Single-session psychotherapy for depression: is it better to focus on problems or solutions?

Sara Murphy Sundstrom

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Single-session psychotherapy for depression: Is it better to be problem-focused or solution-focused?

Sundstrom, Sara Murphy, Ph.D.
Iowa State University, 1993
Single-session psychotherapy for depression:
Is it better to focus on problems or solutions?

by

Sara Murphy Sundstrom

A Dissertation Submitted to the
Graduate Faculty in Partial Fulfillment of the
Requirements for the Degree of
DOCTOR OF PHILOSOPHY

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For the Graduate College

Iowa State University
Ames, Iowa
1993
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INTRODUCTION

Depression has been described as the common cold of mental disorders. This characterization refers to the fact that depression is widespread and often recurs. However, clinical depression is more serious than the common cold because it entails far greater suffering and can also be life threatening (Wells et al., 1989). Reports from the National Institute of Mental Health (NIMH) Epidemiologic Catchment Area (ECA) Program, a large multi-site epidemiological study of mental disorders, estimated an average lifetime prevalence rate for Major Depressive Episode of 5.8% of the population of the United States (Regier et al., 1988). Lifetime prevalence of a particular disorder is estimated on the basis of the "proportion of persons in a representative sample of the population who have ever experienced that disorder up to the date of assessment" (Robins et al., 1984, p. 949). The average one-month prevalence rate (percent of persons who had experienced at least one symptom of the disorder during the one month period prior to assessment) was estimated to be 2.2% (Regier et al., 1988). These figures, which do not include rates for dysthymia or other unspecified depressive disorders, represent millions of people who suffer painful physical and emotional symptoms, whose occupational and social functioning can be impaired, and who can be in danger of suicide.

Because of the large number of people who experience depression and because of its potential seriousness, it is important to investigate possible effective treatments and preventative measures. A wide range of options for dealing with depression is necessary in order to help as many people as possible. Standard treatments for depression are psychotherapy and pharmacotherapy. These treatments, alone and in combination, have been empirically shown to be effective in ameliorating the symptoms of depression (Elkin et al., 1989; Manning & Frances, 1990). However, there are drawbacks to these
treatments and others, such as electroconvulsive shock therapy (ECT), in terms of one or more of the following: (a) willingness to undergo a particular treatment, (b) negative response to a treatment, (c) uncomfortable or harmful side effects of a treatment, and (d) cost and time involved in a treatment.

Specific drawbacks associated with psychotherapy as a treatment include the amount of time and energy necessary to undergo the treatment and the expense of the treatment. It is certainly less time-consuming and less costly to take antidepressant medication than it is to engage in weekly psychotherapy sessions over a period of weeks or months. Nevertheless, many depressed people cannot or will not take antidepressant medication and some require psychotherapy in addition to medication. Also, psychotherapy is the treatment of choice for many mild to moderate depressions.

In recent years, there has been a proliferation of writing and research aimed at explaining and investigating brief approaches to psychotherapy. This has occurred for at least three reasons. First, third party payers have set limits on the number of sessions they will cover. Second, research evidence supports the efficacy of short-term therapies and points to diminishing returns as the number of sessions increases (Howard, Kopta, Krause, & Orlinsky, 1986; Steenbarger, 1992). Third, surveys of mental health agencies, both public and private, have shown that clients are generally seen for less than 10 sessions and that a substantial percentage are seen for only one session (Steenbarger, 1992; Talmon, 1990). In fact, the modal number of sessions across various treatment settings is one (Talmon, 1990). Considering this third point, it seems clear that brief therapy, in terms of numbers of sessions, is commonly practiced whether or not it is intentional.

Unintentional brief therapy clients are often labeled as "drop outs," meaning therapy failures. However, research following up clients who dropped out of therapy indicates
that many of these people did not return to their counselor because they felt they did not need to, that the counseling they received was beneficial and that their lives had improved as a result (Pekarik, 1992; Rockwell & Pinkerton, 1982; Talmon, 1990). One conclusion from all this is that the first session (which in many cases is the only session) is beneficial to clients. It therefore seems reasonable to investigate ways of conducting the first session to maximize its effectiveness. It also seems reasonable to consider that the first session may be all that is necessary to promote long-lasting change.

Solution-focused therapy (de Shazer, 1988; Furman & Ahola, 1992; O'Hanlon & Weiner-Davis, 1989; Walter & Peller, 1992) is one orientation to brief therapy that accepts the possibility that a single session of therapy can be sufficient for clinically significant change. The solution-focused approach is characterized as action-oriented rather than problem-oriented. Whereas many psychotherapies begin with an exploration and explanation of the problem (e.g., Klerman, Weissman, & Rounsaville, 1984), solution-focused therapy proceeds with change strategies at the outset of therapy and essentially dispenses with a discussion of the problem. Some proponents of this approach maintain that it is not even necessary for the therapist to know what the problem is in order to conduct successful psychotherapy (O'Hanlon & Weiner-Davis, 1989).

Proponents of more traditional psychotherapy, including most forms of brief therapy, would maintain that clients have a need to "vent" their problem and that they would feel frustrated and discounted if not allowed to discuss their difficulties. For example, Interpersonal Therapy of Depression (Klerman, Weissman, & Rounsaville, 1984) includes asking clients whether or not they have experienced all the symptoms of major depression and placing clients' experiences within the framework of one of four general interpersonal problem areas. In addition this therapy encourages clients to assume the "sick role" by
viewing depression as an illness. It is important to note that this kind of therapy was specifically developed to treat depression and has subsequently been shown to be effective (Elkin et al., 1989).

The contrast in these approaches seems highly significant and worthy of investigation. Very little research has been done on solution-focused therapy in general and single-session therapy in particular. No comparative outcome studies were found that included the solution-focused approach, and although solution-focused writers have identified depression as appropriate for this kind of treatment, no research was found that investigated its effects on depressed persons.

The research project reported here compared the effects of a single session of problem-focused psychotherapy versus a single session of solution-focused psychotherapy on depressed mood, self-esteem, and client ratings of counselors. Mildly to moderately depressed female college students were recruited as subjects for the study. An individual counseling format was utilized, and experienced female counselors were recruited to conduct the therapy sessions.

Data analysis included testing for significant reductions in depression scores on two measures within each condition. Differential outcomes across treatments were also assessed in terms of depression scores, self-esteem, and impressions of counselors.

This study attempted to answer the following research questions:

(1) Is a single session of psychotherapy associated with reduced levels of depression?

(2) Do the two approaches yield different outcomes in terms of depression scores, self-esteem scores, and impressions of the counselors?
REVIEW OF LITERATURE

The theoretical and research literature on depression includes many thousands of books and journal articles. It would take volumes to review this massive literature in detail, and such a project is clearly beyond the constraints of this paper. Therefore, this review highlights theoretical perspectives and empirical findings especially relevant to the research study reported in this paper.

Definition of Depression

Depression is a ubiquitous condition found in many aspects of normal functioning, medical difficulties, and psychopathology. Kara et al. (1990b) called depression a "spectrum phenomenon" and described it as follows:

Depression spans the entire spectrum of pathology and health. It is manifested in an assortment of psychiatric disorders, which can be psychotic, neurotic, or characterological and can range in presentation from florid, biphasic mood shifts, to chronic mild malaise or even masked symptoms that are disguised as behavioral disturbances. Depression is also a concomitant of abnormal and normal bereavement and of everyday oscillations of emotion. (p. 269)

Many writers define depression as a mood, a symptom, or a syndrome. Depression as a mood state is characterized by feelings of dejection or apathy. This definition includes the normal transitory "blues" and "blahs" experienced by everyone as well as the prolonged hopelessness associated with severe clinical depression. Depression as a symptom is a concomitant of medical or psychiatric illness. Depression can accompany numerous illnesses including hypothyroidism, diabetes, influenza, asthma, multiple sclerosis, schizophrenia, and dementia of the alzheimer's type, and it can be associated with or caused by a number of drugs such as antihypertensives, hormones, antiparkinsonian agents, and anticancer agents (Lobel and Hirschfeld, 1984). Depression
as a syndrome, also called clinical depression, is considered a primary disorder with a collection of symptoms that include depressed mood.

This paper deals with clinical depression, and it is evident in the literature that defining and understanding clinical depression is a difficult process. Within the realm of clinical depression, researchers, theoreticians, and clinicians have struggled and continue to struggle with the definition of this syndrome in terms of its symptoms, etiology, and treatment. Much of the difficulty lies in determining subtypes of depression. It is assumed that depression is not a homogeneous disorder, and the literature reflects a continuing search for clearly identifiable kinds of depression.

Classification of Depression

The search for subtypes of depression has resulted in a number of dichotomous classification systems that have been more or less useful. These include the following: unipolar/bipolar; primary/secondary; exogenous/endogenous; and psychotic/neurotic. (Karasu, 1990a; Lobel & Hirschfield, 1984; Roesch, 1991; Willner, 1985). Unipolar depression involves depressed mood significantly below baseline, whereas bipolar depression is one pole of a separate disorder that is diagnosed by the occurrence of at least one manic episode. Bipolar disorder (manic-depressive illness) has been found to have a greater family component, show greater response to lithium, occur more evenly among males and females, and may be linked to the X chromosome (Herbst & Paykel, 1989; Tsuang & Faraone, 1990).

Primary depression is considered "pure depression" in the sense that the depressed person has no history of pre-existing psychiatric or medical disorder that is a causal factor in the depression. Secondary depression is superimposed on a pre-existing psychiatric disorder, such as schizophrenia, or medical condition, such as hypothyroidism. Secondary
depression may also be a side effect of a drug, such as reserpine, or a normal response to a severe life event, such as the death of a loved one.

Exogenous depression, also called reactive depression or situational depression, is considered the result of external factors, such as negative life events or environmental difficulties. Endogenous means "coming from within" and describes depression that is internally generated through biological processes. Endogenous depression has also been called autonomous depression.

Psychotic depression includes delusions or hallucinations. Neurotic depression is a chronic, milder kind of depression that has also been viewed as characterologically based.

These dichotomies are obviously not mutually exclusive and present conceptual problems. For example, neurotic depression can be endogenous or exogenous when considering its etiology. Unipolar depression can be psychotic or neurotic when considering symptom severity.

A great deal of controversy revolves around the definitions of "endogenous" and "exogenous" depression. Endogenous depression can be defined in terms of etiology, as it is above, in terms of symptom severity, or in terms of response to treatment. Traditionally, endogenous depression has meant severe, biologically based depression that responds only to medication. However, it has been found that so-called endogenous depression can be treated with psychotherapy and that endogenous depression, like exogenous depression, usually involves situational correlates. It can also be said that exogenous depression most certainly involves changes in brain chemistry. (Andreason, 1984; Andreasen, Scheftner, Reich, Hirschfeld, Endicott, Keller, 1986). Discussion of the semantic and diagnostic nightmares involved in applying these dichotomies is provided by Andreasen (1982), Herbst and Paykel (1989), Rush (1986), and Willner (1985).
Symptomatology

The current focus in defining clinical depressions is in terms of objective symptoms as developed by the creators of the American Psychiatric Association's (1987) Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised (DSM III-R). This approach leaves out direct statements concerning etiology or appropriate treatment because these areas are much more in dispute in the literature. Several diagnostic categories involving primary depression are listed in the DSM III-R, but the discussion in this paper is limited to primary, unipolar depression. This kind of depression constitutes three main diagnostic categories: Major Depression, Dysthymia, and Depressive Disorder Not Otherwise Specified (NOS). These categories are distinguished by the number, intensity, and duration of symptoms, with major depression being more severe and often more acute than dysthymia, which is a chronic, milder form of depression. Depressive Disorder NOS is a diagnostic category for disorders that meet some, but not all, of the criteria for either major depression or dysthymia.

Symptoms of clinical depression are listed below. According to the DSM III-R, depression always involves one of the first two symptoms, and presumably that is why depression is classified as a mood disorder. Each of the additional symptoms may or may not be included in a specific diagnosis because depressed persons are not all alike. This list is a synthesis of DSM III-R criteria for a major depressive episode and the narrative discussion of the depressive disorders.

1. DEPRESSED MOOD: Sadness, hoplessness discouragement, tearfulness.

2. LOSS OF INTEREST OR PLEASURE: Inability to enjoy formerly satisfying activities. Sometimes a painful inability to experience pleasure. Loss of interest in sexual activity. Apathy.
3. **IRRITABILITY**: Especially common in children and adolescents.

4. **ANXIETY**: Can include brooding, excessive rumination, panic attacks, and phobias.

5. **SLEEP DISTURBANCE**: Most commonly insomnia involving difficulty falling asleep, waking up during the night, or early morning awakening. Hypersomnia can also occur in which the person sleeps more than usual, takes excessive naps, or experiences daytime sleepiness.

6. **APPETITE DISTURBANCE**: Most commonly loss of appetite but sometimes overeating. Significant weight loss or gain can occur.

7. **LOSS OF ENERGY**: Constant feelings of fatigue and lack of motivation.

8. **PSYCHOMOTOR RETARDATION**: Can include slowed speech, slowed body movements, long pauses before answering, poverty of speech, or muteness.

9. **PSYCHOMOTOR AGITATION**: Inability to sit still, handwringing, pulling or rubbing of hair, skin, or other objects.

10. **WORTHLESSNESS**: Excessive feelings of inadequacy, failure, or guilt. These feelings can be completely unrealistic to the point of being delusional.

11. **IMPAIRED THINKING**: Difficulty concentrating, making decisions, remembering.

12. **THOUGHTS OF DEATH**: Recurrent thoughts of dying, suicidal ideation with or without a plan, suicide attempt.

13. **PSYCHOTIC FEATURES**: Delusions or hallucinations usually mood-congruent but sometimes mood-incongruent.

14. **IMPAIRED FUNCTIONING**: Degree of impairment varies; in severe cases the person may be totally unable to function including maintaining minimal personal hygiene.

These symptoms constitute emotional, somatic, cognitive, and interpersonal manifestations of depression, but the list does not adequately convey the emotional and
physical suffering that clinically depressed persons experience. Insight into the pain of
depression is only possible through the descriptions of affected persons.

described the cognitive symptoms of his severe depression:

That fall, as the disorder gradually took full possession of my system, I
began to conceive that my mind itself was like one of those outmoded
small-town telephone exchanges, being gradually inundated by
floodwaters: one by one, the normal circuits began to drown, causing
some of the functions of the body and nearly all of those of instinct and
intellect to slowly disconnect. (pp. 47-48)

Andreason (1984) said the following about the depression experienced by Sylvia Plath:

Sylvia Plath described her own experience with depression as like being
inside a bell jar, a suffocating and destructive force that separates one
from life and distorts one's perception of it; and she described her fear of
recurrence as a dread that the bell jar might descend to suffocate her
again. (p. 40)

**Theoretical Models**

Current theorizing concerning the etiology and maintenance of mental disorders
involves the diathesis-stress model (Carson, Butcher, & Coleman, 1988). This
metatheoretical conceptualization proposes that psychopathology, including clinical
depression, is a result of the interplay of an idiosyncratic predisposition toward a specific
disorder (the diathesis) and external demands that exceed the person's coping abilities (the
stress).

Stress is viewed in this conceptualization as external demands. Stress requires
adjustment that can exceed the physical and/or emotional coping resources of an individual
and can result in psychopathology such as clinical depression. Stress is often thought of as
life events (past, present, or future), but can also be physical stimuli such as caffeine,
noise, or air pollution. Stress can also include cultural factors such as certain lifestyles (urban, rural, etc.) or role demands such as those associated with gender.

Diatheses are vulnerabilities that place a person at special risk for depression and can be biological, cognitive, or interpersonal. The theories discussed below concentrate on particular diatheses that directly relate to the treatment of depression. Prominent theories of depression include psychodynamic, cognitive, behavioral, interpersonal, and biological perspectives.

Psychodynamic Theory

Recently Karasu (1990a) summarized current psychodynamic approaches to understanding depression as involving the repetition of early childhood disappointments with significant others. These childhood disappointments predispose a person to develop depression, because they produce intrapsychic conflict involving damaged self-esteem (discrepancy between the actual self and the ideal self). Citing Jacobsen, Kohut, and Arieti, Karasu presented a number of associated concepts (pp. 134-135): childhood needs for attachment to empathic objects and later separation-individuation issues that can result in "exaggerated dependency," development of an overly harsh superego resulting in "self-critical ego functions," and "excessive reliance on limited external sources of gratification (another person or a great ambition). All of these processes are seen as unconscious in psychodynamic theory. Interestingly, conceptualizations of the diathesis, which Karasu refers to as "unresolved childhood remnants," have shown an historical progression in psychodynamic thought from being "initially attributed to repressed real events, subsequently to forbidden fantasies, and most recently, to persistent erroneous beliefs." (p. 135).
Cognitive Theories

Beck's cognitive theory. The idea of erroneous beliefs is the cornerstone of Aaron Beck's cognitive theory of depression (Beck, 1973; Beck, Shaw, Rush, Emery, 1979; Beck & Weishaar, 1989). The basic premise of the theory is that beliefs, or underlying assumptions, affect emotions through the appraisal and interpretation of incoming stimuli. As the often quoted ancient Stoic philosopher, Epictetus, said, "Men are disturbed not by things but by the views they take of them."

According to Beck's cognitive theory, beliefs form cognitive structures called schemata that serve to select, organize, appraise, and store incoming information. Schemata are formed from early experiences and are relatively stable. As a result they predispose a person to respond in a particular way to subsequent life events. Schemata can lie dormant for long periods of time and then be activated by environmental stimuli. Certain schemata are associated with depression. Thus, in this theory, depressogenic schemata represent the diathesis for development of depression.

Depressogenic schemata involve unrealistic assumptions. Examples are listed below (Beck & Weishaar, 1989, p. 24; Sacco & Beck, 1985, p. 16):

1. In order to be happy, I have to be successful in whatever I undertake.
2. To be happy, I must be accepted by all people at all times.
3. If I make a mistake, it means that I am inept.
4. I can't live without you.
5. If somebody disagrees with me, it means that person doesn't like me.
6. My value as a person depends on what others think of me.
7. If I don't succeed at everything I do, nobody will respect me.
8. If a person doesn't like me, it means I'm unlovable.
Depressogenic schemata lead to distortions in information processing that produce a negative view of the self, the world, and the future, what Beck called the "cognitive triad." Beck (Beck, Shaw, Rush, & Emery, 1979, p. 14) identified six distorted information processing strategies utilized by depressed persons:

1. Arbitrary inference-drawing a conclusion in the absence of evidence or when the evidence is contrary to the conclusion.

2. Selective abstraction-the tendency to focus on a negative detail in a situation and to conceptualize the entire experience on the basis of this negative fragment.

3. Overgeneralization-the tendency to draw a general rule or conclusion on the basis of one isolated incident and to apply the concept indiscriminately to both related and unrelated situations.

4. Magnification and minimization-the tendency to overestimate the significance or magnitude of undesirable events and underestimate the significance or magnitude of desirable events.

5. Personalization-the tendency to relate external events to oneself without evidence.

6. All-or-none thinking-the tendency to think in absolute black or white, all-or-none terms.

Neither these distorted ways of processing information nor the presence of maladaptive schemata are viewed by Beck as ultimate causes of depression. Rather they are useful in explaining some of the symptoms of depression as well as in operationalizing psychological treatment. Ultimate causality is viewed by Beck and his associates as unknown and likely to be a combination of biological, developmental, and environmental factors. This point seems to have been misinterpreted to some extent in the literature.

**Depressive realism.** A challenge to Beck's notion that depression is associated with unrealistic, distorted negative self-appraisal was made by Lauren Alloy and Lyn Abramson
who asserted that depressed persons are actually more realistic than non-depressed persons, that they are "sadder but wiser" (quoted from the title of a frequently cited article, Alloy & Abramson, 1979). In Abramson and Alloy's view, it is nondepressed persons who engage in unrealistic, biased information processing in order to maintain optimistic self-serving illusions that keep their spirits high. Depressed persons, on the other hand, have fewer illusions about themselves, and this knowledge is depressing. In other words, "the truth hurts."

