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A COMPARATIVE STUDY OF SHORT-TERM TREATMENTS FOR DEPRESSION

By

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ABSTRACT

A COMPARATIVE STUDY OF SHORT-TERM TREATMENTS FOR DEPRESSION

By

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This study compared three approaches to the short-term group treatment of depression and examined the influence of a subject variable, cognitive complexity, on the effectiveness of these treatments.

Depression control workshops were conducted in each of three conditions: cognitive, behavioral and nondirective. Thirty-five moderately depressed community residents participated in the eight-session groups, led by graduate student group leaders. Subjects in all three conditions showed significantly decreased depressive symptomatology as measured by general, cognitive and self-report behavioral measures of depression. These decreases in depression were maintained at a six-week follow-up period. There were no significant differences among the treatment conditions on most of the dependent measures and no significant differences between subjects with high and low levels of cognitive complexity. The implications of the finding that three seemingly different interventions conducted by relatively inexperienced leaders could all lead to significant alleviation of depression were discussed.

To my parents, Bob and Iris Fleming,
for their love and faith in me

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STATEMENT OF THE PROBLEM

Little attention has been paid to specific client variables that might influence the effectiveness of cognitive therapy, although some of the initial research on cognitive therapy for depression has involved clinic populations as well as student populations. One client variable that could effect the ability to benefit from cognitive therapy would be the client's level of cognitive complexity. The concept of cognitive complexity has developed from Kelly's theory of personal constructs (1955) and Werner's developmental theory (1957). Cognitive complexity has been defined as "the relative differentiation of a person's system of dimensions for construing behavior" and as "the capacity to construe social behavior in a multidimensional way" (Bieri, Atkins, Briar, Leaman, Miller & Tripodi, 1975, p. 185). A cognitively complex person is seen as having a more differentiated system for perceiving other's behavior than does a less cognitively complex individual. Cognitive complexity has been described as part of a developmental process, where there is an increased differentiation of one's social environment and an increased variety of behavior as one's cognitive structures develop. Thus, while the child's early conceptions may be global, diffuse and somewhat

unrelated, with development these cognitions become more discrete. Also with development, these concepts are integrated into hierarchically organized systems, with complex patterns of relationship becoming established between concepts, and certain concepts becoming superordinate to others. This increase in development in differentiation and hierarchic integration is thought to be found not only in development from childhood to adulthood, but also in the gradual development of totally new knowledge in a mature individual.

A number of empirical studies (summarized in Bieri, 1975 and Crockett, 1965) have indicated that cognitive complexity may be related to information-processing in social and clinical judgement. The empirical evidence from several of these studies seems to suggest that individuals high in cognitive complexity are more likely than those low in cognitive complexity to use both favorable and unfavorable constructs in their descriptions of people and to entertain the possibility of unbalanced interpersonal relationships. There is also some evidence that cognitively complex people are better able to reconcile potentially conflicting themes in descriptions of other people than less cognitively complex people.

Cognitive therapy may, in fact, be most ideally suited for use with clients who have reached a high level of development of cognitive complexity, since so much of the emphasis in cognitive therapy is on learning to make fine discriminations between adaptive and maladaptive thought patterns and moving away from dichotomous thinking. On

the other hand, a person at a lower level of cognitive complexity might have more difficulty making the distinctions necessary in cognitive therapy and may more effectively be treated with behavior therapy. The purpose of this thesis, therefore, will be to test whether Beck's cognitive approach is equally effective with subjects at high and low levels of cognitive complexity, and to compare it with a self-control behavioral as well as a non-directive approach to the short-term treatment of depression.

RELATED LITERATURE

Cognitive Therapy in General

In every area of psychology, cognitive factors are suddenly gaining recognition. The current popularity of cognitive perspectives is so pervasive that it has been termed the "cognitive revolution" (Dember, 1974; Mahoney, 1977; Weimer & Palermo, 1973). This is especially true in the area of clinical psychology, where new cognitive theories and therapies are springing up at a rapid pace and seem to be flourishing. The list of recent books and articles on cognitive approaches to therapy is too long to enumerate here, and a new journal entitled Cognitive Therapy and Research started in January of 1977. Cognitive therapies have been used to treat every disorder from schizophrenia to stuttering, anxiety to anger, impulsivity to depression, and paranoia to unassertiveness. As Dember (1974) stated, "psychology has gone cognitive" (p. 161).

Interest in thoughts and cognitions is certainly nothing new. Cognitive theorists are especially fond of quoting the ancient philosophers on the subject of cognitions. For example, Buddha, before 480 A.D., said "All that we are is a result of our thoughts, it is founded on our thoughts; made up of our thoughts". In the first

century A.D., the stoic philosopher Epictetus said "Men are disturbed not by things, but by the views which they take of them" (both cited in Ullmann & Krasner, 1975, p. 238). The current upsurge of interest in cognitive variables, however, seems to be a reaction against the relative neglect of cognitive variables in early behaviorism. Psychology is said to have "lost its mind" with the advent of Watsonian behaviorism in the mid 1900's (Dember, 1974). Early behaviorists were eager to dissociate themselves from psychodynamic traditions and "insight" therapies with their highly speculative and untestable theories of internal dynamics. Behaviorists were also trying to develop an orientation which had what they considered to be a firm scientific basis. In pursuit of these goals, however, they tended to reject data and concepts derived from man's internal experience. Psychological constructs were reduced to behavioral observations, and man's private world was not considered to be a useful area of inquiry. Mahoney (1974) calls this era of almost religious avoidance of inferred variables "the Cognitive Inquisition" (p. 3). Most early behavior modifiers restricted their studies to discrete and clearly observable behavior. Skinner himself actually speculated at length about covert phenomena (1953), although his cautions about these phenomena seem to have been misinterpreted as a warning to avoid the study of covert responses entirely.

Since Homme's classic paper on "coverants, the operants of the mind" (1965) and Bandura's summary of the literature pointing toward cognitive-symbolic mediation (1969), the study of cognitive phenomena has gradually become accepted as a scientifically legitimate enterprise. Especially within the past few years, research in this area has mushroomed and many ambitious attempts are being made to identify and control significant mediating behaviors. Excellent reviews of the literature on cognitive mediation in general can be found elsewhere (Johnson & Elson, Note 1; Mahoney, 1974). This paper will focus more specifically on the research and practice of cognitive therapy.

Without necessarily denying the effectiveness of clinical procedures derived strictly from classical and instrumental conditioning, behavior therapists seem to be starting to recognize some of the inadequacies of such limited techniques in dealing with complex clinical cases (Goldfried & Goldfried, 1975; Lazarus, 1971). In fact, it seems rather doubtful that many behavior therapists behave exactly according to their specified techniques (Goldfried & Davison, 1976). For example, when Brown (1967) observed Wolpe treating patients with systematic desensitization, he found that this presumably strict S-R behavior therapist advised patients to "speak up for your rights" and told the patients what to say and how to say it. So it seems likely that cognitive variables have

played an important part in behavior therapy all along, but that now clinical researchers are more willing to acknowledge and study that dimension explicitly.

Cognitive therapy has been broadly defined as "any technique whose major mode of action is the modification of faulty patterns of thinking" and more narrowly defined as "a set of operations focused on a patient's cognitions (verbal or pictoral) and on the premises, assumptions, and attitudes underlying these cognitions" (Beck, 1970, p. 187). One of the problems involved in discussing the effectiveness of cognitive therapy has been pointed out by Meichenbaum (1977). Given the present state of cognitive therapies and the vague definitions used, it does not make sense to subsume them all under a single term or to impose the "uniformity myth" (Kieslar, 1966) by assuming that cognitive therapies are somehow all equivalent. Most of the investigations of "cognitive therapy" use different types of therapy techniques and some of the techniques used share little more than the fact that they have been referred to as "cognitive".

The distinction between cognitive and behavioral therapies has also not been clearly defined. Many cognitive therapy packages have included behavioral techniques, and vice versa. In cases where behavioral methods are used to modify cognitions, the decision seems rather arbitrary as to whether to call it a cognitive or behavioral technique. The trend in psychology seems to be moving towards a cognitive-behavioral integration

(Bergin, 1970; Mahoney, 1977; Taylor & Marshall, 1977) and several treatment packages are currently referred to as "cognitive-behavioral therapy". Bergin (1970) concludes that "there may be highly specific interventions which have a behavioral or cognitive focus, but these are always embedded in a multi-dimensional context or multiple consequences". While researchers in the field are still evaluating the relative effectiveness of the various components of these treatment packages, however, some general classification of "cognitive" and "behavioral" techniques would appear to be useful. At least for the purposes of this paper, the cognitive-behavioral dimension will be viewed as a continuum from a relative emphasis on modifying cognitions and the assumptions and attitudes underlying them to, at the other extreme, a relative emphasis on modifying overt physical behaviors. Thus, even if a therapy package includes both cognitive and behavioral components, it will be discussed in this paper according to what appears to be its emphasis in terms of both theory and techniques. Since often in the past, any therapy that dealt with cognitions at all was classified as a cognitive therapy, the classifications in this paper may differ from those in other studies.

In order to clarify the distinctions between cognitive therapies near the extreme cognitive end of the continuum, Meichenbaum (1977) has divided cognitive therapies into three categories: those that attempt to change irrational belief systems, those that work towards

developing problem-solving ability and coping skills, and those that try to alter faulty thinking styles. This distinction is also somewhat of an oversimplification, since in fact many therapies involve a combination of different categories of cognitive techniques as well as combinations of cognitive and behavioral techniques; however, this classification can be useful in clarifying the differences in relative emphasis of these cognitive approaches.

Changing Irrational Belief Systems

The cognitive therapy that has the longest history and has received the most popular attention in recent years is Albert Ellis' rational-emotive therapy (RET). RET is based on the premise that much, if not all, emotional suffering is due to the irrational ways people construe the world and to the assumptions they make. These assumptions can lead to self-defeating internal dialogues or self-statements that have a negative effect on emotions and behavior. According to Ellis (1958), "for all practical purposes, the sentences that human beings keep telling themselves are or become their thoughts and emotions" (p. 36). Since thoughts and emotions are seen as significantly overlapping in many respects, disordered emotions can be changed by changing one's thinking. Ellis holds that certain core irrational ideas, which have been clinically observed, are at the root of most emotional disturbance. These have been summarized as follows:

1. The idea that it is a dire necessity for an adult human being to be loved or approved by virtually every significant other person in his community.

2. The idea that one should be thoroughly competent, adequate, and achieving in all possible respects if one is to consider oneself worthwhile.

3. The idea that certain people are bad, wicked, or villainous and that they should be severely blamed and punished for their villainy.

4. The idea that it is awful and catastrophic when things are not the way one would very much like them to be.

5. The idea that human unhappiness is externally caused and that people have little or no ability to control their sorrows and disturbances.

6. That idea that if something is or may be dangerous or fearsome one should be terribly concerned about it and keep dwelling on the possibility of its occurring.

7. The idea that it is easier to avoid than to face certain life difficulties and self-responsibilities.

8. The idea that one should be dependent on others and needs someone stronger than oneself on whom to rely.

9. The idea that one's past history is an all-important determiner of one's present behavior and that because something once strongly affected one's life, it should indefinitely have a similar effect.

10. The idea that one should become quite upset over other people's problems and disturbances.

11. The idea that there is invariably a right, precise, and perfect solution to human problems and that it is catastrophic if this perfect solution is not found.

(Ellis, 1962, pp. 61-88)

Like the stoic school of philosophy from two thousand years ago, RET asserts that there are virtually no legitimate reasons for human beings to make themselves terribly upset, hysterical, or emotionally disturbed. Once clients can be taught to challenge the irrational ideas which lead to their emotional problems and to replace them with scientifically testable hypotheses about themselves and the world, they will be less likely to get into further emotional difficulties.

The task of the therapist in RET is to determine the precipitating external events that upset the client, to determine the specific thought patterns and underlying beliefs that give rise to the negative emotions, and then to assist the client in altering these beliefs and thought patterns (Meichenbaum, 1977). Ellis (1971) symbolizes his therapeutic process as an A-B-C-D-E sequence. A refers to an objective experiential event (also called an Activating event). B represents the Beliefs and self-statements that follow the event. C then symbolizes the negative emotional Consequences generated by these thoughts. Emotionally upsetting consequences do not follow directly from any actual activating event, but rather, follow from non-empirical, irrational beliefs about the event. In RET, the therapist teaches the clients how to challenge, question and Dispute (at point D) these irrational beliefs. If the clients persist at challenging these beliefs, they will achieve a new cognitive Effect (point E) that is more rational and less emotionally

disturbing. For example, if a man fails at a job (point A), he might tell himself (at point B) "How awful it is for me to fail! I must be a thoroughly worthless person for failing!". This would lead to the consequences (point C) of feeling depressed and worthless. However, if he disputes (point D) his irrational beliefs, he may get to the point (E) where he can say to himself "It was inconvenient that I failed, and I would rather succeed, but that doesn't make me a worthless person. I'm merely a person who has failed at this one particular job". Feelings and emotions will certainly still exist, and the client may feel sad, disappointed or annoyed that he failed; but hopefully the self-defeating and inappropriate emotions (such as guilt, depression, anxiety, worthlessness or rage) that lead to emotional disturbance can be avoided.

Ellis' own therapy style, and the one that he recommends, is quite forcefully didactic. Ellis explains this as follows:

> More often than not, his (the client's) illogical thinking will be so ingrained from constant self-repetitions, and will be so inculcated in motor pathways (or habit patterns) by the time he comes for therapy, that simply showing him, even by direct interpretation, that he is illogical will not greatly help. . . The therapist, therefore, must keep pounding away, time and time again, at the illogical ideas which underlie the client's fears. . . The rational therapist, then is a frank propagandist who believes wholeheartedly in a most rigorous application of the rules of logic, of straight thinking and of scientific method to everyday life, and who ruthlessly uncovers every vestige of irrational thinking in the

> client's experience and energetically urges him into more rational channels.
>
> (Ellis, 1958, p. 45)

Ellis also advocates the use of various supplementary, behavioral techniques to also help change the client's ideas. Mahoney (1974) sees RET as involving at least the following active components:

> 1. didactic persuasion toward a belief system that emphasizes the role of irrational thoughts in subjective distress and deficient performance; a value system is also communicated--its main premise being that of non-contingent self-acceptance irrespective of performance competencies.
>
> 2. training in the discrimination and systematic observation of self-statements.
>
> 3. training in the logical and empirical evaluation of self-statements.
>
> 4. graduated performance assignments.
>
> 5. immediate and often candid social feedback on a) actual performance progress, b) standard setting, and c) the logical and adaptive nature of private monologues (logical inferences, self-evaluations, etc.).
>
> 6. explicit instructions and selective reinforcement for the therapeutic alteration of self-statements.
>
> 7. extensive therapist modeling of prescribed mediation styles (via self-disclosure, role-playing, etc.).
>
> (pp. 182-183)

Some therapists who agree with the basic premises of RET therapy argue that the forcefulness and bluntness of Ellis' approach may be overpowering and intimidating (Rimm & Masters, 1974) or may backfire if the client feels he's being coerced into changing his beliefs or behavior

(Goldfried, Decenteco & Weinberg, 1974). The procedure called "systematic rational restructuring" is based on premises similar to RET, but differs in its methods of teaching clients to label situations more rationally (Goldfried & Davison, 1976; Goldfried et al., 1974; Goldfried & Goldfried, 1975). Rather than verbally attacking client's irrational beliefs and cajoling them into thinking more logically, in systematic rational restructuring the therapist attempts to get clients to gradually agree to the underlying rationale by having them offer their own arguments against their irrational assumptions. Then clients participate in a series of practice sessions aimed at systematically modifying their internal sentences. Systematic rational restructuring is placed into a learning framework as a self-control technique, where the ultimate objective is to provide individuals with the skills necessary for them to regulate their own behavior. The goal is for emotional upset to eventually provide the signal for the individual to rationally re-evaluate the reason for that upset. RET and systematic rational restructuring share the same theoretical basis, and have been grouped together under the more general term "cognitive restructuring", but they are examples of different procedural means toward effecting the modification of maladaptive cognitive behaviors.

Ellis has been practicing and writing about RET for at least 20 years, but only recently has his work been considered a legitimate subject for scientific

investigation. His work had previously been classified along with several popularized strategies for personal self-improvement which appealed to the general public, but were forbidden territory to "respectable" scientists. For example, Bain (1928) and Dale Carnegie (1948) suggested strategies of thought control to improve personal adjustment, and Norman Vincent Peale (1960) described the "power of positive thinking". There are, however, numerous contrasts between the global and often unrealistic suggestions popularized in these and other best-sellers, and the individualized and specific techniques of RET. Such "miracle cures" are likely to be insensitive to situational conditions and to ignore the importance of working through graduated performance tasks. Most importantly, the proponents of RET are moving towards empirical verification and improvement of their techniques, rather than using unsubstantiated and unbridled claims in order to sell more books.

The substantial body of evidence that symbolic events play a significant role in behavioral disorders (as reviewed in Mahoney, 1974) provides indirect support for the theory behind RET. Velten (1968) was one of the first researchers to test the hypothesis that the interpretations people place on events determine their affective responses to the events. He had students read either Elation, Depression or Neutral self-statements both silently and aloud. After reading these statements, the subjects showed significant differences on four behavioral

measures and a mood checklist. Velten concludes that his results support the claims of Ellis, and he even suggests the use of statement-reading as a type of therapy.

More recent studies have extended Velten's work to consider the influence of cognitive mediation on behaviors that are thought to specifically reflect the state of depression (Hale & Strickland, 1976; Strickland, Hale & Anderson, 1975). They found that subjects who read Depression self-statements reported significantly more depression, anxiety and hostility than subjects who read Elation self-statements. Also, subjects who read Depression statements were less expansive on a graphic constriction-expansion measure, preferred less social and active activities, wrote more slowly and did worse on a digit symbol task than those who read Elation statements. These results seem to provide some implicit support for a cognitive mediation theory of depression, since the response of the subjects in the Depression condition is somewhat similar to the withdrawal and psychomotor retardation reported by clinically depressed people.

A study by May and Johnson (1973) tested the hypothesis that the amount of autonomic activity would be greatest to stressful thoughts, less to neutral thoughts and the least to relaxing thoughts. The results in this study, as in many physiological studies, were not consistent over all the measures of autonomic activity used. Although the results for measures of skin conductance and GSR were not clear, there were significant results in

the predicted direction for measures of heart rate, respiration rate and respiration amplitude. Thus, at least according to these three measures, internally elicited stimuli did seem to provoke physiological stress.

Other researchers have more directly tested hypotheses about RET. Rimm and Litvak (1969) presented subjects with sentence triads that fit into Ellis' model of emotional self-arousal. For example:

A)	Observed event	People don't notice me emough.
B)	Inference	Maybe there is something unattractive about me.
C)	Self-evaluative conclusion	How terrible!

The results showed that this type of negative sentence triad induced substantial physiological arousal as measured by respiration rate and depth. There were, however, no differences in emotional responsiveness to each of the three sentences, as would be predicted by RET theory. A replication of this study done by Russell and Brandsma (1974) further complicates the matter. They found that GSR measures significantly differentiated groups reading negative sentence dyads from groups reading neutral dyads, but respiration rate and depth measures did not. Also, differences in response to sentence A and sentence B occurred only when the sentence dyads were of low personal relevance to the subject, but not when the sentences seemed to be highly relevant to their concerns. As they stand, these two studies support

the basic concept of symbolic self-arousal, but do not directly support Ellis' A-B-C theory of self-arousal per se.

A study by Goldfried and Sobocinski (1975) supported Ellis' assumption that people who maintain certain irrational beliefs tend to become more easily upset than people who do not hold as many irrational beliefs. The authors found that scores on paper-and-pencil measures of social anxiety, test anxiety and speech anxiety all correlated positively with a measure of the tendency to think irrationally. When exposed to tape recorded scenes of ambiguous interpersonal events, subjects who strongly believed that they should expect approval and love from everyone displayed significantly more anxiety and hostility than people who were rated lowest in that belief.

The primary focus of research in this area has been on documenting the effectiveness of RET and other, similar cognitive restructuring approaches in the treatment of various behavioral disorders. A number of successful case studies have been reported by Ellis (1962, 1971) and throughout the journal entitled Rational Living. Other researchers have also reported on their successful use of cognitive restructuring techniques. For example, reports have been made on the use of these techniques with cases of paranoid schizophrenia (Shapiro & Ravenette, 1959; Watts, Powell & Austin, 1973); anxiety proneness (Beck, 1970; Goldfried et al., 1974; Weissberg, 1975), marital problems (McClellan & Stieper, 1973), and

depression (Shapiro, Neufield & Post, 1962). Ellis (1957) used his own case records over a period of several years to compare psychoanalysis with RET. Ellis treated his clients with psychoanalysis for many years before this theoretical model developed and he began to use RET. He reports a much higher success rate with RET, but the possible bias from temporal and sampling errors as well as his own knowledge of the "experimental conditions" makes these results difficult to interpret.

Some controlled studies have also tested the effectiveness of cognitive restructuring. Analogue studies have shown these techniques to be effective in reducing anxiety from the threat of shock (Burkhead, 1970) and in increasing the number of positive self-references used in an initial interview (Baker, 1966). The analogue nature of these studies does, however, place some limits on the generalizability of these findings to clinical situations.

Controlled studies have been conducted to investigate the effects of cognitive restructuring on several types of anxiety: interpersonal anxiety (DiLoreto, 1971; Kanter, 1975), test anxiety (Holroyd, 1975; Maes & Heimann, Note 2; Montgomery, 1971), speech anxiety (Jarmon, 1972; Karst & Trexler, 1970; Trexler & Karst, 1972), and specific phobias (Dolgan, 1968; D'Zurilla, Wilson & Nelson, 1973). Similar studies have also been done on treatments of unassertive clients (Wolfe, 1975) and clients who stutter (Moleski & Tosi, 1976).

Although the evidence from the case studies as well as these controlled studies of cognitive restructuring suggests a certain optimism about the future potential of these clinical techniques, their methodological limitations need to also be considered. The results of one of these studies (Montgomery, 1971) were only weakly positive and not at all consistent across measures, while Jarmon (1972) found that only the RET bibliotherapy (and not the live, group RET) was effective in reducing speech anxiety. Some studies used only self-report outcome measures (DiLoreto, 1971; Montgomery, 1971) while other studies included behavioral measures but only obtained significant results on the subjective measures (D'Zurilla et al., 1973; Karst & Trexler, 1970; Trexler & Karst, 1972). Conversely, Maes and Heimann (Note 2) showed a significant reduction in physiological arousal with the use of RET, but not a significant reduction in subjective distress. Several studies used the principal investigator as a therapist for all the conditions creating the potential problem of experimenter bias (D'Zurilla et al., 1973; Karst & Trexler, 1970; Montgomery, 1971; Trexler & Karst, 1972). Most of the studies did not do any follow-up, and one of the studies that did have a follow-up period (Jarmon, 1972) found that the positive results were not maintained. Also, over half of the studies discussed here used only college student populations who had mild levels of disorder, so that the effectiveness of cognitive restructuring has been most

strongly demonstrated on "YAVIS" clients: young, attractive, verbal, intelligent and successful (Schofield, 1964). The methodological limitations and the inconsistent findings of some of these studies suggest that much further research will be necessary to firmly establish the clinical efficacy of cognitive restructuring approaches to therapy. The evidence that has been collected thus far, and the wide range of problems to which they have been applied, do however seem to augur a promising future for cognitive restructuring therapies.

Improving Problem-Solving Ability and Coping Skills

Unlike Ellis' approach which focuses on the presence of maladaptive and irrational beliefs, advocates of the problem-solving approach focus on the absence of adaptive cognitive problem-solving skills in clinical populations (Meichenbaum, 1977). D'Zurilla and Goldfried (1971) define problem-solving as "a behavioral process, whether overt or cognitive in nature, which a) makes available a variety of potentially effective response alternatives for dealing with the problematic situation and b) increases the probability of selecting the most effective response from among these various alternatives" (p. 108). Adolescent and adult psychiatric patients have been demonstrated to have obvious problem-solving deficits, especially a lack of means-ends thinking (Platt & Spivack, 1972a, 1972b; Shure & Spivack, 1972; Shure, Spivack & Jaeger, 1971). Therefore, it has been hypothesized that teaching

clients more effective cognitive problem-solving skills will have therapeutic value (D'Zurilla & Goldfried, 1971; Goldfried & Goldfried, 1975; Spivack, Platt & Shure, 1976). A number of recent studies have illustrated the use of problem-solving training approaches with various clinical populations. For example, this approach has been used in short-term outpatient therapy (McGuire & Sifneos, 1970), with hospitalized psychiatric patients (Coche & Flick, 1975), ex-drug addicts (Copeman, 1973), high school students with interpersonal anxiety (Christensen, 1974), female alcoholics (Spivack et al., 1976), and with disruptive children (Spivack & Shure, 1974).

D'Zurilla and Goldfried (1971) outline a typical training program in problem-solving where the goals are reached in progressive steps. At the beginning of the program, the therapist demonstrates the 5 main stages of problem-solving: 1) general orientation or "set" to recognize when a problem exists 2) detailed problem definition and formulation 3) generation of many alternatives 4) decision-making and 5) verification and evaluation in terms of the personal, social, short and long-term consequences of the alternatives. First the therapist models these stages by verbalizing the appropriate thought sequences, and then the client gradually takes on a more active role. Eventually, the therapist serves only to guide and encourage the client, to evaluate in vivo application, and to reinforce successive approximations.

The problem-solving approach can be seen as a broad social competence training model, or a form of self-control training, which can be applied in different ways to various populations (Meichenbaum, 1977). In contrast to the problem-solving approach which teaches the client to stand back and systematically analyze problem situations, the coping skills approach focuses on teaching clients what to actively do when confronted by acute stressful situations. This model views the client's cognitions as cognitive skills that can be used in confronting stressful situations.

One example of a coping-skills training package is Meichenbaum's self-instructional training. Meichenbaum emphasizes the importance of private, covert self-statements in problem-solving as well as neurosis. According to Meichenbaum and Cameron (1974), "a large population of clients, who generally fall under the rubric of 'neurotic' seem to emit a variety of maladaptive, anxiety-engendering self-statements. The goal of intervention. . .is to make the neurotic patients aware of the self-statements that mediate maladaptive behaviors and to train them to produce incompatible self-statements and behaviors" (p. 271). The following components of Meichenbaum's self-instructional training have been outlined by Mahoney (1974):

1. didactic presentation and guided self-discovery of the role of self-statements in subjective distress and performance inadequacies.

2. training in the fundamentals of problem solving (e.g., problem definition, anticipation of consequences).

3. training in the discrimination and systematic observation of self-statements.

4. graduated performance assignments.

5. explicit suggestions and self-reinforcement for the modification of self-statements along the lines of "coping" adaptation and performance-relevant attentional focusing.

6. structured modeling of both overt and cognitive skills.

7. modeling and encouragement of positive self-evaluation (self-reinforcement).

8. depending on the treatment package employed, relaxation training combined with the use of coping imagery in a modified desensitization procedure.

(pp. 190-191)

There are many striking similarities between this coping-skills treatment and Ellis' rational-emotive therapy. The main distinction between them seems to center around the relative emphasis on formal logical analysis. Whereas Ellis predominantly uses Socratic dialogue and logical self-examination to change irrational belief systems, Meichenbaum emphasizes the use of graduated tasks, cognitive modeling, directed mediational training and self-reinforcement to change the dysfunctional self-statements.

The empirical evidence for the effectiveness of self-instructional training seems promising. Controlled studies of this treatment package have been done on several different populations: schizophrenics (Meichenbaum

& Cameron, 1973), impulsive children (Meichenbaum & Goodman, 1971), depressed clients (Gioe, 1975; Morris, Note 3), test-anxious students (Meichenbaum, 1972; Sarason, 1973; Wine, 1970), speech-anxious students (Meichenbaum, Gilmore & Fedoravicus, 1971; Norman, 1975), students with fear of snakes (Meichenbaum, 1971), students with dating problems (Glass, Gottman & Shmurak, 1976), smokers (Steffy, Meichenbaum & Best, 1970), clients with anger control problems (Novaco, 1975), the elderly (Labouvie-Vief & Gonda, 1976), and children who are afraid of the dark (Kanfer, Karoly & Newman, 1975). These studies are subject to many of the same limitations as the cognitive restructuring studies discussed earlier. Labouvie-Vief and Gonda (1976) found very weak and inconsistent results, while Norman (1975) got significant results on only the self-report, but not the behavioral, measures. Several studies had possible bias from the principal investigator leading all the treatment conditions, few studies had a follow-up period, and the majority of the studies used only students with mild behavioral problems as subjects. Self-instructional training, along with RET, still needs a great deal more research to establish its clinical efficacy.

Another coping skills training package, which draws heavily from Meichenbaum's self-instructional training, is called stress-inoculation training (described in Meichenbaum, 1977). This package includes 1) a discussion of stress reactions (with emphasis on labeling, attribution,

and arousal-inducing self-statements) 2) relaxation training (presented as an active, coping skill) 3) instructed practice in the emission of coping self-statements (cognitive self-monitoring, preparation for stress, self-reinforcement) and 4) supervised practice in utilizing the coping skills in an actual, stressful situation. The major difference between stress inoculation training and self-instructional training is the presence of supervised practice in an actual stress situation. A study by Meichenbaum and Cameron (cited in Mahoney, 1974) found stress inoculation training to be dramatically more effective than self-instructional training in the treatment of phobias. The authors conclude the self-instructional training alone may effect only mild and temporary benefits which quickly dissipate in the presence of actual stress, and that relevant performance opportunities may be necessary to effect permanent therapeutic results.

Other types of coping skills training have emphasized the act of maintaining an anxiety-arousing image and learning to actively "relax it away" (Goldfried, 1973; Richardson & Suinn, 1973; Suinn & Richardson, 1971). The current data on these approaches is still so meager that no conclusions can yet be drawn about their effectiveness.

Changing Faulty Thinking Styles

Beck (1976) posits that the common psychological disorders center around certain aberrations in thinking.

