be intensive for sustained durations or periodic and not intensive.

During the period following symptomatic recovery, there is opportunity for tertiary prevention that is rehabilitation and achievement of maximal functioning. For most patients, a return to an asymptomatic state and a resumption of normal parental caretaking reduces the parent-child problems and alleviates symptoms in the children. For others, however, where the parent-child relationships have been seriously and chronically impaired or where the adolescent symptoms have become persistent, more is required. It is during this rehabilitative period that parents can begin to consider dealing with the longer-term problems of their children.

It is not uncommon for child guidance referrals to be made or family therapy to be undertaken during this recovery period, as the parents can focus away from their own despair and begin to consider underlying problems in the family or the special needs of a particular child. Social services as well as other social supports that relieve family tensions and pressures should be considered. Mental health workers should recognize the importance of this period for repair, rejuvenation, and reorganization within the family. The dramatic effects achieved by medications quickly and inexpensively can divert the clinician away from helping those families who still require the longer social and psychological interventions. Even among those patients who recover rapidly and whose accompanying family problems resolve, the tendency for depressions to reoccur requires that prompt treatment be available as needed.