According to Alloy, Albright, Abramson, and Dykman (1990), the realistic, negative view that depressed persons have of themselves does not apply to others. When others are appraised, depressed persons' perceptions are unrealistically biased in a positive direction. Nondepressed persons, on the other hand, tend to judge others more realistically. Alloy et al. suggested that the findings of depressive realism research support the idea that "in many situations, depressives' apparent bias against the self may be the result of overly positive judgments about others rather than overly negative perceptions about themselves" (p. 74).

Alloy et al. (1990) conceded that Beck's cognitive therapy is highly effective. However, they speculated that the mechanism for beneficial change does not involve helping depressed clients become more realistic about themselves, as Beck's theory assumes, but rather helping them become more unrealistic. In this way depressed persons may change their thinking to be more self-enhancing and therefore more adaptive.

Research testing depressive realism has employed laboratory experiments that investigated depressed and nondepressed persons' judgments of contingencies, expectancies, self-other evaluations, attributions, and recall of evaluative information (Alloy & Abramson, 1988). Some of this research utilized an objective reference point
against which to compare depressed and nondepressed subjects' thinking, and some of it did not. In their review of the depressive realism literature, Ackerman and DeRubeis (1991) considered only the research containing an objective standard and concluded that findings are mixed and appear to vary according to the experimental task. In other words, depressive realism provides a useful explanation in some but not all experimental situations.

Given at least some experimental support for depressive realism, Abramson et al., (1990) and Alloy and Abramsom (1988) have offered four theoretical perspectives to explain how the laboratory behavior of depressed and nondepressed persons is played out in real-life.

The naive perspective translates experimental results directly into the real-world experiences of depressed and nondepressed persons by maintaining that depressed persons are more realistic than nondepressed persons and that nondepressed persons distort reality in self-enhancing ways.

The ironic perspective states that nondepressed persons' optimistic, self-serving distortions revealed in the laboratory are actually the result of realistic perceptions of themselves based on the feedback they receive in their usual environment. In other words, in a normal environment in which contingencies are not held constant, nondepressed persons "may actually cause good outcomes, experience success, and receive positive feedback about themselves frequently" (Alloy et al., 1990, p. 80). In contrast, depressed persons do not have the skills necessary to rationally assess themselves in the everyday world.

A third explanation, the comic perspective, states that both depressed and nondepressed persons make accurate, realistic judgments about their experiences in their
everyday environment, because they influence outcomes according to how they view the world. This perspective is based on the notion of self-fulfilling prophecy. For example, a depressed person may believe he is incompetent and may exert less effort on a task. Lack of effort may result in failure and thus confirm the person's initial belief that he is incompetent. This example is easily applied in opposite fashion to a nondepressed person who believes herself competent and brings about a favorable result. In laboratory experiments, nondepressed persons are not able to influence outcomes as they can in the real world; therefore, their judgments appear biased.

According to the tragic perspective, both depressed and nondepressed individuals distort reality but in opposite directions. Depressed persons negatively distort information and nondepressed persons positively distort it. The reason depressed subjects appear more realistic in laboratory studies is because experimental cues are more concordant with their biases than with those of nondepressed persons.

Hopelessness depression. A new theory on the depression scene hypothesizes the existence of an as yet unidentified subtype of depression called hopelessness depression (Abramson, Alloy, and Metalsky 1988, 1990). This theory evolved from the helplessness theory of depression proposed by Seligman (1975) and the reformulated helplessness theory developed by Abramson, Seligman, and Teasdale (1978). It also incorporates aspects of Beck's cognitive theory, Constance Hammen's work on inferred negative consequences of negative life events (see Hammen, 1991; 1992), and Harold Kelley's work on attribution (Kelley, 1972). Hopelessness theory is a comprehensive cognitive theory that is intended to explain depression in some, but not all, depressed individuals. This is in contrast to Beck's theory and others that were intended to be applied globally in order to explain depression in a general sense.
Seligman's (1975) helplessness theory postulated that depression results from perceived lack of control over aversive outcomes. Later, Abramson, Seligman, and Teasdale (1978) reformulated the helplessness theory by adding an attributional component. They stated that only when lack of control (helplessness) is attributed to internal, stable, and global factors does depression result.

In a further reformulation, Abramson, Alloy, and Metalsky (1989) specified hopelessness as a proximal sufficient cause for symptoms of depression to occur. Note that in this theory "hopelessness" is designated as a cause and not a symptom of depression.

In order to explain how people become hopeless, the hopelessness theory specifies a causal pathway that begins when a negative life event (the stress) interacts with idiosyncratic cognitive styles (distal contributory causes - the diatheses) and with situational cues such as consensus, consistency, and distinctiveness. This interaction process leads to immediate inferences about the event that can contribute to the development of hopelessness. These inferences, which are referred to as proximal contributory causes, include the following:

1. inferred stable, global causes of particular life events and high importance attached to these events. (Note that the "internal" inference has been dropped.)

2. inferred negative consequences of particular life events (see Hammen, 1992).

3. inferred negative characteristics about the self given negative life events.

Abramson et al. also speculated that other proximal contributory factors, such as lack of support, may influence the development of hopelessness.
Idiosyncratic cognitive styles, mentioned earlier as distal contributory causes, parallel the three kinds of inferences listed above. In other words, depressogenic cognitive styles have to do with beliefs about the nature of negative events (global, stable, highly important, produce negative consequences) and negative aspects of the self. Such cognitive styles are viewed in this theory as specific vulnerabilities and are hypothesized as operating in the presence of negative, but not positive, life events to generate the symptoms of hopelessness depression.

Both life events and cognitive styles are conceptualized as forming continua such that some events are so negative almost anyone would become depressed by them and that some cognitive styles are so negative that many seemingly neutral events may be construed as depressing.

Hopelessness theory hypothesizes a number of symptoms specific to this kind of depression:

1. retarded initiation of voluntary responses (motivational symptom, resulting from helplessness).
2. sad affect, resulting from the negative expectations for the future.
3. serious suicidal ideation and suicide attempt.
4. apathy, lack of energy, psychomotor retardation
5. sleep disturbance
6. cycle of sadness and increasing negative cognitions

Associated features of hoplessness depression could include low self-esteem when attributions are internal, global, and stable as opposed to external causes or internal causes that are perceived as specific and unstable. Low self-esteem could also result when persons infer negative characteristics about themselves as being important and stable.
Effective treatment for hopelessness depression is hypothesized to result when interventions are made at any point along the etiological chain. For example, hopelessness can be attacked directly, or by introducing positive life events, changing the negative attributional style, or changing behaviors that contribute to negative events. Primary prevention is targeted at developing positive cognitive styles and environments.

It should be noted that the etiological emphasis of the hopelessness theory signaled a return to causal-based nosological conceptualizing that was abandoned with the development of the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1980). However, Abramson, Alloy, and Metalsky (1990) emphasized that the hopelessness theory of causality is testable and is therefore qualitatively different from the psychoanalytic concepts used before DSM-III. They furthermore asserted that psychopathological categories based on cause are more useful for purposes of cure and prevention than those based on symptoms.

**Behavioral Theory**

The leading proponent of the behavioral view of depression is Peter Lewinsohn (see Hoberman & Lewinsohn, 1985). According to Lewinsohn, the essential contributing factor in the development of depression is a low rate of response-contingent reinforcement (or a high rate of punishment). Disruption in usual environmental reinforcement results in behavioral deficits that lead to further decreases in reinforcement that in turn lead to further behavioral deficits, and so on. Accompanying this downward spiral are increasing feelings of dysphoria.

Lewinsohn's initial theory stipulated three reasons for low rates of response-contingent reinforcement in the person-environment interaction: (1) lack of positive reinforcers or the
presence of many punishing aspects, (2) lack of personal skills for obtaining positive outcomes or coping with aversive events, and (3) diminished potency of reinforcers or increased impact of negative events.

A modification of the theory (Lewinsohn, Hoberman, Teri, & Hautzinger, 1985) has incorporated cognitive elements from social psychology. Specifically, Lewinsohn and colleagues have hypothesized that an inability to cope with a disruption in automatic, scripted behaviors leads to increased self-awareness and subsequent self-criticism. The resulting feelings of dysphoria give rise to behavioral withdrawal, negative cognitions, and interpersonal difficulties that further magnify the depressed feelings. In contrast to cognitive theories, which conceptualize maladaptive cognitions as precursors of depression, behavior theory considers the negative thinking patterns characteristic of depressed persons as consequences of depressed mood.

Behavioral treatment of depression focuses on increasing positive reinforcement through "alterations in the frequency, quality, and range of the patient's activities and social interactions" (Hoberman & Lewinsohn, 1985, p.47). Therapeutic techniques used in behavioral therapy of depression include daily monitoring of mood, relaxation training, increasing pleasant events, managing aversive events, time management, and social skills training. Social skills training is explicated by Becker, Heimberg, and Bellack (1987).

**Interpersonal Theory**

Interpersonal theory is not as well articulated in the literature as the other psychological theories because this perspective is derived from a number of theoretical and empirical sources (Rounsaville, Klerman, Weissman, Chevron, 1985). The interpersonal perspective is included here because it is the foundation for a manualized psychotherapy of depression that has been empirically shown to be effective in treating depression (Klerman,
Weissman, Rounsaville, & Chevron, 1984) and because it is incorporated into cognitive and behavioral treatments as well. Basically, the interpersonal model of depression focuses on the strong association between depression and difficulties in interpersonal relations.

Important theoretical sources contributing to this perspective include Adolph Meyer (Meyer, 1957, cited in Rounsaville et al., 1985) and Harry Stack Sullivan (Sullivan, 1953, cited in Yalom, 1985). Meyer's "psychobiological" theory emphasized adaptation to the social environment as important in understanding psychopathology. Response to the social environment was viewed by Meyer as being determined by childhood experiences, social roles, and membership in social groups. Meyer's influence spawned a great deal of epidemiological and sociological research.

Sullivan's ideas are regarded as the best expression of the interpersonal approach and are considered to be universally accepted (see Yalom, 1985). According to Sullivan, personality is formed through "reflected appraisals," that is, through feedback from other people, particularly significant others. Personality development begins in early childhood through reactions of parents and other family members. Negative feedback results in lowered self-esteem that can in turn lead to behavior that confirms the negative attitudes of others. This process is termed "self-fulfilling prophecy" and involves "parataxic distortions," or perceptions of others based on preconceived notions rather than real characteristics. Sullivan believed that all psychiatric problems could be translated into interpersonal issues. Depression, for example, could be treated as ..."passive-dependency, isolation, obsequiousness, inability to express anger, hypersensitivity to separation..." (Yalom, 1985, p. 22).

Empirical underpinnings for interpersonal theory include work by Bowlby (1982), Brown and Harris (1978), Coyne (1976), and Hammen (1991). This is by no means an
exhaustive list, but provides examples of highly regarded studies by respected researchers. Bowlby's (1980) theory of attachment as a primary, biologically based need has been observed in the behavior of infants toward their primary caretaker (usually the mother). Secure attachment has been shown to predict healthy social functioning. Disruption of attachment bonds is associated with sadness and depression in both infants and adults.

Brown and Harris (1978) conducted a large community study of women in the Camberwell section of London. This research focused on social factors affecting depression in women. A major finding from this study was that depression was more likely to develop as a result of a provoking agent (severe life event) in women without an "intimate tie, someone [they] can trust and confide in, particularly a husband or boyfriend..." (p. 278). Depression was also found to be associated with the loss of a woman's mother before the age of 11 if substitute care was inadequate and there was an early pregnancy and marriage.

An often-cited study conducted by Coyne (1976) investigated the impact depressed college students had on nondepressed students as a result of 20-minute telephone conversations. Following these brief interactions with depressed persons, the subjects reported themselves significantly more depressed, hostile, anxious, and rejecting. Depressed persons were perceived as sadder, more uncomfortable, weaker, lower in mood, passive, and negative, as well as less motivated to present themselves in a socially acceptable manner.

Hammen (1991) conducted a longitudinal study of children of depressed mothers. Results indicated that children of unipolar depressed mothers seem to be especially subjected to negative and avoidant interaction styles shown by their mothers. The mothers displayed critical and disconfirmatory communications with their children and engaged in behaviors during the Conflict Discussion
task that reflect low involvement and resistance to task focused resolution of the conflict. In turn, such negative and withdrawn patterns are associated with diagnoses and dysfunction in the children... (p. 171)

Interpersonal treatments of depression include group process therapy (Yalom, 1985), family systems approaches (Gotlib & Colby, 1987), and the manualized therapy, Interpersonal Therapy for Depression (IPT) developed by Klerman, Weissman, Rounsaville, and Chevron (1984).

Biological Theories

Genetic implications. Findings from family, twin, and adoption studies offer evidence that unipolar depression runs in families. Although evidence for genetic transmission of bipolar disorder is much more conclusive than that for unipolar depression, occurrence of unipolar depression in first-degree biologic relatives of bipolar and unipolar probands is significantly greater than that in the general population (Tsuang & Faraone, 1990). Means of transmission are largely unknown, although one hypothesis suggests X-chromosome transmission, because unipolar depression is found twice as often in females as in males.

Monoamine hypotheses. The monoamine hypotheses were developed from knowledge of the short-term and long-term effects of many antidepressant medications. Short-term, or acute effects, of monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressants (TCAs) increase the amount of the monoamine neurotransmitters, norepinephrine (NE) and serotonin (5-HT) available in the synapse between neurons. This increase in neurotransmitter was thought to increase postsynaptic neuronal activity. MAOIs inhibit monoamine oxidase, an enzyme that breaks down monoamines, leaving more neurotransmitter intact in the synapse. TCAs prevent the reuptake of neurotransmitter into the presynaptic neuron, also leaving more neurotransmitter in the synapse.
Because therapeutic effects of antidepressant medications are not evident for one to three weeks, long term effects of these medications were investigated. Simply stated, it was found that instead of an increase in postsynaptic neuronal activity, a decrease in this activity may result due to a reduction in beta NE receptor sensitivity and receptor density (numbers of receptors). This would suggest that depression is caused by too much, instead of too little, neurotransmitter and that increasing the amount of neurotransmitter produces an habituation effect. It is possible that this habituation effect is potentiated by an increase in the release of NE by the presynaptic neuron because of the effect of antidepressant medications on presynaptic alpha adrenergic receptors (autoreceptors). Here the effect is one of blocking the autoreceptors so that they become supersensitive and signal the presynaptic neuron to increase levels of NE.

It must be noted that these effects are not consistent for all antidepressant medications. Discussions of these theories are found in Carlson, 1986, McNeal and Cimbolic (1986), and Tipton and Youdin (1989).

**Neuroendocrine abnormalities.** Neuroendocrine causes of depression are hypothesized to occur through the hypothalamic-pituitary-adrenal cortex axis. This pathway is involved in the stress reaction. One important result of stress is an increase of plasma cortisol levels, also found in depressed persons. The inability of depressed persons to suppress cortisol release led to the development of the dexamethasone suppression test (DST). Dexamethasone acts like cortisol in the body and should trigger the suppression of cortisol through a feedback system that works over night. When administered dexamethasone, some depressed persons fail to suppress cortisol, possibly indicating severe endogenous depression.
Biological treatments of depression have centered primarily around antidepressant medications (monoamine oxidase inhibitors, tricyclics, and others such as fluoxetine), and electroconvulsive shock therapy (ECT). These treatments are known to affect the neurotransmitter systems in the brain. Other somatic treatments include light therapy (for seasonal depression), sleep therapy, and changes in diet and exercise habits. Some of these treatments will be discussed in greater detail in the next section.

Discussion

All the theories discussed above point out specific diatheses (vulnerabilities) to developing depression: early childhood disappointments, depressogenic cognitive schemata, realistic pessimism, lack of positive reinforcement, and physiological abnormalities. However, although each theory has distinctive features, there is also considerable overlap.

Biology certainly underlies all psychological theories since depressive symptomatology involves bodily processes, but whether biology is cause or effect is unknown (Andreason, 1984). As McNeal and Cimbolic (1986) pointed out, "It now appears that neither cognitive nor biological formulations alone are sufficient etiological models of depression. A cogent integrative perspective requires the recognition of the complementary rather than competitive roles of biological and cognitive contributions" (p. 1-2).

The psychological theories could also be conceptually integrated since they share many common elements, especially an emphasis on maladaptive beliefs that impact the self, and the importance attached to interpersonal functioning. In fact, the current status of these theories seems to have involved to some extent an evolutionary process of reciprocal influence.
Noticeably absent from the theoretical discussion, however, is a theory of life events, the stress side of the diathesis-stress view of psychopathology. Such a theory would classify life events that trigger depression. Life events have been investigated, but results suggested that life events themselves were not as important as how events are interpreted. Recently, however, Coyne (Coyne, 1989; Coyne & Downey, 1991) urged a "postcognitive" view of depression that would focus more attention on stress. Stress was defined as life events and the context in which they occur. Coyne maintained that life-event questionnaires, previously used in this kind of research, are superficial, thin descriptions of the experience of depressed persons. He cited Brown and Harris's (1978) in-depth interviews as "thick" descriptions that produced significant information about what kinds of events and environments precipitate depression. For example, Brown and Harris found that chronic, enduring events were more frequently associated with depression than were acute events. Coyne also pointed out that this study rated events in terms of the way most people would react. Given the regular occurrence of negative life events, Coyne implied that the question in most cases concerns not what causes depression but rather what prevents people from getting depressed.

Treatment of Depression

It has been estimated that only about one third of persons suffering from a clinical depression seek treatment (Regier, Hirschfeld, Goodwin, Burke, Lazar, & Judd, 1988). This is unfortunate because depression is considered the most treatable of the mental disorders. A number of effective treatments have been developed, and the search continues for additional methods of alleviating depression's painful symptoms. Treatments can be classified as either somatic or psychological.
Somatic Treatments

**Electroconvulsive shock treatment (ECT).** Electroconvulsive shock therapy (ECT) is routinely used in hospitals to treat severely depressed individuals. It is considered a safe and effective treatment when used properly. ECT is the fastest acting treatment for depression, producing significant alleviation of depressive symptoms after 6 to 12 treatments over the course of two to four weeks. Indications for ECT include nonresponse or partial response to other standard treatments (pharmacotherapy or psychotherapy), severe somatic symptoms (sleep or eating disturbances, psyschomotor retardation), psychotic features (delusions or hallucinations), imminent threat of suicide. Elderly persons are often given ECT because antidepressant medications can interact with drugs elderly persons are taking for other disorders. The most troubling aspect of ECT is the loss of memory that occurs as a result of the treatments. Usually the memory loss is slight and involves memories surrounding the procedure, but it can be more serious and affect longer-term memories. Other side effects include headache, disorientation, confusion, and difficulty learning following treatment.

During an ECT treatment the patient is given an intravenous general anesthetic, followed by a muscle relaxant. After the patient is asleep, an electric current is applied to the head either unilaterally on the nondominant hemisphere or bilaterally. Unilateral treatment is thought to minimize memory loss. The electricity induces a brain seizure or convulsion that is assumed to produce the antidepressant effects. The specific brain mechanisms involved in the alleviation of depression through ECT are thought to be similar to those produced by antidepressant drugs. Discussions of ECT are provided by Johnsgard (1989), Lobel and Hirschfeld (1984), Noll, Davis, and DeLeon-Jones (1985), and Roesch (1991).
Pharmacotherapy. Two classes of anti-depressant medications have traditionally been used to treat clinical depression - the tricyclics and the monoamine oxidase inhibitors. Current pharmacotherapy for depression also includes other medications that do not fit into these categories.