According to his theory, patients show faulty or disordered thinking in circumscribed areas of experience and this disordered thinking is the primary cause of mental disorders. In these specific areas, patients have a reduced ability to make fine discriminations, so they tend to make global, undifferentiated judgements and distortions (Beck, 1970). Part of the task of cognitive therapy lies in helping patients to recognize the distortions in their thought patterns and to make the appropriate corrections.

Beck's cognitive model of psychopathology (Beck, 1970) divides the total cognitive organization into two parts: primitive systems of relatively crude cognitive structures (corresponding to Freud's notions of primary process) and more mature systems of refined and elastic structures (corresponding to Freud's secondary process). The primitive schemas are absolute rather than relative, dichotomous rather than graduated, global rather than discriminative. Many of the primitive concepts may be idiosyncratic and unrealistic, but under normal conditions they are tested, authenticated and rejected by higher centers. When the cognitive organization is dislocated in neurotic states, however, these idiosyncratic ideas become hyperactive and tend to supercede the more realistic conceptualizations. The particular form of the psychological disorder is related to the content of the predominant, perseverating verbal cognitions or fantasies.

Beck has distinguished among the common neurotic disorders on the basis of the differences in the content of ideation:

Disorder	Idiosyncratic Ideational Content
Depression	Devaluation of domain
Hypomania	Inflated evaluation of domain
Anxiety Neurosis	Danger to domain
Phobia	Danger connected with specific, avoidable situations
Paranoid State	Unjustified intrusion on domain
Hysteria	Concept of motor or sensory abnormality
Obsession	Warning or doubting
Compulsion	Self-command to perform specific act to ward off danger

(Beck, 1976, p. 84)

One of the main cognitive techniques consists of training the client to recognize his own "automatic thoughts". These are defined as idiosyncratic thoughts that seem to emerge automatically and extremely rapidly prior to the experience of emotion. These cognitions are also described by Ellis as "things that you tell yourself" (1962). In Beck's model, "automatic thoughts" intervene between events and one's emotional reaction to them. When these thoughts are a distorted appraisal of the event, the affect will tend to be inappropriate or extreme. These "automatic thoughts" seem to be relatively autonomous and involuntary in that clients make no effort to initiate them and they can be difficult to "turn off". In addition,

clients seem to accept these thoughts as plausible or reasonable even if they would sound far-fetched to other people or to the clients themselves on another occasion.

Once clients learn to identify their automatic thoughts, they may still have problems examining these ideas objectively since these thoughts can be extremely salient. "Distancing" is Beck's term for the process of gaining objectivity towards these cognitions. Since neurotic individuals tend to accept the validity of these thoughts automatically, it is necessary to train them to distinguish between their thoughts and external reality. Only once clients can distance themselves from their thoughts can they apply the rules of logic and empirical evidence to correcting their cognitive distortions.

Since the client's distorted thought processes may be deeply ingrained, the client may need to go through several steps in order to correct them: 1) becoming aware of the thoughts 2) recognizing what thoughts are awry 3) substituting accurate for inaccurate judgements and 4) receiving feedback as to the usefulness of these changes (Beck, 1976). It often can be helpful for the client to learn to specify the type of cognitive distortions involved in the maladaptive cognitions in order to better understand how affective experiences and maladaptive behaviors are a result of thinking processes which can be changed and controlled. Some of the most common distortions are listed by Beck (1967) as arbitrary

inference, overgeneralization, magnification and minimization, cognitive deficiency and dichotomous reasoning.

Arbitrary inference is the process of drawing a conclusion when the factual evidence is lacking or contrary to the conclusion. Such misconceptions are especially likely to occur when the cues are ambiguous, as is often the case in interpersonal relationships. Intrinsic to this type of thinking is the failure to consider more plausible and probable alternative explanations. This type of distortion often takes the form of personalization (or self-reference), the tendency to make egocentric interpretations of events. For example, neurotic clients may overestimate the degree to which events are related to them and become overly absorbed in the personal meanings of events. Another type of personalization occurs when clients have a tendency to compare themselves with other people.

Overgeneralization is the process of making an unjustified general conclusion on the basis of a single incident. Thus, one incidence of failure can be taken as a sign of total incompetence and worthlessness.

Magnification (termed "catastrophizing" by Ellis, 1962) is the process of exaggerating the meaning or significance of an event. This type of error in evaluation is demonstrated by the tendency to make extreme judgements or to anticipate intensely negative outcomes to everything. The parallel process of minimization

occurs when an individual grossly underestimates his own performance, achievement or ability.

Cognitive deficiency is the process of disregarding an important aspect of a life situation. Clients who use this distortion tend to ignore, or simply not to utilize, information which derives from their own experience. These clients act as though they have a defect in their systems of expectations, and constantly engage in behavior which they later realize is self-defeating.

Dichotomous reasoning (also called "bipolar thinking") is the tendency to make overly simplified and rigid judgements of events as either good or bad, right or wrong, black or white. This thinking in extremes may be confined only to situations which involve particularly sensitive areas. The basic premises underlying this type of thinking are generally couched in absolute terms such as "always" or "never".

Beck's cognitive therapy involves helping clients to evaluate their attributions and performances more realistically. Graded tasks, homework assignments and activity lists provide the behavioral data around which to examine the client's thinking style. Although treatment is generally tailored to fit each individual, Beck's therapy follows a basic pattern. The clients learn to recognize and monitor their cognitions as well as to test and validate the relationships between cognition

and affect. Both semantic and behavioral techniques are used to challenge the validity of negative cognitions and misconceptions. Once the clients recognize their cognitive distortions, the belief systems behind their distortions are then challenged. The clients do their own data collection so that they can review their behavior within the context of their daily lives and their distortions, as well as alternative interpretations, become more apparent.

The effectiveness of Beck's cognitive therapy has so far been systematically studied only in the treatment of depression. The initial results are encouraging but not yet definitive, and the specific techniques have not yet been expanded into the treatment of other types of disorders. Controlled studies which have specifically used Beck's cognitive treatment of depression have been conducted by Shaw (1977), Taylor and Marshall (1977), Schmickley (1976) and Rush, Beck, Kovacs and Hollon (1977). Other researchers have isolated specific aspects of Beck's treatment package for study, such as training in the positive anticipation of future activities (Anton, 1974; Anton, Dunbar & Friedman, 1976). These studies will be presented in more detail after a brief introduction to the cognitive theory of depression.

Cognitive Approach to Depression

The clinical phenomena known today as depression has been recognized for at least 3,000 years. The depressions

of Job and Saul are detailed in the Old Testament, and Hippocrates made the first clinical description of "melancholia" (Friedman and Katz, 1974). Depression's long history has led Beck to conclude that "there are few psychiatric syndromes whose clinical descriptions are so constant through successive eras of history" (1967, p. 5).

The National Institute of Mental Health recently found that the clinical condition of depression is on the increase and is beginning to rival schizophrenia as the nation's number one mental health problem (1973). They estimate that 10% of the general population will have a significant depressive episode at some time in their lives, and that more than 80% of reported suicides can be traced to a precipitating depressive episode. Clearly a public health problem of this magnitude merits much attention from clinical scientists today.

In spite of its long history, most of the important issues concerning the definition, etiology and treatment of depression remain unresolved. The term "depression" is often poorly defined, being used variously to describe normal reactions to life events, abnormal mood states, symptoms, symptom syndromes, disease processes, and even a series of disease processes (Lewinsohn, 1974). There is still much heated debate over the distinctions between neurotic and psychotic depression, endogenous and reactive depression, retarded and agitated depression, unipolar

and bipolar depression, and so on. Although hundreds of investigations have been conducted, the conflicting evidence has thus far done little to clarify these distinctions. An extensive review of the literature related to these controversies is not within the scope of this paper, but may be found in volumes by Beck (1967) and Becker (1974).

The most commonly used classification of depressed individuals has been the distinction between psychotic and neurotic depression. The concept of depression as utilized in this paper most closely corresponds to the descriptions of neurotic depression. In the second edition of the American Psychiatric Association's diagnostic manual (1968), depressive neurosis is described as follows:

> This disorder is manifested by an excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished possession. It is to be distinguished from involutional melancholia and manic-depressive illness. Reactive depressions or depressive reactions are to be classified here.
>
> (p. 40)

Neurotic depressives seem to comprise a somewhat heterogeneous group, defined more in terms of the absence of psychotic features than on the presence of specific neurotic features. Beck (1967) recommends that in distinguishing between neurotic and psychotic depression, "the best guide is to designate as psychotic depressive all cases that show definite signs of psychosis, such as loss of reality, delusions and hallucinations" (p. 84).

Recent studies have in fact shown neurotic depression to be weak as a diagnostic entity, and two recent investigations using cluster analysis have failed to obtain a neurotic cluster of patients (Everitt, Gourlay & Kendell, 1971; Pilowsky, Levine & Boulton, 1969). The neurotic-psychotic distinction does, however, seem to be useful in predicting treatment response. Paykel (1972) found that neurotic depressives were more likely to show a poor response to tricyclic antidepressants than were psychotic depressives. Also, a negative relationship has been reported between neurotic depressive features and response to electroconvulsive therapy (Kiloh & Garside, 1963; Mendels, 1965a, 1965b, 1965c, 1967).

The search for the causes of depression has also not yet been conclusive. According to Beck (1974b), "At one time, this strange affliction was ascribed to demons that allegedly took possession of the victim. Theories advanced since then have not yet provided a more durable solution to the problem of depression" (p. 4). Theories of a physiological cause of depression date back to the belief of ancient Greeks that depression was a result of excessive black bile in the body fluids (Lewinsohn, 1974) and can be found in present times in advanced biochemical and physiological research. Pharmacological treatments of depression have had a parallel development from the ancient story of Penelope taking a drug to dull her grief in Homer's Odyssey to the modern use of such antidepressant drugs as tricyclics and monoamine oxidase inhibitors

(Beck, 1967). Electroconvulsive therapy is also used by some proponents of the theory that depression has a physiological etiology.

Other theorists propose that internal psychological mechanisms are responsible for depression. Psychoanalytic theorists suggest that depression follows the loss of a real or fantasized love object with whom the person had identified so narcissistically that they could not differentiate the external loss from a loss within their own ego. This is experienced as a loss of self-esteem which, along with internalized hostility, results in depression (Freud, 1917). The corresponding treatment would be psychoanalysis, to help the person work through these unconscious dynamics. There have been many other psychological theories with many corresponding therapeutic interventions too numerous to discuss here; extensive reviews of these approaches appear in volumes by Beck (1967), Becker (1974), and Friedman and Katz (1974).

The lack of consensus among researchers about the definition and etiology of depression has led to a corresponding lack of agreement about appropriate methods for assessing depression. Self-report depression scales are the assessment methods which have thus far received the most empirical support. Many self-administered depression scales have been described in the literature, but few of these scales assess similar symptoms of depression, and most of these measures have had limited use and are

supported by relatively little psychometric data (Rehm, 1976). Some interviewer rating scales have also been developed; but they rely on self-report almost as much as the self-administered depression scales do, except that with these measures an interviewer is used to make the final rating. The direct assessment of overt depressive behavior, both verbal and motor, has only recently been attempted and much more research will be needed before the reliability and validity of such measures will be fully established. At present, however, there is no generally accepted or well standardized means for assessing depression.

In his classic work on depression, Beck (1967) maintains that the only thing investigators of depression have consistently agreed upon is its symptomatology. As long as so many key issues remain unresolved, therefore, the most useful definitions of depression seem to involve descriptions in terms of its clinical manifestations. For example, Beck (1974a) divided the signs and symptoms characterizing depressed individuals into four separate categories:

> Emotional: Sadness or apathy; crying spells, dislike; loss of gratification; loss of feelings of affection; loss of sense of humor.
>
> Cognitive: Negative self-concept; negative expectations; exaggerated view of problems; attribution of blame to self.
>
> Motivational: Increased dependency; loss of motivation; avoidance, indecisiveness; suicidal wishes.

> Physical and Vegetative: Loss of appetite; sleep disturbance; fatigability; loss of sexual interest.
>
> (p. 62)

Another method of describing the manifestations of depression has been through factor analysis. For example, Grinker, Miller, Sabshin, Nunn and Nunnally (1961) used factor analysis to combine factors involving descriptions of the feelings and concerns of 96 depressed patients with factors derived from behavioral observations of these same patients. This resulted in four factor patterns describing depression as follows:

a. Feelings: dismal, hopeless, loss of self-esteem, slight guilt feelings.
   Behavior: isolated, withdrawn, apathetic, speech and thinking slowed, with some cognitive disturbances.

b. Feelings: hopeless with low self-esteem, considerable guilt feelings, high anxiety.
   Behavior: agitation and clinging demands for attention.

c. Feelings: abandonment and loss of love.
   Behavior: agitated, demanding, hypochondriacal.

d. Feelings: gloom, hopelessness, anxiety.
   Behavior: demanding, angry, provocative.

One of the most recent and complete descriptions of depression appears in the latest revision of the Diagnostic and Statistical Manual, Third Edition (A.P.A., 1979). The diagnostic criteria for Depressive Episode are listed there as follows:

A. Dysphoric mood or loss of interest or pleasure in all or almost all usual activities and pastimes. The dysphoric mood is characterized by symptoms such as the following: depressed, sad, blue, hopeless, low, down in the dumps, irritable, worried. The disturbance must be prominent and relatively persistent but not necessarily the most dominant symptom. It does not include momentary shifts from one dysphoric mood to another dysphoric mood, e.g., anxiety to depression to anger, such as are seen in states of acute psychotic turmoil.

B. The illness has had a duration of at least two weeks during which, for most of the time, at least four of the following symptoms have persisted and have been present to a significant degree:

(1) Poor appetite or significant weight loss (when not dieting) or increased appetite or significant weight gain.

(2) Insomnia or hypersomnia.

(3) Loss of energy, fatigability, or tiredness.

(4) Psychomotor agitation or retardation (but not mere subjective feelings of restlessness or being slowed down).

(5) Loss of interest or pleasure in usual activities, or decrease in sexual drive (do not include if limited to a period when delusional or hallucinating).

(6) Feelings of self-reproach or excessive or inappropriate guilt (either may be delusional).

(7) Complaints or evidence of diminished ability to think or concentrate such as slowed thinking, or indecisiveness (do not include if associated with obvious formal thought disorder).

(8) Suicidal ideation or wishes to be dead, or any suicide attempt.

C. Not superimposed on either Schizophrenia, Schizophreniform Disorder, or a Paranoid Disorder.

D. None of the following predominate the clinical picture for more than three months after the onset of the Depressive Episode:

(1) Preoccupation with a mood-incongruent delusion or hallucination.

(2) Marked formal thought disorder.

(3) Bizarre or grossly disorganized behavior.

(American Psychiatric Association, 1979, pp. 35-36)

The common cognitive manifestations of depression include such phenomena as low self-esteem, pessimism, guilt and helplessness. Although depression has most traditionally been considered an affective disorder which happens to have cognitive consequences, Beck views these cognitions as the cause of depression and classified depression as primarily a thought disorder (1976). The depressed person shows specific cognitive distortions which Beck terms "the cognitive triad". This triad includes a negative view of the self, of the outside world, and of the future. Depressed people view themselves as "losers" who are inadequate, undesirable and worthless. They see their interactions with their environment as depriving, defeating, and overdemanding, and they fully expect their failures and rejections to continue on far into the future. As a result of these negative beliefs, these people feel depressed and withdraw, becoming passive, self-critical and guilty.

Beck describes the development of depression as a chain reaction that begins with an experience connoting loss to individuals (1976). This loss could be a single, obvious event or a long series of subtle deprivations; but in either case, the individuals feel they have lost

something that is essential for their happiness. If they then interpret everything in terms of a negative "cognitive triad", these negative evaluations may lead to the many emotional, motivational, behavioral and vegetative phenomena of depression (Beck, 1967). Such "secondary" symptoms of depression serve to reinforce their initial beliefs and activate a downward spiral such that the depression becomes progressively worse.

Beck states that

> I have followed a number of people subject to recurrent depressions over long periods of time and have noticed that before the onset of a new depressive episode they begin to show distortions in the way they interpret matters . . .In a number of cases I have been able to arrest the onset of depression by pointing out to the person how he is beginning to misinterpret reality.
>
> (1974b, p. 26)

Although Beck's cognitive theory of depression is largely derived from clinical data, many elements have also been substantiated by correlational and experimental studies. In two studies of the manifest content of patient's dreams, the dreams of depressed psychiatric patients showed a higher proportion of dreams with negative outcomes (termed "masochism") than the dreams of a matched group of nondepressed psychiatric patients (Beck & Hurvich, 1959; Beck & Ward, 1961). The typical dreams of depressed patients portrayed the dreamer as a "loser", suffering some type of deprivation. In an analysis of the verbatim reports of 81 depressed and nondepressed patients in psychotherapy, a preponderence

of the following verbal themes distinguished the depressed from nondepressed patients: low self-regard, ideas of deprivation, self-criticism and self-blame, overwhelming problems and duties, self-commands and injunctions, and escapist and suicidal wishes (Beck, 1963). These depressive cognitions also seemed to be automatic, involuntary, plausible and persevering to the patients.

A series of correlational studies found significant relationships between the depth of depression and the degree of pessimism and negative self-evaluation (Beck, 1972). After recovery from depression, there was a remarkable improvement in the outlook and self-appraisals of the patients. Also, the high correlations between measures of the negative view of the future and the negative view of the self support the concept of the "cognitive triad". When depressed patients' low concepts of their capabilities were modified by allowing them to succeed on a card-sorting task, they did indeed increase their optimism and improved their performance on a second task (Loeb, Beck & Diggory, 1971). Objectively, the depressed patients did perform at least as well as non-depressed patients on both these tasks.

That severely depressed people have a distorted negative self-image has also been demonstrated by Friedman (1964). Well matched depressed and normal subjects were tested on 33 cognitive, perceptual and psychomotor tests. The depressed subjects performed more poorly than the normals on only 4% of the test scores, while they rated

themselves more negatively on 82% of the Clyde Mood Scale items. Friedman concludes that "the actual ability and performance during severe depression is not consistent with the patient's unrealistically low image of himself" (p. 237).

A more recent study by Weintraub, Segal and Beck (1974) substantiates the relationship between depressed mood and negative cognitive content in normal males. A group of 30 student volunteers completed the Depression Adjective Checklist (Lubin, 1965) and a story completion task at two-week intervals over a two-month period. As hypothesized, depression as an affective state was closely related to expectations of discomfort and failure as well as to negative perceptions of interpersonal relationships and the self. In addition, the negative cognitions were more stable and enduring than the negative affect, suggesting that the cognitive component is strongly activated in depressed mood and may even trigger it.

All three of the cognitive approaches to therapy described above have been used for the treatment of depression, although most of the research has centered on the changing of faulty thinking styles in depression. The successful use of specific RET techniques to treat depression has been reported in several case studies (Ellis, 1962; Hauck, 1971), but has not been studied systematically as of yet. In a study of the use of self-instructional training to alleviate depression, Morris (Note 3) compared self-instructional training to a traditional insight-oriented therapy and a no-treatment

control group. Morris found that after six 1½-hour self-instructional training sessions, subjects reported themselves to be less depressed, less anxious, higher in self-esteem and more satisfied with their social interactions than either of the other two groups, and these differences were maintained at a 3-week follow-up period. There was no reliable evidence that the insight therapy was any more effective than the no-treatment control in this study. Although this self-instructional training did focus on the discrimination and modification of self-statements, Morris also explicitly incorporated the techniques of Ellis and Beck into this coping skills package.

Another type of coping skills program was studied by Gioe (1975). He used what he called cognitive modification to change the negative cognitive triad of depressed students into more positive views of themselves, their worlds and their futures. He saw this as a preparation for the acceptance of positive feedback from other people, which was then provided in the form of a 4-hour group interaction session designed to give positive reinforcement for intrapersonal and interpersonal skills and abilities. The actual cognitive modification used was a simplified self-instructional training conducted over five 30-minute sessions on consecutive days. Students were taught relaxation training and then they were presented with positive self-statements as they imagined pleasant scenes. This "cognitive modification" was

compared with the positive group experience alone, a combination of the two treatments, and a no-treatment control group. Gioe (1975) predicted that both components of the treatment would be necessary to produce a therapeutic effect. As predicted, the students in the combination treatment had significantly reduced Beck Depression Inventory scores and used more words to describe their positive qualities than students in each of the three other groups. The author acknowledges the limited generalizability of this study, since the students were only very mildly depressed to begin with, and the treatments were not powerful enough to effect their self-concepts as measured by the Tennessee Self-Concept Scale.

Most of the systematic studies of the effects of cognitive therapy on depression have been based on Beck's cognitive model and emphasize the faulty thinking styles of depressed clients. Taylor and Marshall (1977) compared cognitive therapy with behavioral therapy, a combination of the two strategies, and a no-treatment control group. All treatments were administered individually in six 40-minute sessions by the author. In the cognitive therapy condition, subjects were taught to identity the cognitions that intervened between events and emotions, and to substitute more constructive self-statements for the original negative cognitions. They were also instructed to read positive self-statements 3 or 4 times per day before a high probability behavior, in accordance with the Premack principle (Premack, 1959). In the behavioral

therapy condition, the subjects were taught to identify the behavioral situations in which they became depressed, and to develop alternative behavior patterns designed to give them more positive reinforcement. These alternative behaviors were taught by modeling and role-playing. In addition, subjects were encouraged to increase the range of their positive enjoyable activities. The results showed that all three treatment groups improved significantly more than waiting list controls on all measures of depression, and there were no differences between either the cognitive or the behavioral treatment when used alone. The combined group, however, was significantly more effective than the average of either of its components alone in reducing depression as measured by the Beck Depression Inventory (BDI), Dempsey's D-30 Scale (Dempsey, 1964), and a Self-Esteem and a Self-Acceptance variant of Kelly's Repertory Grid (Kelly, 1955). All results were maintained at a 5-week follow-up period. The conclusions from this study are somewhat limited by the fact that only quite mildly depressed college students were used as subjects, there was no placebo control condition, and all assessments were of a self-report nature. Experimenter bias was also possibly introduced since the senior author conducted all treatments himself and was clearly aware of the specific hypotheses of the study.

A similar comparative study was conducted by Shaw (1977). This study added a nondirective treatment group to the groups used by Taylor and Marshall. In this study,

all treatments were conducted in groups over eight 2-hour sessions by the author. The cognitive modification group showed the most significant changes in BDI and the Hamilton Rating Scale of Depression (Hamilton, 1960). The other two treatment groups had lower depression scores than the waiting list controls, but not as low as the cognitive modification group. At a one-month follow-up, the BDI scores of the cognitive modification group increased slightly, but the scores of the behavior modification group remained stable. This study is also limited by its use of a mildly depressed college student population, only self-report measures, and the one author conducting all the treatment sessions.

Schmickley (1976) studied 11 depressed females from a community mental health center and used four different therapists to avoid some of the possible bias problems. He also designed an Outpatient Depressive Behavior Rating Scale which was filled out daily by each subject and two significant others. Unfortunately, this behavioral measure proved to be quite unreliable, so it did not add much to the results of the study. Rather than having a control group, Schmickley used an intensive case study design with a multiple baseline and each subject serving as her own control. The cognitive treatment was administered individually over four 1-hour sessions. Although Schmickley concluded that the cognitive therapy had demonstrated its effectiveness, his hypotheses were actually only weakly

supported by varying proportions of subject data, and the results are quite inconsistent and unclear.

Beck's own research group at the University of Pennsylvania has also been conducting studies of his cognitive therapy. A study by Rush, Beck, Kovacs and Hollon (1977) compared Beck's cognitive therapy to a generally accepted standard treatment of depression, tricyclic pharmacotherapy. Tricyclic antidepressants have been found to be superior to placebo, marital therapy (Friedman, 1975), social casework treatment (Klerman, DiMascio, Weissman, Prusoff & Paykel, 1974), and brief supportive therapy or psychodynamic group therapy (Covi, Lipman, Derogatis, Smith & Pattison, 1974). Thus Rush et al. (1977) were using the best available treatment for the acute symptoms of depression as a standard for comparison. Their cognitive therapy consisted of a maximum of 20 individual sessions over a 12-week period, while the pharmacotherapy consisted of a maximum of 12 sessions over a 12-week period. Eighteen therapists participated in the study, and none of the principal investigators conducted any of the treatments. The subjects were community outpatients, with more serious depressive histories than most of the subjects in the studies discussed above. The results showed that both treatment groups made significant decreases in depressive symptomatology. Cognitive therapy resulted in significantly greater improvement than pharmacotherapy on the BDI, the Hamilton Rating Scale for Depression, and the Raskin Scale (Raskin, 1970).

In addition, the dropout rate was significantly higher with pharmacotherapy than with cognitive therapy. A 3-month and a 6-month follow-up indicated that treatment gains were maintained over time.

Other studies show support for the effectiveness of one isolated component of Beck's treatment program in combination with one behavioral technique. "Anticipation training" is designed to modify the negative expectations which may limit the amount of positive reinforcement perceived as resulting from an activity (Anton, 1974; Anton, Dunbar, & Friedman, 1976). This training program involves teaching clients to plan six pleasant activities and to actively practice anticipating their positive aspects. Subjects receiving this training for six sessions significantly decreased their reported feelings of depression and increased their reported pleasantness of activities as compared to a self-observation group and a no-treatment control. The authors recommend anticipation procedures as a first step in the treatment of depression, to be followed by more specific interventions tailored to the client's specific needs.

The work of Fuchs and Rehm (1977) on a self-control treatment of depression illustrates the difficulty involved in trying to make absolute distinctions between "cognitive" and "behavioral" therapies. Their treatment package has been classified elsewhere as a cognitive therapy (Meichenbaum, 1977) because of its emphasis on the concept of self-control, even though the primary focus of

treatment is on modifying overt behaviors. The distinction in relative focus may be clarified if we compare the self-control technique of Goldfried, Decenteco and Weinberg (1974) called systematic rational restructuring with the self-control treatment of Fuchs and Rehm. Both treatments emphasize the active ways in which the client can work to control his problems. Systematic rational restructuring is considered a cognitive technique because the client learns how to use anxiety as a signal to rationally reevaluate the reasons for being upset, whereas Fuchs and Rehm's treatment is considered a behavioral therapy because the client learns to arrange his activities and reinforcements such that they are more rewarding to him.

Behavioral Approach to Depression

Since cognitive therapies are so closely and complexly related to behavioral therapies, no discussion of the cognitive therapy of depression would be complete without at least a brief discussion of the behavioral approach to depression. Charles Ferster first laid the groundwork for a systematic behavioral theory of depression when he emphasized the importance of both a topographic and functional analysis of pathology. He recognized that "whether a man who moves and acts slowly is 'depressed' or merely moving slowly is not easily or reliably determined by observing his behavior alone. The relation of his behavior to events in the past or present environment is a critical element in the description" (Ferster, 1965,

p. 9). Ferster later expanded his ideas into a full functional analysis of depression (1973). In this analysis, he pointed out that "the common denominator among depressed persons is the decreased frequency of many different kinds of positively reinforced activity" (p. 861). Lazarus (1968) and Jackson (1972) conceptualized depression similarly, as a consequence of inadequate reinforcement or behavior that has become ineffective at securing reinforcement. Since behavior is a product of so many psychological processes, a single cause of depression cannot be expected. Rather, it is important to understand all the processes that could reduce a person's positively reinforced behavior, and several such processes are outlined by Ferster (1973). One common cycle results when people lose a major source of positive reinforcement such as through the loss of a loved one. People may than receive immediate reinforcement for depressive behaviors from their sympathetic friends. If they do not find alternate means of reinforcement, this depressive behavior may be maintained as the only source of reinforcement they have left.

Lewinsohn and his associates (1974) have developed and tested an extensive behavioral theory of depression. This theory is based on the assumption that a low rate of response-contingent positive reinforcement (which Lewinsohn terms "resconposre") acts as an eliciting stimulus for some depressive behaviors (e.g., dysphoria, fatigue) and is a sufficient explanation for other aspects

of depression (such as low behavior rate). The total amount of resconposre received by an individual is seen as a function of 1) the number of events which are potentially reinforcing for the individual, 2) the availability of reinforcement in the environment and 3) the extent to which behaviors are emitted by the individual which will elicit reinforcement from the environment. Whereas cognitive theorists assign primary causal significance to cognitive distortions, behavior theorists see these as being secondary elaborations of dysphoria, a consequence of low resconposre.

Several studies have been completed thus far which seem to support Lewinsohn's behavioral theory of depression. Lewinsohn and Libet (1972) found a significant association between mood and the number of pleasant activities engaged in by depressed subjects, psychiatric controls and normal controls (with no differences between the groups). MacPhillamy and Lewinsohn (1974) found that depressed subjects had significantly lower levels of reported pleasure, general activity level and perceived potential for reinforcement than normals or nondepressed psychiatric controls. Another study (Libet & Lewinsohn, 1973) found that depressed individuals emit interpersonal behaviors at about half the rate of nondepressed controls, and that they also elicit fewer behaviors from other people than do controls. Lewinsohn, Lobitz and Wilson (1973) discovered that aversive stimuli elicit a greater autonomic response in depressed subjects than in either

psychiatric or normal controls, which would predict greater avoidance and hence lower resconposre on the part of depressed individuals in social situations. In an analogue study, Wener and Rehm (1975) found that different rates of reinforcement led to differences in depressive affect, self-confidence ratings and latency of responding.

Although case studies of the use of behavioral techniques in treating depression have been reported, few methodologically sound, systematic studies with appropriate control groups and follow-up data have yet been conducted. Two of the studies discussed above compared behavioral treatments to cognitive treatment (Shaw, 1977; Taylor & Marshall, 1977). In both studies, the behavior therapy was more effective than the control groups, although Shaw found it to be significantly less effective than the cognitive therapy.

Another promising behavioral approach to depression is the self-control behavior therapy program developed at the University of Pittsburgh (Fuchs & Rehm, 1977; Rehm, Fuchs, Roth, Kornblith & Romano, Note 4). Many of the critical symptoms of depression are seen as constituting, or resulting from, impairment in the three processes of self-control: self-monitoring, self-evaluation, and self-reinforcement (Kanfer, 1971). The therapy program, therefore, consists of training in each of these three processes: self-monotoring of daily pleasant activities and mood, self-evaluation by means of specific behavioral goals and sub-goals for increasing pleasant activities, and

self-reinforcement for successfully achieving these subgoals. A study of 36 depressed women volunteers from the community compared this 6-session self-control program to a nonspecific therapy and waiting list control (Fuchs & Rehm, 1977). The self-control treatment led to more therapeutic change as measured by self-reports of depression, a behavioral measure of activity level, and general psychopathology level on the MMPI. A 6-week follow-up showed general maintenance of this improvement, with the differences between conditions dissipating somewhat due to follow-up improvement in the non-specific condition.

A later study using a similar subject population (Rehm et al., Note 4) compared the same self-control behavior therapy to a behavioral social skills training program. While the self-control group improved more on the measures of self-control, and the social skills group improved more on measures of social skill, the self-control group improved more on self-report of depression and observer ratings of overall depression, negative self-references, and negative references to others. The lack of a control group makes the results more difficult to interpret; but taken together, the results of these two investigations seem to be a good start towards demonstrating the effectiveness of this self-control behavioral therapy of depression.

Most recently, Rehm, Kornblith, O'Hara, Lamparski, Romano and Volkin (Note 5) conducted a study which

investigated the importance of each element of their treatment package to the overall treatment effects. Using 45 subjects from the same type of subject population, they compared five experimental conditions: 1) the full self-control program including training in self-monitoring, self-evaluation and self-reinforcement 2) self-monitoring plus self-evaluation 3) self monitoring plus self-reinforcement 4) self-monitoring only and 5) waiting list control. Each of the experimental conditions were more effective than the waiting list control group in reducing depression as measured by several self-report as well as interview ratings. Thus, in this one study, training in self-monitoring alone seemed as effective as training that includes components of self-evaluation and/or self-reinforcement. No follow-up data was included in this report, however, so it remains unclear as to how the various components of this treatment package might contribute to the maintenance of reduced depression over time.

In a study by McLean, Ogston and Grauer (1973) a behavioral treatment of depression was administered to depressed clients and their spouses. Treatment included training in social learning principles, immediate feedback as to the perception of the verbal interactions between the client and the spouse, and training in the construction and use of reciprocal behavioral contracts. As compared to clients in more traditional therapies, the clients in this behavioral treatment showed more improvement after

eight sessions on both self-report and behavioral measures of depression.

A very simple behavioral technique was investigated by Shipley and Fazio (1973). Clients were taught to confine their expressions of unhappiness to a designated period when they would be neither reinforced or punished by others. After only three sessions, the behavioral group showed significant improvement on the MMPI as compared to an interest support group and a waiting list control. No follow-up period was used, so it cannot yet be determined whether the results of such a seemingly mild intervention would be maintained over time.

In a study by Hammen and Glass (1975), it was found that having depressed students simply increase their pleasant activities did not improve their mood or reduce their depression. Lewinsohn, in his critique of that study (1975), points out several differences between his techniques and those of Hammen and Glass which could explain their lack of results. For example, Hammen and Glass used only students who appeared to be depressed on questionnaires but did not necessarily even present depression as a problem for themselves, and they used their own definition of "pleasant" rather than that of each individual subject. Lewinsohn did, however, conclude that "the prediction that an increase in pleasant activity level will produce a reduction in depression level probably should be restricted to individuals (a) in whom

there is a significant association between activity level and mood. . .and (b) whose baseline pleasant-activity level is low" (1975, p. 730). Hopefully it will eventually be possible, with enough research, to predict more specifically which types of clients can benefit most from which therapeutic techniques.

Conclusions

Since the research in the area of cognitive-behavioral treatments of depression has thus far focused on demonstrating the effectiveness of several large, complex treatment packages, one of the next steps necessary would be to define and isolate those components of the package which are responsible for the resulting change. Each of the treatment packages discussed above consists of several fairly well-defined components which all may or may not be relevant to therapeutic improvement. According to Mahoney (1974), "In the development or unprecedented application of therapeutic procedure, a pragmatic rule of thumb is: First show an effect, then isolate its cause" (p. 198). Now that cognitive therapies have given at least some initial indication of their effectiveness in treating depression, there is a need for much more specificity. This would include comparing the usefulness of different components within a single treatment package, comparing different types of cognitive therapies, comparing different cognitive and behavioral techniques,

and so on. As Paul (1969) points out, the most useful research questions are not the broad, general questions like "Is cognitive therapy effective?" or "Does behavior therapy work?". The ultimate goal of therapy research is to find out, as exactly as possible, "what treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances" (p. 162). Speaking of the need in this field for specificity, Bergin maintains that "there are few assertions in recent literature more widely believed or more persuasively argued than this one" (1969, p. 113).

One concern about cognitive therapy has been that its emphasis on thoughts and beliefs will limit its usefulness for certain types of clients. In an early discussion of RET, Ellis (1958) states that

> Many clients are not bright enough to follow a rigorously rational analysis. For another thing, some individuals are so emotionally aberrated by the time they come for help that they are, at least temporarily, in no position to comprehend and follow logical procedures. Still other clients are too old and inflexible; too young and impressionable; too philosophically prejudiced against logic and reason; too organically or biophysically deficient; or too something else to accept, at least at the start of therapy, rational analysis.
>
> (p. 49)

McLean (1976) also questions the generalizability of cognitive therapy in terms of whether concrete thinkers can be successful in cognitive modification. He points out that depressed clients often have poor concentration, a restricted attention span, agitation and response

retardation which could effect the feasibility of cognitive approaches to the treatment of severe depressions. Beck, Rush and Kovacs, in their cognitive-behavioral treatment manual (Note 6) state that their techniques have been successful with both "endogenous" and "reactive" depressions, but realistically conclude that "like other treatments for depression, it is unlikely that this treatment strategy alone will prove useful for all depressed patients" (p. i). One of the goals of this paper is to begin to clarify what some of those limits on cognitive therapy may be.

One subject variable which would seem to have relevance to the effectiveness of cognitive therapy is cognitive complexity. The term "cognitive complexity" has been defined and conceptualized in a vast number of ways. For the purposes of this study, cognitive complexity will be defined as the distinctiveness of the elements which constitute one's cognitive system (Scott, 1963b) or, conversely, the degree of relatedness of attribute dimensions within a cognitive domain (Condon, Note 11). An interpersonal cognitive system would be considered relatively complex if it contains many interpersonal constructs which are hierarchically integrated to a high degree (Crockett, 1965). The number of dimensions that one employs to make meaning out of a set of stimuli is one component of complexity, but the relatedness of these dimensions is also crucial to an understanding of complexity.

An example, provided by Condon (Note 11) may clarify these two components of complexity. Two people (A & B) may both be able to discriminate among people on each of three attributes (helpfulness, responsibility and friendliness). If for A each attribute is a relatively independent dimension of judgment (such that people who are helpful may or may not be responsible and may or may not be friendly) while for B, these three attributes are completely related (people who are helpful are also responsible and friendly), person A would be defined as more cognitively complex than person B.

One aspect of the research on cognitive complexity which seems especially pertinent to a discussion of cognitive therapy involves dichotomous thinking. Campbell (1960, cited in Bieri, 1961) found that subjects who were rated as low in cognitive complexity were more likely to separate people into two groups on the basis of a good-bad dichotomy than those rated high in cognitive complexity. Also, the cognitively "simple" subjects more often saw social relationships among associates as balanced, with a mutuality of liking or disliking involved, than the more "complex" subjects. In a completely different content area, Scott (1963a) found that subjects with low cognitive complexity grouped nations significantly more often into a dichotomy of positive vs. negative, while subjects with high cognitive complexity included both liked and disliked nations in more differentiated categories. In addition, Supnick (cited in Crockett, 1965) found that the less

cognitively complex individuals gave significantly more univalent descriptions of people than more cognitively complex subjects.

One of the major objectives of cognitive therapy is to alter clients' tendencies to view themselves and their futures in a totally negative way. The goal of the treatment is to help clients learn to make realistic discriminations between specific environmental events and behaviors (e.g., "I did poorly on a quiz") and their judgments of their own self worth (e.g., "I must be a rotten, stupid person"). Although most depressed people may have difficulties differentiating clearly when it comes to their own personal attributes, highly cognitively complex people who are at least capable of identifying complicated patterns of positive and negative attributes in other people may find it easier to learn to make similar discriminations when it comes to their own self-image. On the other hand, people with low cognitive complexity who may use only dichotomous reasoning in all aspects of their lives may find it more difficult to make these changes, since they would be changing not only their way of looking at themselves, but their ways of construing the entire world.

This study will attempt to examine the subject variable of cognitive complexity as it relates to the ability to benefit from short-term treatment of depression by comparing the effectiveness of cognitive, behavioral and nondirective depression workshops for subjects with both high and low levels of cognitive complexity.

HYPOTHESES AND PREDICTIONS

Each of the three types of cognitive therapy discussed in this paper has demonstrated at least some initial effectiveness in treating different types of psychological disorder. With mildly to moderately depressed clients, Beck's cognitive therapy has been studied in attempts to alleviate the depressions of both student and clinic populations. Beck has concluded that "by pinpointing the patient's specific cognitions and demonstrating their invalidity through behavioral or cognitive techniques, the psychotherapist can achieve a rapid improvement in the symptoms of depression" (1974b, p. 19). Considering the range of clients who have already been treated with some success in cognitive therapy, it is hypothesized that, for people of both high and low levels of cognitive complexity, cognitive therapy is more effective in reducing depression than more traditional, nondirective therapy.

> Prediction 1: Subjects in the cognitive groups will show a significantly greater reduction on all the measures of depression after treatment than subjects in the nondirective control groups.

Researchers have also made a start towards demonstrating the effectiveness of behavioral therapies in the treatment of depression. Both student and clinical populations have been treated using behavioral approaches

with some success, and even quite simple behavioral techniques seem to help improve the symptoms of depression. Therefore, it is hypothesized that behavioral self-control therapy will also be more effective in treating depressed clients than is nondirective therapy, regardless of cognitive complexity level.

> Prediction 2: Subjects in the behavioral self-control groups will show a significantly greater reduction on all the measures of depression after treatment than subjects in the nondirective control groups.

Level of cognitive complexity may influence the ability to integrate the information taught in cognitive therapy with previous concepts of the self and to learn further discriminations in cognitive processes. Therefore, it is hypothesized that cognitive therapy is more effective in the treatment of depressed clients with high cognitive complexity than those with low cognitive complexity while behavioral self-control therapy is more effective in treating depressed clients with low cognitive complexity than with high cognitive complexity.

> Prediction 3: Highly cognitively complex subjects will show a significantly greater reduction in overall depression (as measured by the BDI and the D-30 Scale) after being in a cognitive group than subjects with low cognitive complexity. On the other hand, subjects with low cognitive complexity will improve significantly more after being in a behavioral self-control group than subjects with high cognitive complexity.

Since cognitive and behavioral self-control therapy each emphasize different modalities of behavior change, they may both be effective therapeutic strategies in the

modification of depression, although working via different routes. Behavioral self-control therapy, with its emphasis on changing overt behavior, is hypothesized to be especially effective in modifying the behavioral components of depression. On the other hand, since cognitive therapy emphasizes the modification of cognitive behavior, it is hypothesized that cognitive therapy is most effective in reducing the cognitive components of depression.

> Prediction 4: Subjects in the behavioral self-control groups will improve significantly more on the behavioral measures of depression than subjects in the cognitive groups. Subjects in the cognitive groups will, however, improve significantly more on the cognitive measures of depression than subjects in the behavioral self-control groups.

According to Beck (1976), "Since each of the components of depression (emotional, motivational, cognitive, behavioral and physiological) contribute to other components, it might be anticipated that improvement in any one problem area (e.g., cognitive) would lead to improvement in other areas (e.g., behavioral) and would finally spread to include the entire syndrome of depression" (p. 265). It is therefore hypothesized that over time the modality-specific improvements will generalize to effect improvement in other components of depression as well.

> Prediction 5: At the 6-week follow-up point, the pattern of changes in overall depression will be maintained as predicted above; however, the behavioral self-control groups will show increased improvement on the cognitive measures and the cognitive groups will show increased improvement on the behavioral measures of depression.

METHOD

Subjects

Volunteer subjects were recruited from the local community through announcements in the mass media stating that short-term workshops were being offered to help people cope with depression (Appendix A). To qualify for selection, subjects were required to meet each of the following criteria:

1. Self-reported depression of at least 3 weeks duration.
2. Willingness to participate in a treatment and research program.
3. No current involvement in any other psychological treatment program for depression.
4. At least 18 years of age.
5. A Beck Depression Inventory score $\geq$ 17.
6. D-30 score $\geq$ 14.
7. Psychiatric Screening Inventory Alienation score $<$ 70 and Defensiveness scores less than 70 but greater than 30.
8. Clinical judgment based on the test results and at least two telephone interviews (Appendix B) that depression is the major presenting problem and that no obvious psychotic symptoms (e.g., hallucinations, delusions) are present which might warrant hospitalization or extreme suicide risk. People whose depressions were associated with schizophrenia, organic brain disease, alcoholism, or drug addictions were not included in this study.

Subjects fulfilling these criteria would most closely fit

the category "major depressive disorder" according to the American Psychiatric Association's Diagnostic and Statistical Manual, Third Edition (1979).

Ideally, each subject who fit the screening criteria would be randomly assigned to a treatment condition, and groups in all three conditions would begin and run simultaneously. In order to minimize the delay between the subject's response to the media announcements and the actual start of the workshop, however, it was necessary to assign each group of subjects to a treatment condition rather than to assign individuals to treatments. Thus, as soon as sufficient subjects had been screened to form one workshop, that group of subjects was randomly assigned to one of the three treatment conditions and that workshop was started. This way, one group could begin every two weeks rather than having all subjects wait six weeks until there were sufficient subjects to begin all conditions. All screening procedures and interviews were conducted blind to the subjects' experimental condition, since subjects were not assigned to a condition until after the screening was completed.

A total of six workshops were conducted throughout the 9-month course of this study, two in each of the three experimental conditions (cognitive, behavioral self-control and nondirective). Since a committment was made to the subjects that their workshop would begin within two weeks of screening, the groups were of unequal size.

Forty subjects qualified according to the screening criteria and were assigned to groups as follows: 15 subjects in the cognitive condition (in groups of 8 and 7), 14 subjects in the behavioral self-control condition (in groups of 7 each), and 11 in the nondirective condition (in groups of 7 and 4). Three workshops (one in each condition) were run at 2-week intervals during the summer months and three workshops (one in each condition) were run at 2-week intervals during the winter months. The workshops were run during the summer and winter months due to the availability of group leaders at those times.

Written informed consent (Appendix C) was obtained from each subject before the beginning of the screening process. At the conclusion of each workshop, subjects were offered referrals to local agencies if they were interested in further psychological treatment.

Screening Measures

Psychological Screening Inventory

The Psychological Screening Inventory (PSI) was designed by Lanyon (1978) as a brief mental health screening device, to be useful in detecting those people who would most need further psychological attention (Appendix D). The goal of the PSI is to enable users to make specific decisions and predictions that improve over the predictions made without using the test. The PSI consists of 130 personal statements to be answered true or false with items worded at grade school level. The PSI form takes

approximately 15 minutes to complete. The entire PSI contains five scales, but only the two scales used in subject selection for this study will be discussed here: the Alienation Scale (Al) and the Defensiveness Scale (De).

The Al scale was designed to measure the similarity of the subject to hospitalized psychiatric patients, in order to identify people who may need to be examined further for the possibility that they may require inpatient psychiatric treatment. According to Lanyon, high Al scores are associated with the same characteristics as high scores on the MMPI scales most related to serious psychopathology (Sc, F, Pa, and Ma). He describes high Al scorers as "having an unsatisfactory emotional life, being suspicious, sensitive and anxious, feeling unacceptable and alienated, denying normal expression of affect, and perceiving themselves as not responsible for, or in control of, their own lives" (Lanyon, 1978, p. 9). The validity of the Al scale was tested in several ways. Mean Al scores were calculated for 38 different subject groups, and psychiatric patient groups consistently scored close to two standard deviations above the normative mean. Al scores were correlated with scales from other tests, and the highest average correlations (at approximately .5) were shown between the Al scale and the Sc, F and Pa scales of the MMPI. The Al scale was also used to discriminate psychiatric inpatients from normals with a hit-and-miss accuracy of approximately 80%. A highly

significant association was found between scores on the A1 scale and the six MMPI "psychotic signs" delineated by Meehl (1946) and Peterson (1954). Finally, the mean MMPI profiles of subjects with high A1 scores indicated more tendency for high A1 scorers to show psychotic, rather than neurotic, disturbances.

The reliability of the A1 scale was assessed in terms of internal consistency (.62) and test-retest reliability (.66 & .73 in two different samples). Although these reliability coefficients are not high, Lanyon (1978) states that they compare favorably with reliability coefficients for the MMPI.

For use as a screening device in this study, a cut-off score of 70 was used, since Lanyon suggests that scores of 70 or more indicate the desirability of more thorough psychological examination. To minimize the possibility of subjects with psychotic disturbances which require more intensive intervention being admitted into the depression workshops, subjects with A1 scores above 70 were not selected for this study and were referred elsewhere for psychological treatment.

The Defensiveness (DE) Scale of the PSI was designed to assess the subjects' test-taking attitude. A score of 70 or more is seen by Lanyon (1978) as fairly definite evidence of "faking good" and a score of 30 or less indicates the probability of "faking bad". Lanyon found that when using a specific cut-off score in the A1 scale, use of the De scale could improve the accuracy of the

discriminations made. Thus, in order to minimize the probability that a subject was deliberately distorting his or her responses in either direction, which would invalidate the use of the Al scale cut-off scores, subjects were selected for this study only if their De score was less than 70 and more than 30.

Beck Depression Inventory

The Beck Depression Inventory (BDI, Appendix E) has been considered to be "probably the best developed and most widely used self-report depression measure" (Becker, 1974, p. 25). The BDI was developed as a measure of the level of depression in a client, not as a means of distinguishing between standard diagnostic categories (Beck, Ward, Mendelson, Mock and Erbaugh, 1961). The scale consists of 21 categories covering the various psychological, physiological and behavioral manifestations of depression. Each category contains a set of graded self-evaluative statements that are rated from 0 (neutral) to 3 (maximum severity). Analysis of BDI scores done on several large psychiatric samples indicate good reliability and validity for the measure (Beck, 1972; Beck & Beamesderfer, 1974; Beck et al., 1961; Metcalfe & Goldman, 1965). The BDI showed high reliability in terms of internal consistency and stability: split-half Spearman-Brown corrected Pearson r = .93, all items were significantly related to total score at the $p < .001$ level per item, and highly significant test-retest correlations were found.

Inter-rater reliabilities were also quite good. The validity data for the BDI is encouraging as well. Correlations between diagnostician's ratings and BDI scores were found to be .67, and comparable findings have been obtained in several different areas of the United States as well as in 5 countries outside of the U.S. Correlations of the BDI with symptom check-lists, the MMPI D-scale and the Hamilton Rating Scale for Depression range from .66 to .75 (Beck, 1972). Beck and his colleagues (1961) also report that the inventory is sensitive to changes in the severity of depression over time. In terms of construct validity, the BDI has been successfully used as the criterion measure of several simple hypotheses about depression. BDI scores have been found to be unrelated to race, age and intelligence, but females and the less well-educated do tend to obtain higher scores (Beck & Beamesderfer, 1974). One important advantage of the BDI over other measures of depression is its apparent ability to discriminate depression from anxiety (Beck, 1972).

In this thesis, a BDI score $\geq$ 17 was used as the cutting off score for clinical neurotic depression (as suggested by Beck and cited in Schmickley, 1976). This also is compatible with the results of a study by Fahy (1974) who found that the mean BDI score of depressed patients seen in general practice was 17.4.

The D-30 Scale

The MMPI Depression Scale (Hatheway and McKinley, 1956) is one of the oldest and most traditional self-report depression measures. This is a 60-item scale that is based on 49 items which discriminate hospitalized manic-depressive patients in their depressed phase from normals, and 11 items discriminating manic-depressives from other psychiatric patients. Although this scale seems to show consistent validity as an index of client change (Bergin, 1971), it has been said to do reasonably well in predicting differences between nosological groups but poorly in predicting individual differences within groups (Becker, 1974). Thus, similar scores on this scale can reflect quite different depressive states both quantitatively and qualitatively.

In one attempt to overcome this lack of dimensionality, Dempsey (1964) designed a 30-item modification of the original MMPI Depression Scale which he calls the D-30 Scale (Appendix F). He selected 30 of the original 60 items by contextual analysis such that the items related consistently in the same direction to the major underlying dimension within normal and abnormal samples of both sexes. Despite the fact that the number of items was cut in half, the D-30 Scale showed improved reliability over the original scale using both split-half ($r = .88$) and test-retest ($r = .92$) reliabilities. The cut-off score used in the selection of subjects for this study

was a score of 14 on the D-30 scale, which corresponds to a T-score of 70 on the MMPI Depression Scale

Dependent Measures

In addition to the screening procedures, subjects were tested three times: before the start of the workshop, at the end of the workshop, and at a six-week follow-up point. The dependent measures include two measures of over all depression (the Beck Depression Inventory and the D-30 Scale, which were also used in the screening process), two self-report behavioral measures (the Pleasant Events Schedule and the Verbal Behavioral Measure), and two cognitive measures (the Dysfunctional Attitude Scale and the Irrational Beliefs Test).

Dysfunctional Attitude Scale

The Dysfunctional Attitude Scale (DAS) is a measure recently developed by Weissman "to measure the extent to which persons hold beliefs which predispose them to depression" (Note 7). According to Beck's model of psychotherapy (1976), depressed individuals would hold more dysfunctional and distorted attitudes than non-depressed people, so that the goal of his cognitive therapy is to change these dysfunctional attitudes and hence alleviate depression. Thus, the DAS would seem to be an especially appropriate measure of the success of cognitive therapy.

The DAS consists of two parallel forms, each having 40 statements which are rated on a 7-point modified Likert scale, rating from Totally Agree to Totally Disagree (Appendix G). The total DAS score for each person is simply the sum of the scores for each for the 40 statements. The items of the scale were derived clinically, and statements were selected which seemed to most accurately describe the attitudes underlying the cognitive distortions of Beck's cognitive model of depression. Both forms of the DAS were validated in a sample of 355 normal college students. The internal consistency ranged from .89 to .92, while test-retest reliability over an 8-week period was .84. Weissman also found a significant relationship between the salience of a person's dysfunctional attitudes (as measured by the DAS) and the intensity of depression (as measured by the Beck Depression Inventory and the Depression Scale of the Profile of Mood States). In addition, dysfunctional attitudes were found to be more persistent over time than depressed affect. The relationship of age, sex, race and educational level to scores on the DAS was studied; and although both sex and educational level were significantly related to the DAS, these significant differences were small, accounting for only 4% of the variance. Weissman has shown that the DAS discriminates among normals at varying levels of depression, but further research is needed to determine whether the DAS can also be useful in discriminating among various psychiatric groups.

Irrational Beliefs Test

The Irrational Beliefs Test (IBT) is an instrument constructed by Jones (1968) to measure irrational beliefs within the framework of Ellis. Although it would be most appropriate as a measure of the effectiveness of Ellis' rational-emotive therapy, the theories behind RET and Beck's cognitive therapy are closely enough related so that the IBT is also an appropriate outcome measure of Beck's cognitive therapy. This test is being used in addition to the DAS as a measure of attitudes that might predispose people to depression.

The IBT consists of 100 items measuring the relative presence or absence of 10 irrational beliefs in separate scales (Appendix H). The cross validation sample included 178 college students, 72 state mental hospital patients and 177 normal adult volunteers. Construct validities were found to range from .561 to .824 with a mean of .699. Homogeneity reliability coefficients ranged from .662 to .801 with a mean of .737, based on inter-correlations of item scores and scale scores. Test-retest reliabilities were .921 for a full scale and from .675 to .872 for individual scales. Eight of the ten IBT scales correlated highly with admitted psychiatric symptomatology, and the differences between IBT scores of a normal adult sample and a mental hospital sample were highly significant for eight of the scale scores. Age was not found to be significantly related to irrational beliefs, but there

were significant sex differences specific to scales, and education level had a negative functional relationship to IBT scores which involved most scales. It was concluded that the IBT was "sufficiently reliable and valid as a measure of irrational beliefs for use in both research and specific clinical needs" (Jones, 1968).

Pleasant Events Schedule

The Pleasant Events Schedule (MacPhillamy & Lewinsohn, Note 8) is an assessment device for the measurement of positive reinforcers in adults. The Reinforcement Survey Schedule (Cautela & Kastenbaum, 1967) was the first such assessment device, but it is best suited to the assessment of potential reinforcers which are available to therapists or teachers in the clinic or classroom. The Pleasant Events Schedule (PES), however, was designed primarily for use in assessing events which occur in a person's natural environment. The original PES consists of 320 items which are rated both with regard to their frequency and their subjective enjoyability over the preceding 30 days. The items were selected empirically from items generated by people of diverse ages, educational and social backgrounds in an attempt to avoid restricting items to those which might have obvious stereotyped pleasurable associations. The intrascale homogeneities were found to be consistently over .96 using coefficient alpha (Chronback, 1951). The test-retest reliability was not quite so strong. For all items together, the

percent agreement was 76% and Pearson r was .53 for frequency ratings, while for enjoyability ratings the percent agreement was 69% and Pearson r was .55. Several different types of validity have also been examined, with promising, if not conclusive, results. On the whole, the PES scales seem to possess "reasonable degrees of factorial stability, item homogeneity, stability over time, statistical independence, convergent and discriminant validity with alternative concurrent measures of the same variables, predictive validity, and the ability to discriminate in the predicted direction between groups of people having differing psychological characteristics" (MacPhillamy & Lewinsohn, Note 8, p. 33).

Scores on the Pleasant Events Schedule have been found to discriminate significantly between depressed people and both normal individuals and people with psychological problems other than depression (MacPhillamy & Lewinsohn, 1974). Lewinsohn and his colleagues (Lewinsohn & Graf, 1973; Lewinsohn & Libet, 1972) have also demonstrated that depressed mood correlates with activity. Since behavioral theory posits that depression is a result of a low rate of response-contingent positive reinforcement (Lewinsohn, 1974), measures of pleasant activities have been used as outcome measures of self-reported behavior change in studies of therapy with depressed clients (Anton, 1974; Anton et al., 1976; Fuchs & Rehm, 1977; Rehm et al., Note 4 and Note 5).

The 49-item version used in this study (Appendix I) was made up of the items which best correlated with depression (Lewinsohn & Graf, 1973). This same version was also used by Ruchs & Rehm (1977) and Rehm et al. (Note 4 and Note 5) in their research on depressed clients. Subjects were given two separate scores on the PES: PESA is the rating of the frequency of pleasant events, while PESB is the rating of the enjoyability of these events.

Verbal Behavioral Measure

In order to measure overt behavior associated with depression, a behavioral measure similar to that used successfully by Rehm et al. (Note 4) was also included in this study. At each testing session, each client was individually asked to say something about his or her current functioning. These statements were audio-taped so that several undergraduate raters who were blind to conditions could later rate each speech on a 5-point scale of Overall Depression and count the number of sentences containing positive self-references, negative self-references, positive other-references, and negative other-references. In order to adjust for the actual number of sentences spoken, the rate of negative self-references and negative other-references was calculated. Thus, the Verbal Behavioral Measure (VBM) includes an Overall Depression Rating, a Negative Self-Reference Rate and a Negative Other-Reference Rate.

Cognitive Complexity Scale

The many different conceptualizations of cognitive complexity have led to as many different measures of the concept. The tendency for each research team to develop their own measures and use only these measures in their research has led to a lack of clarity about the possible unity of the concept and the empirical relationship between these measures. Vannoy (1965) tried to find the commonality among the many conceptions of cognitive complexity by administering 20 different measures to 113 male undergraduate subjects. Some of these measures had been explicitly designed to measure cognitive complexity, while other measures were included which Vannoy merely thought might reflect such a variable. His failure to find a large first factor on which most of these measures were substantially loaded led him to conclude that "no such predisposition (as cognitive complexity) exists or none of the instruments included in the test battery is a valid measure of it" (p. 387). In his clever critique of Vannoy's study, Condon (Note 11) compares Vannoy's procedures to trying to find a needle in a haystack and concludes that "following Vannoy's logic to its absurd extreme, one would deny the existence of the needle due to its lack of commonality with the surrounding hay!" (p. 11).

Only three of the measures included in Vannoy's study are similar to the concept of cognitive complexity as used in the present study. When Condon (Note 11)

reanalyzed Vannoy's data using only these three measures, the factor analysis yielded a first factor which accounted for 56% of the total variance. While this procedure is not wholly legitimate statistically, it does suggest that some common element may exist among these measures. Thus, rather than abandon the concept of cognitive complexity as invalid, further research might prove more useful by discriminating among the various definitions of cognitive complexity and trying to find empirical relationships among measures which are at least ostensibly measuring the same concept.

The cognitive complexity scale used in this study consisted of judgments of 20 personal acquaintances on each of 20 7-point semantic differential scales (Appendix J). Osgood's semantic differential scales have been widely used to assess individuals' cognitive space. Osgood and his colleagues stress that the semantic differential is not any one particular test with standard concepts and standard scales; rather, it is a general method which is to be adapted to the specific research problem for which it is used (Osgood, Suci & Tannenbaum, 1957). In this adaptation of the semantic differential, role descriptions of 20 people were provided to subjects and they were instructed to list the 20 different adquaintances who best fit the descriptions. Each acquaintance was then rated on each of 20 attribute scales. The results were then factor analyzed for each subject

individually, and the cognitive complexity score was calculated as the number of dimensions that accommodated 75% of the variance, a technique suggested by Thompson (Note 12).

This measure is most similar to measures used previously by Ware (1958, cited in Osgood, 1962) and Condon (Note 11). Ware had subjects rate 31 simple but varied concepts on 20 semantic differential scales, and used the percentage of variance extracted by the first factor as his measure of "dimensionality". Condon (Note 11) had subjects rate 28 personal acquaintances on the same semantic differential scales used in the present thesis, labeling the average absolute interattribute correlation as his measure of "dimensional complexity". On this measure, Condon found internal consistency as measured by Chronbach's alpha to be .93. The similarily of the concepts behind these three measures is clear, but the slight variations in techniques of measurement leave comparisons among these measures somewhat confusing and difficult.