**Tricyclic antidepressants (TCAs).** TCAs are the most commonly prescribed antidepressants. These drugs are called tricyclic because of their three-ring chemical structure. Related to the TCAs are the tetracyclics, which are four-ring compounds. According to Schatzberg and Cole (1991), there are eight tricyclic and two tetracyclic antidepressants on the market in the United States. The generic names of these drugs and their corresponding brand names are listed below. One of these, clomipramine, is not approved by the Federal Food and Drug Administration for anti-depressant use, but rather is approved to treat obsessive-compulsive disorder.

**Tricyclics**
- amitriptyline (Elavil, Endep)
- clomipramine (Anafranil)
- desipramine (Norpramin, Pertofrane)
- doxepin (Sinequan, Adapin)
- imipramine (Tofranil, Janimine, Sk Pramine)
- nortriptyline (Pamelor, Aventyl)
- trimipramine (Surmontil)

**Tetracyclics**
- amoxapine (Asendin)
- maprotiline (Ludiomil)
Most TCAs and related drugs are known to block the reuptake of norepinephrine and serotonin, thus increasing the amount of these neurotransmitters in the synapse. They are also known to block acetylcholine receptors producing the well-known anticholinergic side effects, including dry mouth, blurred vision, constipation, and urinary hesitancy. Blockage of histamine receptors is thought to produce the sedating effects of some of these drugs. Other side effects of TCAs include orthostatic hypotension (dizziness when standing up), heart palpitations, stimulation, weight gain, impotence, and skin rashes.

Response to TCAs generally takes two weeks and significant improvement can take up to four to six weeks. A therapeutic dose must be acquired gradually and can be checked by testing the blood plasma levels of the drugs. Response to TCAs can be augmented by the addition of lithium.

**Monoamine oxidase inhibitors (MAOIs).** The MAOIs are not prescribed as often as the TCAs because they can produce dangerously high blood pressure (hypertensive crises) if the patient eats foods containing tyramine (aged cheese, red wine, beer, brewer’s yeast, dry sausage, smoked fish, Italian green beans, and beef or chicken liver). Tyramine is a pressor amine that is normally deactivated by MAO. When MAO is inhibited, tyramine can cause unnecessary stimulation of the sympathetic nervous system causing elevations of blood pressure that can lead to stroke or cardiac collapse (Carlson, 1986, p. 700).

Despite this and other side effects, MAOIs are effective antidepressants and are particularly useful in treating anxious, endogenous, and atypical depressions (Schatzberg & Cole, 1991). They inhibit monoamine oxidase, a substance that metabolizes monoamines. By inhibiting MAO, these drugs increase the amount of monoamine neurotransmitters and therefore work in a similar fashion to the TCAs. Clinical response
to MAOIs can be augmented with lithium carbonate or L-tryptophan. The FDA has
approved the following MAOIs for use as antidepressants: isocarboxazid (Marplan),
phenelzine (Nardil), selegiline (Eldepryl), tranylcypromine (Parnate).

Newer antidepressants. Three new antidepressants have been approved by
the FDA. Fluoxetine (Prozac) blocks the reuptake of serotonin but has little effect on the
action of norepinephrine. Although this drug produces side effects similar to the TCAs,
they are less intense. Shatzberg and Cole (1991) reported that the side effect profile for
Prozac is similar to placebo. One acute affect of fluoxetine is weight loss, whereas most
tricyclics cause weight gain. In addition to depression, fluoxetine is indicated in the
treatment of panic disorder and obsessive-compulsive disorder (Physicians Drug

Trazadone (Desyrel) also appears to be primarily a serotonin agonist. It is not
anticholinergic but produces side effects similar to the TCAs through other mechanisms.
Schatzberg and Cole (1991) recommended trazadone for outpatients with mild to
moderate depression who have difficulty falling asleep.

Bupropion (Wellbutrin) is a unicyclic whose mode of action is unknown. It is not a
MAO inhibitor and demonstrates only weak norepinephrine and serotonin reuptake
blockade (Physicians Drug Handbook, 1992). Bupropion is not anticholinergic, and so
side effects are mild. Sexual dysfunction may be less likely than that associated with
TCAs. This drug is contraindicated in patients with a history of seizure disorder or to
factors predisposing for seizures such as head trauma, anorexia nervosa, and bulimia.
General effectiveness of pharmacotherapy. Garvey (1992) reported the following response rates for antidepressant medications, placebo, and no treatment:

- TCAs: 70%
- MAOIs: 65%
- Lithium: 55% (better for bipolar disorder)
- Tryptophan: 55%
- Placebo: 35%
- No treatment: 15-25%

It can be seen from these figures that a substantial number of depressed patients do not receive benefit from pharmacotherapy. This fact further emphasizes the need for a variety of treatments for depression.

Exercise. Although exercise is generally thought to elevate mood and produce a sense of well-being, it is not usually considered a standard treatment for depression. However, antidepressant effects of physical activity have been demonstrated in a number of research studies with clinically depressed persons, and as a result some investigators have advocated the use of exercise as an adjunct to psychotherapy or pharmacotherapy or as an alternative treatment to these standard procedures (Johnsgard, 1989; Morgan, 1987).

Definition. The American College of Sports Medicine has identified three kinds of exercise: (1) cardiorespiratory or aerobic endurance, (2) muscular strength and endurance, and (3) flexibility, coordination, and relaxation (American College of Sports Medicine, 1980, cited in Simons, McGowan, Epstein, Kupfer, & Robertson, 1985). All research reviewed in the next section concerns the first or second type. An assumption running through the exercise literature is that aerobic exercise is more beneficial than
nonaerobic exercise in elevating mood. However, as the following literature review reveals, this assumption has not been supported.

**Efficacy of exercise in treating depression.** Empirical research investigating the effects of exercise on depressed mood has been reviewed at least seven times since 1985 (Doan & Scherman, 1987; Leith & Taylor, 1990; Martinsen, 1987; Mellion, 1985; North, McCullagh, & Tran, 1990; Simons, McGowan, Epstein, Kupfer, & Robertson, 1985; Taylor, Sallis, & Needle, 1985). All these reviews are narrative except for the North, McCullagh, & Tran (1990) paper which reported the results of a comprehensive meta-analysis. Interestingly, there is much overlap in these authors' selection of studies, and many of the studies come from the literature comparing exercise and psychotherapy for treating depression. It is important to note that all these reviews examined research that dealt with the effects of exercise on depression. (This is in contrast to a body of literature reporting elevations in mood among normal persons as a result of exercise.) However, it must also be noted that not all subjects who participated in this depression research met diagnostic criteria for clinical depression.

Without exception, the reviewers cited above concluded that exercise has a positive effect on depression. The overall consensus seems to be in agreement with Leith and Taylor (1990) who concluded that "the current literature suggests the potential use of exercise as a psychological therapeutic tool and/or intervention technique aimed at promoting mental wellness" (p. 231).

Other pertinent findings from studies included in these reviews include the following: (1) lack of an association between reduction of depression and aerobic fitness (Doyne, Chambless, & Beutler, 1983; Doyne, Ossip-Klein, Bownam, McDougall-Wilson, & Neimeyer, 1989; McCann & Holmes, 1984), and (2) possible similarity in the biochemical
changes associated with antidepressant medications and those associated with exercise (Martinsen, 1985; Martinsen, Medhus, & Sandvik, 1985).

The most recent, comprehensive, and sophisticated review was the North, McCullah, and Tran (1990) meta-analysis. Of interest here was their question, "What is the magnitude of the antidepressant effect of exercise compared with other treatments?" Results suggested that exercise was a significantly better treatment of depression than no treatment, easier exercise, relaxation, and enjoyable activity groups. Exercise was not significantly better than anaerobic exercise or psychotherapy. When compared to psychotherapy plus exercise, exercise alone was significantly less beneficial in the treatment of depression. North, McCullah, and Tran pointed out that comparisons with combined psychotherapy and exercise were based on very few studies and that more research is needed to clarify the possible additive or potentiating effects of these treatments.

Hypothesized mechanisms for the antidepressant effects of exercise. A number of biological and psychological mechanisms have been offered in the literature to explain the antidepressant effects of exercise. Biological mechanisms include (1) conditioning effects (increased aerobic capacity, for example, (2) endorphin release, and (3) greater monoamine activity in the brain. Discussions of these mechanisms are found in Goldfarb, Hatfield, Armstrong, and Potts, 1990; Markoff, Ryan, and Young, 1982; Morgan, 1985; North, McCullough and Tran, 1990; Ossip-Klein, Doyne, Bowman, Osborn, McDougall-Wilson, and Neimeyer, 1989; Ransford, 1982; Simons et al., 1985; Sothmann, 1991; Sothmann, Hart, and Horn, 1991.

Psychological mechanisms proposed to operate in relieving depression when people exercise are discussed by Greist et al., 1979; Martinsen, 1987, Mellion, 1985; Morgan,
1985; Ransford, 1982; and Simons et al., 1985. These include (1) distraction, (2) enhanced mastery/self-efficacy, and (3) access to positive cognitions.

**Psychological Treatments**

This section focuses on three prominent psychotherapies for depression: cognitive behavior therapy, interpersonal therapy, and a coping with depression course. All these therapies are associated with major research institutions, and their efficacy has been empirically demonstrated.

**Cognitive-behavior therapy.** Cognitive-behavior therapy was developed at the University of Pennsylvania by Aaron Beck and associates. *Cognitive Therapy of Depression* (Beck, Shaw, Rush, & Emery, 1979) was the result of much empirical and clinical work and is still the primary manual for this kind of therapy. Cognitive therapy is also described by Beck and Weishaar (1988, 1989); DeRubeis and Beck (1988); Perris (1989); and Sacco and Beck (1985).

Cognitive therapy of depression is an active, time-limited, structured, directive, flexible, insight-oriented therapeutic approach that is intended to promote beneficial change in dysfunctional thoughts and maladaptive assumptions. Proponents claim that these changes in thinking cause depression to lift and decrease the possibility of recurrence. Components of the therapy include a strong client-therapist collaborative relationship, attention to the phenomenological world of the client, and between-session homework assignments. The essence of cognitive therapy involves challenging the thinking patterns of the client through conversations during the therapy hour as well as "experiments" designed by the therapist and carried out by the client.

Before cognitive therapy begins, the client's depression level, general health, home environment, and suicidal risk are assessed for indicators of the need for hospitalization,
drug therapy, medical treatment, etc. After determining a client's appropriateness for this kind of therapy, the rationale behind cognitive therapy is presented to the client and she or he is asked to read a pamphlet called *Coping with Depression* (Beck & Greenburg, 1974). Subsequent sessions include inquiring about the client's experiences since the last session, a review of the last session's homework assignment, setting of an agenda for the current session, addressing the agenda, assigning homework, and briefly summarizing and discussing the current session.

Techniques used in cognitive therapy include such behavioral techniques as graded task assignment, activity scheduling, and assertiveness training, as well as cognitive techniques such as logging automatic thoughts that arise in upsetting situations, examining the evidence about negative self-assertions, exploring the meaning behind a thought, reattribution, searching for alternative solutions, and searching for alternative explanations. These techniques reflect the behavioral as well as the cognitive aspects of this therapy.

The overall strategy for a course of cognitive therapy is clearly outlined by Sacco and Beck (1985) who discussed five major steps:

- **Step 1** - Identify and Monitor Dysfunctional Automatic Thoughts
- **Step 2** - Recognize the Connection between Thoughts, Emotion, and Behavior
- **Step 3** - Evaluate the Reasonableness of the Automatic Thoughts
- **Step 4** - Substitute More Reasonable Thoughts for the Dysfunctional Automatic Thoughts
- **Step 5** - Identify and Alter Dysfunctional Silent Assumptions (pp. 8-16)
These steps constitute the cognitive part of cognitive behavioral therapy. In the earliest stage of therapy, before the five steps are implemented, behavioral strategies are used to increase the activity level of severely depressed persons.

Interpersonal therapy. Interpersonal therapy was developed over a span of 12 years for use in the New Haven-Boston Collaborative Depression Project conducted during the 1970s. The manual for this therapy is entitled Interpersonal Psychotherapy of Depression (Klerman, Weissman, Rounsaville, & Chevron, 1984).

The basic tenet of interpersonal therapy is that depression is associated with difficulties in interpersonal relationships manifested as interpersonal loss (grief), role disputes, role transitions, or interpersonal deficits. Interpersonal therapy does not specify a cause and effect relationship between depression and impaired interpersonal functioning; it is assumed that depression can cause interpersonal difficulties and that interpersonal difficulties can cause depression.

Interpersonal therapy is a short-term, goal-oriented therapy that accepts the medical model of depression as an illness and allows clients to assume the "sick role." The sick role releases the client from responsibility for the illness and enables him or her to withdraw from some usual duties and obligations. However, the sick role demands that the person seek help and cooperate with treatment. Educating clients about depression and its symptomatology is seen as therapeutic in interpersonal therapy, and this information is conveyed during the initial sessions. Subsequent sessions are used for targeting particular interpersonal issues and dealing with them through various techniques.

IPT techniques are numerous and varied. They include nondirective exploratory techniques, directive elicitation of information about interpersonal relationships, encouragement of affect, clarification, communication analysis, use of the therapeutic
relationship (discussing the client's feelings about the therapist and/or the therapy), and behavior change techniques (modeling, role playing, decision analysis, education, advice). Specific homework is not assigned in IPT.

**Coping with Depression course.** The Coping with Depression course was developed at the University of Oregon Depression Research Unit in the 1970's by Peter Lewinsohn and his colleagues (Lewinsohn, Steinmetz, Antonuccio, & Teri, 1984, cited in Vanvalkenburg, 1985). This treatment is publicized as an educational experience designed to treat unipolar depression. A class, generally consisting of 6 to 8 students, is taught by advanced graduate clinical psychology students. A textbook and a student workbook are utilized to impart information about the social learning (behavioral) theory of depression as a learned phenomenon, as well as specific skills that can be used to ameliorate the depression. Skills taught include rewarding oneself, monitoring mood, relaxation techniques, increasing pleasant events, constructive thinking, and social assertion (Lewinsohn, Steinmetz, Antonuccio, & Teri, 1985). Methods of teaching include instruction, class exercises, and homework assignments. Class exercises, as they are described by Brown and Lewinsohn (1984), seem to be somewhat similar to group therapy:

Typically participants were asked to share with the class their experiences in doing the homework... When appropriate, instructors modeled and participants role-played responses to particular problem situations while the other participants were encouraged to provide constructive feedback. Classes were conducted so as to promote cohesiveness among participants: Instructors attempted to promote supportive exchanges among participants concerning their efforts to control their depression. (p. 777)

The Coping with Depression course consists of 12 sessions conducted over a period of eight weeks. There are two sessions a week for the first four weeks followed by weekly session for the remaining four weeks.
Efficacy of Psychotherapy in the Treatment of Depression

This section focuses on empirical research testing the efficacy of psychotherapy in the treatment of depressed persons. It has been assumed in this line of research that significant benefits of psychotherapy can be demonstrated by designing research that involves the following:

1. comparison of psychotherapy with no treatment (usually a wait-list control group).
2. comparison of psychotherapy with pharmacotherapy.
3. comparison of psychotherapy with a placebo condition or alternate kind of treatment (such as relaxation or social skills training).

Obviously, the viability of psychotherapy as a treatment for depression depends on its greater demonstrated benefit compared to no treatment. The usefulness of psychotherapy is also shown when its benefits are similar to those of drug therapy, which is considered the standard reference treatment. Comparing psychotherapy with a placebo condition is controversial since it has been hypothesized that psychotherapy and placebo work through similar psychological mechanisms (Parloff, 1986).

Literature reviews. Reviews by Dobson (1989); Nietzel, Russell, Hemmings, and Gretter (1987); Robinson, Bernan, and Neimeyer (1990); and Steinbrueck, Maxwell, and Howard (1987) point to the efficacy of psychotherapy in the treatment of depression. All these reviewers have concluded that psychotherapy is significantly better than no treatment and that it compares favorably with pharmacotherapy in reducing depressive symptoms. Comparisons with placebo conditions are less conclusive. Furthermore, significant differences in kinds of psychotherapy have not been found in these reviews.

Steinbrueck, Maxwell, and Howard (1983) conducted a meta-analysis comparing the effect sizes of drug therapy and psychotherapy for unipolar depression. They found the
mean effect size for psychotherapy (1.22) to be significantly higher than the mean effect size for drug therapy (.61). When confounds were removed through regression analysis, the effect size for psychotherapy was still nominally larger, but it was no longer significantly higher. Effect sizes among the psychotherapies, behavioral therapy, social learning-interpersonal therapy, cognitive therapy, a combination of cognitive, social learning, and behavioral therapy, and unspecialized marital therapy, were not statistically different. The authors concluded that psychotherapy may be somewhat more effective than drug therapy for the treatment of depression.

A meta-analysis by Nietzel et al. (1987) focused on the clinical significance of treatment outcomes. They included only studies that used the Beck Depression Inventory (BDI) to assess depression. Using BDI responses from these studies, they compared initially depressed persons treated with psychotherapy with nondepressed persons and people in general. Results showed movement from the 99.9 percentile to the 94.7 percentile for treated persons in comparison to nondepressed persons. When compared to the general population, treated persons moved from the 99.8 percentile at pretreatment to the 76.1 percentile at the end of treatment. The authors concluded that psychotherapy is modestly effective in the treatment of depression. They recommended a cutoff score of 10 on the BDI as an indicator of normalcy vs. depression, with higher scores indicating depression. The authors also concluded that outcome from individual psychotherapy was more clinically significant than results from group therapy. They found that type of therapy, duration of therapy, training of therapists, number of therapists, and type of subject assignment (random vs. nonrandom) were not associated with clinical significance.

Dobson (1989) investigated the efficacy of Beck's cognitive therapy for depression through meta-analysis. Like Nietzel et al. (1987), Dobson used BDI scores as the
criterion in his analyses. The mean effect size for 10 studies was -2.15, which indicated that persons treated with cognitive therapy did better than 98% of controls.

A more comprehensive meta-analysis was conducted by Robinson, Berman, and Neimeyer (1990). Psychotherapies were classified as cognitive, cognitive-behavioral, and general verbal (client-centered, psychodynamic, and interpersonal therapies). A number of measures of depression were included in the analyses. Results showed that there was greater improvement as a result of treatment than as a result of no treatment, but that the outcome of treatment with psychotherapy was not significantly better than attention or pill placebo. This review is notable because when comparing the psychotherapies, the authors used a regression procedure to remove the effects of investigator allegiance. When these allegiance effects were removed there were no significant differences among the psychotherapies.

In addition to type of psychotherapy, no significant effects were found on the basis of treatment modality (individual vs. group), duration of treatment, therapist experience, initial severity of depression, diagnostic status of the subjects, or research design characteristics. When the effects of investigator allegiance were removed from studies comparing psychotherapy, pharmacotherapy, and their combination, no significant differences emerged. Robinson, Berman and Neimeyer (1990) also investigated the clinical significance of psychotherapy effects. Using the same procedure as Nietzel et al. (1987), they compared BDI scores with the means of nondepressed persons and people in general. They found that persons treated with psychotherapy improved significantly but were still more depressed than persons in both normative groups.

Regarding treatment of depression with psychotherapy, Robinson, Berman, and Neimeyer concluded that
...the magnitude of improvement over the course of therapy appeared impressive. On average, clients were functioning within one standard deviation of the general population after treatment compared with a pretreatment difference of more than two standard deviations. Such a change clearly represents substantial improvement. (p. 40)

**NIMH-TDCRP.** Not included in these reviews are the results of a large, state-of-the-art research project conducted by the National Institute of Mental Health (Elkin et al., 1989; Elkin, Parloff, Hadley, & Autry, 1985). This project, called the NIMH Treatment of Depression Collaborative Research Program (NIMH-TDCRP), was unique in its scope and methodological rigor. This multi-site project compared the effectiveness of individual cognitive-behavior therapy, interpersonal therapy, imipramine-clinical management, and a pill placebo-clinical management control to treat unipolar depression. Imipramine-clinical management was considered the reference treatment against which the psychotherapies were compared. Cognitive-behavior therapy and interpersonal therapy were chosen because they were developed specifically to treat depression, were explicated in treatment manuals, were derived from different theoretical orientations, and had been empirically shown to be effective with depressed persons. Therapists were carefully trained, and subjects were carefully screened.