In addition to the screening measures and dependent measures, subjects were asked to fill out brief questionnaires at the post-test and follow-up periods, rating their opinions of the workshop and their group leader (Appendix K).

Group Leaders

The group leaders used in this study were six first-year graduate students in a clinical psychology doctoral program. Each group leader led a group in the condition which, according to their self-report, seemed closest to his or her own personal orientation towards psychological treatment. Throughout the study, the group leaders remained blind to the specific hypotheses of the study. Leaders were informed that the study was designed to look at subject variables which effected individual subjects' success in the different workshops, and that in general subjects were expected to improve in all three conditions.

Prior to participating, all group leaders were provided with a manual appropriate to their experimental condition, a session-by-session workshop outline, and a required reading list. Training consisted of two separate two-hour sessions for leaders in each condition, where a summary of the appropriate intervention mode was presented and questions about the manuals and readings were discussed.

In the cognitive condition, leaders used the cognitive modification manual and session-by-session treatment outline as used by Shaw (1977, Appendix L). Relevant readings included the individual treatment manual used by Beck and his colleagues (Beck et al., Note 6).

The manual and session-by-session outline used for the behavioral self-control condition was the self-control therapy manual used in studies by Fuchs and Rehm (1977) and Rehm et al. (Note 4). The only significant change made in the manual was to expand the program from a 6-session to an 8-session workshop, in order to keep the actual amount of time spent in the workshop consistent across conditions (Appendix M). The group leaders had all previously read Bandura's Principles of Behavior Modification (1969) and in addition were assigned to read the first six chapters in Mahoney and Thoresen's Self-Control: Power to the Person (1974).

The manual used for the nondirective workshops was made up of exerpts from the manual used by the Drug Education Center (Hughes, 1977), the Listening Ear Crisis Center (Thornton, Note 9) and the Adolescent Diversion Project (Kantrowitz, Note 10). This manual focuses on teaching the skills seen as "necessary and sufficient" conditions for therapeutic change in nondirective approaches: accurate empathy, unconditional positive regard, and genuineness (Appendix N). In addition, relevant readings which specifically discuss nondirective treatment in groups were assigned, including articles by Hobbs (1951) and by Dickenson (1967).

Once each workshop had started, twice weekly supervision sessions were held separately for leaders in each experimental condition.

Treatment

The treatment programs, described as Depression Control Workshops, were conducted in six groups, each consisting of four to eight group members and a group leader. Sessions were held twice a week for approximately two hours per session, and each entire workshop lasted four weeks. Sessions were tape-recorded, and blind undergraduate raters rated random samples of the tapes to see whether they could identify which treatment was being used. This was done as a check to see that the different treatment conditions did indeed differ from each other and follow the appropriate treatment model.

All workshops started out with the same general introductions to the Depression Control Workshops (Appendix O). After this introduction and any general questions, the workshops varied according to the different therapeutic conditions.

Cognitive Workshop

Session 1. After the standard introduction, a specific rationale for the cognitive approach was presented. The history and current status of each client's symptoms were then explored in an attempt to delineate the major maladaptive sequences in the client's life. The group leader concentrated on the specific events leading up to a depressive episode and the member's response to these events. The leader then tried to develop hypotheses

about the member's idiosyncratic response patterns and some of his or her basic attitudes and beliefs.

Session 2. The leader helped each group member to delineate the maladaptive cognitions and self-verbalizations which occurred in response to various events. This was done by discussing those specific events which were followed by feelings of sadness or depression. These events were discussed in terms of the chain of environmental stimuli → cognitions → affect. The first homework assignment was for the members to write down the thoughts that occurred immediately before any feelings of sadness or depression until the next session.

Session 3. The homework assignment was discussed, and the leader pointed out the close connections between the thoughts and feelings of depression. The leader helped the members to categorize their cognitions in terms of the major themes and distortions involved. Methods of challenging the validity of these thoughts (such as separating "ideas" from "facts" and checking out assumptions) were introduced, and alternatives to these misconceptions were discussed. Homework involved the "double column technique": Members wrote down their depressogenic thoughts on the left side of a sheet of paper, and wrote more realistic answers to these cognitions on the right side.

Session 4. Homework was discussed and the objective discussion of cognitions was encouraged. The leader

provided feedback about the members' attempts to correct their depressive thoughts. In addition, members were encouraged to discuss and become more aware of the non-depressing situations and activities in which they were successful or which they enjoyed. They also were asked to record positive statements about themselves and to repeat these positive thoughts in order to invalidate any negative, depressive thoughts. If a member had trouble recording positive statements about himself, the leader and other group members reflected good points honestly seen in the person and encouraged them to add to the list of positive thoughts themselves as the workshop went on.

Session 5. Homework was discussed and the leader continued to teach members to evaluate the validity of their cognitions. Once a cognition was established as invalid, the member was taught to neutralize it by verbalizing the reasons why the thought was erroneous, each and every time it occurred. The leader guided the group members through the logical steps of reasoning, and verbally modeled this behavior. The group also examined alternative explanations and ways of conceptualizing and solving problems, so that members learned to consider alternatives to depressive cognitions and then to evaluate each alternative. The homework assignment was to be repeated again, and any problems doing the homework were discussed.

Session 6. Homework was discussed and an attempt was made to begin clarifying the assumptions and attitudes which

were behind the individual's cognitions. These assumptions center on the members' views of their worlds, themselves and their futures. These chronic attitudes were inferred from examining recurrent themes in members' cognitions and the way they responded to different situations. Further information was obtained by probing members about their reasoning, values and beliefs in a safe, noncondemnatory atmosphere. The leader worked to maintain this safe atmosphere within the group, and to ensure that other group members did not interfere with the emotional behavior which accompanied exploration of these core assumptions. The homework assignment was continued.

Session 7. Homework was discussed and basic assumptions were examined in an objective manner. The same strategies which were used to modify depressive cognitions were then used to modify basic assumptions, but this was a slower, more difficult process. It was stressed in the session that these changes might not happen quickly, but group members were encouraged to challenge these assumptions and to examine alternatives often. They were also asked to observe the positive consequences of these attitude changes. The therapist actively helped the members to explore their assumptions in a safe atmosphere, without telling the clients how to run their lives and taking responsibility away from them. For homework, members were asked to record any changes which were taking place in their attitudes.

Session 8. Homework was discussed and an attempt was made to integrate assumptions and their effects. Future plans of the members were discussed and the importance of continuing to use the skills learned in this workshop beyond the end of training was stressed. The members were asked for feedback on the effectiveness of the training, and feelings about termination were discussed. Referral sources were identified for members who were interested in further treatment.

Behavioral Workshop

Session 1. After the standard introduction, a brief discussion and summary of the types of problems being brought to the group took place. A specific rationale for behavioral therapy was presented in colloquial language, and members were taught a basic behavioral framework. Emphasis was placed on how moods are a result of one's behavior, and how rewards tend to increase the frequency of the rewarded behavior and lack of rewards or punishment tend to decrease the frequency of that behavior. The importance of learning to control one's own behavior through self-monitoring, self-evaluation and self-reward was stressed. An overview of the entire treatment program was presented.

Session 2. This session focused on a didactic presentation and discussion of the importance of accurate self-monitoring. Positive activities were pinpointed as target behaviors, and the importance of increasing the frequency

of positive activities was stressed. Members were given a Positive Activities List as a guide in learning to discriminate positive activities, but the variety of individual differences was also discussed. The homework assignment was for each group member to record a one-line description of each of their day's positive activities. In addition, they were asked to rate their mood on a 10-point scale after each event was logged. Members were also given a graph on which to record their daily average mood and total number of positive activities. The assignment was discussed in detail and any questions were answered.

Session 3. A general check-in procedure was followed at the beginning of this session and each subsequent session. In this session, about 20 minutes were spent on group discussion of the homework, and 10 to 15 minutes were spent on each individual's log. Specific examples from the homework were tied to the basic principles of self-monitoring, and all appropriate uses of the homework were reinforced verbally by the therapist. The guidelines for successful self-monitoring were reviewed and discussed. The assignment for the next session was for each member to continue the previous assignment. In addition, they were asked to choose a few classes of positive activities that were especially significant or difficult to them and to concentrate on increasing the frequency of those activities. Strategies for increasing the rate of positive behaviors were discussed.

Session 4. After a brief check-in period, the self-evaluation phase began. The importance of setting realistic and obtainable goals in evaluating oneself accurately was stressed. To facilitate learning realistic self-evaluation, members selected specific goals using their logs to identify desirable but low-frequency classes of behavior that they wanted to increase. They developed specific behavioral criteria or sub-goals that were discrete, attainable, overt and immediately discernable in terms of their own behavior. The therapist gave examples of goals and sub-goals, and the group discussed and made suggestions about the goals and sub-goals of each individual. The homework assignment was to plan and write about three sub-goals for each class of behavior they had committed themselves to work on (hierarchically arranged). In addition to the usual monitoring and graphing, the members were asked to record each engagement in a sub-goal behavior and were encouraged to deliberately engage in sub-goal behavior.

Session 5. After a long check-in period, members were taught to judge their own ongoing behaviors by comparing them to their own, pre-set sub-goals. A point system made the sub-goals more explicit. From 1 to 5 points were assigned by the member to each sub-goal on the basis of the subjective importance and/or difficulty of the behavior. Ways of shaping particularly difficult or important activities were described, and the guidelines

for successful self-evaluation were reviewed and discussed. For homework, members were asked to record their point values of accomplished behaviors and to maximize their total number of points.

Session 6. In this session, the self-reinforcement phase began. After the check-in period, members were taught the general principles of reinforcement, and especially of self-reinforcement. Clients constructed "reward menus" of highly pleasant and freely available rewards, and were encouraged to start off with generously low prices. The homework assignment was to continue the self-monitoring and self-evaluation procedures, as well as to self-administer rewards from the menu as points were earned. The importance of following strict contingencies of reinforcement was stressed.

Session 7. After a long check-in period, the guidelines for successful self-reinforcement were reviewed and discussed. The group leader reinforced high self-evaluation, increased positive behaviors, the following of self-reinforcement schedules, and any self-reinforcing statement made (such as statements of self-confidence, self-esteem, etc.). The complete homework assignment of self-monitoring, self-evaluation and self-reinforcement was continued.

Session 8. This session started with a long check-in period where an attempt was made to integrate the three phases of the training program. Future plans of the

members were discussed, and the importance of continuing to use the skills learned in this workshop beyond the end of training was stressed. The clients were asked for feedback on the effectiveness of training, and feelings about termination were discussed. Referral sources were identified for members who were interested in further treatment.

Nondirective Workshop

The nondirective condition was not divided into session-by-session outline, since in nondirective approaches the same general procedures are followed throughout the treatment program. Session 1 did include the standard introduction. Then a specific rationale for nondirective treatment was presented. From that point on, all the sessions followed the same general format. Discussion centered on depression, its manifestations and current life events. The group leader attempted to provide the three essential ingredients of nondirective therapy: accurate empathy, unconditional positive regard, and genuineness. Accurate empathy involved both the leader's sensitivity to current feelings and the ability to communicate this understanding to the group members. Genuineness involved responding in an authentic and sincere manner. This does not mean that the leaders always disclosed their total self to the group, but that whatever the leaders did reveal was a real aspect of themselves. Unconditional positive regard involved accepting the

members as people, separate from any evaluations of their behavior or thoughts. At its highest level, this meant nonpossessively caring for all the members as individuals who are allowed to have their own feelings, experiences, and behaviors.

Several specific techniques were used to facilitate the nondirective workshop. The leader identified the members' feelings as accurately and specifically as possible and conveyed this understanding to the members. In addition, the leader clarified the statements made by group members by reflecting the feelings and paraphrasing the content of the statements. Confrontation of discrepancies was also used in the workshop. Confrontation is defined as "the halting of any on-going interaction for the purpose of assessing its intentions, consequences, or possible alternatives" (Kantrowitz, Note 10, p. 40). Confrontations may be initiated through feedback to the members about how their behavior is effecting the leader, self-disclosure by the leader, or by direct questioning. These basic techniques were used throughout all workshop sessions. The leader did not attempt to structure the content of the sessions nor provide a specific conceptualization of the central factors involved in maintaining depression. In addition, the leader did not offer suggestions or coping strategies to the members, but attempted to facilitate their autonomy, trusting that the members would find their own resources for ultimately finding and carrying out a solution to their problems.

The goal of nondirective group treatment is to achieve "group treatment" and not just individual treatment within the group. The members themselves took on some of the role of the leader. To encourage this, the leader delayed slightly before responding to a member in the hopes that some other group member would respond in a manner that facilitated further self-exploration. If, however, some important feeling went unrecognized or if group members denied the feelings of a member, the leader stepped in to maintain a dependable atmosphere of acceptance and understanding within the group.

In the final session, the members were asked for feedback on the effectiveness of the workshop, and their feelings about termination were discussed. Referral sources were identified for members who were interested in further treatment.

RESULTS

Of the 40 subjects who originally qualified and were admitted to the study, 5 did not complete the study. Two subjects (one in the cognitive and one in the behavioral self-control condition) dropped out after one workshop session, one subject (in the nondirective condition) dropped out after the second workshop session, one subject (in the cognitive condition) dropped out after three sessions and one subject (in the nondirective condition) attended only the first, second and sixth sessions. The dropout rate did not differ significantly among experimental conditions $\chi^2(2) = .694$. T-tests were used to compare this group of drop-outs to the group of subjects who completed the workshops. These tests indicate that the non-completers did not differ significantly from the completers on demographic characteristics or pre-test scores. Therefore, all the following analyses and discussions are based on the data from the 35 subjects who completed the study.

The final subject population included 13 subjects in the cognitive condition (seen in groups of 7 and 6), 13 subjects in the behavioral self-control condition (seen in groups of 7 and 6), and 9 subjects in the nondirective condition (seen in groups of 5 and 4). This

sample includes 27 females and 8 males, with ages ranging from 19 to 68 years. The demographic characteristics of the subjects are summarized in Table 1.

Scores on the pre-test measures are presented in Table 2. For the Verbal Behavioral Measure, only the measures of Overall Depression and Rate of Negative Self-References are included in the analysis. So few references were made to others during the taping of this measure, that it was decided to eliminate Rate of Negative Other-References from the analysis. Two undergraduate raters (who were blind to conditions) independently rated each of the tape-recorded speeches in random order. Ratings were made of Overall Depression (on a 5-point scale), number of positive self-references and number of negative self-references. Inter-rater reliability, calculated using Pearson correlations, was .725 for the Overall Depression Rating, .88 for number of positive self-references, and .92 for negative self-references. The ratings for the two raters were averaged, and the Negative Self-Reference rate was calculated as the number of negative self-references divided by the sum of both positive and negative self-references.

One-way analyses of variance were performed on all the pre-test data to verify that the conditions were actually equated by the random assignment procedure. For all of the variables except one, there were no significant differences among conditions. There were, however,

Table 1

Demographic Characteristics of Subjects

Variable	Cognitive Condition (N = 13)	Behavioral Self-control Condition (N = 13)	Nondirective Condition (N = 9)
Sex			
Female	8	10	9
Male	5	3	0
Mean Age in Years	40.7	38.7	34.3
Highest Level of Education Completed			
High School graduate	3	4	2
Some additional education	4	3	2
B.A., B.S.	2	6	3
Education beyond B.A., B.S.	4	0	2
Occupation			
Professional and Semi-professional	5	4	4
Clerical, Sales Skilled Workers	3	5	1
Homemakers	2	3	2
Student	0	1	2
Retired or Unemployed	3	0	0
Ethnic Group			
Caucasian	12	12	8
Black	0	0	1
Hispanic	1	1	0
Marital Status			
Never Married	3	2	2
Married	7	5	3
Divorced, Separated Widowed	2	6	4
Remarried	1	0	0
Previous Therapy			
Yes	9	10	4
None	4	3	5

Table 2

Pre-Assessment Scores of Subjects According to Groups

Measure	Cognitive Condition (N = 13)	Behavioral Condition (N = 13)	Nondirective Condition (N = 9)	F Ratio	Significance of F
Beck Depression Inventory					
Mean	23.46	24.15	26.44	.74	.48
S.D.	6.60	5.32	5.08		
D-30 Scale					
Mean	19.77	20.77	22.22	1.37	.27
S.D.	3.56	2.98	3.80		
Dysfunctional Attitude Scale					
Mean	129.85	150.85	183.22	5.95	.006*
S.D.	31.58	40.39	33.95		
Irrational Beliefs Test					
Mean	311.54	325.77	332.22	1.90	.16
S.D.	26.87	27.65	21.09		
Pleasant Events Schedule - Question A					
Mean	102.31	102.92	98.00	.40	.67
S.D.	14.16	13.08	12.81		
Pleasant Events Schedule - Question B					
Mean	109.61	120.85	117.77	1.59	.22
S.D.	19.54	15.60	12.11		
Verbal Behavioral Measure - Negative Self-Reference Rate					
Mean	.63	.69	.68	.41	.67
S.D.	.15	.20	.18		
Verbal Behavioral Measure - Overall Depression					
Mean	4.00	4.15	3.87	.26	.77
S.D.	.84	.90	.92		
Cognitive Complexity					
Mean	3.69	3.54	3.55		
S.D.	.85	1.27	.88	.08	.92

*Statistically significant

significant differences among conditions on the Dysfunctional Attitude Scale (DAS), $F(2,32) = 5.95$, $p = .006$. T-test comparisons show that at pre-test, subjects in the nondirective condition scored significantly higher on the DAS than subjects in the cognitive condition, $t(20) = -3.78$, $p = .001$.

One-way analyses of variance were also performed for the individual group data to determine whether the data for both groups within each condition could be pooled for the analysis. The analysis of variance for group data was consistent with the analyses for data by conditions, with the only significant difference among groups being on the DAS, $F(5,29) = 2.76$, $p = .037$. Thus, for all the remaining analyses, the data for the 2 groups within each treatment condition has been pooled.

The major analysis of this study was a 3 x 3 (treatment x time) analysis of variance for repeated measures with a nested design (subjects nested within treatments). This analysis was designed to analyze the differences among the experimental groups as well as to analyze the differences among the three testing periods (pre-test, post-test and 6 week follow-up). In addition to these comparisons, a comparison was planned between the average of the means of the two more structured treatment conditions (the cognitive and the behavioral self-control conditions) and the mean for the unstructured nondirective condition to test for a general effect of an

active, structured treatment program for depression. Finally, a 3 x 2 (treatment x cognitive complexity level) analysis of variance was used to determine whether cognitive complexity level influenced the effectiveness of the three treatment conditions.

To simplify the presentation of the data, the tables will include data pertinent only to main effects. Interactions between factors will be discussed separately when they are significant.

Treatment Effects

The data concerning the effect of treatment condition upon the various measures of depression are presented in Table 3. The analysis of variance showed that, with data for all three testing times combined, there was a significant treatment effect for the DAS, $F(2,32) = 3.58$, $p = .04$. It has previously been noted, however, that the DAS was the one measure on which the treatment conditions had not been equated by the randomization process. A priori contrasts (Tables 4 & 5) do, in fact, indicate that none of the comparisons at post-test or follow-up show significant differences among the treatment conditions. Thus, it does seem that the significant treatment effect on DAS is accounted for by the pre-test differences, and not by any differential treatment effects after the workshops started.

Table 3

Main Effects of Treatment Conditions

Measure	Cognitive Condition[a] (N = 13)	Behavioral Condition[a] (N = 13)	Nondirective Condition[a] (N = 9)	F Ratio	Significance of F
Beck Depression Inventory					
Across all times	15.97	14.36	17.63	.810	.454
Post-test	12.92	7.92	14.78	2.02	.149
Follow-up	11.54	11.00	11.67	.0228	.977
D-30 Scale					
Across all times	15.64	15.33	18.37	1.50	.239
Post-test	13.38	12.00	17.33	1.93	.162
Follow-up	13.77	13.23	15.55	.38	.689
Dysfunctional Attitude Scale					
Across all times	123.72	134.15	157.56	3.58	.040*
Post-test	119.54	123.85	142.89	1.70	.199
Follow-up	121.77	127.77	146.56	1.25	.300
Irrational Beliefs Test					
Across all times	296.85	302.85	317.74	1.57	.224
Post-test	291.61	287.00	309.33	1.09	.350
Follow-up	287.38	295.77	311.67	1.26	.298
Pleasant Events Schedule - Question A					
Across all times	106.72	113.23	105.07	1.26	.298
Post-test	109.38	119.15	106.33	2.18	.129
Follow-up	108.46	117.61	110.89	1.08	.352

Table 3 (cont.)

Measures	Cognitive Condition[a] (N = 13)	Behavioral Condition[a] (N = 13)	Nondirective Condition[a] (N = 9)	F Ratio	Significance of F
Pleasant Events Schedule - Question B					
Across all times	113.41	121.20	117.59	.691	.509
Post-test	115.89	116.08	115.67	.001	.999
Follow-up	114.77	126.69	119.33	1.40	.260
Verbal Behavioral Measure- Negative Self-Reference Rate					
Across all times	.4397	.4285	.4737	.2215	.8026
Post-test	.3028	.1495	.3755	4.554	.0185*
Follow-up	.3189	.3303	.3286	.0068	.9933
Verbal Behavioral Measure - Overall Depression					
Across all times	3.19	3.09	3.12	.047	.954
Post-test	2.375	1.885	2.889	3.81	.0332*
Follow-up	2.61	2.53	2.33	.125	.883

[a]Entries in these columns refer to the mean scores.
*Statistically significant

Two of the behavioral measures, the VBM Negative Self-Reference Rate and the VBM Overall Depression Rating, show significant differences among treatment conditions at post-testing, $F(2,31) = 4.554$, $p = .0185$, and $F(2,31) = 3.81$, $p = .0332$, respectively. Planned comparisons (Tables 4 and 5) indicate that at post-test subjects in the behavioral self-control condition had significantly lower Negative Self-Reference Rates than subjects in either the nondirective or the cognitive conditions. Also, the comparison between the two more structured conditions combined and the unstructured nondirective condition shows that, directly after the workshop ended, subjects in the structured conditions as a whole had significantly lower Negative Self-Reference Rates than subjects in the nondirective condition, $t(31) = -2.115$, $p = .043$. These differences were not maintained at follow-up, as shown in Table 5.

At post-testing, the VBM Overall Depression Rating was significantly lower for the behavioral condition than for the nondirective condition, $t(31) = 2.747$, $p = .010$. Also, when combined, the subjects in both structured conditions showed significantly lower Overall Depression Ratings than the nondirective condition, $t(31) = -2.316$, $p = .027$. Here again, however, neither of these differences was maintained at the 6-week follow-up period.

Although none of the other measures of depression showed differences among the treatment conditions that were significant at the .05 alpha level, there were some strong trends that are worth mentioning here. At

Table 4

A Priori Contrasts Among Treatment Conditions at Post-test

Measure	T-value	Degrees of Freedom	2-tail Probability
Beck Depression Inventory			
Cognitive-Nondirective	-.506	32	.616
Behavioral-Nondirective	1.870	32	.071
Cognitive-Behavioral	1.508	32	.141
(Cognitive + Behavioral)-Nondirective	-1.332	32	.192
D-30 Scale			
Cognitive-Nondirective	-1.429	32	.163
Behavioral-Nondirective	1.930	32	.062
Cognitive-Behavioral	.554	32	.583
(Cognitive + Behavioral)-Nondirective	-1.883	32	.069
Dysfunctional Attitude Scale			
Cognitive-Nondirective	-1.777	32	.085
Behavioral-Nondirective	1.449	32	.157
Cognitive-Behavioral	-.362	32	.719
(Cognitive + Behavioral)-Nondirective	-1.809	32	.080
Irrational Beliefs Test			
Cognitive-Nondirective	-1.134	32	.265
Behavioral-Nondirective	1.430	32	.163
Cognitive-Behavioral	.327	32	.746
(Cognitive + Behavioral)-Nondirective	-1.437	32	.160
Pleasant Events Schedule - Question A			
Cognitive-Nondirective	.455	32	.652
Behavioral-Nondirective	-1.914	32	.065
Cognitive-Behavioral	-1.612	32	.117
(Cognitive + Behavioral)-Nondirective	1.328	32	.194

Table 4 (cont.)

Measure	T-value	Degrees of Freedom	2-tail Probability
Pleasant Events Schedule - Question B			
Cognitive-Nondirective	.023	15.4[a]	.982
Behavioral-Nondirective	-.033	18.6[a]	.974
Cognitive-Behavioral	-.020	16.2[a]	.984
(Cognitive + Behavioral)-Nondirective	.034	19.8[a]	.973
Verbal Behavioral Measure - Negative Self-Reference Rate			
Cognitive-Nondirective	-.908	31	.371
Behavioral-Nondirective	2.870	31	.007*
Cognitive-Behavioral	2.109	31	.043*
(Cognitive + Behavioral)-Nondirective	-2.115	31	.043*
Verbal Behavioral Measure - Overall Depression			
Cognitive-Nondirective	-1.382	31	.177
Behavioral-Nondirective	2.747	31	.010*
Cognitive-Behavioral	1.453	31	.156
(Cognitive + Behavioral)-Nondirective	-2.316	31	.027*

[a]Separate variance estimates were necessitated rather than pooled variance estimates, since the Bartlett test showed that the variances were not homogeneous.
*Statistically significant.

Table 5

A Priori Contrasts Among Treatment Conditions at Follow-up

Measure	T-value	Degrees of Freedom	2-tail Probability
Beck Depression Inventory			
Cognitive-Nondirective	-.037	32	.971
Behavioral-Nondirective	.191	32	.850
Cognitive-Behavioral	.171	32	.865
(Cognitive + Behavioral)-Nondirective	-.128	32	.899
D-30 Scale			
Cognitive-Nondirective	-.652	32	.519
Behavioral-Nondirective	.848	32	.403
Cognitive-Behavioral	.217	32	.829
(Cognitive + Behavioral)-Nondirective	-.841	32	.407
Dysfunctional Attitude Scale			
Cognitive-Nondirective	-1.548	32	.131
Behavioral-Nondirective	1.173	32	.249
Cognitive-Behavioral	-.414	32	.681
(Cognitive + Behavioral)-Nondirective	-1.526	32	.137
Irrational Beliefs Test			
Cognitive-Nondirective	-1.581	32	.124
Behavioral-Nondirective	1.035	32	.308
Cognitive-Behavioral	-.604	32	.550
(Cognitive + Behavioral)-Nondirective	-1.467	32	.152
Pleasant Events Schedule - Question A			
Cognitive-Nondirective	-.343	32	.734
Behavioral-Nondirective	-.949	32	.350
Cognitive-Behavioral	-1.428	32	.163
(Cognitive + Behavioral)-Nondirective	.340	32	.736

Table 5 (cont.)

Measure	T-value	Degrees of Freedom	2-tail Probability
Pleasant Events Schedule - Question B			
Cognitive-Nondirective	-.576	32	.568
Behavioral-Nondirective	-.929	32	.360
Cognitive-Behavioral	-1.665	32	.106
(Cognitive + Behavioral)-Nondirective	.198	32	.844
Verbal Behavioral Measure - Negative Self Reference Rate			
Cognitive-Nondirective	-.085	32	.933
Behavioral Nondirective	-.014	32	.989
Cognitive-Behavioral	-.109	32	.914
(Cognitive + Behavioral)-Nondirective	-.039	32	.969
Verbal Behavioral Measure - Overall Depression			
Cognitive-Nondirective	.473	32	.639
Behavioral-Nondirective	-.409	32	.686
Cognitive-Behavioral	.071	32	.944
(Cognitive + Behavioral)-Nondirective	.494	32	.625

post-testing, subjects in the behavioral condition show less depression than subjects in the nondirective condition as measured by the BDI ($p = .071$), the D-30 Scale ($p = .062$), and the PES-Question A ($p = .065$). In addition, subjects in the cognitive condition have lower scores at post-test on the DAS than those in the nondirective condition ($p = .085$). These differences tend towards significance. At follow-up, however, none of these differences are maintained.

Analyses of group data can often be misleading, and discussions of statistical significance which pertain only to the consistency of between-group differences may have little or no bearing on the issue of clinical relevance. In addition to the above analyses, therefore, it would seem appropriate to compare the numbers of subjects in the various conditions who scored in the nondepressed range of the BDI (less than 11 according to Beck, 1972) at post-test as compared to pre-test. Before the beginning of the workshops, all subjects scored in the clinically depressed range of the BDI (greater than 17). At post-test, however, 61% of the subjects in the behavioral condition, 54% of the subjects in the cognitive condition, and 22% of the subjects in the nondirective condition had moved into the nondepressed range of the BDI. Fisher's exact probability test of change from pre-test to post-test showed that this change in the number of nondepressed subjects was highly significant for the behavioral condition

(p = .0008) and for the cognitive condition (p = .0002), but not significant for the nondirective condition (p = .23). This same pattern was maintained at follow-up, with significant pre-test to follow-up changes being shown by the behavioral condition (p = .0002) and the cognitive condition (p = .020) but not for the nondirective condition (p = .10).

Time Effects

There were strongly significant time effects across all three conditions on most of the measures of depression (Table 6). In fact, the only measure of depression that did not show a highly significant time effect was Question B of the Pleasant Events Schedule. Thus, on these general, cognitive, and behavioral measures of depression there were significant differences among scores at the pre-test, post-test and follow-up periods. Planned t-test comparisons (summarized in Table 7) show that, for all three treatment conditions combined, subjects had significantly lower depression scores after taking part in the depression workshops than they had shown before the workshop. These measures also showed significantly lower depression scores at follow-up than at the pre-test, substantiating that these lower depression scores were maintained at follow-up. There were no significant differences between any of the depression scores at post-test and follow-up periods.

No significant interactions were found between the treatment and time factors.

Table 6

Main Effects of Time Factor for all Treatment Conditions Combined

Measure	Pre-test	Post-test	Follow-up	F Ratio	Significance of F
Beck Depression Inventory					
Mean	24.49	11.54	11.37	62.91	.0005*
S.D.	5.74	8.70	7.80		
D-30 Scale					
Mean	20.77	13.88	14.03	30.17	.0005*
S.D.	3.46	6.54	6.20		
Dysfunctional Attitude Scale					
Mean	151.37	127.14	130.37	12.58	.0005*
S.D.	40.56	30.92	37.19		
Irrational Beliefs Test					
Mean	322.14	294.46	296.74	17.43	.0005*
S.D.	26.54	36.12	35.68		
Pleasant Events Schedule - Question A					
Mean	101.42	112.23	112.49	16.81	.0005*
S.D.	13.19	15.98	16.38		
Pleasant Events Schedule - Question B					
Mean	115.89	115.89	120.37	.946	.394
S.D.	16.75	26.58	18.47		
Verbal Behavioral Measure - Negative Self Reference Rate					
Mean	.66	.26	.33	34.54	.00001*
S.D.	.175	.20	.25		
Verbal Behavioral Measure - Overall Depression					
Mean	4.21	2.60	2.60	32.34	.0005*
S.D.	.861	.912	1.34		

*Statistically significant

Table 7

Planned Comparisons of Depression Scores at the Three Testing Periods for all Treatment Conditions Combined

Measure	T-value	Degree of Freedom	2-tail Probability
Beck Depression Inventory			
Pre-Post	10.08	34	.001*
Pre-Follow-up	9.48	34	.001*
Post-Follow-up	.12	34	.903
D-30 Scale			
Pre-Post	6.20	34	.001*
Pre-Follow-up	6.54	34	.001*
Post-Follow-up	-.17	34	.868
Dysfunctional Attitude Scale			
Pre-Post	4.12	34	.001*
Pre-Follow-up	3.37	34	.002*
Post-Follow-up	-.92	34	.364
Irrational Beliefs Test			
Pre-Post	4.69	34	.001*
Pre-Follow-up	4.36	34	.001*
Post-Follow-up	-.68	34	.500
Pleasant Events Schedule - Question A			
Pre-Post	-4.51	34	.001*
Pre-Follow-up	-4.37	34	.001*
Post-Follow-up	-.17	34	.868
Verbal Behavioral Measure - Negative Self Reference Rate			
Pre-Post	10.04	32	.001*
Pre-Follow-up	6.51	33	.001*
Post-Follow-up	-1.20	33	.238
Verbal Behavioral Measure - Overall Depression			
Pre-Post	9.36	32	.001*
Pre-Follow-up	6.61	33	.001*
Post-Follow-up	-.77	33	.448

*Statistically significant

Cognitive Complexity Effects

Subjects were divided into two groups according to their scores on the Cognitive Complexity Scale: subjects with complexity scores less than or equal to 3 were considered to be in the Low Complexity group and subjects with scores greater than or equal to 4 were placed in the High Complexity groups. A 3 x 2 (Treatment by Cognitive Complexity level) analysis of variance was conducted to determine whether level of cognitive complexity, as measured by this Cognitive Complexity Scale, influenced the effectiveness of the three treatment conditions. The data concerning effects of cognitive complexity are summarized in Table 8.

A significant complexity effect was found on the DAS, $F(1,29) = 4.05$, $p = .054$. Planned t-test comparisons show that at post-testing, subjects with high levels of cognitive complexity have significantly higher DAS scores than subjects with lower levels of cognitive complexity, $t(33) = -2.09$, $p = .044$. There are also trends in a similar direction at pre-test, $t(33) = -1.79$, $p = .082$, and at follow-up, $t(33) = -1.81$, $p = .080$.

Of particular interest were any interactions between cognitive complexity level and treatment conditions, since such interactions would indicate that cognitive complexity differentially influenced the effectiveness of the three treatment conditions. There were no significant interactions between complexity level and workshop condition on

Table 8

Main Effects of Cognitive Complexity Level for all Treatment Conditions Combined

Measure	Low Cognitive Complexity[a] (N = 17)	High Cognitive Complexity[a] (N = 18)	F Ratio	Significance of F
Beck Depression Inventory	16.46	15.46	.227	.637
D-30 Scale	15.83	16.91	.505	.483
Dysfunctional Attitude Scale	128.29	148.19	4.051	.054
Irrational Beliefs Test	299.56	311.65	1.668	.207
Pleasant Events Schedule - Question A	110.93	105.65	1.332	.258
Pleasant Events Schedule - Question B	121.04	113.77	1.601	.216
Verbal Behavioral Measure - Negative Self Reference Rate	.4274	.4151	.054	.817
Verbal Behavioral Measure - Overall Depression	3.20	3.07	.226	.638

[a]Entires in these columns refer to mean scores

any of the measures of depression. There was, however, such a significant interaction for ratings on the post-test question of "would you recommend this type of workshop for a close friend with depression?" $F(2,22) = 4.78$, $p = .019$. When comparisons were made for each condition separately, it was found that this difference resulted from the fact that in the nondirective condition, subjects with high levels of cognitive complexity rated their workshop significantly more positively than subjects with low levels of complexity, $t(7) = -4.08$, $p = .005$.

Additional Analyses

One way analysis of variance was used to test for differences among treatment conditions on subject's post-test and follow-up ratings of the workshop and their group leader. Questions were rated on a 7-point scale, with 7 being the most positive answer possible. These results are presented in Table 9 and Table 10. Significant differences were found between treatments on each of the following questions:

At post-test -

1) To what degree has this workshop been helpful to you in coping with depression?
2) To what degree has this workshop been helpful to you in other areas, besides depression?
3) To what degree has your depression been reduced as a result of this workshop?

Table 9

Differences Among Treatment Conditions on Answers to Post-test Questionnaire

Question	Cognitive Condition[a] (N = 13)	Behavioral Condition[a] (N = 13)	Nondirective Condition[a] (N = 9)	F Ratio	Significance of F
1) To what degree has this workshop been helpful to you in coping with depression?	5.00	6.20	3.83	4.48	.022*
2) To what degree has this workshop been helpful to you in other areas, besides depression?	4.42	6.30	4.67	4.09	.029*
3) To what degree has your depression been reduced as a result of this workshop?	4.25	5.80	3.83	3.57	.043*
4) To what degree do you feel better able to cope with future depressions as a result of this workshop?	4.83	6.00	4.33	2.72	.085
5) Was this type of workshop appropriate for you?	5.17	6.20	4.33	2.26	.126
6) Would you recommend this type of workshop to a close friend with depression?	5.75	6.80	5.33	3.92	.033*
7) How likable did you find your group leader?	6.42	6.30	5.83	.80	.460
8) How competent did you find your group leader?	5.75	5.90	4.17	2.54	.099
9) Do you plan to seek further treatment for depression?	3.5	3.7	3.67	.039	.962

Table 9 (cont.)

Question	Cognitive Condition[a] (N = 13)	Behavioral Condition[a] (N = 13)	Nondirective Condition[a] (N = 9)	F Ratio	Significance of F
10) Do you plan to seek further treatment in areas other than depression?	3.92	3.10	3.83	.713	.500

[a]Entries in these columns refer to the mean rating on a 7-point scale, with 7 being the most positive possible response.
*Statistically significant.

Table 10

Differences Among Treatment Conditions on Answers to Follow-up Questionnaire

Question	Cognitive Condition[a] (N = 13)	Behavioral Condition[a] (N = 13)	Nondirective Condition[a] (N = 9)	F Ratio	Significance of F
1) To what degree has this workshop been helpful to you in coping with depression?	4.67	6.00	4.00	2.03	.152
2) To what degree has this workshop been helpful to you in other areas, besides depression?	3.92	6.30	3.83	7.10	.003*
3) To what degree has your depression been reduced as a result of this workshop?	4.33	5.20	4.0	.822	.451
4) To what degree do you feel better able to cope with future depressions as a result of this workshop?	4.58	5.50	4.0	1.30	.290

[a]Entries in these columns refer to the mean rating on a 7-point scale, with 7 being the most positive possible response.
*Statistically significant.

4) Would you recommend this workshop to a close friend with depression?

At follow-up -

1) To what degree has this workshop been helpful to you, in other areas, besides depression?

T-test comparisons (summarized in Table 11) show that for each of these questions, subjects in the behavioral self-control condition answered significantly more positively than subjects in either the cognitive or the nondirective conditions.

A procedure suggested by Shaw (1977) was used to evaluate whether the treatment protocols had been adhered to and the treatment conditions could be discriminated from each other. Three 10-minute sections were selected from the tapes of each treatment session at random. Two undergraduate raters were trained to identify the crucial components of each type of workshop and then independently rated these sections of the tapes in random order, trying to determine which type of program was being conducted. These raters showed 100% agreement on their ratings. The chi-square test showed that a significantly greater number of sessions were correctly identified than would be expected by chance, $\chi^2(1) = 106.87$, $p < .001$.

Table 11

Comparisons Among Treatment Conditions for Post-test and Follow-up Questions that showed Significant Differences

Question	T-value	Df	2-tail Probability
Post-test			
1) To what degree has this workshop been helpful to you in coping with depression?			
Cognitive-Nondirective	1.26	20	.222
Behavioral-Nondirective	-3.55	11.27[a]	.005*
Cognitive-Behavioral	-2.30	18.18[a]	.034*
2) To what degree has this workshop been helpful to you in other areas, besides depression?			
Cognitive-Nondirective	-.18	20	.856
Behavioral-Nondirective	-3.33	20	.003*
Cognitive-Behavioral	-3.30	18.64[a]	.004*
3) To what degree has your depression been reduced as a result of this workshop?			
Cognitive-Nondirective	.36	20	.720
Behavioral-Nondirective	-3.25	20	.004*
Cognitive-Behavioral	-2.42	24	.023*
4) Would you recommend this workshop to a close friend with depression?			
Cognitive-Nondirective	.52	20	.608
Behavioral-Nondirective	-3.06	10.96[a]	.011*
Cognitive-Behavioral	-2.75	17.65[a]	.013*
Follow-up			
1) To what degree has this workshop been helpful to you in other areas, besides depression?			
Cognitive-Nondirective	-.53	20	.600
Behavioral-Nondirective	-2.39	19	.027*
Cognitive-Behavioral	-3.25	23	.003*

[a]Separate variance estimates were necessitated rather than pooled variance estimates, since the Bartlett test showed that the variances were not homogenous.
*Statistically significant.

DISCUSSION

This study was designed to compare three different types of short-term treatment for depression and to examine how the subject variable of cognitive complexity might be related to the effectiveness of each of these workshops. After participation in either the cognitive, behavioral or nondirective workshop, subjects in this study showed a significant decrease in depressive symptomatology, as measured by general, cognitive, and behavioral measures of depression. This decrease in reported depression was consistently maintained at the end of a six-week follow-up period.

While all three depression control workshops led to a decrease in depression, most of the specific hypotheses of this study were not confirmed. No significant differences were found between the cognitive and the nondirective conditions on any of the measures of depression, so even though changes in the number of subjects in the nondepressed range on the BDI were significant for the cognitive condition and not for the nondirective condition, Prediction 1 was not supported in this study.

Prediction 2 was given only mild support by this study. Rather than showing a greater reduction on all the measures of depression, the behavioral condition showed greater

improvement than either the nondirective or cognitive conditions on only one of the depression measures. On the Verbal Behavioral Measure, the one measure that did not rely solely on self-report, subjects in the behavioral condition did make significantly fewer negative self-references and sounded signficantly less depressed on a tape-recording at post-test than subjects in the other two conditions. None of the other measures of depression showed differences among the treatment groups that are statistically significant, although changes in the number of subjects in the non-depressed range on the BDI were highly significant for the behavioral condition but not for the nondirective condition. In addition, subjects rated their behavioral workshop significantly more positively than subjects in either the cognitive or the nondirective workshops.

Concerning the specifically cognitive and behavioral measures of depression, only part of Prediction 4 was supported. Subjects in the behavioral condition did improve significantly more than those in the cognitive condition on one behavioral measure, but subjects in the cognitive condition did not improve significantly more on any of the cognitive measures of depression than those in the behavioral condition.

The results of this study showed substantially weaker treatment differences than the previous studies of cognitive and behavioral self-control therapy which were discussed earlier. In exploring some of the variables which

might account for these differences, comparisons will be drawn between this study and the other studies which have used similar treatment models, including research done by Beck et al. (1977), Fuchs and Rehm (1977), Shaw (1977) and Taylor and Marshall (1977).

Whenever one is comparing treatments based on models designed by other researchers, one major issue to explore in drawing conclusions is how representative the treatments were of the original treatment models. One important factor that relates to this issue is the lack of clinical experience of the group leaders in this study. Using relatively inexperienced group leaders, this study constituted a rather stringent test of the hypotheses, and it could be argued that the treatments were not given a fair chance since the group leaders were not experienced enough to follow the models to their full advantage. Although all the other studies listed above also used graduate student therapists, the group leaders used in this study were only in their first year of clinical training and had not previously had any formal, supervised clinical experience. This factor could have been crucial in weakening the differences among experimental conditions. The relative lack of experience of the leaders, however, makes it especially impressive that subjects in all three conditions did show significant reductions in depression.

Having had raters listen to random sections of the workshop tapes and judge which type of group was being

conducted does at least serve as a check that the workshops were recognizably different and followed the basic format intended for each condition. The behavioral approach used was not intended to represent behavioral treatments of depression as a whole, but was specifically designed to follow the self-control program developed by Rehm and his colleagues (Fuchs and Rehm, 1977; Rehm et al., Notes 4 and 5). The cognitive workshops conducted were not expected to represent each of the three different types of cognitive therapy discussed above, but were modeled after Beck's particular approach to cognitive therapy, as outlined by Shaw (1977). One factor of possible importance is that the behavioral self-control program had originally been designed to be conducted in groups, while Beck's cognitive therapy program was designed to be used with individual clients. In this study, where all the workshops were conducted in groups, the behavioral self-control condition seemed to be somewhat more successful in reducing depression than the cognitive condition. While some studies have tested Beck's approaches with groups (Shaw, 1977; Taylor and Marshall, 1977), it is notable that those studies have used only undergraduate student populations. The studies done on clinical populations by Beck and his colleagues (1977) have used an individual approach. Thus, it may well be that, with an older, non-student population such as used in this study, Beck's cognitive approach is more effective when conducted individually than in groups.

Another variable that could have been related to the lack of consistent differences among the treatment conditions in this study is the difference between the "placebo" condition of this study and the previous studies. The only other studies which have examined similar treatment models which included some type of attention control condition were the studies by Shaw (1977) and by Fuchs and Rehm (1977). In both of these previous studies, bias due to the therapists' knowledge of the hypotheses of the study could have effected the results. Shaw (1977) conducted all of the groups himself, so he was clearly not blind to the hypotheses of his study. The two therapists in Fuchs and Rehm's study (1977) were presented with readings and a detailed manual for the self-control condition, but no equivalent formal preparation for the nonspecific condition, so it was most likely clear to them which condition was expected to lead to greater improvement. Even when an earnest attempt is made to minimize experimenter bias and lead each group with equal enthusiasm, one's expectancies that one group will be more effective than the other are likely to have some effect on how the group is conducted.

In the present study, the group leaders remained blind to the specific hypotheses of the study throughout the workshop period. The study was presented to the leaders as research into the subject variables affecting how much clients benefited from each of the workshops, rather than

a comparison of the effectiveness of the three different types of workshop. The expectancy was set that all three workshop conditions would be effective, but that certain types of clients might benefit more from one workshop than another. Given that subject variables were actually a major facet of this study and that the principal investigator was known to use components of all three conditions in her own clinical work, it seemed quite plausible that all three conditions would be expected to succeed. Thus, each condition was treated equally seriously as a treatment group, with a treatment manual, readings, and equal amounts of training and supervision. Some experimenter bias was still possible since the principal investigator supervised all the group leaders herself, yet she too was more focused on the subject variables and did expect all conditions to show significant reduction of depression.

This careful attempt to minimize bias against the nondirective condition may have resulted in a more effective nondirective condition than most attention control groups. When the results for the nondirective conditions are compared across studies, it does seem possible that this is part of what accounts for the different treatment effects between the current study and the Shaw (1977) study, since the nondirective condition in this study did show a greater rate of improvement than the similar condition in Shaw's study. This cannot account completely for the lack of strong treatment differences in this study, however, since

the nonspecific group in the study by Fuchs and Rehm (1977) did show improvements similar to the nonspecific group in this study, yet their self-control condition still showed significantly greater reductions in depression.

Although multiple group leaders were included in this study to minimize experimenter bias, having only two group leaders in each condition meant that there were not enough leaders to insure that specific leader variables were randomized across conditions. In fact, the limited supply of available group leaders and the attempt to assign leaders to groups that they preferred and could lead with enthusiasm led to the sex of group leaders not being balanced across conditions. Leaders for both cognitive groups were female, while all the leaders in the other conditions were male. In addition, the sizes of the groups were different across conditions, with the nondirective groups containing 4 to 5 members while groups in the other two conditions had 6 to 7 members. Thus, the groups differed on several dimensions and it remains unclear as to how these differences might have affected the results. Ideally, future research in this area would use a large sample of group leaders, equal numbers of members in each group, and a balance of sexes of both members and group leaders across conditions so that the groups and conditions would be more clearly comparable.

As with any research, the generalizability of the findings in this study is limited by the specific characteristics of the subjects. Although this study did not use

the undergraduate subject population so typical of psychological studies, the use of advertising in the mass media to recruit subjects (as also used by Fuchs and Rehm, 1977) differentiates this study from those using true clinical populations. The scores of subjects on the screening measures and data from the interviews do indicate that these subjects showed moderate levels of depression and would be appropriate clients at an outpatient clinical setting. In fact, 23 of the 35 subjects had been involved in outpatient therapy within the past few years, a fact supporting the similarity between these subjects and an outpatient clinical population.

The specific criteria for selection to this study also limits the generalizability of these findings. The subjects in this study showed moderate levels of depression comparable to the other studies done in this area, but none of the subjects had obviously psychotic symptoms, serious intent to commit suicide, or depressions associated with schizophrenia, organic brain disorder, alcoholism or drug addictions. One subject variable distinguishing subjects in this study from those in previous studies testing similar models of treatment is that subjects in this study tended to be older, with a mean age of 38 years. It could be that older depressed clients are somewhat less amenable to change through short-term structured workshops than younger clients with similar levels of depression, and that this was related to the weaker treatment effects in this study.

Another issue worth consideration in any treatment outcome research is whether the outcome measures adequately measure improvement in the phenomenon under investigation. This study, as well as most outcome studies examining treatments for depression, relies heavily on self-report measures of depression. Good, reliable behavioral measures of depression have not yet been developed but are badly needed to supplement the data from self-report measures. It is noteworthy that the one behavioral measure in this study, the Verbal Behavioral Measure (VBM), proved to be the only measure that was sensitive to differences among the treatment conditions. The VBM did not show patterns that were radically different from those of the self-report measures, but these patterns of differences among treatment conditions were more strongly and clearly exemplified by this behavioral measure than by the self-report measures. The VBM is based on the behavioral measure used by Rehm and his colleagues in their research (Fuchs and Rehm, 1977; Rehm et al., Notes 4 and 5) and both these measures are new enough that their psychometric properties have not yet been thoroughly investigated. The sensitivity of the VBM to the treatment effects in this study does indicate some promise for this measure, so further research to examine its psychometric characteristics seems to clearly be in order.

The results of this study with regard to cognitive complexity do not confirm Prediction 3. In fact, contrary

to expectation, subjects with high levels of cognitive complexity scored higher on the Dysfunctional Attitude Scale (DAS) than subjects with low cognitive complexity, especially at the time of the post-testing. Subjects at both levels of complexity showed significantly reduced DAS scores from pre-test to post-test, but subjects with high cognitive complexity had started with higher DAS scores and maintained the difference across the three time periods. The variable of cognitive complexity has not been previously investigated in relation to depression, but these data suggest that there may be a complex relationship between cognitive complexity and depression. For example, one hypothesis that might explain this data is that when people who are high in cognitive complexity become depressed, they manifest the cognitive component of depression most strongly, giving them more pronounced dysfunctional attitudes than people with low cognitive complexity, who may manifest depression somewhat differently.

Besides the possibility of a complex relationship between depression and cognitive complexity, deficiencies in the concept or measurement of cognitive complexity itself could be responsible for the disappointing results of this aspect of the study. The definition and measures of cognitive complexity are still the subject of so much controversy among researchers that it could be argued that cognitive complexity is related to the success of individuals in different types of short-term workshops, but

simply not as defined or measured in this study. More cooperation among researchers in this area, empirical findings comparing and contrasting various measures and definitions of cognitive complexity, and further research to clarify the relationship between cognitive complexity and depression will all be needed before the variable of cognitive complexity is likely to be a useful predictor of the effectiveness of different treatments for depression.

At the end of the relatively brief 6-week period, the few significant differences among treatment conditions which had existed at post-test were no longer present, and there was no significant improvement on any of the depression measures from the post-test to the follow-up period. Therefore, Prediction 5 was not confirmed in this study. This finding is consistent with the results of previous studies in this area, which suggests that the treatment approaches being compared may show no real differences which last over even brief periods of time. In particular, the two other studies that included non-specific control groups (Shaw, 1977 and Fuchs and Rehm, 1977) found that many of the significant differences between conditions at post-test became only non-significant trends at the end of brief follow-up periods. It is important to note that it is the differences between the treatment conditions that show a tendency to disappear over brief periods of time, not the overall reductions of the subjects' depression.

What is especially striking in this study is that, despite the lack of experience of the group leaders, subjects in all the conditions improved markedly in their depressive symptomatology, and these improvements were consistently maintained after a 6-week follow-up period. A waiting list control group was not included in this study due to the practical and ethical problems involved in deliberately withholding assistance from a group of depressed people. Without this type of control group, it could be argued that the depression was simply following its natural course and that none of the workshops had anything to do with the high rate of symptomatic improvement. To conclusively answer this argument, it would be necessary to replicate this study, including a waiting list control group as one of the conditions. In other studies using similar subject populations which did include a waiting list control group, however, subjects in the control groups did not show significant decreases in depression from pre-test to post-test. Although this support is admittedly indirect, it does seem unlikely that the pronounced improvements shown in all three conditions of this study were merely spontaneous and unrelated to participation in the depression control workshops.

The marked improvement of subjects in all three conditions of this study is especially interesting in light of the recent finding by Rehm et al. (Note 5) that each component of their self-control treatment package was

effective in reducing depression when used separately as well as when combined with other elements of the package. Thus, a treatment as simple as self-monitoring alone proved to be significantly more effective in reducing depression than that of a waiting list control group and equally as effective as approaches combining all three components of the self-control program. Given that such relatively simple interventions used by relatively inexperienced therapists and group leaders can result in reductions in depression that are highly significant both statistically and clinically, it seems clear that further research into the use of short-term approaches to the treatment of depression is warranted. Longer follow-up studies are definitely needed to determine whether these reductions in depression are stable or temporary, and such studies are currently in progress by Beck as well as by Rehm (Note 13). While it is clear that further research is needed to overcome the limitations of this study and to isolate the mechanisms resulting in change from even simple interventions, this study does demonstrate potential for the use of inexperienced group leaders, and perhaps even paraprofessionals, to help ameliorate the increasing problem of depression.

APPENDICES

APPENDIX A

SAMPLE MEDIA ANNOUNCEMENT USED TO RECRUIT SUBJECTS

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SAMPLE MEDIA ANNOUNCEMENT USED TO RECRUIT SUBJECTS

Depression Control Workshops

We will conduct Depression Control workshops at the MSU Psychological Clinic throughout the winter of 1979 to help people cope with depression. Each group will consist of six to eight members and a group leader, and will meet two evenings per week for four weeks. The groups will be led by graduate students in clinical or counseling psychology at Michigan State University, and the program will be supervised by Dr. Dozier Thornton. The groups will be free of charge to people who complete some research questionnaires.

This is not group therapy, but a workshop where people can work together to try to find ways to overcome depression. Separate workshops will be starting on January 15, January 29, and February 12. Interested individuals should call Barbara Fleming at the MSU Psychological Clinic at (517) 355-9564.

APPENDIX B

STANDARDIZED TELEPHONE INTERVIEW

APPENDIX B

STRUCTURED TELEPHONE INTERVIEW

Hello, I'm Barbara Fleming from the MSU Psychological Clinic. I understand that you are interested in more information about the Depression Control Workshops. I'll just briefly describe the groups and if you decide you're interested, we can discuss it in more detail, okay?

The workshops will meet two evenings per week for four weeks, making the complete workshop a total of eight sessions. Each group consists of four to eight group members and a group leader who is a graduate student in clinical psychology at Michigan State University. The purpose of the group is to help each member better cope with his or her depression. The groups are for people who feel that they have a problem with depression in their own lives, and there is a screening process designed to ensure that the people in each group will have similar enough concerns so that they are likely to work well together. There is no charge for the group in terms of money, but since these groups are part of a research project we do ask that you pay for the group by filling out a series of research forms at three different points

in time: before the workshop begins, at the end of the workshop, and six weeks after the workshop has ended. Do you have any questions?

(If subjects asked for more details about what would actually go on in the groups, they were told that several different leaders would be running different groups, and each leader had a different style of running groups as well as different techniques that they felt were useful in helping people cope with depression. The one thing that all the groups have in common is that the members are all encouraged to actively work together to explore ways of coping with depression.)

If you think you might be interested in participating in this workshop, the first step would be to spend some time talking with me over the telephone about yourself and what depression is like for you, so that we can both get a better idea as to whether this workshop might be helpful to you. If, at the end of our discussion, we both decide that this workshop does seem appropriate for you, we would schedule a time for you to come in and complete the screening forms and the first set of research questionnaires. I will then call and let you know within 24 hours of the screening session whether it seems that this would be an appropriate workshop for you. If not, I will be glad to talk with you about what I have learned

through the interview and screening process, and I will do my best to help you find resources in the community that will better suit your needs. The screening process is not designed to determine whether you are "good enough" or "depressed enough" for the workshops; rather, we are trying to form groups of people who are most likely to benefit from the workshop.

Would you like to take some time now to discuss this further, or would you prefer that we set up another time to talk?

First of all, I'd like to get some factual information (age, marital status, occupation, level of education, current or previous therapy, etc.).

The word "depression" is used in many different ways. What exactly is depression like for you and how does it affect your life?

(An open-ended discussion of the person's experience of depression follows. Information is gathered about how depression affects each of the areas listed below. Each area is discussed within the context of a conversation and areas not mentioned spontaneously by the subject are introduced into the discussion by the interviewer.)

Areas informally covered within the interview:

1. Loss of interest or pleasure--How does depression affect your interest or enjoyment of family, friends, work, hobbies and interests, sex? Are you withdrawing from or avoiding people or activities?

2. Self-image--How do you currently feel about yourself? What are your good points, bad points? How do you see yourself in comparison to other people?

3. Worry and guilt--How much do you worry? What do you worry about? What do you feel guilty about, blame yourself for? Do you deserve to be punished?

4. Future orientation--How do you view your future? What plans, goals do you have?

5. Sleep--How does depression affect your sleep? Trouble falling asleep, waking early, restless sleep, sleeping too much? How many hours of sleep do you get per day?

6. Appetite--How does depression affect your appetite? Eating less or more than usual? Losing or gaining weight? How much?

7. Fatigue--Have less energy than ususal? Feel too tired to do things? Physical slowness of movement or speech?

8. Agitation--More restless, tense than usual? Speeding up of movement or speech? More irritable than usual?

9. Suicide--Have you thought about harming or killing yourself? Made plans? How would you do it? Any attempts? Are you considering suicide now?

10. Functioning--How does depression affect your ability to do your job, housework? Trouble making decisions? Concentrating?

11. Alcohol and drug use--How does depression affect your drinking and drug use? How much and often do you drink? What drugs do you use, how much and often? Do you consider your drinking or drug use to be a problem?

12. Health--How is your physical health? Have you had a check-up within the past year? What were the results? Are you worried about your health? What medications are you on?

What medical problems have you had in the past? What hospitalizations have you had? If psychiatric, what diagnosis?

13. Strange or unusual experiences--Is there anything unusual about the way things look, sound, smell? Do you feel that things are unreal? Have you ever felt that you were outside your body?

14. Time frame of depression--How long has this been a problem? How often do you feel depressed? Ups and downs? Fluctuations related to time of day, seasons?

15. Precipitants of depression--Can you generally tell what you are depressed about? What generally leads to depression? What seems to lead to feeling better?

16. What else should I know that would help me to understand what depression is like for you?

APPENDIX C

RESEARCH CONSENT FORM

APPENDIX C

Research Consent Form

1. I have freely consented to take part in a scientific study being conducted by Barbara Fleming under the supervision of Dr. Dozier Thornton, Professor in the Department of Psychology.

2. The study has been explained to me and I understand the explanation that has been given and what my participation will involve. More specifically, participation involves attending and sharing in eight workshop sessions, led by graduate students in clinical psychology at MSU, and completing research questionnaires at the beginning and end of the workshop and at a six-week follow-up period.

3. I understand that I am free to discontinue my participation in the study at any time without penalty.

4. I understand that the workshop sessions will be audio-taped, and the tapes will be used for research purposes only. I understand that I may withdraw my permission for use of these tapes at any time.

5. I understand that the tapes and the results of this study will be treated in strict confidence and that I will remain anonymous. The tapes will be kept for no more than five years from the date noted below; and as soon as the tapes are no longer useful for research purposes, they will be erased or destroyed. Within these restrictions, results of the study will be made available to me at my request.

6. I understand that my participation in the study does not guarantee any beneficial results to me.

7. I understand that, at my request, I can receive additional explanation of the study after my participation is completed.

Signed _____ Dated _____

APPENDIX D

PSYCHOLOGICAL SCREENING INVENTORY

APPENDIX D

Psychiatric Screening Inventory

If a statement tends to be TRUE for you, place a check in the column headed T: that is

F	T
	✓

If a statement tends to be FALSE for you, place a check in the column headed F: that is

F	T
✓	

Please try to answer all questions.