Overall results indicated that the subjects in all treatment conditions were significantly improved and that the two psychotherapies were not significantly different from each other or from the imipramine-CM condition. These results are encouraging, but are considerably tempered by the finding that for the most part these three treatments were not significantly different in efficacy from the placebo-CM condition (Elkin et al., 1989) for moderately depressed persons. As mentioned above, the placebo may operate in similar ways to psychotherapy, and in addition, the clinical management component could be viewed as supportive psychotherapy since it involved up to 30 minutes of verbal
contact with a trained mental health clinician. With severely depressed persons, however, there was strong evidence for the superiority of imipramine-CM and some evidence for the superiority of interpersonal therapy over placebo-CM.

**How psychotherapy works.** The psychotherapy literature appears to follow three lines of thought concerning how psychotherapy works. One line focuses on specific effects or techniques associated with the various kinds of psychotherapy. Examples of these techniques are included in the discussions of the psychotherapies for depression above. Specific effects are explained in terms of the theoretical orientation of a given treatment.

However, despite different theoretical underpinnings and different techniques, the various psychotherapies have not been shown to be significantly different in their overall effectiveness with depression. As a result, it is important to consider the hypothesis that psychotherapy works through nonspecific factors common to all effective psychotherapies (Frank & Frank, 1991; Torrey, 1986). Nonspecific factors include expectancy effects, emotional arousal, learning and mastery, personal and professional characteristics of the therapist, and a reasonable explanation for the difficulty. Changes in thinking, behavior, or both have been hypothesized to be the mechanism through which all psychotherapy works (Robinson, Berman, Neimeyer, 1990). Rogers (1961) considered communication of empathy and unconditional positive regard as most important. Strong (1968) focused on cognitive dissonance as the mechanism by which psychotherapy promotes change, and Carter and Gelso (1985) considered the client-therapist relationship paramount. Recently Schuyler (1991) offered 14 "Principles of Practical Psychotherapy" (pp. 15-19) that he considered essential for any kind of successful psychotherapy:

1. Educate the Patient About His or Her Clinical Condition
2. Educate and Engage Significant Others
3. Maintain Optimism and Mobilize the Patient's Hope
4. Identify and Utilize the Patient's Resources
5. Teach Skills When They are Lacking
6. Accept the Patient
7. Encourage the Patient to Become Self-Observant
8. Provide Structure When Needed
9. Discourage Major Decision-Making
10. Encourage Appropriate Risk-Taking
11. Provide the Patient With an Explanatory System
12. Encourage the Generation of Alternative Beliefs
13. Encourage (Provide) Mastery Experiences
14. Facilitate the Regaining of Perspective

The third line of thinking concerns individual response to treatment. It has been hypothesized that the nonsignificant findings in comparative psychotherapy studies are due to the masking of differential individual outcomes. The idea here is that the emphasis should not be on psychotherapy as a whole but rather on what techniques work best with what kinds of people (Paul, 1966).

Patient characteristics may play an important role in response to different forms of psychotherapy. Evidence from the NIMH-TDCRP indicated that persons who were more socially competent than other subjects in interpersonal relationships responded better to IPT. Persons who exhibited less cognitive distortion responded better to CBT (Sotsky et al., 1991). These findings are the opposite of what would be predicted by the theories underlying these two psychotherapies. Beutler and Clarkin (1990) highlighted patient expectations, coping ability, and personality patterns as important to kind of treatment undertaken. Sorting out the kinds of client characteristics that are especially meaningful
for treatment selection is a difficult task and constitutes an area that needs further research.

The Proposed Research

It is interesting (and somewhat disquieting) that comparative psychotherapy research often finds attention placebo manipulations to be similar to psychotherapy in their beneficial effects on clients (Elkin et al., 1989; Robinson, Berman, & Neimeyer, 1990). These results suggest the possibility that much less therapy time is needed than is ordinarily assumed. In the case of mildly to moderately depressed persons, it seems reasonable to speculate that very short-term therapy could prove useful. This is supported to some extent by Howard, Kopta, Krause, & Orlinsky (1986) who found that depressed persons responded to lower doses of psychotherapy than anxious or borderline/psychotic persons. If these investigators had divided depressed persons into mild/moderate and severe categories, the beneficial dose for the mild/moderate group might have been very low indeed.

Given all this, it seems important to investigate very brief interventions with depressed persons to determine whether or not they are helpful. The study proposed here will assess the effect on depressed mood and impressions of the therapist of a single session of either problem-focused or solution-focused therapy. The problem-focused condition represents a combination of standard first-session procedure and the first session of Interpersonal Therapy of Depression (IPT) previously discussed in this paper. The solution-focused condition represents a relatively new, qualitatively different orientation to psychotherapy and is discussed below.
Single-Session Therapy (SST)

In recent years, some clinicians have experimented with the idea that a single-session of therapy can be all that is necessary to facilitate client change. Prominent in this orientation to therapy are Michael Hoyt, Robert Rosenbaum, and Moshe Talmon in association with Kaiser-Permanente, a large health maintenance organization (Hoyt, 1990; Hoyt, 1992b; Hoyt, Rosenbaum, & Talmon, 1992; Rosenbaum, Hoyt, & Talmon, 1990; and Talmon, 1990). The monetary advantages of very brief therapy in this setting are obvious, but these psychologists have argued convincingly that the idea of SST should be seriously considered in its own right.

Rationale for SST. One of the arguments for SST is long-standing evidence of its common occurrence. Talmon (1990) cited research indicating that in various kinds of settings, both public and private, the modal number of sessions is one (1) and that 20-80% of clients in a particular setting are seen for only one session. The implication here is that clinicians need to assume that the first session may be the last.

Another argument for SST is its apparently beneficial effects. It has traditionally been assumed that the "practice" of SST meant treatment failures since it was unintentional. However, Rosenbaum, Hoyt, and Talmon (1990); Rockwell and Pinkerton (1982); and Talmon (1990) cited researchers who concluded that one- or two-session "drop outs" were not necessarily treatment failures. This follow-up research revealed that a majority of these clients were pleased with the services they had received and considered their problems significantly improved.

Recently, Pekarik (1992) conducted a study of therapy drop outs. A "drop out" was defined as a client who did not come for two consecutive sessions and who did not cancel. Although this study did not investigate attrition after one session, the results are
instructive for the purposes of this paper. Among adult clients, Pekarik found that approximately equal numbers dropped out because they were satisfied with the therapy, were dissatisfied with the therapy, or were unable to continue therapy because of practical obstacles such as no means of transportation. On an objective measure of client improvement, satisfied dropouts did not differ from clients who had completed treatment.

Another interesting aspect of the Pekarik (1992) study was the finding that therapists considered the dropouts a homogeneous group of treatment failures. This discrepancy between client and therapist outcome ratings is found elsewhere in the treatment literature (Beutler, Arizmendi, Shanfield, Crago, and Hagaman, 1983, for example) and suggests the possibility that therapists need to be more in tune with clients' wishes and potentialities.

The potential benefit of SST was suggested in research by Cummings and Follette (1976, cited in Talmon, 1990 and Rockwell & Pinkerton, 1982), known as the Kaiser-Permanente Studies, in which it was found that a single session of psychotherapy was associated with reduced utilization of medical services in a prepaid health plan. Cummings and Follette admitted that "The findings that one session only, with no repeat psychological visits, could reduce medical utilization by 60 percent over the following five years, was surprising and totally unexpected" (p. 167).

**Research on intentional SST.** Talmon (1990) reported a study on planned SST conducted at Kaiser Permanente by Hoyt, Rosenbaum, and Talmon. These clinicians clinically interviewed sixty patients ranging in age from 4 to 94. Their sample included several different racial/ethnic groups, and a wide range of concerns, including depression, for one session of therapy. Fifty-eight of these patients were followed up by telephone three to 12 months later. Thirty-four (58%), who had said they did not need further help at the end of their session, reported at follow-up that they had not sought therapy
elsewhere. Seventy-nine percent reported at follow-up that the SST had been sufficient, and 88% reported much improvement or improvement. This study provides some evidence for the efficacy of a single session of therapy.

The potential of clients to feel satisfied with psychotherapy and benefit from it after one session as well as the fairly high probability that they will not return for additional psychological treatment, leads to the conclusion by advocates of SST that therapists should conduct the first session as if it were the last. Thus, they recommend that therapists conduct first sessions (and any subsequent sessions) in a way that will maximize their effect on clients (Talmon, 1990).

Philosophy of SST. According to Hoyt, Rosenbaum, and Talmon (1992), maximizing the effect of each session of psychotherapy entails adopting an overall "solution-oriented" perspective evident in the following list of attitudes necessary to conduct SST:

1. View each session as a whole, potentially complete in itself. Expect change.
2. The power is in the patient. Never underestimate your patient's strengths.
3. This is it. All you have is now.
4. The therapeutic process starts before the first session, and will continue long after it.
5. The natural process of life is the main force of change.
6. You don't have to know everything in order to be effective.
7. You don't have to rush or reinvent the wheel.
8. More is not necessarily better. Better is better. A small step can make a big difference.
9. Helping people as quickly as possible is practical and ethical. It will encourage patients to return for help if they have other problems, and will also allow therapists to spend more time with patients who require longer treatments. (p. 3 of manuscript)
Indications and contraindications of SST. Hoyt, Rosenbaum, and Talmon (1992) also presented a list of the kinds of persons who are most likely to benefit from SST.

1. Patients who come to solve a specific problem for which a solution is in their control.
2. Patients who essentially need reassurance that their reaction to a troubling situation is normal.
3. Patients seen with significant others or family members who can serve as 'natural supports and co-therapists.'
4. Patients who can identify (perhaps with the therapist's assistance) helpful solutions, past successes, and exceptions to the problem.
5. Patients who have a particularly 'stuck' feeling (e.g., anger, guilt, grief) toward a past event.
6. Patients who come for evaluation and need referral for medical examinations or other non-psychotherapy services (e.g., legal, vocational, financial, or religious counseling).
7. Patients who are likely to be better off without any treatment such as 'spontaneous improvers,' nonresponders, and those likely to have 'negative therapeutic reaction.'
8. Patients faced with a truly insoluble situation, such as trying to "fix" or "cure" an aged parent's Alzheimer's Disease. Since a problem may be defined as something that has a solution, it will help to recast goals in terms that can be proactively addressed.

Persons for whom SST is contraindicated include those who are suicidal or psychotic, request long-term therapy, need help with a disorder with a strong biological or chemical component such as schizophrenia, bipolar disorder, drug addiction, or panic disorder, have a long-standing eating disorder or severe obsessive-compulsive disorder, or suffer from the effects of abuse.

Techniques of SST. Advocates of SST suggest the following general techniques for conducting effective single-session therapy: tell clients that one session may be all that is necessary; allow enough time to accomplish something (90 minutes for an individual);
reframe problems in such a way that they are solvable ("focusing on pivot chords");
identify the client's strengths; provide an opportunity for the client to experience
something new through role-playing, Gestalt techniques, ceremonies, interpretation, etc.;
review the session by giving and receiving feedback; and follow up with a phone call or
office visit. In addition, an important part of SST is to make it clear to the client that the
door is open for additional service when needed. SST can thus be viewed, paradoxically,
as open-ended, time-unlimited therapy.

Solution-Focused Therapy

In order to maximize the effectiveness of sessions, SST utilizes (among other things)
concepts from solution-focused therapy (deShazer, 1988; Furman & Ahola, 1992;
O'Hanlon & Weiner-Davis, 1989; Peller & Walter, 1989; Walter & Peller, 1992). This
approach to psychotherapy was developed in large part at the Brief Family Therapy Center
(BFTC) in Milwaukee where Steve deShazer is director. The evolution of this approach
and the influences on it are discussed in (O'Hanlon and Weiner-Davis 1989) and Walter
and Peller (1992). Without embarking on a lengthy discussion, suffice it to say that one
important influence on solution-focused therapy as well as on SST is Milton Erickson.
The commonalities of the two approaches seem to represent attempts at understanding
and emulating the thinking and work of Erickson, especially his principle of utilization,
that is, using the responses, experiences, and interests of clients to help them (see Hoyt,

It is also important to note that proponents of solution-focused therapy accept the
possibility that one session of therapy can be sufficient. As Walter and Peller (1992) put
it, "every session is the first; every session is the last" (p. 141). Thus, it could also be said
that solution-focused therapy utilizes SST. Because of the overlap in these approaches, both will be utilized in the proposed study.

In order to facilitate change as quickly as possible, solution-focused therapy eliminates or mostly eliminates discussion of clients' problems. This is in sharp contrast to traditional approaches which emphasize spending a great deal of time understanding clients' difficulties. As de Shazer (1988) explained it,

Most initial therapy sessions begin with the client describing the complaint or problem that led him or her to seek therapy. Frequently, the therapist will then explore the complaint in great detail, although what the therapist considers important varies from model to model. As a solution-focused model has become more developed, this phase has become shorter and shorter, and has taken on less and less importance. (p. 51)

Proponents of solution-focused therapy believe that, theoretically at least, a therapist does not even need to know what a client's problem is in order to help him or her. The solution-focused approach is concerned with behavior and thinking patterns that solve problems. Identifying and/or constructing these with the client is the essence of this approach. It is assumed that beneficial change begins before the initial therapy session and that the job of therapists is to allow this momentum to continue and, if possible, facilitate its acceleration.

Implicit in the foregoing discussion is the idea that solution-focused therapy is concerned with clients' strengths and resources rather than their shortcomings and pathology. Walter and Peller (1992) related a story to illustrate the solution-focused perspective on conducting psychotherapy.

A few years back, during that rare year when the Chicago Cubs succeeded in winning their division championship, there was a time when one of the leading hitters was in a slump. Jim Frey, the manager of the team, spotted this hitter in the clubhouse one day. The hitter,
with hopes of improving his performance, was watching films of himself up at bat. Now you can probably guess what films he chose to watch. Right! He chose films of the times when he was in the slump, when he was striking out and generally doing everything but what he wanted. He, of course, was trying to find out what he was doing wrong so he could correct his mistake. He probably subscribed to the "What is the cause of the problem?" question. However, you can imagine what he was learning by watching films of slump batting; he was learning in greater and greater detail how to be a slump batter.

So we like to think that Jim Frey must have been a "closet" solution-focused brief therapist. He joined his hitter, complimented him on his dedication to the game and on attempting to improve himself. Jim then made one suggestion to the hitter - that he go back to the film room, find films from when he was really hitting the ball, and then watch those films instead. (p.5)

Assumptions of solution-focused therapy. O'Hanlon and Weiner-Davis (1989) and Walter and Peller (1992) listed and explicated assumptions of solution-focused therapy. It can be seen in the following synthesized list that the solution-focused orientation is constructivist in its underlying philosophy.

1. Reality can be constructed by the therapist in such a way as to create the expectancy of change that can work like a self-fulfilling prophecy. This is similar to experimenter effects found to operate in research.

2. People have all the resources they need to solve their problems.

3. Clients are always cooperating. They really want to change. There is no such thing as resistance. When clients do not follow therapists' suggestions, they are "simply educating therapists as to the most productive and fitting method of helping them change" (O'Hanlon & Weiner-Davis, 1989, pp. 21-22).

4. Clients are the experts on their problems. It is they who know what they need and who must define the goals of therapy.

5. Change is always occurring. It is the therapist's job to identify, facilitate and accelerate positive change. Oftentimes positive change begins before the first therapy session.

6. A small change can lead to larger change.

7. It is not necessary to know much about clients' problems or the deep, underlying causes of problems to facilitate change.
8. Rapid resolution of problems is possible.

9. Reality can be co-constructed by the therapist and client in such a way as to generate solutions to problems.

Techniques of solution-focused therapy. There are numerous techniques associated with solution-focused therapy. These are all intended to help generate solutions and include the following:

1. Normalizing. This entails reframing problems in such a way that they are no longer considered problems.

2. Specifying concrete goals. Defining problems in terms of manageable solutions.

3. Eliciting exceptions to the problem. In other words, pinpointing times when the problem does not happen and identifying what the client is doing or thinking differently at those times. This leads to the prescription to keep doing what works.

4. Asking the miracle question. This question is stated something like this, "If a miracle happened and you woke up tomorrow and your problem had disappeared, how would you know; what would you be doing and thinking differently?"

5. Giving compliments. This is done at the end of sessions and is meant to highlight clients' strengths and resources as well as to promote a sense of responsibility.

6. Assigning the Formula First Session Task. This is stated something like this, "Between now and the next time we meet, take notice so that you can describe to me what happens in your life (marriage, family, etc.) that you want to continue to have happen." This task is meant to encourage a positive outlook, generate more change.

Research on solution-focused therapy. As mentioned previously, the solution-focused approach was developed primarily at the Brief Family Therapy Clinic in Milwaukee by Steve de Shazer and a team of therapists. These clinicians conducted step-by-step qualitative psychotherapy research from which this model emerged. However, no published qualitative or quantitative studies were found testing the efficacy of this approach against other therapies.
Application to Depression

SST and solution-focused therapy were not developed specifically to treat depression, but it seems reasonable to assume that depressed persons, especially those who are mildly to moderately depressed, could benefit from these approaches. Peller and Walter (1989) provided a rationale for using the solution-focused approach with depressed clients with their excellent description of depressive "inductions."

How often it happens that our ongoing clients come into our offices and tell us about how they continue to feel depressed or anxious. As they continue to report their stories and feelings, they appear to be performing an induction on themselves as they elicit increasingly negative experiences and feelings. Their "symptomatic" trances become deeper as they recount and report on how bad they feel. The worse they feel, the more negative memories come up, spiraling in a vicious cycle.

If therapists do not do something to interrupt clients at those times, the induction continues and then clients feel worse and remain seemingly trapped. Unfortunately, the clients play out these negative inductions on themselves every day... Eventually they are convinced that not only do they feel that way, but that they are that way. (p. 314)

Peller and Walter (1989) went on to propose that a solution-focused approach could reverse this negative process and promote a positive spiraling of cognitive and affective processes. In other words, a focus on positive coping and personal strengths could generate positive associations in depressed persons, leading to changes in behavior and affect. This seems likely and was a major impetus for the proposed study.

On the other hand, the solution-focused approach might prove frustrating to depressed persons for a number of reasons. First, it discourages the "venting" of problems. Talking about problems along with emotional catharsis is considered therapeutic by most schools of therapy. It is possible that depressed persons need to go through the process of negative induction without interruption by their therapist. Also, without the opportunity to talk about their problems and express negative affect, depressed persons may feel as if
their difficulties are being minimized or discounted. This may also happen if significant problems are "normalized" out of existence.

Second, the solution-focused approach dispenses with providing clients with a diagnostic label (major depression, dysthymia) and allowing them to assume the "sick role." These elements are considered comforting and therapeutic by proponents of IPT, and without them therapy might prove to be less effective. Since IPT has been shown to be effective in treating depression, these factors cannot be easily discounted. However, IPT was not intended to be implemented in only one session.

Third, the solution-focused approach emphasizes clients' strengths and includes the giving of compliments at the end of the first session. This may be anti-therapeutic for depressed persons who are often "invested" in feeling guilty and worthless, and the messages of the therapist to the contrary may be construed as insincere or naive. Also, depressed persons may need more than one session to feel resourceful enough to deal with their problems.

**Application to College Students**

A single-session, solution-focused approach seems particularly applicable to student counseling centers whose clientele for the most part are young, intelligent, functional, busy, and impatient and where counselor time is insufficient to provide long-term therapy to the number of students requesting services.

Depression among college students is described by Cole (1988); Hammen (1980); Marx and Schulze (1991); Oliver and Burkham (1979); Schwartz (1990); and Vredenburg, O'Brien, and Krames (1988). Although some of the information in these reports is contradictory, it can be said that a significant number of college students are
depressed, that in many or most cases the depression is not a transitory phenomenon, and that depression is associated with particular personality and experiential variables.

A single-session of solution-focused therapy for depressed college students may be beneficial because it may help the students identify specifically what they need to do to feel better, provide a boost to their self-esteem by highlighting their strengths, and help identify other campus resources such as tutoring services, or assertiveness-training groups, that could be helpful to them. Vredenburg, O'Brien, and Krames (1988) expressed surprise that so few depressed students in their sample had sought help. Perhaps students would feel more comfortable talking to a counselor knowing that one session without pressure to return for protracted treatment is possible and probable.

On the other hand, a problem-focused approach may be more beneficial because of the reasons discussed above. The proposed study is designed to investigate the possibility that one session of counseling is beneficial for dysphoric college students and that one of these approaches is more beneficial than the other.
METHOD

This study investigated the relative effects of two psychological interventions on depressed mood, self-esteem, and perceptions of the counselor in college students. Students experiencing mild to moderate depression were seen individually for a single session of either problem-focused or solution-focused psychotherapy. All procedures used in this research were reviewed and approved by the Department of Psychology and the Iowa State University Human Subjects Committees.

Changes in mood, self-esteem, and perceptions of the counselor were assessed at the beginning of a one-week follow-up session by comparing responses on the Beck Depression Inventory (BDI), the Depression Adjective Checklist (DACL), and the Rosenberg Self-Esteem Scale (SES). Perceptions of the counselor were assessed with the Counselor Rating Form-Short Form (CRF-S).

This research project attempted to ascertain (1) whether or not a single session of therapy is associated with a reduction in depression scores and (2) whether or not the two conditions produce differential outcomes in depression, self-esteem, and ratings of counselors.

Participants

Clients

Female students reporting symptoms of mild to moderate depression served as clients in this study. Students were considered appropriate for the study if they scored 10 or higher on the Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), administered during routine mass testing conducted by the psychology department at a large midwestern university. The Inventory to Diagnose Depression (IDD, Goldston, O'Hara, & Schartz, 1990; Zimmerman, Coryell, Corenthal, & Wilson,
1986) was also administered during mass testing sessions to ascertain the percentage of participants who met DSM III-R diagnostic criteria for Major Depression. All client participants received extra credit points in their psychology courses in return for their participation in the study.

Approximately 40 female students initially scoring from 12-29 on the BDI participated in the study. The average age of the clients was 19. (range, 18-25). Sixty percent reported never having been to a counselor before; nearly 40% reported having experienced some type of counseling before the study; and two clients reported having been hospitalized for a mental or emotional disorder. Approximately 34% of the sample met diagnostic criteria for Major Depression at mass testing according to scores on the IDD. Over 75% of the client sample were freshman. Approximately 20 academic majors were represented in this sample. One client was receiving concurrent treatment (group counseling).

Counselors

The individual and follow-up sessions were conducted by 21 female counselors who were experienced professionals, counseling psychology interns, or advanced counseling psychology graduate students. They ranged in age from 24 to 50 and in years of experience from one year of clinical training to 15 years post-degree. The counselors included students, licensed social workers, and licensed psychologists.

All counselors participated in a two-hour training session covering the procedures and treatment protocols utilized in the study. Separate training sessions were conducted for each condition.
Instruments

Measurement of Depression

Three instruments were employed in this study to measure depression: the Beck Depression Inventory (BDI), the Depression Adjective Checklist (DACL), and the Inventory to Diagnose Depression (IDD).

The IDD was administered during the mass testing session to determine how many students could be diagnosed with a clinical depression. The IDD is a self-report inventory that contains the criteria for Major Depression specified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised* (DSM III-R, APA, 1987). These criteria are symptom-based and relatively straightforward.

Major depression is diagnosed on the basis of either sad mood or lack of interest or pleasure and at least four additional symptoms from the following list: significant weight loss or weight gain, insomnia or hypersomnia, psychomotor retardation or agitation, fatigue or loss of energy, feelings of worthlessness or inappropriate guilt, difficulty concentrating and/or making decisions, suicidal ideation or suicide attempt. Five symptoms must be present most of the day nearly every day over at least a two week period.

Many of these symptoms are also contained in the BDI, which was the primary means of identifying potential participants during mass testing. The BDI was also administered pre- and post-treatment, i.e., at the beginning of the treatment session and at the beginning of the follow-up session. The DACL measures mood in a format that is markedly different from the BDI and thus serves as an alternative way of measuring depression. The DACL was also administered to participants pre- and post-treatment.
Inventory to Diagnose Depression (IDD). The IDD is a 25-item, self-report questionnaire that contains the DSM III-R criteria for diagnosing Major Depression. Twenty-two of the items present five alternatives rank-ordered in terms of severity. Respondents are asked to mark items that have pertained to them over a two-week period. The last three questions assess diurnal variation of symptomatology, environmental reactivity (can the person feel better if something pleasant happens), and qualitative similarity or difference with normal grieving. For purposes of this study the IDD was scored according to the five diagnostic criteria for Major Depression; the last three items were not used.

Zimmerman, Coryell, Corenthal, and Wilson (1986) reported psychometric properties of the IDD based on a study with psychiatric inpatients. They found reliability to be very high. The test-retest correlation coefficient was 0.98 on consecutive days, the split-half reliability coefficient was 0.93, and Cronbach's alpha was 0.92. Validity data were also impressive; the IDD correlated 0.80 with the Hamilton Rating Scale for Depression and 0.87 with the Beck Depression Inventory.

Favorable psychometric data were also reported by Goldston, O'Hara, and Schartz (1990), who administered the IDD to college students. In this study the test-retest stability (over 48 hours) was .92, a split-half reliability coefficient was .86, and Cronbach's alpha was .84. The IDD correlated .81 with the Beck Depression Inventory, .81 with the Carroll Rating Scale, and .72 with the Center for Epidemiologic Studies-Depression Scale. Also, a principal components analysis revealed a large general depression factor for both men and women on the IDD. (See Appendix A.)
Beck Depression Inventory (BDI). The BDI is a self-report questionnaire that measures intensity of depression on affective, cognitive, behavioral, and somatic dimensions. It consists of 21 items containing four alternatives rated on the basis of severity from 0 to 3. Responses to each item are added together to obtain the final depression score. Scores can range from 0 to 63. Although no official scoring criteria have been published, the Center for Cognitive Therapy (see Beck, Steer, & Garbin, 1988) suggests the following guidelines for interpreting BDI scores:

- 0-9 Normal Range
- 10-18 Mild to Moderate Depression
- 19-29 Moderate to Severe Depression
- 30-63 Severe Depression

Beck, Steer, and Garbin (1988) reported psychometric data gathered on the BDI over a 25-year period. Internal consistency calculations revealed a mean coefficient alpha of 0.81 for non psychiatric adults. Mean correlations with clinical ratings and the Hamilton Rating Scale for Depression for non psychiatric adults were 0.64 and 0.74 respectively. Similar mean correlations were found with the Zung Self-Rating Depression Scale and the D scale of the Minnesota Multiphasic Personality Inventory.

It is important to point out that the usefulness of the BDI in diagnosing depression is questioned in the literature (Fitzgibbon, Cella, & Sweeney, 1988; Kendall, Hollon, Beck, Hammen, Ingram, 1987; Oliver & Simmons, 1984). Lack of correspondence between scores on the BDI and DSM III-R diagnostic criteria for Major Depression has generated the discussion. It is generally agreed that the BDI does provide a measure of dysphoria or depression, but is not a clear-cut diagnostic instrument in terms of DSM III-R nosology. (See Appendix B.)
Depression Adjective Checklists (DACL). The DACL (Lubin, 1965) are lists of adjectives pertaining to feelings. The DACL Form E was used in this study and all normative and psychometric data reported below pertain to this form of the checklists. In addition, since this study involved only female participants the normative and psychometric data reported apply only to females.

On the DACL, respondents check those adjectives that describe how they are feeling in general. Adults take approximately two and one-half minutes to complete the list. Scores are obtained by calculating the number of depressive adjectives endorsed and then adding this amount to the number of positive (non depressed) adjectives not endorsed. The range of scores is 0 to 34.

Lubin (1981) reported normative data from the National Depression Survey (Levitt & Lubin, 1975, cited in Lubin, 1981). A mean score of 8.08 was attained for a sample of predominately college-aged female non psychiatric patients. In contrast, depressed psychiatric patients scored 20.39. In a sample of 556 normal females a raw score of 8 was found to be equivalent to a standard score of 50.

Reliability data reported by Lubin (1981) included an internal consistency of .88 computed by means of a two-way analysis of variance and a split-half reliability index of .84 for normals and .88 for patients. Test-retest correlations over a period of one week were .19 for a sample of 75 (unspecified population).

Cross validation of the DACL was assessed by comparing the mean scores of normals, non-depressed patients, and depressed patients. Significant differences were found among these groups. Mean scores for females on Form E were as follows: (a) 7.84 for normals, (b) 13.21 for non-depressed patients, and (c) 20.39 for depressed patients.
Concurrent validity of the DACL was assessed by comparing scores on Form E with a 13-point self-rating scale of depression. Significant correlation coefficients were found for depressed persons (.89) and for non-depressed persons (.60). A correlation of .84 was found between the DACL and the Depression Scale of the MAACL. (See Appendix C.)

**Measurement of Self-Esteem and Perceptions of Counselors**

**Rosenberg Self-Esteem Scale (SES).** The SES is a 10-item, unidimensional scale on which respondents endorse items according to a four-point scale from (1) strongly disagree to (4) strongly agree. The SES was originally developed to be scored as a Guttman scale. However, following the suggestion of Wallace (1988), a Likert scoring system was used in this study. Respondents obtain average scores ranging from 1.0 to 4.0 with higher scores indicating higher self-esteem.

Self-esteem, as conceptualized by Rosenberg (1989), refers to how a person views himself or herself in relation to others.

When we speak of high self-esteem, ..., we shall simply mean that the individual respects himself, considers himself worthy; he does not necessarily consider himself better than others, but he definitely does not consider himself worse: he does not feel that he is the ultimate in perfection but, on the contrary, recognizes his limitations and expects to grow and improve. Low self-esteem, on the other hand, implies self-rejection, self-dissatisfaction, self-contempt. The individual lacks respect for the self observed. The self-picture is disagreeable, and he wishes it were otherwise. (p. 31)

Reliability of the SES was reported by Rosenberg (1989) in terms of reproducibility (93%) and scalability (73% for items and 72% for individuals). These figures indicate adequate reliability for the SES. The SES was validated in terms of its association (in the expected direction) with depression, peer-group reputation, and physiological symptoms of anxiety.
Wallace (1988) reviewed studies that assessed the psychometric properties of the SES using the Likert scoring system. On samples of college students, measures of internal consistency ranged from .74 to .83. Correlations with college GPA ranged from -.01 to -.05. (See Appendix D.)

Counselor Rating Form - Short Form (CRF-S). The CRF-S consists of 12 adjectives on which clients rate their counselor from (1) Not Very to (7) Very. All the adjectives refer to desirable qualities in a counselor (e.g., experienced, friendly, reliable, and warm). The CRF-S contains three scales: attractiveness, expertness, and trustworthiness, and each scale contains four items. The range of average scores on each of the scales is 1-7, with higher scores conveying a more positive impression of the characteristic assessed.

Epperson and Pecnik (1985) found that college students discriminated among Carl Rogers, Fritz Perls, and Albert Ellis on the expertness and attractiveness scales using the CRF-S when they viewed the film, Three Approaches to Psychotherapy (Shostrom, 1966). Epperson and Pecnik also reported a median internal consistency of .82 (range, .63 to .89) for the three CRF-S scales. Construct validity for this instrument is based on a confirmatory factor analysis performed by Corrigan and Schmidt (1983) who found a three-factor oblique model in their data corresponding to the attractiveness, expertness, and trustworthiness dimensions. A potential problem with the CRF-S is the lower reliability and independence of the trustworthiness scale compared to the expertness and attractiveness scales (Epperson & Pecnik, 1985; Ponterotto & Furlong, 1985). This was taken into consideration when the data from this study were analyzed. (See Appendix E.)
Procedure

Initial Contact with Clients

Undergraduate research assistants telephoned female students who scored in the mild to moderately depressed range on the BDI (10-29) during a mass testing session and scheduled those interested in participating for a 1 and 1/2 hour individual session. Scheduling of these individual sessions occurred as soon as possible after the mass testing session, which typically was two to three weeks after this initial assessment.

Because the research assistants were not qualified to conduct a clinical interview, students were not told on the phone why they were selected for participation in this research or about the treatment phase of the research. They were told that they would receive an extra credit point for going to the scheduled appointment and would initially be asked to respond to some paper and pencil questionnaires. They were also told that they would have the option of participating in subsequent phases of the research (with the possibility of earning two additional extra credit points) and would learn more about these from the experimenter. (See Appendix F.)

Treatment Session

At the beginning of the session, the students filled out the BDI, the DACL, and the SES. Modified informed consent was used for this phase of the research. (See Appendix G.) Next, the experimenters (counselors) explained to the participants why they were chosen for this study and asked them to read and sign the informed consent statement for the treatment phase of the research, indicating that they understood the procedures involved in this research, including possible benefits and negative consequences; that they voluntarily agreed to participate; that all data would be confidential; that they could
withdraw from participation at any time; and that they would not hold the university liable for injury incurred as a result of participation in the study. (See Appendix H.)

At this point, students were asked whether or not they wanted to continue with the interview. Those who did not want to continue to participate were given a list of places where they could go for help if they so desired (Appendix I). Those who agreed to participate were then clinically interviewed according to a "problem-focused" or a "solution focused" protocol determined by random assignment of clients to treatments. Following treatment, the counselors administered the DACL and then arranged to meet with their client one week to 10 days later.

All but one of the sessions were videotaped. Only the counselor was on camera in these videotapes in order to protect the confidentiality of the clients. Videotaping began after clients were informed both verbally and in writing and after they gave their written consent.

**Follow-up Interview**

At the beginning of this interview, clients again filled out the DACL, the SES, and the BDI. In addition, all clients responded to the Counselor Rating Form and to a statement requesting that they write down how they perceived their experience with the research. These questionnaires were placed by the clients into a large manila envelope and sealed so that responses were not seen by the counselors. This was intended to minimize demand characteristics.

The second part of the follow-up interview consisted of checking on the progress and status of the clients, debriefing them about the research project, and referring them to appropriate sources of help. All clients were given a debriefing sheet and a list of places to seek help. (See Appendices I and J.)
Treatments

Appendices K and L contain the treatment protocols. Both protocols include an orienting statement, questions, and feedback. A brief summary of the treatments and the therapeutic factors they contain follows. At the end of this section is an explanation of the manipulation check used to assess counselor adherence to treatment protocol.

It is important to note that the counselors were instructed to use the protocol as a guide and were not instructed to read the questions verbatim or in the order listed. In other words, counselors were encouraged to keep to the "spirit" of the protocol and to deal gently with clients' deviations from the treatment context (i.e., a client who begins to talk about problems in the solution-focused condition and vice versa).

Problem-Focused Treatment

The problem-focused treatment involved exploring the client's problem(s), including symptoms and associated features of depression, possible causes of the depression (stressors), unsuccessful coping strategies, and negative feelings about self. If a client's symptoms fit a DSM-III-R diagnosis for major depression, she was told the diagnosis. At the end of this treatment, the client was encouraged to take good care of herself, as if she had the flu, in order to feel better. This treatment represented a combination of standard therapeutic procedure and Interpersonal Therapy of Depression (Klerman, Weissman, Rounsaville, 1984) and as such was considered, for the purposes of this study, the standard reference treatment with which the solution-focused treatment was compared.

The problem-focused treatment contains a number of factors thought to be therapeutic. First, asking a client about symptoms of depression and providing her with a diagnosis conveys the comforting information that her experiences are part of a known disorder and therefore shared by others. Second, this approach gives the client an opportunity to
"vent" her problems and frustrating attempts at solving them. Any emotional catharsis that occurs from talking about her situation and from reflections of negative affect from the counselor can also be very therapeutic. Third, the feedback at the end of the session provides nurturing to the client and allows her to feel a sense of relief in hearing that she is not to blame for her illness and can take the opportunity to take care of herself.

Solution-Focused Treatment

The solution-focused treatment was intended to direct attention away from negative rumination to positive ways of making change. This treatment also was intended to highlight the client's resources and previous or current coping strategies that have been successful. Specific behaviors were targeted as desirable and as indicating life without the depression, so that change appears more possible and probable. Feedback at the end of the session included compliments concerning the client's resources and a directive statement asking the client to take note of the things in her life she would like to continue. This protocol was validated through a letter and phone conversation with John Walter, co-author of Becoming Solution-Focused in Brief Therapy (Walter & Peller, 1992).

The solution-focused protocol also contains a number of therapeutic ingredients, all of which are intended to help clients gain a sense of control over their problems. This approach is thought to empower clients by eliciting positive coping strategies (exceptions) that they are employing in the present or have used in the past. Clients can become so concerned with problems and coping strategies that do not work that they are unaware of what they are doing that does work. Awareness of beneficial behaviors imparts a sense of control and the message that change is already occurring. The "miracle question" also elicits positive coping strategies and directs attention toward the future. This question is, "If you were to wake up tomorrow morning and the (problem) had miraculously
disappeared, what would you be doing or saying to yourself differently?" By answering
the miracle question, clients can envision what needs to be done to feel better and are
empowered because the ideas are self-generated. Another empowering aspect to this
treatment is the feedback at the end, which includes compliments about clients' resources.
The directive to take notice of what "you would like to continue to have happen in your
life" serves to remind clients that there are positive aspects to their lives.

To summarize, the solution-focused therapy was intended to change the negative
schemata and feelings of helplessness and hopelessness of depressed clients into more
positive ways of thinking about themselves and their problems by highlighting practical
ways of coping.

Assessment of Counselor Adherence to Treatment Protocol

Four undergraduate research assistants who were "blind" to treatment condition
reviewed the same 15-minute segment of each of 37 videotapes of the counseling sessions
starting from a point 5 minutes into the session and rated them according to one of two
protocols. Raters were instructed to rate the tapes independently.

Two of the assistants rated the segments globally as either solution-focused, problem-
focused, or undetermined. They were provided with a brief narrative description of each
treatment condition to use as a guide in making their decisions about how to rate the
tapes. A short practice session was held to clarify these procedures. (See Appendix M.)

The two other research assistants rated each counselor verbalization from the
videotape segments according to the following categories: symptoms, problems, coping,
future, and undetermined. They were given brief descriptions of each category and
participated in a short practice session. (See Appendix N.)
Global ratings of the videotapes were analyzed using Cohen's kappa statistic for interrater reliability and for association with the intended focus of the sessions. Ratings of counselor statements were correlated using Pearson product-moment correlations to ascertain interrater reliabilities for each category of ratings (problem, solution, and undetermined). A multivariate analysis of variance (MANOVA), followed by univariate analyses of variance (ANOVA$s$), were utilized to assess significant differences in mean ratings within each treatment condition.

**Design and Analyses**

Each female client was paired with a female counselor in this study and experienced either the problem-focused condition or the solution-focused condition. Therefore, clients were nested in treatment condition. It was decided to cross counselors with treatment condition, but because of scheduling difficulties and time constraints, only 7 out of 21 counselors conducted both kinds of therapy. Fourteen counselors conducted only one session, and therefore, most counselors were nested in treatment condition.