T	F	
		1. I enjoy classical music.
		2. I am usually happy.
		3. Being a TV announcer would be fun.
		4. I am happy just being alone.
		5. Shooting is a good sport.
		6. At times I lose all my drive.
		7. I guess I am not very efficient.
		8. I have never broken a major law.
		9. I do not worry about going insane.
		10. Things are always frightening me.
		11. Sometimes I don't quite know what to say.
		12. I forget things more quickly nowadays.
		13. People usually understand me.
		14. I think carefully about all my actions.
		15. I think there is something wrong with my memory.
		16. I am active in clubs.
		17. I don't get sick very often.
		18. It is fun to bet.
		19. I am rarely at a loss for words.
		20. When I sleep I toss and turn.
		21. I guess I know some pretty undesirable types.
		22. I do not like to gamble.
		23. I often find it hard to concentrate.
		24. I have sometimes drunk too much.
		25. I am sensitive to the needs of others.
		26. I would like to be more outgoing.
		27. I break more laws than many people.
		28. My friends were always welcome at home.
		29. Adults should not shout and yell so much.
		30. As a child I occasionally stole things.
		31. All people tell "white lies."
		32. I am pretty healthy for my age.
		33. My thoughts are sometimes unusual.

T	F	
		34. I enjoy the theater.
		35. I take all my responsibilities seriously.
		36. High speeds thrill me.
		37. I am tempted to sleep too much.
		38. I do not curse.
		39. Most people are honest with themselves.
		40. I do not like to perform for others.
		41. My health is no problem for me.
		42. Sometimes I am no good for anything at all.
		43. Strange voices have spoken to me.
		44. I would not like to be an actor.
		45. I have sometimes sat about when I should have been working.
		46. I'm afraid I broke a few rules at school.
		47. Warm relationships are difficult for me.
		48. At times I am a little shy.
		49. I frequently feel nauseated.
		50. My childhood home was happy.
		51. I have sometimes been tempted to hit people.
		52. I was always well behaved in school.
		53. I sometimes get all steamed up.
		54. My appetite is very healthy.
		55. I am extremely persistent.
		56. I am often tired during the day.
		57. My school teachers had some problems with me.
		58. Odd things have happened to me in my lifetime.
		59. I do not like to sit and daydream.
		60. Few people win arguments with me.
		61. I am easily distracted from a task.
		62. I rarely wake up tired.
		63. People should look after themselves first.
		64. Sometimes I am tempted to break something.
		65. I have been tempted to leave home.
		66. I have no trouble controlling my urges.
		67. I am rather a loud-mouth at times.
		68. Most people are looking for sympathy.
		69. I am a fairly conservative person.
		70. Much of my life is uninteresting.
		71. Some people really wish me harm.
		72. My parents like (or liked) my friends.
		73. I have little confidence in myself.
		74. I seldom feel frightened.
		75. People think I am pretty calm.
		76. Drug addiction is very undesirable.
		77. I feel isolated from other people.
		78. It is very hard to embarrass me.
		79. I have a lot of energy.
		80. I never act without thinking.
		81. The world has always seemed pretty real.
		82. I have avoided people I did not wish to speak to.

T	F	
		83. People tend to watch me.
		84. The world is full of odd things.
		85. I like to obey the law.
		86. I have never had a strange mental attack.
		87. I always do my work thoroughly.
		88. People generally like to help others.
		89. I would make a good leader.
		90. I sometimes feel I am in a world alone.
		91. My troubles are not all my fault.
		92. I enjoy talking in front of groups.
		93. I find it hard to start a conversation.
		94. I don't like to rush about.
		95. When I get nervous my hands tremble.
		96. People stop talking when I approach.
		97. Being a racing driver would be fun.
		98. Life treats me badly.
		99. I have rarely been punished.
		100. My failures are largely due to myself.
		101. I would like to be really important.
		102. I stay away from trouble.
		103. Sometimes I hear noises inside my head.
		104. I rarely stumble or trip when I walk.
		105. Many people do not know how sensitive I am.
		106. If I don't like somebody, I say so.
		107. My life is definitely worthwhile.
		108. I think carefully about most things I do.
		109. I rarely feel anxious in my stomach.
		110. People think I am more immature than I am.
		111. At times I feel worn out for no special reason.
		112. We should obey every law.
		113. Some of my relatives have done strange things.
		114. I am painstaking and thorough.
		115. I rarely or never get headaches.
		116. My parents are (or were) too conservative.
		117. I am usually the one to open a conversation.
		118. People often embarrass me.
		119. It is very easy for me to make friends.
		120. Sometimes the police use unfair tricks.
		121. Occasionally I feel dizzy or light-headed.
		122. At school I was never easy to manage.
		123. I am extremely talkative.
		124. Some people simply have too much energy.
		125. I feel that people keep secrets from me.
		126. I like to let others start a oonversation.
		127. I can usually judge what effect I will have on others.
		128. My strength often seems to drain away from me.
		129. Sometimes I wish I could control myself better.
		130. I have a soft voice.

--by Richard I. Lanyon, Ph.D.

APPENDIX E

BECK DEPRESSION INVENTORY

APPENDIX E

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 particuarly 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 don't get real satisfaction out of anything anymore.
   3 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 quite 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 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 anymore 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 or irritated more easily than I used to.
    2 I feel irritaed 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.
    3 I believe that I look ugly.

15. 0 I can work about as well as before.
    1 It takes an 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 one to two 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 five pounds.
[2] I have lost more than 10 pounds.
[3] I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes_____ No_____

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 thing 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 F

THE D-30 SCALE

APPENDIX F

The D_{30} Scale

This scale consists of numbered statements. Read each statement and decide whether it is true as applied to you or false as applied to you.

If a statement is TRUE or MOSTLY TRUE, as applied to you, write TRUE in the space provided. If a statement is FALSE or NOT USUALLY TRUE, as applied to you, write FALSE in the space provided. If a statement does not apply to you or if it is something that you don't know about, make no mark on the sheet.

Remember to give YOUR OWN opinion of yourself. Do not leave any blank spaces if you can avoid it.

___1. My daily life is full of things that keep me interested.
___2. I am about as able to work as I ever was.
___3. I find it hard to keep my mind on a task or job.
___4. At times I feel like smashing things.
___5. I have had periods of days, weeks, or months when I couldn't take care of things because I couldn't "get going."
___6. My sleep is fitful and disturbed.
___7. I prefer to pass by school friends, or people I know but have not seen for a long time, unless they speak to me first.
___8. I am a good mixer.
___9. I wish I could be as happy as others seem to be.
___10. I am certainly lacking in self-confidence.
___11. I usually feel that life is worthwhile.
___12. I don't seem to care what happens to me.
___13. I am happy most of the time.
___14. I seem to be about as capable and smart as most others around me.
___15. I do not worry about catching diseases.
___16. Criticism or scolding hurts me terribly.
___17. I certainly feel useless at times.
___18. Most nights I go to sleep without thoughts or ideas bothering me.
___19. During the past few years I have been well most of the time.

___20. I cry easily.
___21. I cannot understand what I read as well as I used to.
___22. I have never felt better in my life than I do now.
___23. My memory seems to be all right.
___24. I am afraid of losing my mind.
___25. I feel weak all over much of the time.
___26. I enjoy many different kinds of play and recreation.
___27. I brood a great deal.
___28. I believe I am no more nervous than most others.
___29. I have difficulty in starting to do things.
___30. I work under a great deal of tension.

From: Dempsey, P. A. A unidimensional depression scale for the MMPI. Journal of Consulting Psychology. 1964, 28, 364-370.

APPENDIX G

DYSFUNCTIONAL ATTITUDE SCALE

APPENDIX G

Dysfunctional Attitude Scale

This Inventory lists different attitudes or beliefs which people sometimes hold. Reach EACH statement carefully and decide how much you agree or disagree with the statement.

For each of the attitudes, show your answer by placing a checkmark (✓) under the column that BEST DESCRIBES HOW YOU THINK. Be sure to choose only one answer for each attitude. Because people are different, there is no right answer or wrong answer to these statements.

To decide whether a given attitude is typical of your way of looking at things, simply keep in mind what you are like MOST OF THE TIME.

Example:

ATTITUDES	TOTALLY AGREE	AGREE	VERY MUCH AGREE	SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE
1. Most people are okay once you get to know them.				✓				

Look at the example above. To show how much a sentence describes your attitude, you can check any point from totally agree to totally disagree. In the above example, the checkmark at "agree slightly" indicates that this statement is somewhat typical of the attitudes held by the person completing the inventory.

Remember that your answer should describe the way you think MOST OF THE TIME.

HOW TURN THE PAGE AND BEGIN

From: Weissman, A.N. The Dysfunctional Attitude Scale: A Validation Study. Unpublished doctoral dissertation, University of Pennsylvania, 1978.

ATTITUDES Remember, answer each statement according to the way you think most of the time.	TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE
1. You can be a happy person without going out of your way in order to please other people.							
2. I have to impress new acquaintances with my charm, intelligence, or wit or they won't like me.							
3. If I put other people's needs before my own, they should help me when I want them to do something for me.							
4. It is shameful for a person to display his weaknesses.							
5. People will like me even if I am not successful.							
6. People who have the marks of success (good looks, fame, wealth) are bound to be happier than people who do not.							
7. I should try to impress other people if I want them to like me.							
8. If a person I love does not love me, it means I am unloveable.							
9. I ought to be able to solve my problems quickly and without a great deal of effort.							
10. If a person is indifferent to me, it means he does not like me.							
11. I should be able to please everybody.							
12. Others can care for me even if they know all my weaknesses.							
13. If people whom I care about do not care for me, it is awful.							

ATTITUDES	TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE
14. Criticism need not upset the person who receives the criticism.							
15. My life is wasted unless I am a success.							
16. People should prepare for the worst or they will be disappointed.							
17. I must be a useful, productive, creative person or life has no purpose.							
18. A person should think less of himself if other people do not accept him.							
19. I do not need other people's approval for me to be happy.							
20. I can enjoy myself even when others do not like me.							
21. My value as a person depends greatly on what others think of me.							
22. If I make a foolish statement, it means I am a foolish person.							
23. If a person has to be alone for a long period of time, it follows that he has to feel lonely.							
24. A person should be able to control what happens to him.							
25. If a person is not a success, then his life is meaningless.							

ATTITUDES	TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE
26. A person doesn't need to be well liked in order to be happy.							
27. If someone performs a selfish act, this means he is a selfish person.							
28. I should always have complete control over my feelings.							
29. I should be happy all the time.							
30. If people consider me unattractive it need not upset me.							
31. Whenever I take a chance or risk I am only looking for trouble.							
32. A person cannot change his emotional reactions even if he knows they are harmful to him.							
33. I may be able to influence other people's behavior but I cannot control it.							
34. People will reject you if they know your weaknesses.							
35. People should be criticized for their mistakes.							
36. One should look for a practical solution to problems rather than a perfect solution.							
37. If I do well, it is probably due to chance; if I do badly, it is probably my own fault.							

ATTITUDES	TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE
38. The way to get people to like you is to impress them with your personality.							
39. Turning to someone else for advice or help is an admission of weaknesses.							
40. A person should do well at everything he undertakes.							

APPENDIX H

IRRATIONAL BELIEFS TEST

APPENDIX H

Irrational Beliefs Test

This is an inventory of the way you believe and feel about various things. There are a number of statements with which you will tend to agree or disagree. You will be given an answer sheet with spaces to circle one of five possible answers to each item. For each statement, you should mark your answer sheet as follows, according to your own reaction to the item:

Circle D if you STRONGLY DISAGREE
Circle d if you MODERATELY DISAGREE
Circle n if you NEITHER AGREE NOR DISAGREE
Circle a if you MODERATELY AGREE
Circle A if you STRONGLY AGREE

It is not necessary to think over any item very long. Mark your answer quickly and go on to the next statement.

Be sure to mark how you actually feel about the statement, not how you think you should feel.

Try to avoid the neutral or "n" response as much as possible. Select this answer only if you really cannot decide whether you tend to agree or disagree with a statement.

1. It is important to me that others approve of me.
2. I hate to fail at anything.
3. People who do wrong deserve what they get.
4. I usually accept what happens philosophically.
5. If a person wants to, he can be happy under almost any circumstances.
6. I have a fear of some things that often bothers me.
7. I usually put off important decisions.
8. Everyone needs someone he can depend on for help and advice.
9. "A zebra cannot change his stripes."
10. There is a right way to do everything.

11. I like the respect of others, but I don't have to have it.
12. I avoid things I cannot do well.
13. Too many evil persons escape the punishment they deserve.
14. Frustrations don't upset me.
15. People are disturbed not by situations but by the view they take of them.
16. I feel little anxiety over unexpected dangers or future events.
17. I try to go ahead and get irksome tasks behind me when they come up.
18. I try to consult an authority on important decisions.
19. It is almost impossible to overcome the influences of the past.
20. There is no perfect solution to anything.

21. I want everyone to like me.
22. I don't mind competing in activities where others are better than I.
23. Those who do wrong deserve to be blamed.
24. Things should be different from the way they are.
25. I cause my own moods.
26. I often can't get my mind off some concern.
27. I avoid facing my problems.
28. People need a source of strength outside themselves.
29. Just because something once strongly affects your life doesn't mean it need do so in the future.
30. There is seldom an easy way out of life's difficulties.

31. I can like myself even when many others don't.
32. I like to succeed at something but I don't feel I have to.
33. Immorality should be strongly punished.
34. I often get disturbed over situations I don't like.
35. People who are miserable have usually made themselves that way.
36. If I can't keep something from happening, I don't worry about it.
37. I usually make decisions as promptly as I can.
38. There are certain people that I depend on greatly.
39. People overvalue the influence of the past.
40. Some problems will always be with us.

41. If others dislike me, that's their problem, not mine.
42. It is highly important to me to be successful in everything I do.
43. I seldom blame people for their wrong doings.
44. I usually accept things the way they are, even if I don't like them.
45. A person won't stay angry or blue long unless he keeps himself that way.

46. I can't stand to take chances.
47. Life is too short to spend it doing unpleasant tasks.
48. I like to stand on my own two feet.
49. If I had different experiences I could be more like I want to be.
50. Every problem has a correct solution.

51. I find it hard to go against what others think.
52. I enjoy activities for their own sake, no matter how good I am at them.
53. The fear of punishment helps people be good.
54. If things annoy me, I just ignore them.
55. The more problems a person has, the less happy he will be.
56. I am seldom anxious over the future.
57. I seldom put things off.
58. I am the only one who can really understand and face my problems.
59. I seldom think of past experiences as affecting me now.
60. We live in a world of chance and probability.

61. Although I like approval, it's not a real need for me.
62. It bothers me when others are better than I am at something.
63. Everyone is basically good.
64. I do what I can to get what I want and then don't worry about it.
65. Nothing is upsetting in itself--only in the way you interpret it.
66. I worry a lot about certain things in the future.
67. It is difficult for me to do unpleasant chores.
68. I dislike for others to make my decisions for me.
69. We are slaves to our personal histories.
70. There is seldom an ideal solution to anything.

71. I often worry about how much people approve of and accept me.
72. It upsets me to make mistakes.
73. It's unfair that "the rain falls on both the just and the unjust."
74. I am fairly easygoing about life.
75. More people should face up to the unpleasantness of life.
76. Sometimes I can't get a fear off my mind.
77. A life of ease is seldom very rewarding.
78. I find it easy to seek advice.
79. Once something strongly affects your life, it always will.
80. It is better to look for a practical solution than a perfect one.

81. I have considerable concern with what people are feeling about me.
82. I often become quite annoyed over little tings.
83. I usually give someone who has wronged me a second chance.
84. I dislike responsibility.
85. There is never any reason to remain sorrowful for very long.
86. I hardly ever think of such things as death or atomic war.
87. People are happiest when they have challenges and problems to overcome.
88. I dislike having to depend on others.
89. People never change basically.
90. I feel I must handle things in the right way.
91. It is annoying but not upsetting to be criticized.
92. I'm not afraid to do things which I cannot do well.
93. No one is evil, even though his deeds may be.
94. I seldom become upset over the mistakes of others.
95. Man makes his own hell within himself.
96. I often find myself planning what I would do in different dangerous situations.
97. If something is necessary, I do it even if it is unpleasant.
98. I've learned not to expect someone else to be very concerned about my welfare.
99. I don't look upon the past with any regrets.
100. There is no such thing as an ideal set of circumstances.

From: Jones, K.G. A factored measure of Ellis' irrational belief system, with personality and maladjustment correlates. Doctoral dissertaiton, Texas Technological College, 1968. Dissertation Abstracts International, 1969, 29, 4379-4380B.

APPENDIX I

PLEASANT EVENTS SCHEDULE

APPENDIX I

Pleasant Events Schedule

This schedule is designed to find out about the things you have enjoyed during the past month. The schedule contains a list of events or activities which people sometimes enjoy. You will be asked to go over the list twice, the first time rating each event on how many times it has happened in the past month and the second time rating each event on how pleasant it has been for you. There are no right or wrong answers.

Please rate every event. Work quickly; there are many items and you will not be asked to make fine distinctions on your ratings. Please make your ratings on the answer sheets provided. Use the answer sheet labeled "A" to answer Question A; use the sheet labeled "B" to answer Question B.

Directions--Question A

On the following pages you will find a list of activities, events, and experiences. HOW OFTEN HAVE THESE EVENTS HAPPENED IN YOUR LIFE IN THE PAST MONTH? Please answer this question by rating each item on the following scale:

1. This has not happened in the past 30 days.
2. This has happened a few times (1 to 6) in the past 30 days.
3. This has happened often (7 or more) in the past 30 days.

Place your rating for each item on answer sheet labeled "A." Here is an example: an item might be "Being in the country." Suppose you have been in the country three times during the past 30 days. Then you would mark a "2" on the answer sheet next to item number 1.

Important: Some items will list more than one event; for these items, mark how often you have done any of the listed events. For example: "Doing art work (painting, sculpture, drawing, movie-making, etc.)." You should rate the item on how often you have done any form of art work in the past month.

Since this list contains events that might happen to a wide variety of people, you may find that many of the events have not happened to you in the past 30 days. It is not expected that anyone will have done all of these things in one month.

1. Laughing
2. Being relaxed
3. Being with happy people
4. Eating good meals
5. Thinking about something good in the future
6. Having people show interest in what you have said
7. Thinking about people I like
8. Seeing beautiful scenery
9. Breathing clean air
10. Being with friends
11. Having peace and quiet
12. Being noticed as sexually attractive
13. Kissing
14. Watching people
15. Having a frank and open conversation
16. Sitting in the sun
17. Wearing clean clothes
18. Having spare time
19. Doing a project in my own way
20. Sleeping soundly at night
21. Listening to music
22. Having sexual relations with a partner of the opposite sex
23. Smiling at people
24. Being told I am loved
25. Reading stories, novels, poems or plays.
26. Planning or organizing something
27. Going to a restaurant
28. Expressing my love to someone
29. Petting, necking
30. Being with someone I love
31. Seeing good things happen to my family or friends
32. Complimenting or praising someone
33. Having coffee, tea, a Coke, etc., with friends
34. Meeting someone new of the same sex
35. Driving skillfully
36. Saying something clearly
37. Being with animals
38. Being popular at a gathering
39. Having a lively talk
40. Feeling the presence of the Lord in my life
41. Planning trips or vacations

42. Listening to the radio
43. Learning to do something new
44. Seeing old friends
45. Watching wild animals
46. Doing a job well
47. Being asked for my help or advice
48. Amusing people
49. Being complimented or told I have done well

Directions--Question B

Now please go over the list once again. This time the question is: HOW PLEASANT, ENJOYABLE, OR REWARDING WAS EACH EVENT DURING THE PAST MONTH? Please answer this question by rating each event on the following scale.

1. This was not pleasant (Use this rating for events which were either neutral or unpleasant.)
2. This was somewhat pleasant. (Use this rating for events which were mildly or moderately pleasant.)
3. This was very pleasant. (Use this rating for events which were strongly or extremely pleasant.)

Important: If an event has happened to you more than once in the past month, try to rate roughly how pleasant it was on the average. If an event has not happened to you during the past month, then rate it according to how much you think it would have been. When an item lists more than one event, rate it on the events you have actually done (if you haven't done any of the events in such an item, give it the average rating of the events in that item which you would like to have done.)

Place your rating for each event on the answer sheets labeled "B." Here is an example: An item might be "Being in the country." Suppose that each time you were in the country in the past 30 days you enjoyed it a great deal. Then you would rate this event "3," since it was "very pleasant."

The list of items may have some events which you would not enjoy. The list was made for a wide variety of people, and it is not expected that one person would enjoy all of them.

Now go back to the list of events, start with item 1, and go through the entire list rating each event on roughly how pleasant it was (or would have been) during the past 30 days. Please be sure that you rate each item.

From: MacPhillamy, D. J. and Lewinsohn, P. M. Manual for the Pleasant Events Schedule, unpublished manuscript, 1976.

APPENDIX J

COGNITIVE COMPLEXITY SCALE

APPENDIX J

Cognitive Complexity Scale: Role Descriptions

1. Yourself
2. The person you know whom you would most like to be like
3. The person you've met recently whom you would most like to get to know
4. Your closest friend (same sex)
5. The most successful person you know personally
6. The person you most like to socialize with
7. Someone you kow personally whom you admire
8. The person you most dislike of the same sex
9. The person with whom you would most like to share your intimate thoughts and feelings
10. Your closest friend (opposite sex)
11. Someone you know personally for whom you feel sorry
12. The person you least like to socialize with
13. The person you've met recently whom you would least like to get to know
14. The person you most dislike of the opposite sex
15. The person you know whom you would least like to be like
16. The least successful person you know personally
17. The person with whom you would most like to work on a project that is important to you
18. The person you know who most depends on you
19. The person with whom you would least like to share your intimate thoughts and feelings
20. The person with whom you would least like to work on a project that is important to you.

Cognitive Complexity Scale: Bi-Polar Personality Attributes

1.	considerate	inconsiderate
*2.	intelligent	unintelligent
3.	wise	foolish
*4	perceptive	unperceptive
5.	openminded	closeminded
*6.	interesting	uninteresting
7.	warm	cold
8.	confident	not confident
*9.	creative	not creative
10.	skillful	not skillful

*11.	hardworking	lazy
*12.	responsible	irresponsible
13.	beautiful	ugly
*14.	friendly	unfriendly
15.	competent	incompetent
16.	sociable	unsociable
*17.	trustworthy	untrustworthy
18.	independent	dependent
*19.	dependable	undependable
*20.	clever	not clever

*These scales were reversed to reduce the possibility of scale checking biases.

APPENDIX K

POST-TEST AND FOLLOW-UP QUESTIONNAIRES

APPENDIX K

Group Member Post-Workshop Questionnaire

1. To what degree has this workshop been helpful to you in coping with depression?

   Not Helpful ___/___/___/___/___/___ Very Helpful

2. To what degree has this workshop been helpful to you in other areas, besides depression?

   Not Helpful ___/___/___/___/___/___ Very Helpful

3. To what degree has your depression been reduced as a result of this workshop?

   None ___/___/___/___/___/___ Very Much

4. To what degree do you feel better able to cope with future depressions as a result of this workshop?

   None ___/___/___/___/___/___ Very Much

5. Was the workshop of appropriate length to be helpful to you?

   Too Short ___/___/___/___/___/___ Too Long

   a. If length was inappropriate, how many sessions would you estimate to have been more appropriate?

      _____ sessions

6. Was this type of workshop appropriate for you?

   Inappropriate ___/___/___/___/___/___ Very Appropriate

7. Would you recommend this type of workshop to a close friend in depression?

   Strongly Advise Against It ___/___/___/___/___/___ Strongly Recommend It

8. What is your opinion of your group leader?

   Very Unlikable ___/___/___/___/___/___ Very Likable

   Very Competent ___/___/___/___/___/___ Very Incompetent

9. Do you plan to seek further treatement for depression?

Definitely Not __/__/__/__/__/__ Definitely Will

10. Do you plan to seek further treatment in areas other than depression?

Definitely Will __/__/__/__/__/__ Definitely Not

11. Any further comments you wish to make:_____

_____

_____

_____

_____

Group Member Follow-Up Questionnaire

1. To what degree has this workshop been helpful to you in coping with depression?

   Not Helpful _/ / / / / /_ Very Helpful

2. To what degree has this workshop been helpful to you in other areas, besides depression?

   Not Helpful _/ / / / / /_ Very Helpful

3. To what degree has your depression been reduced as a result of this workshop?

   None _/ / / / / /_ Very Much

4. To what degree do you feel better able to cope with future depressions as a result of this workshop?

   None _/ / / / / /_ Very Much

5. Have you sought further treatment for depression?

   Yes No (circle one)

   a. If no, do you plan to seek further treatment for depression?

   Definitely Not _/ / / / / /_ Definitely Will

6. Have you actually become involved in further treatment for depression?

   Yes No (circle one)

   a. If yes, what type of treatment are you receiving?

   _____

   b. Where are you receiving treatment? By whom?

   _____

7. Have you sought further treatment in areas other than depression?

   Yes No (circle one)

   a. If no, do you plan to seek further treatment in areas other than depression?

   Definitely Will _/ / / / / /_ Definitely Not

8. Have you actually become involved in further treatment in areas other than depression?

Yes No (circle one)

a. If yes, what type of treatment are you receiving?

_____

b. Where are you receiving treatment? By whom?

_____

9. Any further comments you wish to make: _____

_____

_____

_____

_____

APPENDIX L

COGNITIVE TREATMENT MANUAL FOR DEPRESSION

APPENDIX L

COGNITIVE TREATMENT MANUAL FOR DEPRESSION

Protocol for Cognitive Therapy of Depression

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Objective and Rationale

The major objective for this therapy will be to alter the idiosyncratic, maladaptive ideation of depressed patients. According to the cognitive paradigm of depression, a depressed person systematically misconstrues his experiences so that he views himself and his future in a negative way. It is important to distinguish between normal and abnormal reactions. A depressed individual's reactions to environmental events is based on a faulty interpretation of the stimuli and therefore, neutral or even favourable events result in a negative conclusion. The patient's faulty assumptive system results in his negative conceptualizations of experiences and these negative concepts are thought to contribute to the other symptoms of depression such as the lack of adaptive behaviour, the affective state and the physiological manifestations. As a result, a depressive cycle is established in which the negative thinking, the unpleasant affect, the physical symptoms and the self-defeating, maladaptive behaviour reinforce each other.

The ultimate goal of this cognitive therapy is to modify the patient's faulty assumptive system thereby reducing the probability that the individual will respond to stressful stimuli in a depressive manner in the future. A more immediate aim of therapy, to alter the individual's current depression, is also attainable using cognitive therapy. By concentrating on specific depressive symptoms, the cognitive therapist attempts to help patients recognize faulty or irrational thinking and to make the appropriate corrections. In doing so he may concentrate on cognitive, behavioural or affective phenomena. This doesn't imply,

in the case of a behavioural focus, that the therapist's interventions are based on conditioning theory. Rather, the cognitive components are examined and if needed, modifications in those components are attempted. Examples of this strategy will be presented later. The general strategy used to counteract the depression, then, is to use techniques that will enable the patient to interpret his experiences in a positive and rational way.

Treatment

While flexibility is normally the rule with this and most treatments, the goals of research require that the outlined procedures are followed as closely as possible. It is most important that the therapist remain with this specific treatment for only then can the effects of treatment be systematically studied. The therapist should be as warm, interested and helpful as he would be in any helping relationship. The main difference between this approach and the more traditional methods is that with cognitive therapy the therapist guides and directs the course and content of treatment. Also, like behaviour therapy, cognitive therapy does not require that the patient obtain insight into the origin of the symptoms and thus, a minimum of therapy time is spent on introspection and little or none is spent searching for etiological factors. Since the diagnosis of depression will have been determined prior to the therapist's contact with the patient, focus on the treatment will begin with the first session.

As noted previously, cognitive therapy utilizes a number of techniques whose major mode of action is the modification of faulty patterns of thinking. A basic session by session outline was provided in Table 2 of the main text.

There are six major procedures involved in the use of cognitive therapy:

(1) Presentation of general and specific rationale of treatment
(2) Exploration of history and current status of symptoms.
(3) Exploration of depressive cognitions.
(4) Examination, evaluation and modification of these cognitions.
(5) Identification of underlying assumptions.
(6) Examination, evaluation and modification of basic premises and assumptions.

Specific Procedures

1. Presentation of general and specific treatment rationale.

It is important that each patient understand and accept the treatment process. A brief explanation of the theory and course of treatment should be presented and clarified if questions arise. It should be made clear that in depression the thoughts of individuals are very important. If any patient has trouble understanding, explanations should be rephrased in language that he can understand. Questions from more sophisticated subjects should be dealt with openly to allay any doubts they might have; e.g., "We have found that patients receiving this treatment do not require drugs." The patients should also be informed of a telephone contact that will be available 24 hours a day to handle emergency problems.

The general instructions (on a separate page) should be presented initially. These instructions are designed to control for the initial expectancies of patients in all groups as well as giving patients a general outline of treatment.

The following specific rationale for the cognitive therapy should be a sufficient introduction.

> The symptoms that you are experiencing (a review of the symptoms may be included here) are all related to the way that you interpret and think about situations in your life. Because we are all individuals, the way that we react to events in our lives may be quite different. On the other hand, individuals who feel depressed often react in a similar way to many of their problems. As a result of your past experiences with people and situations you have learned to react in a particular manner. For example, say I asked you to outline in detail everything that I have said to you in the last five minutes; some people might react by thinking, "I can't do that," others might think "Why does he want me to do that?" and still others might think, "He's got to be kidding!" Each person reacts in his or her own particular way.
>
> Initially in our session we are going to look at some of the difficulties or problems that you are having and hopefully, how to

resolve these difficulties. It will be important for us to find out how you reacted to specific situations in your life and what effect these reactions have on your feelings. By looking carefully at your reactions we will have a better idea of how to best help you. We will then be able to examine alternative ways of coping with stresses, specifically those which could be used to prevent future depressions.

We've used this treatment with many depressed individuals with excellent results. Most of the procedures will become clearer after we get into them. Do you have any questions before we continue?

2. Exploration of history and current status of symptoms.

This phase is an extremely important one. In exploring the patient's relevant life history the therapist attempts to identify major sequences in the patient's life. The therapist should develop hypotheses about the patient's style and idiosyncratic response patterns to important life experiences. The therapist should also attempt to reconstruct with the patient the stages in the development of his depression. The information concerning the patient's specific concepts and attitudes which should become evident will be utilized throughout the treatment. Recall that the cognitive paradigm of depression assumes that depression is precipitated when a stressful situation (or stressful situations) interacts with a particular cognitive structure (i.e. negative self image, negative view of world and/or negative view of future). Following the reasoning that many individuals would not have become depressed if they had been in the same situation as the depressed person, the therapist should attempt to delineate the salient features of the stressors and of the patient's response. The stressors are not under the patient's control but the response pattern is. It is the cognitive structure, therefore, that requires modification. On reviewing the development of the depression, the therapist should begin to ascertain what cognitive structure changes would be of the most benefit to the patient. This strategy also requires that the patient concentrate on specific problems rather than symptoms, thereby increasing his/her objectivity and understanding of the depression.

When the stages of development of the depression are better understood the therapist should have some idea of the assumptions, attitudes, beliefs, values etc. that the patient has. While the major objective of the therapy is to make some alteration in the patient's cognitive structure it is difficult at this stage for most patients to examine these cognitive components productively. For this reason, the therapist at this point should concentrate on specific events in the client's current life and his/her response to these events. The goal here is to intervene in the depressive cycle and alter the patient's depressive cognitions. These cognitions are obviously reflections of the patients more elaborate assumptions, attitudes, etc.

3. Exploration of depressive cognitions.

These depressive cognitions have been referred to as "self-statements" and "things that the patient tells himself" (Ellis, 1962) as well as "automatic thoughts" (Beck, 1967). These thoughts reflect the distortions that occur in the depressed state and may range from a mild distortion to a complete misinterpretation. The thoughts may be triggered by environmental stimuli or may occur spontaneously but in depression they lead to an unpleasant affect. For example, Beck (1967) reported that one patient felt sad every time he made a mistake. After exploring the thoughts which occurred after he made a mistake he reported thinking "I'm a dope" or "I never do anything right." This procedure, therefore, serves to make patients aware that self-verbalizations do occur and more importantly, effect the affective state of the patient. Patients should be instructed to record the thoughts which lead to unpleasant affect, thereby completing the chain; environmental stimuli → cognition → affect.

4. Examination, evaluation and modification of the depressive cognitions.

The depressed cognitions are closely related to affective and behavioural phenomena of depression. A decrease in adaptive behaviour often results in thoughts such as, "I won't be able to do it," or "If I do this I will only feel worse" invade the patient's phenomenological field. To this point, therapy has been structured to facilitate the patient's awareness that depressive cognitions occur and effect his depression. As the patient becomes more adept at recognizing the wording of his depressive cognitions he can view them more objectively. Beck (1970) referred to "distancing" as the process of

gaining objectivity towards the cognitions. The therapist should assist the patient in categorizing his cognitions, generally by defining the major themes such as self-blame, inferiority or deprivation. It is important to emphasize that of the innumerable ways in which he can interpret his life experiences he tends to perseverate in a few stereotyped interpretations or explanations. Also, the defining characteristic of these interpretations is that they are negative, self-defeating and irrational.

After the patient learns to recognize the idiosyncratic content and other characteristics of the cognitions, the therapist should begin to train him to evaluate the validity and accuracy of the cognitions. A number of techniques may be useful in the evaluation and modification of these cognitions.

(1) Distinguishing "ideas" from "facts." It is important to indicate to patients that thoughts are not equivalent to external reality, and no matter how convincing they seem, they should not be accepted unless validated by some objective procedure. The goal here is to help the patient shift from a deductive analysis of experiences (by far the most common in depression) to more inductive procedures. The basic therapeutic doctrine is as follows: simply because the patient thinks something does not necessarily mean that it's true.

(2) Checking observations. The validation of the patient's interpretations and judgments depends on checking the accuracy and completeness of the initial environmental observations. In many instances, fallacious thinking is involved in the cognitive responses of depressed persons. The following are three common categories of cognitive distortion.

(a) Arbitrary inference refers to the process of drawing a conclusion when evidence is lacking or is actually contrary to the conclusion. For example, a depressed woman, who was kept waiting for a few minutes by the therapist thought, "He has deliberately left in order to avoid seeing me."

(b) Overgeneralization refers to the process of making an unjustified generalization on the basis of a single incident. An example is the patient who thinks, "I never succeed at anything," when he has a single isolated failure.

(c) Magnification refers to the propensity to exaggerate the meaning or significance of a particular event. Ellis (1962) used the term "catastrophizing" to refer to this kind of response. Many examples of this type of distortion involve persons exaggerating the intensity or significance of stressful events.

The therapist should utilize these categories of distorted responding in the examination and evaluation of the patient's cognitions. By following this strategy the patient will become more aware of the distortions and with training, will be able to respond to the thoughts in a more appropriate manner. As homework, patients should be introduced to the "double column technique" (Beck, 1976). The patient should continue to write down his/her depressogenic thoughts on the left hand side of a piece of paper. On the right side he/she should write down the realistic answers to these cognitions. For example:

Unreasonable	Reasonable
I never succeed.	This isn't true, my past record doesn't support such a claim. (Overgeneralization)
I am weak, for any criticism seems to trip this irrational thought.	This is an opportunity to fight these thoughts and get them under control once and for all.

The patient's record of thoughts and responses should be closely monitored by the therapist. It should provide data for discussions and feedback from the therapist. Once the particular cognition is established as invalid, it should be neutralized by the patient (or initially, the therapist) by stating precisely why it is inaccurate, inappropriate or invalid. By verbalizing the reasons that the thought was erroneous every time it occurs, the patient will be able to reduce the intensity and frequency of the thought as well as the accompanying affect.

(3) Examining alternative explanations. A third strategy that can be used to break up the patient's negative cognitive set, is to show him the alternative ways of conceptualizing and solving problems. That is, the patient is trained to consider the alternatives to the depressive cognitions and then to evaluate these alternatives. For example, the thought, "Robert has not called. He doesn't love me, should be weighed against, "He loves me. He is just very busy and thinks that I am improving and therefore isn't worrying and calling all the time."

(4) Building on positives. The phenomenological field of the depressed patient is constantly flooded with negative depressogenic cognitions. The three procedures just discussed are utilized by the therapist to alter these depressive cognitions. In addition, it is often useful to replace these negative thoughts with positive ones for, as shown by Velten (1968) positive thoughts may lead to pleasurable affect. Two techniques may be used with respect to this strategy, with the goals of increasing the patient's awareness of situations in which they are successful and of increasing positive self-verbalizations.

The first technique requires that the patient agree that activity is better than inactivity (i.e., he feels better when active). The main argument here is that the patient has more depressing thoughts when he/she is inactive. The patient is asked to keep a record of the activities which result in pleasurable affect. These activities will vary with the individual. By keeping this record the patient will have more objective data to counter negative thoughts (i.e., "I do succeed in some tasks; yesterday I fixed the toaster."). The second technique involves having the patient record positive statements about himself. This process may be a difficult one for the patient at first and the therapist may have to reflect honestly good points he sees in the patient. As therapy progresses, however, the patient should be encouraged to add to the list. The patient is then asked to repeat the positive thoughts immediately after he/she invalidates and neutralizes any negative, depressive thoughts. In summary, the patient is informed that "people who are depressed have trouble seeing themselves and their environment as they really are," but this can be corrected with accurate record keeping and objective interpretations.

5. Identification of underlying assumptions.

The procedures to be described here are directed towards the patient's assumptions of his world, himself and his future. An individual's concepts are drawn from his experiences, from the attitudes and opinions communicated to him by others, and from his identifications. Related to these concepts is the way the individual sets goals, assesses and modifies his behaviour and explains the occurrences in his life. These assumptions or concepts also underlie the criticisms, punitiveness and blame that the patient directs towards himself.

The objective of this section of treatment is to identify the chronic attitudes and assumptions. The content of the chronic attitudes may be inferred from the

examination of the recurrent themes in the patient's cognitive responses to specific situations. The therapist should have been developing hypotheses about these attitudes from the initial session. Further information about the patient's basic premises and assumptions may be obtained by asking him either what he bases a particular conclusion on, or his reasons for a specific judgment. An inquiry into his values and beliefs will yield additional data.

Beck (1976) suggested a number of attitudes that predispose people to excessive sadness or depression. Examples are:

(a) In order to be happy, I have to be successful in whatever I undertake.
(b) To be happy, I must be accepted by all people at all times.
(c) If I make a mistake, it means that I'm inept.
(d) I can't live without love.
(e) If somebody disagrees with me, it means that he doesn't like me.
(f) My value as a person depends on what others think of me.

6. Examination, evaluation and modification of basic premises and assumptions.

Following the identification of the patient's maladaptive assumptions, the therapist's objective is to modify or attenuate them on the basis that they partly determine the content of the individual's cognitions. It follows that a modification or attenuation of these assumptions will alter the way he organizes and interprets specific experiences, as well as how he sets his goals and goes about achieving them. Also, since the predominance of deductive (as opposed to inductive) thinking is an important determinant of the cognitive distortions in depression, any correction of the invalid major premises will tend to reduce the erroneous conclusions.

The strategies involved in modifying basic assumptions are similar to those used in the modification of the depressive cognitions. Once the assumptions are identified they can be examined and evaluated as to their validity. Changing these assumptions and attitudes is a more difficult task. Sometimes the patient can see the fallacy of his basic assumptions and may acknowledge their irrationality in the office. Nevertheless, change requires more

than acknowledgement. The patient should be encouraged to challenge the assumptions by stating the reasons that they are invalid.

It should be stressed that the changes should not be expected to happen quickly. The maladaptive attitudes, like all of a person's attitudes, most often have developed over a long period of time. The patient will have to examine and utilize alternatives, as well as experience the consequences of such attitude changes, many times in and out of the therapist's office before changes are structuralized, i.e. before they become permanent formations in the cognitive structure.

Efran (Note 14) made some important comments regarding a specific set of assumptions that are particularly relevant to depression, namely, self-criticisms. He suggested that basically the patient would like to be able to say comfortably, with full attention, and without evasion, in what way he is displeased with himself. It is the therapist's job to help him do this by making it "safe" for the patient. To do this the therapist must guard against emitting cues that he intends to be condemnatory or act superior with regard to what the patient has to say. Efran (Note 14) noted that an emphasis on "problem solving" is usually detrimental, as is any feeling by the therapist that he should be responsible for telling the client how he can better run his life. The cognitive therapist, when dealing with assumptive systems, doesn't actively tell the patient what to do. Rather, the therapist is active in setting the situation so that the patient can objectively examine his assumptions. Thus any evaluative or modification procedures should not be initiated until the assumptions have been clearly identified and examined. This is extremely important, for the therapist who challenges the patient's initial attempts at defining his beliefs, attitudes, etc. will probably give the patient an "unsafe" message. Also, recall that the overall objective is for the patient to feel (have) mastery of his world, and therefore, the patient, not the therapist should be responsible for how he runs his life.

A Session by Session Outline of the Treatment Procedures: Cognitive Modification

	OBJECTIVE	METHOD (TECHNIQUE)
WEEK 1 SESSION 1	A. Introduction - GENERAL AND TREATMENT SPECIFIC B. Delineate major maladaptive patterns and sequences in patient's current life. C. Emphasis that depression should not be viewed in terms of specific problems and not in terms of symptoms.	A. Goals and rationale B. --Review events leading to depressive episode. --Review history of past depressions. --If possible, therapist should attempt to ascertain the features of patient's responding (i.e., selective responding to specific types of experiences).
WEEK 1 SESSION 2	A. Delineate maladaptive cognitions occurring in response to environmental stimuli--patients should be aware of self-verbalizations.	A. Discuss specific events which occur and which are followed by feelings of sadness or other depressive symptoms--investigate the cognitive component in the chain, stimuli → cognition → affect. B. Introduce homework--patients should be instructed to write depressogenic thoughts down.
WEEK 2 SESSION 3	A. Awareness that thoughts (negative) do occur and result in feelings of sadness, etc. B. Introduce methods of dealing with thoughts--challenging their validity.	A. Discussion of homework--point out what is invalid about thinking (e.g. "I never succeed"). This statement is an overreaction. Allow patient to challenge thought if he/she is capable. B. Correct misconceptions, provide alternatives. Homework: continue to record thoughts and try to record realistic replies to these cognitions.
WEEK 2 SESSION 4	A. Continue to focus on maladaptive cognitions and methods of dealing with them. Establish invalidity of thoughts. B. Increase patient awareness of non-depressive situations and responses which occur in their lives--neutralize pessimism.	A. Promote objective discussion of cognitions--provide feedback about attempts to correct thoughts. B. In addition to recording maladaptive thoughts patients should record (situations/activities) in which they were successful or which they enjoyed. Also list their positive features--CONTINUE THROUGHOUT TRT.

	OBJECTIVE	METHOD (TECHNIQUE)
WEEK 3 SESSION 5	A. Ascertain patient's response to homework assignment--discuss problems related to homework. B. Continue to train patients to evaluate validity and accuracy of cognitions. C. Once cognitions established as invalid train patient to neutralize them by verbalizing why. D. Check on homework--problems, difficulties.	A. These assignments should be continued as they provide a method for looking objectively at experiences and self. B. Provide alternative ways of looking at situations, solving them, etc. C. Therapist guides patient through logical steps of reasoning. e.g. THOUGHT: "I won't be able to do it." RESPONSE: "This isn't true. I've done it many times before. I may be a little slower when I'm depressed but I know what to do and if I do things step-by-step there's no reason why I can't do it."
WEEK 3 SESSION 6	A. Begin to clarify assumptions and attitudes which underlie individual's cognitions. (Notice difference between dealing with specific cognitions versus dealing with patients' assumptions.)	A. Chronic attitudes may be inferred from the patient's responses to particular situations--information should also be obtained by questioning patient on his reasoning, values, beliefs, etc. e.g. "In order to be happy I have to be successful." "My value as a person depends on what others think of me." B. Provide atmosphere of "safety" by not responding in a condemnatory or superior manner. This is particularly important if patient is dealing with self-criticism. *Core assumptions may be accompanied by emotional behaviour, etc. This behaviour should not be interfered with.
WEEK 4 SESSION 7	A. Examine the assumptions of patients in objective manner.	A. Using similar methods as with the specific cognitions investigate invalid logic--explore alternative assumptions--discuss effects major changes in attitude may have. Homework: patients should record changes which have taken place in their attitudes, etc.
WEEK 4 SESSION 8	A. Final session integrating assumptions and effects. B. Discuss future plans of patients feedback re: treatment effectiveness.	

APPENDIX M

BEHAVIORAL SELF-CONTROL MANUAL

APPENDIX M

Behavioral Self-Control Manual

Brian F. Shaw

University of Western Ontario

Treatment

While flexibility is normally the rule with this and most treatments, the goals of research require that the outlined procedures are followed as closely as possible. It is most important that the therapist remain with this specific treatment for only then can the effects of treatment be systematically studied. The therapist should be as warm, interested and helpful as he would be in any helping relationship. The main difference between this approach and the more traditional methods is that with behaviour therapy the therapist guides and directs the course and content of treatment. Also, like cognitive therapy, behaviour does not require that the patient obtain insight into the origin of the symptoms and thus, a minimum of therapy time is spent on introspection and little or none is spent searching for etiological factors. Since the diagnosis of depression will have been determined prior to the therapist's contact with the patient, focus on the treatment will begin with the first session.

Presentation of General and Specific Treatment Rationale

It is very important that each patient understand and accept the treatment process. A brief explanation of the theory and course of treatment should be presented and clarified if questions arise. It should be made clear that in depression the behaviours of individuals are very important. If any patient has trouble understanding, explanations should be rephrased in language that he can understand. Questions from more sophisticated subjects should be dealt with openly to allay any doubts they might have; e.g., "We have found that patients receiving this treatment do not require drugs." The patients should also be informed of a telephone contact that will be available 24 hours a day to handle emergency problems.

The general instructions (on a separate page) should be presented initially. These instructions are designed to control for the initial expectancies of patients in all groups as well as giving patients a general outline of the workshop.

It is important to do a great deal of "structuring" in the treatment of depressed individuals so that there is a clear mutual understanding of expectations, goals, time commitments and other conditions.

The following specific rationale for the behavioural therapy should be a sufficient introduction.

"The symptoms that you are experiencing (a review of symptoms may be included here) are all related to the interaction between you and your environment (i.e., family, friends, job, hobbies). Because we are all individuals our daily activities are probably quite different. On the other hand, individuals who feel depressed often do not engage in behaviours which might decrease their depression."

"Initially in our sessions we are going to look at some of the difficulties or problems that you are having and hopefully how to resolve these difficulties. We hope to find out as much information as we can about you and your behaviour so that we can sit down and arrive at some mutually acceptable treatment goals. The workshop will then focus on achieving our goals."

"These workshops have been used with many depressed individuals with excellent results. Most of the procedures will become clearer after we get into them. Do you have any questions before we continue?"

Self-Control Therapy Manual

Lynn P. Rehm

University of Pittsburgh

SESSION 1: Establish rapport, give rationale.

A. Introductions
   1. Confidentiality
   2. Self-introductions

B. Rationale

Give clients a basic behavioral framework. Answer questions and lead discussion on the following issues. Involve clients by asking them to give examples of each point from their own lives.

   1. Mood is a result of behavior--how you feel depends on what you do. Depression follows when actions fail to obtain desired outcomes/satisfactions.
   2. Reward--define in terms of subjective values/ pleasurable outcomes. Mention individual differences in goals as natural.
   3. Types of rewards
      a. Comment on variety.
      b. Stress social/symbolic as commonly highly important to human beings, and give examples.
      c. Define positive reinforcement as any event/ result that can be gained by own actions and which is rewarding.
      d. Define contingent as an "if and only if" condition (positive reinforcement contingent on own action/behaviors).
      e. Stress important role of positive reinforcement in human behavior (increases, maintains, shapes instrumental responding) and feelings (depression ensues when reinforcements are lost or delayed). People behave for contingent rewards.
   4. Role of self-reinforcement
      a. Necessary to bridge the gap when external reinforcements are not immediately forthcoming but behavior must endure to gain ultimate rewards: absence of external controls requires self-control.

b. Self-control is a process composed of several behaviors, skill in which is necessary to enable one to judge, adjust, and keep going one's behaviors aimed at earning external reinforcements ultimately.
c. Situations requiring skillful self-control very frequent in our culture, and normal part of adult human functioning.
d. Consequences of failure to apply self-control effectively in absence of external controls are extinction (behaviors gradually cease--passivity, inactivity, etc.) and depression.
e. Questions concerning willpower should be answered in terms of self-control behaviors, which need to be learned and applied.

5. Three aspects of self-control: introduce the terms self-monitoring (SM), self-evaluation (SE), self-reward (SR) and draw parallel between influencing another person's behavior and directing own actions.

C. Overview

Outline program procedure, structuring experience for clients so that they can easily follow the program. Give the following points of information:

1. Goal is to learn more effective SM, SE, SR behaviors so that these self-control (SC) skills can be used by each client to modify their own depressive patterns of behavior.
2. Accumulative, sequential, 8-session training program--focus will be on SM for two weeks, SE for two weeks, and SR for two weeks.
3. Procedure within each two-week phase will consist of:
   a. Explanation of principles and directions on "how-to-do-it" (specification of new behaviors).
   b. Learning by doing--daily systematic practice (homework) in real life of skills being taught.
   c. Feedback--in sessions, discussions will revolve around clients' reports of real-life experiences and around planning how to be better the next week.

SESSION 2

A. Introduction to SM

Orient clients towards positive activities as target behaviors. Pass out Positive Activities Survey--clients' forms and have group read directions and skim items. Answer questions and lead discussion covering the issues below; involve clients by asking for examples from their own lives.

1. Positive activities--define as those direct, active, instrumental behaviors that have a high probability of ultimately being rewarded and rewarding (i.e., they usually result in pleasant outcomes in time, though not necessarily immediately or always). These are the behaviors that are desirable and gratifying.
2. Necessity to increase frequency of positive activities--to overcome depression, clients must deliberately seek out opportunities to engage in these positive behaviors.
3. Individual differences--discuss differences in what is valued/desired as an outcome and personal responsibility to choose goals. Stress PAS as list of suggestions only--each client must choose which items are most important for her/him and aim at increasing those significant behaviors.

B. Instructions for SM

Give directions for homework and instigate use of SM skills in real life.

1. Pass out SM logs and instruct clients in their use. Lead discussion on the following points:
   a. Record as soon after you make a positive response as is possible. Keep materials conveniently at hand (e.g., in purse, pocket) and bring them (PAS, log, etc.) to sessions.
   b. Three guidelines for monitoring:
      (1) Look at your own behaviors, not at outcomes or external events.
      (2) Monitor positive acts, not failures or negative behaviors.
      (3) Monitor every positive response--any step in the right direction counts and needs to be recorded when you are trying to shape up a particular target class of behaviors.
   c. Log each positive activity engaged in; describe briefly in terms of one of the PAS items (note item #) in the column for that day.
   d. Record subsequent mood right after positive activity: rate mood from 0 (miserable) to 10 (euphoric) and enter rating in column provided for that day. Ignore the last column (points) for now. End of day summary--compute and record average mood for day. End of week summary (last page of log)--record total # of positive activities for week; compute and record average daily mood.
2. Pass out Self-Graphing forms and instruct in use. Clients should plot day's number of positive activities and average mood at end of each day (ignore points).

C. Close Session
Repeat directions and remind clients of next meeting. Have clients write these down on their PAS forms.
1. Three guidelines for SM--monitor own behaviors, monitor positive (not negative) and focus on steps (components) of specific target behaviors that need to be increased/improved.
2. Record as soon after each behavior as feasible. Keep materials with you, compute average mood at end of each day and graph day's # of positive activities and average mood. Just before next session, compute and record total # of positive activities and average daily mood for the week.
3. Stress importance of following directions so as to learn by objectivity and modifying own behavior.
4. Remind clients of next meeting date and place and to bring PAS and filled-in log and graph forms with them.
5. End session warmly.

SESSION 3

Review of SM: Reinforce accurate SM and instigate planning of increased engagement in positive activities. Prompt clients to reiterate and internalize the points made last week, and to help each other as a cohesive group.

A. Check-in
Follow the procedure outlined at the end of this manual. Allot about 20 minutes to group discussion, and about 10-15 minutes to each individual's log (total of approximately 1½ hours). Emphasize the three rules for SM by translating clients' reports of their experiences during the week back into these basic principles:
1. Monitor own behaviors, not external events.
2. Monitor positive responses--those that are direct and active efforts to achieve desired outcomes.
3. Focus on specific target behaviors--not global categories, personality traits, overgeneralizations, or descriptive labels.

B. Instructions for next week
1. Continue monitoring, recording and graphing positive activities and mood as before, aiming to increase overall total frequency of positive behavior.
2. Choose a few classes of positive activities that are particularly significant or difficult for you personally and concentrate on increasing your frequency of engaging in those priority goals.

3. Strategies for increasing rate of positive behaviors (prompt clients to use any and all of these):
   a. Increase # of times you do each activity.
   b. Increase amount of time you spend on each activity.
   c. Increase variety (# of different positive activities) by trying some new ones (concentrate on priority goals)--deliberately seeking out opportunities to engage in those areas.
4. Close session reminding clients of next meeting date and place, and to bring their forms with them.

SESSION 4

Didactic instruction in SE criteria-setting behavior.

A. Check-in
   Follow the procedure at the end of this manual. Allott about 15 minutes to group discussion, and about five minutes to each individual's log (total of about 45 minutes). Reinforce SM behaviors and increasing of positive activities.
B. Introduction to SE
   Orient clients towards getting appropriate subgoals for evaluation of their own behavior. Involve clients in discussion and prompt examples around the following issues:
   1. Depressed people often set goals too high (perfectionism), too far out into the future, or too much in terms of ultimate outcomes rather than required behaviors. Stress that inappropriate goals do not permit one to use feedback of own ongoing behaviors to guide oneself, and thus result in giving up in despair or being over-dependent on other people's judgments and values.
   2. Setting realistic SE subgoals or criteria for components of own behavior:
      a. Necessity of choosing own subgoals yourself.
      b. Defining them in terms of own behaviors that you are trying to modify or maintain--set subgoals in terms of what you have to do next (not in terms of what you want to gain) so as to move towards your chosen goal.
      c. Planning--think about what you need to do to get the rewards you want.
      d. Evaluate your ongoing behaviors (not your whole self) by comparing them to your pre-set subgoals/criteria--adjust your actions accordingly, as necessary to meet and/or surpass your planned criteria.

e. Avoid overgeneralization in evaluating yourselves (stress this point and give examples). It is illogical and depressing to draw sweeping conclusions about your whole self and worth--compare specific, observable behavior to its respective pre-set criteria subgoal only and draw conclusions only about the behavior and what further needs to be done.

C. Instructions for SE subgoal setting:
Train clients in effective behaviors for setting criteria for SE.
1. Two guidelines for SE subgoal setting--
   a. Plan specific subgoals, or steps towards achieving main goals--these are your intentions, or behavioral resolutions for yourself.
   b. Define subgoals in terms of components or stages of positive behavior--set targets for behaviors. Set behavioral subgoals in as observable, immediate, attainable terms as possible--such that you can absolutely know whether and when you have achieved them and/or what more you must do to succeed at obtaining satisfactions.
2. Modeling of subgoal setting--direct clients to refer to their own copies of PAS to follow along.
   a. Read example subgoals for the first 3-5 items, using therapists' copy of PAS (briefly discuss and answer questions as you do so).
   b. Prompt clients to contribute suggestions on the next few items while you continue to give example subgoals. Reinforce active participation.
   c. Require group members to set appropriate subgoals on next few items--reinforce good suggestions and give feedback but do not model further. Continue discussing subgoals for PAS items, having clients suggest them and write down ones they feel they can use, for as long as there is time.

D. Directions for following week:
1. Instruct clients to plan and write in about three subgoals of their own choosing for each PAS item they have committed themselves to work on (i.e., their self-chosen priority goals or target behaviors). Suggest that these subgoals be arranged hierarchically according to difficulty or order in which they must be enacted.
2. Direct clients to continue monitoring and graphing as before, but now to record each engagement in a subgoal/component behavior. They should briefly

describe what they did, note what PAS item it is a subgoal of, and rate their subsequent mood.
3. Instigate increased rate of engaging in positive activities by encouraging clients to deliberately engage in subgoal behaviors.

SESSION 5

Review of SE subgoal setting and continuation of SE training.

A. Check-in
Follow the routine procedure, allowing a total of about 60-75 minutes for this.
1. Focus on choosing and defining of subgoals--ask each client to state which PAS items they have singled out to work on and what subgoals they have set for them.
2. Reinforce efforts to clearly delineate and specify component behaviors; also reinforce efforts to increase positive activities by engaging in subgoal behaviors.
3. Emphasize observable, immediate, attainable criteria for subgoals.

B. Continuation of SE training
Teach clients to judge their own ongoing behavior by comparing them to their own, pre-set subgoals.
1. Introduce the symbol of points. Instruct clients to assign from 1 to 5 points to each positive subgoal behavior they set; grading should be based on the subjective importance and/or difficulty of the behavior (more points should be awarded for more significant or difficult activities).
2. Instructions for logging--tell clients to continue monitoring and recording behaviors as they did last week, and additionally to write down (in the column provided) the # of points they award themselves for each logged behavior. They are to evaluate their own behavior right after they do it, by comparing it to its respective pre-set subgoal, and record the "grade" or # of points, they assign it.
3. Instruct clients to total and compute average number of points each day, and to compute daily average points at the end of the week.

C. Particularly difficult or important activities need to be shaped (learned by successive approximations or trial and success).
Do this by:

1. Breaking down subgoals into more basic components or steps, such that the first few are readily achievable. Arrange these components in sequence of steps, according to difficulty or order in which they must be enacted (hierarchy).
2. When these component behaviors are carried out, they should be assigned more points (graded generously)--every step in the right direction counts and must be evaluated generously when you are first starting.
3. Each time you do one of these significant activities, deliberately form a sentence in your mind, praising your progress or achievement--e.g., "That was right," or "That's good, I'm getting there." Stress that this sort of normal positive SE is the aim of the point system exercise and that clients should deliberately practice self-encouragement as much as possible to establish good habits.

D. Review of the three guidelines for SE
Encourage note-taking.
1. Plan subgoals (preset behavioral criteria) for achieving desired outcomes through your own positive acts.
2. Set subgoals realistically--in observable, immediate, attainable terms. Define subgoals in terms of steps of own behavior.
3. Evaluate own ongoing behaviors independently, by comparing them to their respective pre-set subgoals. Adjust actions and efforts.

E. Directions for week:
1. Prompt clients to maximize their total # of points by using any and all of the following strategies.
   a. Do each positive activity more often.
   b. Do more different positive activities.
   c. Set more reasonable, achievable subgoals.
   d. Work at a few higher, more significant, or more difficult subgoals and grade these generously.
   e. Break down new or significant behaviors into components so that you can get started at doing these.
2. Stress that more points can be earned by doing positive activities that are personally more significant or difficult, but clients should not neglect to accumulate points in easier ways too, when they are tired, discouraged or have little time, since it is the total amount of positive activity that counts.

SESSION 6

Didactic instruction in principles of SR and establishing effective SR schedules.

A. Check-in
Follow the routine, allowing about 45 minutes. Have each client state what their priority goals were for the week, what subgoals they set for these, and what points were awarded for meeting the criteria on significant activities. Focus on total # of points. Reinforce high SE and setting of behavioral criteria that are observable, attainable, immediate. Stress evaluation of own ongoing behaviors by comparing them to their respective preset criteria.