The raw data consisted of scores on the BDI, the DACL, the SES, and the CRF-S. Effectiveness of treatment (within subjects effects) and differential treatment effects (between subjects effects) were assessed with multivariate analyses of variance (MANOVA$s$) using a repeated measures model for the BDI, the DACL, and the SES separately. This approach to repeated measures designs was suggested by Vasey and Thayer (1987). Protected paired-t comparisons were utilized to explore significant multivariate effects. Counselor was not a factor in these analyses. Potential differences in scores across treatment conditions on the three scales of the CRF-S were assessed using a multivariate analysis of variance (MANOVA).
RESULTS

Inventory Scores

Mean scores for all inventories used in this study, except the Inventory to Diagnose Depression, are found in Table 1. Means are presented in this table by treatment condition and for the whole sample. Below is a discussion of the scores for the overall sample for each inventory.

Inventory to Diagnose Depression (IDD)

The IDD was administered during mass testing sessions and was scored dichotomously to determine whether or not participants met DSM III-R diagnostic criteria for Major Depression. Results indicated that approximately 32% of the sample who participated in this research met diagnostic criteria for Major Depression.

Beck Depression Inventory (BDI)

The BDI was administered three times to each client: (1) during a mass testing session, (2) immediately prior to her therapy session, approximately two weeks after the mass testing session, and (3) at follow-up, approximately one week later. Clients scored an average of 17.35 (range 12-29, $SD=3.74$) at mass testing, 16.80 (range 10-32, $SD=5.51$) immediately pre-treatment, and 10.90 (range 3-22, $SD=4.32$) at follow-up. These scores indicate that this sample of students was experiencing moderate depression at mass testing and immediately prior to the therapy sessions and mild depression at follow-up. The mean follow-up score of 10.90 falls close to the normal range of scores (below 10).

Depression Adjective Checklist (DACL)

The DACL was also administered three times during this study: (1) immediately prior to the therapy sessions, (2) immediately after the therapy sessions, and (3) at follow-up. Mean scores for these times were 16.2 (range 6-30, $SD=5.06$), 10.2 (range 1-25,
Table 1. Mean inventory scores

<table>
<thead>
<tr>
<th>Inventory</th>
<th>Mass Testing</th>
<th>Pre-Session</th>
<th>Post-Session</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem-Focused Condition (n=20)</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>BDI</td>
<td>17.05</td>
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<td>11.00</td>
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<td>DACL</td>
<td>16.90</td>
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<tr>
<td>SES</td>
<td>2.50</td>
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<td>CRF-A</td>
<td>6.39</td>
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<tr>
<td>CRF-E</td>
<td>5.62</td>
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<tr>
<td>CRF-T</td>
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<tr>
<td>Solution-Focused Condition (n=20)</td>
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<td></td>
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<tr>
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<tr>
<td>DACL</td>
<td>15.50</td>
<td>9.65</td>
<td>10.75</td>
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<td>SES</td>
<td>2.56</td>
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<td>CRF-A</td>
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<tr>
<td>CRF-E</td>
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<td>CRF-T</td>
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<tr>
<td>Whole-Sample Means (N=40)</td>
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<tr>
<td>BDI</td>
<td>17.35</td>
<td>16.80</td>
<td>10.85</td>
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<tr>
<td>DACL</td>
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<td>SES</td>
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<tr>
<td>CRF-T</td>
<td>6.41</td>
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</table>

*BDI=Beck Depression Inventory, DACL=Depression Adjective Checklist-Form E, SES=Rosenberg Self-Esteem Scale, CRF-A=Counselor Rating Form-Short Version Attractiveness Scale, CRF-E=Counselor Rating Form-Short Expertness Scale, and CRF-T=Counselor Rating Form-Short Form Trustworthiness Scale.*

*Time interval from mass testing to pre-session=2 weeks, from pre-session to follow-up=7 to 10 days.*
SD=.474), and 12.0 (range 0-26, SD=5.91) respectively. These scores can be compared with a mean score of 8.0 for a normal sample of females and a mean score of 20.39 for depressed female psychiatric patients (Lubin, 1981).

**Rosenberg Self-Esteem Scale (SES)**

The SES was administered prior to the therapy sessions and at follow-up. The mean score for pre-treatment was 2.5 (range 1.9-3.5, SD=.45) and for follow-up was 2.6 (range 1.6-3.7, SD=.49) indicating a lack of high self-esteem among this student sample and no change over the course of the research. Scores on the SES can range from 1.0 to 4.0 with higher scores indicating greater feelings of self-worth and self-confidence.

**Counselor Rating Form-Short Version (CRF-S)**

The CRF-S was administered at follow-up to assess perceptions of the counselor. The range of possible scores is 1.00 to 7.00 with higher scores indicating more favorable perceptions of the counselor. Mean scores were 6.46 on the Attractiveness Scale (range 4.00-7.00, SD=.69), 5.75 on the Expertness Scale (range 3.00-7.00, SD=.94), and 6.41 on the Trustworthiness Scale (range 4.25-7.00, SD=.69), indicating that, overall, the counselors were perceived as likable, skillful, and trustworthy.

**Inventory Correlations**

**Correlations Between Responses on Each Inventory**

Table 2 lists the correlations of responses on the BDI, the DACL, and the SES. As can be seen in this table, responses on each inventory were significantly correlated with later administrations of the inventory except in the case of mass testing and follow-up scores on the BDI.
Table 2. Correlations between scores on inventories

<table>
<thead>
<tr>
<th>Time of Administration(^a)</th>
<th>Correlation</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beck Depression Inventory</strong></td>
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<td></td>
</tr>
<tr>
<td>Mass testing/pre-treatment</td>
<td>0.5610</td>
<td>.0002</td>
</tr>
<tr>
<td>Pre-session/follow-up</td>
<td>0.3791</td>
<td>.0158</td>
</tr>
<tr>
<td>Mass testing/follow-up</td>
<td>0.2352</td>
<td>.1440</td>
</tr>
<tr>
<td><strong>Depression Adjective Checklist</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-session/post-session</td>
<td>0.5500</td>
<td>.0004</td>
</tr>
<tr>
<td>Post-session/follow-up</td>
<td>0.4373</td>
<td>.0068</td>
</tr>
<tr>
<td>Pre-treatment/follow-up</td>
<td>0.4014</td>
<td>.0103</td>
</tr>
<tr>
<td><strong>Rosenberg Self-Esteem Scale</strong></td>
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</tr>
<tr>
<td>Pre-session/follow-up</td>
<td>0.8105</td>
<td>.0001</td>
</tr>
</tbody>
</table>

\(^a\)Time interval from mass testing to pre-session=2 weeks, from pre-session to follow-up=7 to 10 days.

Correlations Between Inventory Scores at Pre-Treatment and at Follow-up

Table 3 shows correlations between scores on the BDI, the DACL, and the SES at pre-treatment and follow-up. Significant positive correlations were found between the BDI and the DACL at both pre-treatment and follow-up. This was expected since these two inventories purport to measure the same construct. Significant negative correlations were found between the BDI and the SES at both pre-treatment and follow-up. These correlations were also expected since greater depressive symptomatology is assumed to be associated with lower self-esteem. Pre-treatment scores on the DACL and the SES were
Table 3. Correlations between inventory scores at pre-treatment and follow-up

<table>
<thead>
<tr>
<th>Inventories</th>
<th>Correlation</th>
<th>p-value</th>
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</thead>
<tbody>
<tr>
<td><strong>Pre-Session</strong></td>
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<tr>
<td>BDI/DACL</td>
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<td>DACL/SES</td>
<td>-0.2800</td>
<td>.0802</td>
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<tr>
<td><strong>Follow-Up</strong></td>
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<tr>
<td>BDI/DACL</td>
<td>0.6247</td>
<td>.0001</td>
</tr>
<tr>
<td>BDI/SES</td>
<td>-0.5246</td>
<td>.0005</td>
</tr>
<tr>
<td>DACL/SES</td>
<td>-0.5230</td>
<td>.0004</td>
</tr>
</tbody>
</table>

aBDI=Beck Depression Inventory, DACL=Depression Adjective Checklist-Form E, SES=Rosenberg Self-Esteem Scale.

bTime interval from pre-session to follow-up=7 to 10 days.

not significantly correlated, but follow-up scores on these two measures were significantly negatively correlated.

Manipulation Check

Global Ratings of Sessions

Two undergraduate students viewed a 15-minute segment of 37 videotaped sessions and rated each session as problem-focused, solution-focused, or undetermined. These raters agreed with each other 92% of the time and with the intended focus of the sessions 89% and 92% of the time.
In order to correct for chance agreement, Cohen's kappa statistic also was calculated to measure interrater reliability and association of ratings with the intended focus of the sessions. Agreement between the raters was high, $K = 0.842$. Kappa coefficients for association of ratings with the intended focus of the sessions were 0.783 and 0.841 for the two raters.

**Ratings of Counselor Statements**

Two different undergraduate students rated counselor statements in the same 15 minute segment of the 37 videotapes and tallied them according to five categories—symptoms, problems, coping, future, and undetermined. The "symptoms" and "problems" categories pertained to the problem-focused approach and were summed to yield one frequency score for problem-focused statements. The "coping" and "future" categories pertained to the solution-focused approach and were also summed to yield one frequency score for solution-focused statements. Undetermined ratings were counted to yield one score for this category of statements. The frequency of statements classified within each category (problem, solution, undetermined) served as the raw data for Pearson product-moment correlations to determine interrater reliabilities. These correlations were 0.90 ($p = .0001$) for problem-focused statements, 0.82 ($p = .0001$) for solution-focused statements, and 0.54 ($p = .0006$) for undetermined statements.

Because the respective correlations were high for problem-focused and solution-focused statements, the frequencies were averaged across raters, and the means for each tape were used to determine association of ratings with the intended focus of the sessions. A one-way (treatment) multivariate analysis of variance (MANOVA) using Pillai's Trace as the multivariate statistic revealed a significant main effect for treatment condition, $F(3, 33) = 18.81$, $p = .0001$. Subsequent exploration with univariate tests revealed significant
effects for the problem-focused statements, $F(1,35) = 38.82, p = .0001$ and for the solution-focused statements, $F(1,35) = 43.37, p = .0001$ but not for the undetermined statements, $F(1,35) = 0.52, p = .4770$. Means and standard deviations for each category of statements by intended treatment condition are listed in Table 4.

Summary

These results indicate that, overall, the counselors in this study adhered to the treatment protocols. It was decided to retain data in which there was disagreement between raters or between raters and the intended focus of the sessions for the main analyses because these discrepancies were few and because such discrepancies reflect the reality of counseling. In addition, it can be argued that the tenor of these sessions could have changed after the 15 minutes reviewed by the raters.

Table 4. Means, standard deviations, and F ratios for ratings of counselor statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Problem-Focused (n=17)</th>
<th>Solution-Focused (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Problem</td>
<td>28.65</td>
<td>14.28</td>
</tr>
<tr>
<td>Solution</td>
<td>4.91</td>
<td>6.74</td>
</tr>
<tr>
<td>Undetermined</td>
<td>3.15</td>
<td>1.18</td>
</tr>
</tbody>
</table>

$^a$ F ratios are based on 1,35 degrees of freedom.

* $p = .0001$
Main Analyses

The split plot design, with treatment as the between subjects variable and time as the within subjects variable, was analyzed with a multivariate analysis of variance (MANOVA) approach, which does not result in a biased test of repeated measures variables when sphericity assumptions cannot be met (see Vasey & Thayer, 1987). Following the suggestion of Olson (1976), Pillai's Trace was used as the multivariate test statistic.

Protected paired-t comparisons on mean change scores were used to explore the significant main effects for time. Using a correction factor suggested by Hedges (1981), unbiased effect sizes were also calculated where there was significant change. According to Cohen's (1969, cited in Howell, 1987) criteria, effect sizes can be categorized as follows: small, 0.20; medium, 0.50; and large, 0.80. Findings from these analyses are reported in detail below. Means for the BDI, the DACL, and the SES by treatment condition are found in Table 1. Mean change scores, T statistics, and effect sizes for these inventories are found in Table 5.

Beck Depression Inventory

Results from the MANOVA on mass testing, pre-session, and follow-up scores on the BDI revealed an overall significant effect for time, $F(2, 37)=34.32, p=.0001$. Neither treatment, $F(1,38)=0.01, p=.9299$, nor the interaction of treatment and time, $F(2,37)=0.18, p=.8345$ was significant.

Exploration of the significant main effect for time with paired-t comparisons revealed no significant change from mass testing ($M=17.35$) to pre-session ($M=16.80$), $T(39)=0.76, p=.4548$. This was expected since clients received no treatment during this interval and indicates that improvement did not occur for this sample of students as a result of the passage of time alone. Significant change was found from mass testing
Table 5. Mean change, t statistics, and effect sizes for client improvement by inventory

<table>
<thead>
<tr>
<th>Inventory</th>
<th>Timea</th>
<th>Mean Change</th>
<th>T (df)</th>
<th>p-value</th>
<th>ES</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI</td>
<td>Mass testing to pre-session</td>
<td>0.55</td>
<td>0.755 (39)</td>
<td>.4548</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pre-session to follow-up</td>
<td>5.95</td>
<td>6.762 (39)</td>
<td>.0001</td>
<td>1.05</td>
</tr>
<tr>
<td></td>
<td>Mass testing to follow-up</td>
<td>6.50</td>
<td>8.218 (39)</td>
<td>.0001</td>
<td>1.27</td>
</tr>
<tr>
<td>DACL</td>
<td>Pre-session to post-session</td>
<td>5.973</td>
<td>8.119 (36)</td>
<td>.0001</td>
<td>1.31</td>
</tr>
<tr>
<td></td>
<td>Post-session to follow-up</td>
<td>-1.919</td>
<td>-2.080 (36)</td>
<td>.0446</td>
<td>-0.34</td>
</tr>
<tr>
<td></td>
<td>Pre-session to follow-up</td>
<td>4.225</td>
<td>4.206 (39)</td>
<td>.0001</td>
<td>0.69</td>
</tr>
<tr>
<td>SES</td>
<td>Pre-session to follow-up</td>
<td>-0.375</td>
<td>-0.814 (39)</td>
<td>.4208</td>
<td></td>
</tr>
</tbody>
</table>

aTime interval from mass testing to pre-session=2 weeks, from pre-session to follow-up=7 to 10 days.

(M=17.35) to follow-up (M=10.85), T(39)=8.22, p=.0001 and from pre-session (M=16.80) to follow-up (M=10.85), T(39)=6.77, p=.0001. Effect sizes for these intervals were 1.27 and 1.05 respectively. (See Figure 1)
Depression Adjective Checklist

The MANOVA on DACL scores (administered pre-treatment, post-session, and at follow-up) revealed a significant main effect for time, $F(2, 34)=31.07, p=.0001$. Neither treatment, $F(1,35)=1.81, p=.1872$, nor the interaction of treatment and time, $F(2,34)=0.45, p=.6403$ was significant.

Paired-t comparisons showed significant positive change from pre-session ($M=16.20$) to post-session ($M=10.14$), $t(36)=8.12, p=.0001$, suggesting that the therapy sessions had a positive immediate effect on the clients. An effect size of 1.31 was found for this change. There was also significant positive change on the DACL from pre-session ($M=16.20$) to follow-up ($M=11.98$), $t(39)=4.21, p=.0001$. The effect size for this change interval is 0.69. In contrast, there was significant negative change on the DACL from post-session ($M=10.14$) to follow-up ($M=11.98$), $t(36)=-2.08, p=.0001$. The effect size for change here is -0.34.

These results indicate that the degree of positive change in mood experienced immediately following the sessions was not fully maintained to follow-up, although there was significant positive change overall. Since the DACL is a state-dependent measure, it seems reasonable to conclude that in this study it was operating as expected. (See Figure 2)

Rosenberg Self-Esteem Scale

The MANOVA on SES scores revealed no significant effect for treatment, $F(1,38)=0.11, p=.7412$, time, $F(1,38)=0.646, p=.4265$ or the Time x Treatment interaction, $F(1,38)=0.072, p=.7902$. Thus, unlike responses on the BDI and DACL, responses on the SES indicated no overall change across time in the women who participated in this study.
Figure 1. Mean change in Beck Depression Inventory (BDI) scores over time

Figure 2. Mean change in Depression Adjective Checklist (DACL) scores over time
Analysis of Responses on the Counselor Rating Form-Short Form

A one-way multivariate analysis of variance (MANOVA) on the three scales of the CRF-S revealed no significant main effect for treatment $F(3,36)=0.428$, $p=.7341$, indicating there were no significant differences in how the clients perceived their counselor as a function of treatment condition.
DISCUSSION

Results from this study generally were consistent with previous comparative psychotherapy outcome research with depressed persons (Elkin et al., 1989; Robinson, Berman, & Neimeyer, 1990). Although this kind of research has supported the general efficacy of psychotherapy for treating depression, it has not provided evidence for the greater benefit of one type of therapy over others. The study reported here is no exception.

However, there are several distinctive aspects of this study that contribute useful information to this area of research. First, this study investigated the effects of a single session of therapy rather than a number of sessions, such as the 16 utilized in the Elkin et al., 1989 study. Second, this study compared a relatively untested type of therapy, solution-focused therapy, against what could be considered the standard practice of focusing on client problems during the first session. Third, this study assessed not only changes in mood and depressive symptoms but also perceptions of self and the counselors, which can have theoretical as well as clinical significance. These points and others are discussed below.

Single-Session Psychotherapy

Multivariate analyses of variance followed by paired-t comparisons revealed overall client improvement from pre-treatment to follow-up on the BDI and the DACL. Thus, a single session of therapy was strongly associated with an immediate improvement in mood that was sustained for one week.
Problem-Focused vs. Solution-Focused Therapy

No significant differences in reducing depressive symptoms were found between the problem-focused and solution-focused treatment conditions. As stated above, this lack of differential effectiveness between therapies is consistent with previous comparative psychotherapy research with depressed persons cited in this paper. However, this previous research compared well-known and well-tested therapies, some of which were specifically developed to treat depression.

In contrast, the solution-focused approach utilized in this study was not developed to treat depression, and it had not been tested with depressed persons. Nevertheless, the solution-focused approach performed well against the more traditional practice of encouraging clients to discuss their problems and express negative affect during the first session. The efficacy of the solution-focused approach is noteworthy because it seemed reasonable to expect that depressed persons might become frustrated and unresponsive if they were not allowed to "vent" their problems.

Process Factors

The treatment protocols in this study were designed to provide a clear contrast between focusing on clients' complaints and focusing on clients' successful coping strategies, and yet no significant differences were found between conditions. Despite this, clients benefited from their therapy session. It is interesting to reflect on how the results of this study provided information concerning the mechanisms that contributed to positive change and those that resulted in null findings.

Nonspecific Factors

One explanation for the significant positive change observed as well as the absence of differential treatment effects is the presence of nonspecific therapeutic factors in both
treatment conditions (discussed previously in this paper) such as expectancy effects, emotional arousal, cognitive dissonance, learning and mastery, and personal and professional characteristics of the therapist. For example, learning and mastery were present in both conditions. In the problem-focused condition, clients learned about symptoms of depression and were able to sort out what might be causing their own dysphoric feelings. In the solution-focused condition, clients were able to become more consciously aware of coping techniques they were already using to feel better.

Counselor characteristics. Most important may have been the personal and professional characteristics of the counselors in this study. Their ability to form therapeutic relationships and convey unconditional positive regard and empathy may have been very crucial elements in the benefit derived by clients in this study. This would also explain clients' overall high ratings of the counselors and the lack of perceived differences between conditions on the three scales of the CRF-S.

Client characteristics. A discussion of process factors must also include client characteristics. The clients in this study had not sought professional help with their difficulties and were not severely depressed. They were young and intelligent and part of an environment that provides lots of opportunity for peer support. These characteristics suggest that these young women were ideal candidates for a single episode of caring attention from an empathic counselor. Persons who seek professional help and/or are more severely depressed may not respond as quickly.

Demand characteristics. It should also be noted that demand characteristics were high in this study and that the positive change could be attributed to participants' feeling that they ought to appear improved. Although attempts were made to minimize this kind
of response set, it remains a viable explanation for the observed improvement. On the other hand, lack of virtually any change on the SES refutes this hypothesis.

**Passage of time.** The passage of time always presents the possibility of a confound in this kind of research. In order to examine this possibility, change from mass testing to pretreatment was assessed using the BDI. In other words, the clients served as their own controls. No change was found for this client sample until they experienced a counseling session.

**Perceptions of Self**

Results from this study showed virtually no change in mean scores on the SES. Both pre- and post-treatment scores for this sample of college women indicated a lack of high self-esteem, suggesting that low regard for self was constant regardless of the presence or absence of depressed feelings. Since the SES can be considered the most trait-dependent inventory utilized in this research, it appears that fundamental beliefs about self did not change for these women as a result of a single session of therapy. From the standpoint of several of the theories of depression, the negative self-schemata and/or positive other-schemata would suggest that the women in this sample are predisposed to experience recurring depression. An important question is whether or not additional sessions of counseling could facilitate positive change on the SES and thus serve a preventative function.

**Limitations of the Study and Issues for Future Research**

This study contained a number of limitations. First, the "clients" in this study had not sought professional help with their concerns. Stronger conclusions concerning the efficacy of a single session of therapy and the relative benefits of problem-focused and solution-focused approaches could be made if actual clients participated in a study of this
kind. On the other hand, the results support the contention that many depressed persons do not seek help and if they did, would benefit from treatment.

Second, because of practical constraints, the number of sessions conducted by each counselor was not uniform, and this arrangement may have biased the data. A large subset of the counselors (14) conducted only one session and another subset conducted more than two sessions. One counselor, the principal investigator, conducted eight sessions, but she was crossed with treatment condition to avoid bias toward one treatment. Analysis of the data with the principal investigator's sessions deleted revealed no change in the results.

Third, more intensive training of the counselors could have been undertaken in order to produce purer treatment conditions. Approximately half the training time (1 hour) was devoted to the research procedures (e.g., administering the questionnaires, debriefing and referring the clients for additional treatment). More time explaining, demonstrating, and practicing the treatments could contribute to a stronger study.

Fourth, the research design did not account for client characteristics that could have shed light on which treatment would be suitable for which clients. Informal comments by the counselors in the study indicated that some sessions went more smoothly than others and that a given condition seemed to fit or not fit a particular client. Future research is needed to address this question.

Fifth, this study also did not address counselor characteristics or desires regarding treatment condition. Several counselors expressed a preference for one approach over the other. However, in this study, counselors were assigned to treatment condition on the basis of their availability for a training session and the type of session that was needed to balance the data collection rather than their preference. Several counselors stated that.
given the opportunity to conduct the session freely, they would incorporate both approaches. Additional research with a combination condition could prove interesting.

Implications for Clinical Practice

Because of the analogue nature of this study (participants had not sought professional help), the limited population involved (young college women experiencing mild to moderate depression), and the sex of the counselors (all female), caution must be exercised in applying the results of this study to treatment of depression in general. However, given these considerations, the results of this research suggest that a single session of therapy can be useful for some clients and that a solution-focused approach is a viable alternative to an in-depth discussion of client complaints.
REFERENCES


APPENDIX A

INVENTORY TO DIAGNOSE DEPRESSION
INVENTORY TO DIAGNOSE DEPRESSION

INSTRUCTIONS: Read each group of statements carefully. Then pick out the one statement in each group that best describes the way you have been feeling the PAST TWO (OR MORE) WEEKS. Fill in the circle on the answer sheet that corresponds with your response for each question.

1. 1 I do not feel sad or depressed.
   2 I occasionally feel sad or down.
   3 I feel sad most of the time, but I can snap out of it.
   4 I feel sad all the time, and I can't snap out of it.
   5 I am so sad or unhappy that I can't stand it.

2. 1 My energy level is normal.
   2 My energy level is occasionally a little lower than normal.
   3 I get tired more easily or have less energy than usual.
   4 I get tired from doing almost anything.
   5 I feel tired or exhausted almost all of the time.

3. 1 I have not been feeling more restless and fidgety than usual.
   2 I feel a little more restless or fidgety than usual.
   3 I have been very fidgety, and I have some difficulty sitting still in a chair.
   4 I have been extremely fidgety, and I have been pacing a little bit almost every day.
   5 I have been pacing more than an hour per day, and I can't sit still.

4. 1 I have not been talking or moving more slowly than usual.
   2 I am talking a little slower than usual.
   3 I am speaking slower than usual, and it takes me longer to respond to questions, but I can still carry on a normal conversation.
   4 Normal conversations are difficult because it is hard to start talking.
   5 I feel extremely slowed down physically, like I am stuck in mud.
5. 1 I have not lost interest in my usual activities.
   2 I am a little less interested in one or two of my usual activities.
   3 I am less interested in several of my usual activities.
   4 I have lost most of my interest in almost all of my usual activities.
   5 I have lost all interest in all of my usual activities.

6. 1 I get as much pleasure out of my usual activities as usual.
   2 I get a little less pleasure from one or two of my usual activities.
   3 I get less pleasure from several of my usual activities.
   4 I get almost no pleasure from most of the activities which I usually enjoy.
   5 I get no pleasure from any of the activities which I usually enjoy.

7. 1 I have not noticed any recent change in my interest in sex.
   2 I am only slightly less interested in sex than usual.
   3 There is a noticeable decrease in my interest in sex.
   4 I am much less interested in sex now.
   5 I have lost all interest in sex.

8. 1 I have not been feeling guilty.
   2 I occasionally feel a little guilty.
   3 I often feel guilty.
   4 I feel quite guilty most of the time.
   5 I feel extremely guilty most of the time.

9. 1 I haven't lost any weight.
   2 I've lost less than 5 pounds.
   3 I've lost between 5-10 pounds.
   4 I've lost between 11-25 pounds.
   5 I've lost more than 25 pounds.

10. 1 My appetite is not greater than normal.
     2 My appetite is slightly greater than normal.
     3 My appetite is clearly greater than usual.
     4 My appetite is much greater than usual.
     5 I feel hungry all the time.
11. 1 I haven't gained any weight.
     2 I've gained less than 5 pounds.
     3 I've gained between 5-10 pounds.
     4 I've gained between 11-25 pounds.
     5 I've gained more than 25 pounds.

12. 1 I am not sleeping less than normal.
     2 I occasionally have slight difficulty sleeping.
     3 I clearly don't sleep as well as usual.
     4 I sleep about half my normal amount of time.
     5 I sleep less than 2 hours per night.

13. 1 I am not sleeping more than normal.
     2 I occasionally sleep more than usual.
     3 I frequently sleep at least 1 hour more than usual.
     4 I frequently sleep at least 2 hours more than usual.
     5 I frequently sleep at least 3 hours more than usual.

14. 1 I do not feel like a failure.
     2 My opinion of myself is occasionally a little low.
     3 I feel I am inferior to most people.
     4 I feel like a failure.
     5 I feel I am a totally worthless person.

15. 1 I haven't had any thoughts of death or suicide.
     2 I occasionally think life is not worth living.
     3 I frequently think of dying in passive ways (such as going to sleep and not waking up) or that I'd be better off dead.
     4 I have frequent thoughts of killing myself, but I would not carry them out.
     5 I would kill myself if I had the chance.

16. 1 I can concentrate as well as usual.
     2 My ability to concentrate is slightly worse than usual.
     3 My attention span is not as good as usual, and I am having difficulty collecting my thoughts, but this hasn't caused any problems.
     4 My ability to read or hold a conversation is not as good as it usually is.
     5 I cannot read, watch TV, or have a conversation without great difficulty.
17. 1 I make decisions as well as I usually do.
   2 Decision making is slightly more difficult than usual.
   3 It is harder and takes longer to make decisions, but I do make them.
   4 I am unable to make some decisions.
   5 I can't make any decisions at all.

18. 1 My appetite is not worse than normal.
   2 My appetite is slightly worse than usual.
   3 My appetite is clearly not as good as usual, but I still eat.
   4 My appetite is much worse now.
   5 I have no appetite at all, and I have to force myself to eat even a little.

19. 1 I do not feel anxious, nervous or tense.
   2 I occasionally feel a little anxious.
   3 I often feel anxious.
   4 I feel very anxious most of the time.
   5 I feel terrified and near panic.

20. 1 I do not feel discouraged about the future.
   2 I occasionally feel a little discouraged about the future.
   3 I often feel discouraged about the future.
   4 I feel very discouraged about the future most of the time.
   5 I feel that the future is hopeless and that things will never improve.

21. 1 I do not feel irritated or annoyed.
   2 I occasionally get a little more irritated than usual.
   3 I get irritated or annoyed by things that usually don't bother me.
   4 I feel irritated or annoyed almost all the time.
   5 I feel so depressed that I don't get irritated at all by things that used to bother me.

22. 1 I am not worried about my physical health.
   2 I am occasionally concerned about bodily aches and pains.
   3 I am worried about my physical health.
   4 I am very worried about my physical health.
   5 I am so worried about my physical health that I cannot think about anything else.
ANSWER THE FOLLOWING 3 QUESTIONS ONLY IF YOU INDICATED 2, 3, 4, OR 5 ON QUESTION #1.

23. Mark on the answer sheet the statement that best describes how your mood varies during the course of the day:

1 I clearly feel the most depressed in the morning.
2 I clearly feel the most depressed in the afternoon.
3 I clearly feel the most depressed in the evening.
4 I do not feel consistently more depressed during any particular part of the day.

24. Do you feel any better when something pleasant happens or someone tries to cheer you up?

1 Yes, I feel almost normal for a short time.
2 I feel a little better, but I still feel somewhat depressed.
3 No, I don't feel any better.

25. How does the feeling of depression or sadness compare with the depression you would feel after someone close to you died? (If the two types of depression differ ONLY in severity, indicate #1.)

1 There is no difference between the two types of depression.
2 There is a definite difference between the two.
APPENDIX B

BECK DEPRESSION INVENTORY
BECK DEPRESSION INVENTORY

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1.  
   0 I do not feel sad.  
   1 I feel sad.  
   2 I am sad all the time, and I can't snap out of it.  
   3 I am so sad or unhappy that I can't stand it.

2.  
   0 I am not particularly discouraged about the future.  
   1 I feel discouraged about the future.  
   2 I feel I have nothing to look forward to.  
   3 I feel that the future is hopeless and that things cannot improve.

3.  
   0 I do not feel like a failure.  
   1 I feel I have failed more than the average person.  
   2 As I look back on my life, all I can see is a lot of failures.  
   3 I feel I am a complete failure as a person.

4.  
   0 I get as much satisfaction out of things as I used to.  
   1 I don't enjoy things the way I used to.  
   2 I am dissatisfied or bored with everything.

5.  
   0 I don't feel particularly guilty.  
   1 I feel guilty a good part of the time.  
   2 I feel guilty most of the time.  
   3 I feel guilty all of the time.
6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse off than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
      1 I cry more now than I used to.
      2 I cry all the time now.
      3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I ever am.
       1 I get annoyed of irritated more easily than I used to.
       2 I get irritated all the time now.
       3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
       1 I am less interested in other people than I used to be.
       2 I have lost most of my interest in other people.
       3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
       1 I put off making decisions more than I used to.
       2 I have greater difficulty in making decisions than before.
       3 I can't make decisions at all anymore.
14. 0  I don't feel I look any worse than I used to.
    1  I am worried that I am looking old or unattractive.
    2  I feel that there are permanent changes in my appearance that make me look
        unattractive.

15. 0  I can work about as well as before.
    1  It takes extra effort to get started at doing something.
    2  I have to push myself very hard to do anything.
    3  I can't do any work at all.

16. 0  I can sleep as well as usual.
    1  I don't sleep as well as I used to.
    2  I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3  I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0  I don't get more tired than usual.
    1  I get tired more easily than I used to.
    2  I get tired from doing almost anything.
    3  I am too tired to do anything.

18. 0  My appetite is no worse than usual.
    1  My appetite is not as good as it used to be.
    2  My appetite is much worse now.
    3  I have no appetite at all anymore.

19. 0  I haven't lost much weight, if any, lately.
    1  I have lost more than 5 pounds.  I am purposely trying to lose
        weight by eating less.  Yes  No
    2  I have lost more than 10 pounds.
    3  I have lost more than 15 pounds.

20. 0  I am no more worried about my health than usual.
    1  I am worried about physical problems such as aches and pains, or upset
        stomach, or constipation.
    2  I am very worried about physical problems, and it's hard to think of much else.
    3  I am so worried about my physical problems that I cannot think about anything
        else.

21. 0  I have not noticed any recent change in my interest in sex.
    1  I am less interested in sex than I used to be.
    2  I am much less interested in sex now.
    3  I have lost interest in sex completely.
APPENDIX C

DEPRESSION ADJECTIVE CHECKLIST
DEPRESSION ADJECTIVE CHECKLIST

DIRECTIONS: Below you will find words which describe different kinds of moods and feelings. Some of the words may sound alike, but we want you to check all the words that describe your feelings. Work rapidly and check all the words which describe how you feel IN GENERAL.

1. _____ Unhappy
2. _____ Active
3. _____ Blue
4. _____ Downcast
5. _____ Dispirited
6. _____ Composed
7. _____ Distressed
8. _____ Cheerless
9. _____ Lonely
10. _____ Free
11. _____ Lost
12. _____ Broken
13. _____ Good
14. _____ Burdened
15. _____ Forlorn
16. _____ Vigorous
17. _____ Peaceful
18. _____ Well
19. _____ Apathetic
20. _____ Chained
21. _____ Strong
22. _____ Dejected
23. _____ Awful
24. _____ Glum
25. _____ Great
26. _____ Finished
27. _____ Hopeless
28. _____ Lucky
29. _____ Tortured
30. _____ Listless
31. _____ Safe
32. _____ Wilted
33. _____ Criticized
34. _____ Fit
APPENDIX D

ROSENBERG SELF-ESTEEM SCALE
ROSENBERG SELF-ESTEEM SCALE

Please Respond to each statement using the following 4-point scale.

1     2     3     4
Strongly Disagree  Disagree  Agree  Strongly Agree

1. I feel that I'm a person of worth, at least on an equal plane with others.
2. I feel that I have a number of good qualities.
3. All in all, I am inclined to feel that I am a failure. *
4. I am able to do things as well as most other people.
5. I feel I do not have much to be proud of. *
6. I take a positive attitude toward myself.
7. On the whole, I am satisfied with myself.
8. I wish I could have more respect for myself. *
9. I certainly feel useless at times. *
10. At times I think I am no good at all. *

* These items were reverse scored.
APPENDIX E
COUNSELOR RATING FORM-SHORT FORM
COUNSELOR RATING FORM-SHORT FORM

Listed on the following page are a number of characteristics on which counselors might vary. Each characteristic is followed by a 7-point scale that ranges from "NOT VERY" to "VERY." Please circle the number at the point on the scale that best represents how you perceived your counselor.

For example:

FUNNY

NOT VERY  

\[1 \ldots \ 2 \ldots \ 3 \ldots \ 4 \ldots \ 5 \ldots \ 6 \ldots \ 7\]

VERY

WELL-DRESSED

NOT VERY  

\[1 \ldots \ 2 \ldots \ 3 \ldots \ 4 \ldots \ 5 \ldots \ 6 \ldots \ 7\]

VERY

These ratings might show that the counselor did not joke around much, but was well-dressed.

PLEASE RATE YOUR COUNSELOR ON EACH OF THE CHARACTERISTICS ON THE FOLLOWING PAGES. Although all of the following characteristics are probably desirable, counselors may differ in the degree to which they exhibit the characteristics. We are interested in how you view these differences.
EXPERIENCED

NOT VERY

1....  .2....  .3....  .4....  .5....  .6....  .7...

VERY

EXPERT

NOT VERY

1....  .2....  .3....  .4....  .5....  .6....  .7...

VERY

FRIENDLY

NOT VERY

1....  .2....  .3....  .4....  .5....  .6....  .7...

VERY

HONEST

NOT VERY

1....  .2....  .3....  .4....  .5....  .6....  .7...

VERY

LIKEABLE

NOT VERY

1....  .2....  .3....  .4....  .5....  .6....  .7...

VERY

PREPARED

NOT VERY

1....  .2....  .3....  .4....  .5....  .6....  .7...
RELIABLE

NOT VERY                                VERY
1.... 2.... 3.... 4.... 5.... 6.... 7

SINCERE

NOT VERY                                VERY
1.... 2.... 3.... 4.... 5.... 6.... 7

SKILLFUL

NOT VERY                                VERY
1.... 2.... 3.... 4.... 5.... 6.... 7

SOCIABLE

NOT VERY                                VERY
1.... 2.... 3.... 4.... 5.... 6.... 7

TRUSTWORTHY

NOT VERY                                VERY
1.... 2.... 3.... 4.... 5.... 6.... 7

WARM

NOT VERY                                VERY
1.... 2.... 3.... 4.... 5.... 6.... 7
APPENDIX F

TELEPHONE SCRIPT
TELEPHONE SCRIPT

Hello, my name is ________________, and I am a psychology research assistant. During a mass testing session in which you participated, you granted us permission to call you concerning additional research opportunities. Do you remember the mass testing session?

I am calling to invite you to participate in a research project that will begin next week. You will be able to earn at least one, and possibly three, extra credit points.

If you are interested, I will schedule you to meet individually with an experimenter. You need to plan to spend 1 and 1/2 hours for this meeting. The first thing you will be asked to do is to retake one of the questionnaires you took during the mass testing session and also take two other short questionnaires. After you finish the questionnaires, the interviewer will talk to you about other parts of the research, and you will have the opportunity to decide whether or not you want to continue to be a participant.

Are you interested in participating?

IF THE SUBJECT SAYS "YES," SAY

We are scheduling people in the evenings and on the weekend in the psychology building. Evening times are Monday-Thursday from 6:00-7:30 and from 7:30-9:00 or you can be scheduled on Saturday or Sunday 2:00-3:30 or 3:30-5:00.
What time would be good for you?

**IF THE SUBJECT CHOOSES AN EVENING TIME, SAY**

Since you have chosen to come in the evening, we encourage you to think about your safety and arrange transportation for yourself in advance of the meeting. There is also the option of calling the campus escort service at 4-4888.

You will meet the experimenter in the psychology building, West Lagomarcino Hall by the experiment bulletin board. Do you know where this is located? The experimenter will be a female and will know your name. You just need to stand by that bulletin board and she will approach you.

[If the subject wants to know why she was selected or wants to know more details about the research, tell her that you cannot give her any more information on the telephone but that these questions will be answered when she meets with the interviewer.]

**IF THE STUDENT REFUSES TO PARTICIPATE, SAY**

Part of this research project involves disseminating information about the counseling services on campus. The Student Counseling Service is located on the third floor of the Student Services Building and offers personal counseling in individual and group formats. Also available are career counseling services which include individual career counseling,
career assessment workshops, and computer-assisted career exploration. SCS also provides substance abuse assessments, biofeedback, and learning disability screening. Do you have any questions about any of these services?
APPENDIX G
INFORMED CONSENT-PHASE I
DESCRIPTION OF THE RESEARCH

Attached to this sheet are three brief questionnaires concerning stress, mood, and self-perceptions. The first questionnaire includes items pertaining to negative mood, such as feelings of sadness and guilt, and also items dealing with physical problems such as difficulty sleeping. The second questionnaire asks you to check adjectives that describe your mood, and the third questionnaire asks about how you perceive yourself as compared to others.

Each questionnaire will take approximately 5-10 minutes to complete.

CONFIDENTIALITY

Your responses to the questionnaires will be kept confidential. Your name will not appear on the questionnaires, and any report resulting from this research study will not contain personally identifiable information. Persons not directly involved in this research project will not have access to the research data.

BENEFITS AND RISKS

By participating in this research, you will be helping to further the science of psychology, and you can feel good about your contribution. In addition, you may benefit from learning more about yourself as you respond to the questionnaires.

Although we do not anticipate any harmful effects from responding to these questionnaires, you may feel some emotional discomfort associated with the personal nature of the questions.

YOUR RIGHTS

Participation in this research is voluntary, and you have the right to withdraw at any time without loss of credit. You will be awarded one extra credit point for this phase of the research.

If at any time you have questions or concerns about this research or your part in it, you may talk with the experimenter or you may contact Sara Sundström, M.S. at the Student Counseling Service (294-5056) or Douglas Epperson, Ph.D. at W206 Lagomarcino Hall (294-2047). You may also contact the members of the Department of Psychology's Ethics Committee, Dr. Norman Scott, Dr. Veronica Dark, and/or Dr. Lloyd Avant through the Department of Psychology, W112 Lagomarcino Hall (294-1742).

YOUR COMPLETION OF THE QUESTIONNAIRES WILL SIGNIFY YOUR CONSENT TO PARTICIPATE
APPENDIX H
INFORMED CONSENT FOR DEPRESSION RESEARCH
TREATMENT #1 AND TREATMENT #2
INFORMED CONSENT FOR DEPRESSION RESEARCH
TREATMENT #1

Description of the Study

This study will investigate the effectiveness of two very brief psychological treatments for depression. Both treatments under consideration have been shown to be helpful in relieving depression, but it is not clear whether or not they are equally effective. The paragraph that follows is a description of the treatment that you will receive. At the end of the study, we will tell you about the other treatment.

During the next part of this session (about 40-50 minutes), the experimenter, who is a trained counselor, will be asking you some questions about your situation, with the goal of helping you explore problems you may be having now or have experienced in the past. She will encourage you to express your feelings and think about the causes of your depression. At the end of the session, your counselor will give you some feedback about the session and will set up an appointment with you for a short follow-up session in two weeks. When you return in two weeks, your counselor will ask you to respond to some short questionnaires and will want to know how you have been doing. During the follow-up session, you will also receive additional information about this research project.

The first session will be videotaped, but the camera will be focused only on the counselor. In other words, you will not be seen in the tape. However, your voice and your counselor's voice will be heard on the tape so that we can check your counselor's adherence to the treatment guidelines. Videotapes will be erased after all data are collected and analyzed.

Criteria for Participation

Participants in this study must be experiencing mild to moderate depression and be willing to talk about their concerns with a counselor. In addition, participants must not currently be receiving psychological or medical treatment for depression. If there is a likely medical reason for the depressive symptoms, appropriate referrals will be made.

Time Requirement and Extra Credit

You will be asked to spend 40-50 minutes in the first session and 1/2 hour in the follow-up session. One extra credit point for the first session and one extra credit point for the follow-up session will be awarded in the psychology course you designate. Recording of extra credit will occur at the beginning of each session.
Your Rights

Participation in this study is voluntary, and therefore you are free to withdraw from the study at any time without loss of credit earned. You have the right to know the results of the study at its conclusion.

If at any time you have questions or concerns about this research or your part in it, you may talk with your counselor or you may contact Sara Sundstrom, M.S. at the Student Counseling Service (294-5056) or Douglas L. Epperson, Ph.D., at W206 Lagomarcino Hall (294-2047).

You may also contact the members of the Department of Psychology's Ethics Committee, Dr. Norman Scott, Dr. Veronica Dark, and/or Dr. Lloyd Avant through the Department of Psychology, W112 Lagomarcino Hall (294-1742).

Confidentiality

Your participation in this study will be kept confidential by the investigators and counselors. Any identifying information will be kept in a locked filing cabinet. Reports of results of this study will not include information that could reveal the identity of any individual participant.

The investigators and counselors are ethically bound not to reveal your identity or discuss your concerns with anyone who is not directly involved in this project. Exceptions to confidentiality are legally and ethically mandated if it becomes clear that there is imminent danger to you or others. In these circumstances appropriate action will be taken to ensure the safety of all concerned.

Benefits and Risks

It is our belief that most of the participants in both treatment conditions will experience a decrease in depression and an increase in self-esteem. Although we expect the treatments to be beneficial, they will most likely involve some emotional discomfort associated with the discussion of feelings and personal issues.

Every effort will be made to minimize the risks and discomforts to participants in this study. The entire study will be supervised by a licensed psychologist, and counselors will be advanced graduate students or experienced professionals.

Emergency Medical or Psychological Treatment

Although we do not anticipate any negative consequences, we want you to know that any medical or psychological emergency that may occur as a direct result of participation in this research will be treated at the University Student Health Center, University Student Counseling Service (both located in the Student Services Building) and/or referred to Mary Greeley Hospital or another treatment source. Compensation for treatment of any injuries that may occur as a direct result of participation in this research may or may not be paid by Iowa State University depending on the Iowa Tort Claims Act. Claims for compensation will be handled by the Iowa State University Vice President for Business and Finance.
Consent Statement

I understand all of the risks involved in participating in this study, and I hereby elect to voluntarily participate. Additionally, I release, waive, discharge, and covenant not to sue Iowa State University, the Board of Regents of the state of Iowa, the state of Iowa, its officers, servants, agents, or employees, (hereafter Releasees) for any loss, damage, or injury that may be sustained by me due to my participation in the above-mentioned study, excepting occurrences resulting from the wanton or intentional conduct of the Releasees.

IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT that I have read the foregoing Waiver of Liability and Hold Harmless Agreement, understand it, and sign it voluntarily; that I am at least eighteen (18) years of age and fully competent, or my parent(s) or guardian(s) will sign in my stead; and I execute this Release for full, adequate and complete consideration, fully intending to be bound by same.

----------------------------------------

Signature

------------------

Date
INFORMED CONSENT FOR TREATMENT OF DEPRESSION RESEARCH

TREATMENT # 2

Description of the Study

This study will investigate the effectiveness of two very brief psychological treatments for depression. Both treatments under consideration have been shown to be helpful in relieving depression, but it is not clear whether or not they are equally effective. The paragraph that follows is a description of the treatment that you will receive. At the end of the study, we will tell you about the other treatment.

During the next part of this session (about 40-50 minutes), the experimenter, who is a trained counselor, will be asking you some questions about your situation, with the goal of helping you explore solutions to the problems you are experiencing. She will encourage you to continue doing the things that have worked for you in the past and will help you devise new ways of coping. At the end of the session, your counselor will give you some feedback about the session and will set up an appointment with you for a short follow-up session in two weeks. When you return in two weeks, your counselor will ask you to respond to some short questionnaires and will want to know how you have been doing. During the follow-up session, you will also receive additional information about this research project.

The first session will be videotaped, but the camera will be focused only on the counselor. In other words, you will not be seen in the tape. However, your voice and your counselor's voice will be heard on the tape so that we can check your counselor's adherence to the treatment guidelines. Videotapes will be erased after all data are collected and analyzed.

Criteria for Participation

Participants in this study must be experiencing mild to moderate depression and be willing to talk about their concerns with a counselor. In addition, participants must not currently be receiving psychological or medical treatment for depression. If there is a likely medical reason for the depressive symptoms, appropriate referrals will be made.

Time Requirement and Extra Credit

You will be asked to spend 40-50 minutes in the first session and 1/2 hour in the follow-up session. One extra credit point for the first session and one extra credit point for the follow-up session will be awarded in the psychology course you designate. Recording of extra credit will occur after each session.
Your Rights

Participation in this study is voluntary, and therefore you are free to withdraw from the study at any time without loss of credit earned. You have the right to know the results of the study at its conclusion.

If at any time you have questions or concerns about this research or your part in it, you may talk with your counselor or you may contact Sara Sundstrom, M.S. at the Student Counseling Service (294-5056) or Douglas L. Epperson, Ph.D., at W206 Lagomarcino Hall (294-2047).

You may also contact the members of the Department of Psychology's Ethics Committee, Dr. Norman Scott, Dr. Veronica Dark, and/or Dr. Lloyd Avant through the Department of Psychology, W112 Lagomarcino Hall (294-1742).

Confidentiality

Your participation in this study will be kept confidential by the investigators and counselors. Any identifying information will be kept in a locked filing cabinet. Reports of results of this study will not include information that could reveal the identity of any individual participant.

The investigators and counselors are ethically bound not to reveal your identity or discuss your concerns with anyone who is not directly involved in this project. Exceptions to confidentiality are legally and ethically mandated if it becomes clear that there is imminent danger to you or others. In these circumstances appropriate action will be taken to ensure the safety of all concerned.

Benefits and Risks

It is our belief that most of the participants in both treatment conditions will experience a decrease in depression and an increase in self-esteem. Although we expect the treatments to be beneficial, they will most likely involve some emotional discomfort associated with the discussion of feelings and personal issues.

Every effort will be made to minimize the risks and discomforts to participants in this study. The entire study will be supervised by a licensed psychologist, and counselors will be advanced graduate students or experienced professionals.

Emergency Medical or Psychological Treatment

Although we do not anticipate any negative consequences, we want you to know that any medical or psychological emergency that may occur as a direct result of participation in this research will be treated at the University Student Health Center, University Student Counseling Service (both located in the Student Services Building) and/or referred to Mary Greeley Hospital or another treatment source. Compensation for treatment of any injuries that may occur as a direct result of participation in this research may or may not be paid by Iowa State University depending on the Iowa Tort Claims Act. Claims for compensation will be handled by the Iowa State University Vice President for Business and Finance.
Consent Statement

I understand all of the risks involved in participating in this study, and I hereby elect to voluntarily participate. Additionally, I release, waive, discharge, and covenant not to sue Iowa State University, the Board of Regents of the state of Iowa, the state of Iowa, its officers, servants, agents, or employees, (hereafter Releasees) for any loss, damage, or injury that may be sustained by me due to my participation in the above-mentioned study, excepting occurrences resulting from the wanton or intentional conduct of the Releasees.

IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT that I have read the foregoing Waiver of Liability and Hold Harmless Agreement, understand it, and sign it voluntarily; that I am at least eighteen (18) years of age and fully competent, or my parent(s) or guardian(s) will sign in my stead; and I execute this Release for full, adequate and complete consideration, fully intending to be bound by same.

__________________________________________  _______________________
Signature                                      Date
APPENDIX I

MENTAL HEALTH SERVICES
MENTAL HEALTH SERVICES

STUDENT COUNSELING SERVICE
(Student Services Building) 294-5056

STUDENT HEALTH CENTER
(Student Services Building) 294-5801 (24 hours)

EMERGENCY 911 (24 hours)

OPEN LINE 233-5000
M-F 3:00p-12:00 a
S-S 9:00a-12:00 a

MARY GREELEY MEDICAL CENTER
(Duff Ave. and 11th St.) 239-2155 (24 hours)

CENTRAL IOWA MENTAL HEALTH
(713 S. Duff) 232-5811
APPENDIX J
DEBRIEFING INFORMATION
DEBRIEFING INFORMATION

The research study in which you participated compared the effectiveness of two single-session psychological treatments for depression. One treatment was "problem-focused" and the other treatment was "solution-focused." You experienced one of these two treatments.

In the problem-focused treatment, participants discussed their depressive symptoms and current and past stressors. This exploration of problems included expression of feelings as well as an attempt to promote insight into what might be causing the difficulties. In addition, participants were asked about unsuccessful coping techniques they had tried. The rationale for focusing on problems in a counseling session is that people can experience relief and can gain insight just by being able to talk about their problems with an understanding and supportive person. This "venting," as it is sometimes called, is usually incorporated into traditional therapy sessions and it is what people often do when they talk to close friends about life's frustrations.

In the solution-focused treatment, participants were encouraged to explore ways of coping with their problems. They were asked to think about times when they have not felt depressed and what they were doing during those times to make themselves feel better. Participants in this condition were also asked to imagine what they will be like when they are not depressed. These questions were intended to emphasize the probability of change and highlight the strengths and resources of participants. The rationale for focusing on solutions is that clients benefit from a positive outlook and behavioral specificity in dealing with their issues. In other words, it is thought that with a focus on solutions, therapy clients will assume change is inevitable and will concentrate on specific ways of bringing positive change about.
This research was intended to assess the effects of these treatments on the mood and self-esteem of the participants. Proponents of solution-focused therapy maintain that this more positive way of conducting therapy leads to better results, but we wondered whether or not persons in this condition might become frustrated with not being able to "vent" their problem. On the other hand, traditional therapies almost always include discussion of client concerns, assuming that it is important for both the client and the therapist to determine what is wrong and what attempts at coping have failed. We were interested in finding out whether this focus on negatives would result in fewer antidepressant effects.

We were also interested in finding out how the participants perceived their counselor and the counseling session as a whole. Client perceptions of counselors in terms of liking, trustworthiness, and expertise are considered very important to the outcome of psychotherapy. We wondered whether counselors conducting problem-focused therapy would be perceived differently than those conducting solution-focused therapy. Sometimes clients like their counselor but for one reason or another do not respond well to therapy. Interestingly, the opposite can also occur; clients can become angry with their counselor but markedly improve. We tried to assess these kinds of responses also.

We encourage you to share your opinions about this research and your experience with it. Your comments can provide us with important insights into the therapy process that could ultimately benefit persons seeking psychological help. Please talk with your counselor or put your thoughts in writing on the attached sheet.

If you have any questions about this research that are not answered here, please contact Sara Sundstrom, the principal investigator in this project, at the Student Counseling Service, 294-5056. Thank you for participating in this research. We hope you have benefited from the treatment you received. If you need further help with depression
or other difficulties, we urge you to contact the Student Counseling Service (294-5056), located on the 3rd floor of the Student Services Building.
APPENDIX K

PROBLEM-FOCUSED PROTOCOL
PROBLEM-FOCUSED PROTOCOL

OPENING STATEMENT: Do you remember the mass testing session in which you participated? Your responses on two of the questionnaires indicated that you were feeling stressed out and depressed. For the next 45 minutes or so I would like to give you the opportunity to talk about your problems, and I will try and help you clarify them and understand them better. During this interview, I will be asking you some questions, but it is up to you to decide whether or not you want to answer them.

QUESTIONS:

1. Can you tell me how you have been feeling lately? Have you experienced... (Review all the symptoms and associated features of depression.)

2. How long have you felt this way? When did all of this start? (If the student meets all the diagnostic criteria for depression, tell him or her the diagnosis.)

3. What was going on in your life when the depression started? In other words, what do you think is causing all these uncomfortable feelings?

4. What is going on now that is keeping the depression from going away? (Allow subject to talk about stressors.)

5. How have you tried to make yourself feel better? What coping strategies have not worked for you?

6. How do you feel about yourself right now? Are there aspects of yourself that you would like to change?

FEEDBACK: I would like to summarize what you have told me during this session. You have felt __________________________ and attribute these feelings to
From all that you have told me, it sounds as if you have had a difficult time lately. Between now and the follow-up interview in two weeks, I encourage you to take good care of yourself (as if you had the flu) physically, mentally, and emotionally. Try to eat well and sleep well, and get some exercise. You may also want to talk with a friend and engage in more activities that you enjoy. In other words, be good to yourself, and allow yourself some time to feel better.
APPENDIX L

SOLUTION-FOCUSED PROTOCOL
SOLUTION-FOCUSED PROTOCOL

OPENING STATEMENT: Do you remember the mass testing session in which you participated? Your responses on two of the questionnaires indicated that you have been feeling stressed out and "down" lately.

(Allow the client to state the problem if he or she seems to need to do this.)

I'm really sorry to hear that ____________________________________________.

I would like to help you figure out ways to feel better and cope with_________________.

During the next 45 minutes or so, I will ask you some questions that I think will help you focus on useful solutions to your problem. Before we start, however, I want you to know that you don't have to answer anything you don't want to.

QUESTIONS

I. GOAL QUESTION

If you had gone to a counselor, what would you want to accomplish?

[How would you know you had accomplished this?]

II. MIRACLE QUESTION

If you were to wake up tomorrow morning and the __________ had miraculously disappeared, what would you be doing (or saying to yourself) differently?
[Important: If subject discusses what she would not be doing, ask, What would you be
doing INSTEAD?]

III. EXCEPTIONS QUESTION

How is this happening now?

How do you make this happen?

[Can you think of a time fairly recently (or in the past) when things were going fairly
well (or a little bit better) and you felt happier/more confident/etc.? What were you doing
during those times? What were you saying to yourself during those times?]

FEEDBACK

I. COMPLIMENTS

I am impressed with _____________. (Highlight subject's insights, resources,
positive behaviors, etc.) Encourage the subject to continue doing what works.

II. FIRST SESSION TASK

Between now and the next time I see you (in two weeks), take notice of what is going
on that you would like to see continue.
APPENDIX M
MANIPULATION CHECK
MANIPULATION CHECK

Global Rating Sheet

SESSION # ___________  RATER _____________________  DATE _________

Please listen to 15 minutes of the counseling session and rate the content of the session as either solution-focused or problem-focused. If the focus of the session is unclear to you, check the category labeled "undetermined."

SOLUTION-FOCUSED ______

PROBLEM-FOCUSED ______

UNDETERMINED ______
Explanations for Global Ratings

**Solution-Focused Condition**

In the solution-focused condition, the counselor will ask questions, make statements, or use words that encourage her client to talk about times when problems are absent or seem manageable. These times can be in the past, present, or future. The counselor will help the client discuss behaviors, situations, self-talk, or interactions with other people that are perceived by the client as positive.

Should the client talk about problems or difficulties, the counselor will re-direct the conversation toward more positive aspects of the client's life. The counselor will also work to empower the client by asking questions or making statements that indicate that the client has done something to make positive things happen. The counselor may also give the client compliments about her resources, behaviors, or insights.

**Problem-Focused Condition**

In the problem-focused condition, the counselor will ask questions, make statements, or use words that encourage her client to talk about the difficulties in her life. The counselor will help the client become aware of the symptoms of depression she is experiencing such as sadness, lack of interest in formerly enjoyable activities (apathy), fatigue, hypersomnia, insomnia, overeating, undereating, lack of motivation, anxiety, excessive worrying, irritability, anger, resentment, difficulty concentrating or remembering, difficulty making decisions, social withdrawal, feelings of guilt and/or worthlessness, and thoughts of death and may label the client's experience as major depression.

The counselor will also help the client discuss the stressors in her life, i.e., what the client perceives as the causes of her depression. These can include situations,
relationships, difficult past experiences, client behaviors, negative feelings about self, etc. The counselor will reflect negative affect and encourage the expression of negative emotions. Also, the counselor will encourage the client to talk about coping techniques that have not worked.
Rating Sheet for Counselor Verbalizations

SESSION # ___________ RATER ________________________ DATE __________

Please listen to 15 minutes of the counseling session, and classify each counselor verbalization according to the following categories. Record using the tally method.

Symptoms  Problems  Coping  Future  Undetermined
Explanation of Categories for Ratings of Counselor Verbalizations

**SYMPTOMS**: Questions, statements, words by the counselor indicating that she is seeking information about symptoms of depression. This would include reflection of negative affect and labeling the client's condition as major depression.

NOTE: Symptoms of depression include sadness, lack of interest in activities previously considered enjoyable (apathy), fatigue, hypersomnia, insomnia, overeating, undereating, lack of motivation, anxiety, excessive worrying, irritability, anger, resentment, difficulty concentrating or remembering, difficulty making decisions, feelings of guilt and/or worthlessness, social withdrawal, and thoughts of death.

**PROBLEMS**: Questions, statements, words by the counselor that encourage the client to talk about her difficulties or complaints. These include complaints or concerns about situations, other people, or herself (stressors).

**COPING**: Questions, statements, words by the counselor that encourage the client to talk about past or present times when she feels better or copes better. This includes counselor statements that focus the client on exploring positive aspects of her life.

**FUTURE**: Questions, statements, words by the counselor that encourage the client to think about how things would be or will be when she feels good (the problem is gone, or she feels more in control). This includes activities, self-talk, and interactions with other people.

**UNDETERMINED**: Verbalizations by the counselor that do not fit one of the above categories.