B. Introduction to SR
Orient clients towards shaping and maintaining their own positive behavior by contingent administration of SR. Discuss the following issues:
1. SR is the basis of motiviation--makes efforts more enjoyable. Depressives fail to SR+, excessively SR-.
2. Contingent rewards shape, maintain, and increase preceding behavior. Stress that reinforcement of positive acts and extinction ofnegative (rather than punishment) has been shown to be the most effective way to learn, and produces self-confidence/self-esteem and positive mood/feelings. Discourage self-punishment.
3. "Lock up" rewards--administer them contingently, only when you meet or surpass your criteria for behavior (subgoals). Comment on the loss of reinforcer effectiveness if rewards are freely taken noncontingently and how this is squandering your resources. Encourage group to discuss this point fully and to commit themselves to self-administer rewards contingently only.
4. Maximum effects occur when rewards come immediately after target behavior. Stress importance of evaluating own behavior (points, self-approving covert sentences) as it occurs and to make a mental note at least, if you can't immediately log it and reward it. Points bridge time gap, but must be backed up.
5. Types of rewards--any freely available reinforcer can be used for SR--covert or overt, tangible or nontangible; opportunity to engage in some highly pleasing activity is often a good reward. Stress immediate availability, pleasure, and precise

specification (quantitative description) of rewards. Use tangible rewards and observable activities when first learning, to establish habits of covert SR+.

C. Reward Menus
Establishing SR+ schedules.
1. Instruct clients to make a list on the back of their PAS of several rewards that are highly pleasant and freely available. Suggest that some of their easier positive activities may already be so satisfying that the chance to do them can serve to reinforce more challenging positive behaviors. Answer questions as clients work on lists--prompt explicitness and quantitative specification of rewards.
2. Instruct clients to decide how many points they will require of themselves to earn (trade-in) each reward. They should write down the # of points they promise themselves to earn before partaking of that reward, next to each reward. When completed, each client should have a reward menu with rewards listed on the left and their "prices" in # of points on the right.
3. Encourage generosity of SR, no hoarding of points, and contingent SR only (no "credit"). Point out missing points can always be earned by doing an easy positive activity subgoal before rewarding yourself.

D. Review the three SR guidelines
Encourage notetaking.
1. Reward positive behaviors, rather than berating self for failures.
2. Reward each positive response (whenever behavior meets or surpasses a subgoal) contingently, and as immediately as possible (use points and covert sentences to bridge delays).
3. Be generous with rewards at first (low "prices"--fade or thin them out--up demands on self) after new positive behavior is well established--i.e., is frequent, easy, and pleasant.

E. Directions for week
Continue monitoring subgoal behaviors and assigning points but be sure to trade-in points for rewards (back up the points with reinforcement) as soon as you've accumulated the contracted amount. Stress importance of following reward menus closely.

SESSION 7

Review of SR

A. Check-in
Follow the routine procedure, allowing about one hour for it.
1. Focus on SR principles, reviewing the three guidelines:
   a. Reward positive behaviors--ignore mistakes. Rewards should be freely available, hedonic, immediate.
   b. Reinforce each step in the right direction with a contingent reward (use points and covert sentences to bridge delays).
   c. Be generous with rewards when you are first starting--set prices low enough to assure frequent self-reward.
2. Reinforce high SE and increased positive behaviors. Especially reinforce clients' efforts to follow their SR schedules and SR statements (expressions of self-confidence, self-esteem, positive affect, etc.).

B. Directions for week
Continue homework from last session

SESSION 8: Integration of all phases.

A. Check-in
Follow the routine procedure, allowing about one hour for it.
1. Review the guidelines for SM, SE and SR.
2. Reinforce clients for all three phases of program: SM, SE and SR.

B. Instructions for final week
Prompt clients to continue using self-control behaviors, especially covert SR+, beyond the end of training and at any time in future, as necessary.
1. Point out that the complete chain of SC behavior (SM, SE, SR) has only just been learned and should be practiced for at least several weeks to obtain full benefits. Offer to supply extra logs for all interested clients at the last session.
2. Instruct clients to continue logging, assigning points, and trading them in for rewards according to their menus for the next week. Clients are to bring their final week's completed logs to the post-test session.

C. Termination
Ask each client in turn to express their positive and negative feelings about her experiences with the group and the program. State your own feelings about ending and lead discussion about termination feelings.

Encourage clients to continue working on their problems and induce expectancy of continued progress after termination. Allow group to make social plans, if they wish. Remind them of follow-up testing.

D. Close

Close by reminding group of date and place for post-testing and to bring their last logs with them.

Check-in Procedure

General Tactic. Review by taking client reports of specific experiences over the last week and translating them into basic principles.

A. Group as a whole

Ask how things went over the week with the program.

1. Check for technical difficulties--reexplain mechanics where necesary.
2. Ask clients what they found out, or what happened as a result of following the program. Reinforce all reports of efforts to apply self-control and to increase positive activities.
3. Encourage group cohesiveness--prompt clients to help each other and to offer suggestions on how to handle difficulties.

B. Individual logs

Review each client's in turn.

1. Check log (name, completed summary data) and collect. Give client new log for next week.
2. Check graph--comment on relationship between rate of positive activities and mood, if possible.
3. Ask client to summarize highlights: What did she/he set out to do (priority goals) over the week, and what success did she have.
4. Reinforce (attention, empathy, praise) increases in frequency of positive behaviors, mood ratings, and/or points. Involve rest of group in reinforcing client. Have client tell how she/he achieved improvements. Encourage her/him to teach others by sharing ideas she/he found useful and helpful. Ask her/him about plans for next week.
5. Prompt planning to apply SC skills to solve problems and improve if client's frequency of positive responding, mood, or points are low and/or she makes depressive complaints. Prompt others to model and support specific problem solving in this client.

Positive Activities Survey--Directions

Attached is a list of suggested postiive activities, to help you in getting started. Positive activities are those that you can expect will usually result in pleasant, satisfying, or rewarding outcomes in time. They are direct actions on your surroundings (people and/or object) to achieve what you desire, or what would give you pleasure. In order to feel better, you will need to work towards increasing your frequency of engaging in these direct, active, positive behaviors.

There are individual differences in what is desired, considered pleasant, or valued as an outcome. No one is expected to find all of the suggested activities worthwhile. Neither is this list of suggestions comprehensive. You are encouraged to add your own items as you discover them and to select your own goals and priorities. For the present, try not to focus on activities that result in unwanted or unpleasant consequences for you. Concentrate on those activities that would lead to consequences you personally value or that you have previously enjoyed.

Objective self-observation is critically essential in changing your behavior pattern and resultant moods. Throughout this program you will be keeping daily logs of what positive activities you do, and how you feel immediately afterwards. You should monitor every positive activity you engage in, no matter how small. As immediately after your positive action as possible, record what you did (briefly describe the class of positive activities it comes under) and then rate your subsequent mood. Rate your mood on a scale from: 0 - worst or most miserable feelings you have ever experienced, to 10 - best or most elated feelings you have ever experienced. A rating of 5 would indicate a neutral feeling experience--neither particularly joyous nor particularly unpleasant for you.

Positive Activities

1. Trying to make new friends.
2. Arranging to be with happy and/or interesting people.
3. Expressing yourself to another person in an open way.
4. Getting another person interested in you.
5. Cooperating with other people.
6. Getting involved in new circles of people (e.g., special interest group, social organization, community service, social or political movement, academic or professional group).
7. Initiating social interactions.
8. Arranging to go out (e.g., to a concert or show, exhibit, restaurant or bar, dance, party or other social affair).
9. Doing a favorite or new hobby, project or physical activity.
10. Learning something new or figuring something out (e.g., puzzle, new skill, intellectual or personal problem).
11. Going on a trip (e.g., to the park, beach, or country, zoo or fair, downtown for shopping, sightseeing or exploring an area, etc.).
12. Caring for your self.
13. Making yourself attractive.
14. Actively enjoying beautiful weather.
15. Getting a good meal.
16. Physically contacting another person.
17. Looking at attractive scenery.
18. Deliberately thinking about something good (e.g., physical pleasure, social event, personal achievement).
19. Making time for yourself.
20. Other pleasurable activity (please describe).

APPENDIX N

NONDIRECTIVE MANUAL

APPENDIX N

Nondirective Manual

Treatment

While flexibility is normally the rule with this and most treatments, the goals of research require that the outlined procedures are followed as closely as possible. It is most important that the therapist remain with this specific treatment for only then can the effects of treatment be systematically studied. The therapist should be as warm, interested and helpful as he would be in any helping relationship. Since the diagnosis of depression will have been determined prior to the therapist's contact with the patient, focus on the treatment will begin with the first session.

Presentation of General and Specific Treatment Rationale

It is very important that each patient understand and accept the treatment process. A brief explanation of the theory and course of treatment should be presented and clarified if questions arise. It should be made clear that, in depression, discussing the feelings of individuals is very important. If any client has trouble understanding, explanations should be rephrased in language that she/he can understand. Questions from more sophisticated subjects should be dealt with openly to allay any doubts they might have; e.g., "We have found that patients receiving this treatment do not require drugs." The patients should also be informed of a telephone contact that will be available 24 hours a day to handle emergency problems.

The general instructions (on a separate page) should be presented initially. Those instructions are designed to control for the initial expectancies of subjects in all groups as well as giving subjects a general outline of the workshop.

The following specific rationale for the nondirective workshop should be a sufficient introduction:

"The symptoms that you are experiencing (a review of symptoms may be included here) are all related to the ways you deal with your feelings. Because we are all individuals, the ways that we deal with our feelings may be quite different. On the other hand, most of us do not even recognize, let alone accept, many of our own important feelings.

"Initially in our sessions we are going to look at some of the difficulties or problems that you are having and hopefully how to resolve these difficulties. By gaining awareness of the feelings, values and beliefs that are relevant to your problems, we will be better able to assist you in solving your own problems in a way that satisfies you.

"These workshops have been used with many depressed individuals with excellent results. Most of the procedures will become clearer after we get into them. Do you have any questions before we continue?"

Compiled from:

Hughes, R. DEC, Inc. Listening Skills Manual. East Lansing, Michigan: DEC, Inc., 1977.

Thornton, D.W. (Ed.). Listening Ear Manual, Unpublished manuscript, 1974.

Kantrowitz, R. (Ed.). A relationship manual for nonprofessionals working with delinquents. Unpublished manuscript, Michigan State University, 1977.

The Helping Relationship and The Helping Process

Physically, the helping relationship consists of a speaker, who presents a problem, and a listener, who uses certain skills to engage the speaker in the helping process. As we see it, there are also some crucial affective and attitudinal elements of the helping relationship. These are warmth, genuineness, and respect toward the speaker on the part of the listener, and the listener's belief that, if he demonstrates these affective elements while engaging the speaker in the helping process, the speaker can and will take the risk to solve his own problems, and learn to know himself better. Carl Rogers and others who have developed "client-centered therapy" have repeatedly shown that to the extent that listeners demonstrate these affective and attitudinal elements in the helping process, their speakers are helped, and that trust develops, both between the speaker and listener, and within the speaker himself.

There are three stages of the helping process, as we see it:

(1) Accurately labelling feelings and the sources of the feelings that the speaker is discussing. This is called empathic listening and responding. This stage, in particular, builds trust and is the foundation for Stages 2 and 3.

(2) Helping the speaker explore his thoughts and values that are related to the problem, and integrating these with his feelings. This is called Values and Attitudes Clarification.

(3) Helping the speaker develop and act on a behavioral plan to solve the problem; what to do and how to do it. This is, simply, Problem-Solving.

At base, then, the helping process is a series of interactions wherein the speaker gains awareness of those feelings, beliefs, and values that are relevant to the development and implementation of a plan to resolve his problem. The ultimate goal of the process is for the speaker to solve his problem in a way that satisfies him, and at the same time, to learn to solve other problems by the same (or a similar) process. The listener acts as a helper in facilitating the speaker's self-exploration and the resolution of the problem by his use of empathy, values clarification and problem-solving.

We will be giving you a set of skills to learn and practice so that you will be able to help a speaker in any stage of the helping process in which he needs assistance. Once you have mastered these skills, you will be ready to do crisis work, and will be able to be helpful to clients who ask you for assistance.

Introduction to Empathy

In this first stage of the helping process, your central task will be to respond to the feelings you hear the speaker expressing in a way that lets the speaker know you accept and understand those feelings. When you do this, you are making an empathic response; you are feeding back, or reflecting, the feelings the speaker is having. We believe that by responding empathically, a listener can aid a speaker in getting all of the information he will need to deal more effectively with his problem.

Because of previous learnings (with society, parents, friends), many of us find it uncomfortable and/or difficult to experience, label, or talk about our feelings. We are supposed to: "be rational;" "be cool, calm, and collected;" "keep a stiff upper lip." Our feelings are supposedly what get us into trouble; everything would supposedly be fine if we would just keep our heads and ignore our guts. So, people ask us to talk about what happened (thus, making a situation response), or, they tell us what we should do (or should have done), giving us solution responses.

But feelings are as important as our "rational" thoughts: they serve as barometers, telling us (or trying to!) what we do or don't want, expect, like, believe, and value in our world. Feelings don't cause problems; they exist with problems. Psychosomatic medicine has shown that unexpressed, ignored, or denied feelings can mess us up, sooner or later, with things like headaches, ulcers, and other physical ailments. We all know that unexpressed feelings can lead to bad moods, nervousness, or "flying off the handle." So, it definitely appears that feelings need to be dealt with, especially when a person is having a problem that he has feelings about. They need to be talked about, owned, and integrated into a person's awareness of himself and his problem.

Empathic responses to a person's statements about his problem help him to constructively deal with his feelings and his problem in that:

(1) They encourage the speaker to discuss and explore his feelings.

(2) They give the speaker permission to have, own, and discuss his feelings.

(3) They build trust between the speaker and the listener, which enables the speaker to explore himself more completely.

(4) They place final responsibility for dealing with the problem on the speaker; he basically leads the interaction and comes to his own conclusions about his problem.

Thus, empathic responses begin to counteract many of the "anti-feeling" messages that most of us have learned. In doing this, they help a speaker learn more about himself, and increase the chances that he will be satisfied with and carry through the resolution to his problem.

Feelings

When a speaker is talking about a problem she is experiencing, she will often talk about three things related to the problem: The situation, her symptoms, and her feelings.

The situation, or storyline, is what has happened to the speaker. It's what she did, or they did, or she said, or they said. It is the series of events that have occurred which are part of the speaker's problem.

The symptoms the speaker describes are the physiological responses that the speaker has had to the situation she is in. She laughs, she cries, she has a knot in her stomach. The symptoms a speaker describes will often give you a clue to what she is feeling.

Feelings are the emotional or affective labels that we put on our physiological responses to a given situation. Examples of feelings are happy, sad, mad, scared.

When you listen to a speaker discussing a personal problem, we would like you to focus on her feelings, since these are what are often at the base of a speaker's concern. Different people will respond to identical situations with different symptoms; some people will label the same symptoms with different feeling labels. It is the feeling that the

speaker has that to a large extent personalizes her experience of a given situation. Becoming more aware of her reactions and feelings in a situation will give a speaker more information with which to know herself, and upon which to base her own actions in this, and in future, situation(s).

Owning of Feelings

When someone "owns" his feelings, he recognizes them, labels them, and takes responsibility for them. He basically says, "This is my feeling about this situation." Speakers differ in their abilities to own and communicate their feelings as they experience them. To distinguish between experiencing and owning a feeling, consider the person, who with reddened face, tight jaw, frown, and pounding fist, yells, "I AM NOT ANGRY!!!" He experiences all of the symptoms of anger, yet does not label--own--his feeling. Or, consider the woman who, crying softly, says, "That was a rotten thing for her to do." It is obvious that she is feeling sad, or hurt, or both, but she hasn't said, "I feel sad." She hasn't owned her feeling.

It is our bias that feelings are important to deal with when a person is having a problem. Thus, it seems "better" when a person can own his feelings when he wants than when he can't. In the next section of the training program, we will talk about ways to help a speaker own his feelings. Now, we want you to simply identify whether or not this owning is occurring, and, if so, to what extent.

To fully own his feeling, a speaker:

(1) Expresses his feeling here and now.
(2) Expresses the full intensity of the feeling.
(3) Recognizes that it is his feeling; that no one or nothing made him feel the feeling; that the feeling is his response to another person, situation, or thing.
(4) Labels the source of the feeling (the situation or event that stimulates the feeling).

Can you think of other aspects of owning feelings?

Ways of not owning feelings include:

(1) Talking about situations as though the feeling attached is so "obvious" that it need not be mentioned or labelled.
(2) Talking about feelings as they were in the past, or how they may be in the future.

(3) Using "minimizers:" "kind of," "sort of," "a little bit," "maybe," to diminish the feelings intensity.
(4) Talking in a philosophical manner about feelings "people" have.
(5) Using vague feeling words.

It is important that a listener identify if and how well a speaker owns his feelings for a couple of reasons. First, it helps the listener attend to feelings and respond to them. Second, it gives the listener good information about how the speaker deals with his feelings (vaguely? intellectually? specifically?), which then lets the listener know how much time he will have to spend working with the speaker to get his feelings out and integrated, before moving on to values and problem-solving.

We would like you to practice identifying statements in which feelings are owned, and evaluating how clearly or fully they are owned. To give you all a common reference point in your practicing, we've devised a scale that places owning of feelings on a continuum, and spells out three distinct levels of owning feelings. At Level One, feelings are owned the least, at Level Three, they're owned the most. Please read and discuss the Owning of Feelings Scale with your group.

Ownings of Feelings Scale

LEVEL ONE:
--Speaker denies having feelings.
--If speaker states feelings, they are seen as coming from outside himself, and as being somehow forced on him. He denies or disowns responsibility for his feelings.
--Speaker talks in an abstract or philosophical manner about his personal feelings.

LEVEL TWO:
--Speaker usually owns his feelings in past or future terms; here and now feelings, when expressed, are talked about in a general manner, with little intensity.
--Speaker uses minimizers when talking about past feelings, or owning present feelings.
--Speaker sometimes identifies the source of his feelings, and takes minimal responsibility for the feelings, often using the phrase, "He/she/it made me feel _____."

LEVEL THREE: --Speaker clearly owns, identifies, and takes responsibility for his here and now feelings, and expresses them with emotion.
--Speaker owns the intensity of his feelings.
--Speaker clearly identifies the source of his feelings.

Labeling and Responding to Feelings

The purpose of this section is to develop your skills in responding to feelings. In a previous section, you learned to discriminate between feelings, situations, and symptoms. In this section, we would like you to specifically label feelings, and make empathic responses to the speaker, using those labeled feelings to do so.

Specific labeling of feelings occurs when a speaker or listener talks about feelings using words that are precise and clear descriptions of feelings. What do we mean by "precise" and "clear?" Answer: feeling words that leave no doubt about what the feeling is.

Some examples of unclear, vague, abstract feeling words, along with some possible precise meanings are:

"blah" could mean: apathetic, listless, bored
"bummed" could mean: depressed, sad, angry, disappointed
"hassled" could mean: nervous, pressured, angry, preoccupied
"uptight" could mean: threatened, angry, irritated
"upset" could mean: sad, angry
"down" could mean: depressed, sad, ashamed, guilty

Other vague words like "good," "bad," "up," etc., present the same kinds of confusing messages. Thus, using vague words like these to describe feelings can result in confusion for both the speaker and the listener, since neither can be sure what the other means by the words. Therefore, avoid using vague feeling words; especially, avoid "lingo" or jargon that can have any one of a number of meanings depending upon the speaker's age, peer group, or hometown region.

Specific labeling of feelings also involves accurately talking about the intensity of the expressed feelings. Differences in intensity can be expressed in a couple of ways:

(1) By using different feeling words of the same family. For example, to express different degress/intensities of ANGRY:

--annoyed --disgusted
--irritated --furious
--enraged

Other feelings like happy, sad, and scared, have a family of related words that differ in their intensity.

(2) By choosing to use modifiers. For instance, "You feel. . ."

slightly very
somewhat extremely
quite

". . .pleased!" Different modifiers with the same feeling word can specifically label feelings' intensities.

CAUTION! Be EXTREMELY careful NOT to use minimizers like "a little," or "a bit," or the modifiers "kind of" and "sort of." Many of us use these modifiers because we learned that strong feelings (especially strong "negative" feelings) are not admissable or permitted; saying we're "a little bit" angry supposedly makes the anger more acceptable. In the helping relationship, however, minimizers decrease your potency as a helper, and convey to the speaker that it isn't OK to own feelings intensely. Furthermore, how much is "kind of?" Is your "kind of" the same as another person's? In summary, avoid the use of these modifiers. If you are sure that the speaker only feels "a little" whatever, use a different minimizer to reduce the intensity. If you aren't sure, don't use a minimzer at all.

Undercurrents. Sometimes the speaker will appear to be having another feeling besides the one she is talking about, the one she states. Let's look at an example:

Speaker: I didn't get asked to the dance by my boyfriend. That makes me angry.
Listener: I hear you being really angry, but it also looks like you're hurt.

While the speaker states she is angry, her tears convey that she is sad or hurt. The listener picked up on this, and responded to both the anger and the hurt. The hurt is an undercurrent. Undercurrents are feelings that the speaker may be experiencing, but that she has not yet labeled or owned. Ways of picking up on this kind of feeling include:

(1) watching non-verbal behavior and labeling the feelings the speaker shows you but doesn't talk about;

(2) imagining yourself in the speaker's shoes and labeling what you think she might be feeling;

(3) using your understanding of "human nature" to label what you suspect she might be feeling, given the situation she describes.

CAUTION!!! Labeling undercurrents is not to be confused with telling the speaker how she should feel. Telling the speaker how she should feel is not helpful, and it will stop her from exploring her feelings with and trusting you as quickly as your walking out of the room. Labeling undercurrents only brings out feelings that the speaker already appears to be experiencing, or has hinted at, but hasn't herself labeled.

Responding to stated and undercurrent feelings. Once you can accurately label the feelings a speaker is expressing, you can go on to responding to the speaker's feelings.

Responding to feelings is different than responding in the way most of us are used to responding to a person sharing a concern with us: with solution responses, situation responses, or with sympathetic responses.

Solution responses are listener statements that tell the speaker what the listener thinks the speaker should do to solve her problem. These are not helpful to the speaker most of the time; they take the focus off of the speaker, and place her in one-down position to the listener (since the listener apparently knows what's best for the speaker).

Situation responses are listener statements that respond to what has happened to or around the speaker. They increase the amount of storyline and decrease the amount of feelings the speaker will discuss.

Sympathetic responses are of the "That's too bad," or "You poor thing," varieties. They place the speaker in a one-down position again, and don't do much for developing the speaker's resources for dealing with her feelings.

Responses to feelings (or, empathic responses) reflect, or mirror, the feelings you hear the speaker expressing, using the same or similar specific feeling words she used, in a declarative statement (not in a question).

This is simply another form of feedback: Telling the speaker what feelings you hear her expressing to you. Empathic responses, given in a warm, caring, and acceptant manner, let the speaker hear and focus on (sometimes for the first time) what she has been saying, and tell her that it's okay for her to continue expressing her feelings.

Again, when you respond empathically to a speaker, you respond to the stated or undercurrent feelings, using the same or similar words she used (or, with undercurrents, implied). These are the types of responses we are asking you to make in this training program.

How to Make an Empathic Response. We offer these suggestions to give you a framework for responding to feelings. Hopefully, they will help you develop your empathic skills more quickly than if they were not here. You will probably feel awkward using them at first, but you will become more comfortable with them as you practice your skills.

(1) Empathic openers. Empathic openers are ways to tell the speaker that what you are about to say is your impression of what she's been saying. They add tentativeness to your responses, thereby leaving the speaker some room to disagree with you. Some empathic openers you could use are:

"You seem to be feeling_____."
"It sounds like you feel_____."
"I hear you saying you feel_____."
"I get the impression you feel_____."

(2) Keep your responses SHORT!! Mince your words. One sentence is ideal at this point.

(3) In any one response, respond to only one feeling. Later, we'll talk about responding to conflicting feelings and making summaries; then, we'll ask you to respond to more than one feeling. If the speaker talks about more than one feeling, choose the last one mentioned, OR the one that sounds predominant to you.

We have another scale for you to use to evaluate your group members' (and your own!) empathic responses. Please read over the scale.

Responding to Feelings Scale

LEVEL ONE--Listener responds to facts and information, situation, or storyline.
--Listener does not respond to speaker's stated feelings.
--Listener rejects and/or denies speaker's feelings by judging, ridiculing, putting them down, giving advice, or coming up with quick solutions.

LEVEL TWO--Listener responds to the stated feelings of the speaker, mirroring the feelings in the same or similar specific feeling words.
--Listener is accepting of the speaker's feelings: s/he does not deny, ridicule, or otherwise reject the speaker's feelings.
--Listener's non-verbal behavior is attentive to the speaker.

LEVEL THREE
--Listener responds to speaker's stated feelings, and goes on to label undercurrents that are implicit (though not actually stated) in the speaker's statements.
--Listener emphasizes the intensity of the speaker's feelings by using tone of voice, gestures, and words which accent feelings.

Specific Labeling of Feelings with Sources

The purpose of this section is to help you polish your skills in responding to feelings. We would like you to continue to respond to feelings very specifically. We would also like you to start connecting the specific feelings with their respective sources in some of your empathic responses.

Specific labeling of feelings with sources occurs when a listener briefly summarizes the event or situation that has stimulated a feeling in the speaker, along with reflecting the feeling itself. It's talking about both the feeling and "where the feeling is coming from" in specific terms. This can be extremely helpful to a speaker when he is having a number of different feelings about a number of facets of his concern. In that type of situation, it is easy for both the speaker and the listener to be (or become!) confused. Specifically labeling feelings with their sources and reflecting these to the speaker can clarify the speaker's feelings for both him and you.

As with labeling feelings specifically, there are clear and vague ways to label sources. Let's look at some examples of unspecific versus specific summaries of sources.

Speaker: I think I'm pregnant. I'm really worried about what my parents will think.

Specific Response: You sound frightened about how your parents might react if you're pregnant.

Unspecific Response: You sound worried about that.

"How your parents might react" is specific. It spells out the situation the feeling "frightened" is coming from.

"That" is vague and unclear, in that it doesn't clarify what the speaker is worried about. It doesn't tell the speaker that you've been listening.

Another example:

Speaker: My parents have been fighting and it really hurts me to watch it.

Specific Response: You feel hurt when your parents fight.

Unspecific Response: You feel hurt when you see people fight.

This response trades specific people for people-in-general. The same thing can be done with situations. Both should be avoided.

Finally:

Speaker: My sister broke my favorite record last night! I was so mad at her I could've hit her!!!"

Specific Response: You felt really angry because she broke your favorite record.

Unspecific Response: You felt mad because she did that.

So, in general, try to avoid vague source summaries like "that," "when that happened," or "when people. . ." They don't help clarify a speaker's thoughts and feelings as well as more specific source statements like the ones above.

How to Respond to Feelings with Sources. As before, there are a couple of "formulas" you can use to get started.

"You feel _____because_____."

"When _____, you feel/felt _____."

As you become more adept at labeling feelings with sources, you can develop more natural-sounding ways of responding. Remember to keep your source summaries brief, so that your responses stay short.

When to Respond to Feelings and Sources. During this training program we will be asking you to respond to feelings with their sources in the majority of your responses. When you are actually listening to a client, you will probably wish to reduce the number of feelings-with-sources responses you make; since they can result in overly-long responses. For now, we want you to become skilled enough to be able to make these responses easily and effectively. This is your practice time for developing this skill. Later, we will discuss how and when you might choose to respond to feelings with or without sources; for now, please respond with sources as often as you can.

Please read over the following scale. As with the other scales, we would like you to learn to respond at a Level Two on this, the Specific Labeling of Feelings With Sources Scale. Once you have read and become familiar with the scale, go on to use the tape, as before.

Labeling of Feelings with Sources Scale

LEVEL ONE--Listener does not label speaker's feelings and/or sources of the feelings.
--Listener moves the speaker away from the feelings and sources which are most important to him.
--Listener does not match the appropriate feelings to the appropriate sources.

LEVEL TWO--Listener responds to speaker's stated feelings and sources by:
using abstract and general terms;
using the same or similar words that the

The examples in this section are taken from Training Manual for Counseling Skills. Washington, D.C. National Drug Abuse Training Center, 1973, p. 24, 37, and 38.

speaker used;
matching the appropriate feelings to the appropriate sources.

LEVEL THREE--Listener labels specific feelings and specific sources for those feelings.
--Listener focuses on those feelings he sees as most important to the speaker's concern.
--Listener reflects undercurrent feelings and sources.

Responding to Conflicts in Speaker Feelings

A person is in conflict when she has one or more pairs of opposing or incompatible feelings about a person, action, or situation. For example, a man starting to date one woman steadily may feel excited and afraid about getting involved in this new relationship. Similarly, a woman graduating from college may feel happy to be finished with school, and sad to be leaving the familiar security of the lifestyle she has known for four years.

Ambivalence--the experience of having opposing or incompatible feelings about something--is unpleasant for many of us. We feel uncomfortable, unsure, confused; we have a hard time knowing who we are, what we feel, or what we want to do about our continually changing feelings.

An important part of the helping process is sorting out a speaker's conflict in her feelings. Until a person knows and understands all of the feelings that are in conflict, she cannot move towards resolving the conflict in a satisfactory way--one which takes all of her feelings into account.

Later in this training program, we will teach you a specific model for helping a person decide upon a course of action for dealing with her ambivalence, or conflict; at this point, the skill we would like you to master involves recognizing the ambivalence a speaker is expressing, and responding to that ambivalence by accurately labeling the feelings that are in conflict.

The first three examples in this section are taken from Training Manual for Counseling Skills. Washington, D.C.: National Drug Abuse Training Center, 1973.

Let's consider three speakers, each discussing a personal conflict.

Speaker: I love my boyfriend and I really care about him, but it's just too confining living with him. Our relationship is not helping me grow as a person. I want to leave, but it's hard to give him up.

The feelings that are in conflict here are caring and love versus feeling confined and stagnant. Later, she will probably decide between wanting to leave and wanting to stay, but right now she needs to clarify the feelings that lead to wanting to stay or to go.

Let's look at another example:

Speaker: I want to quit my job, because I can't stand working for that S.O.B. any longer. I need to get out, but there's no place to go. I've looked around for jobs, but this town's dry. It gets me down to look for a job.

Here, the feelings in conflict are feeling frustrated with his job and feeling depressed and hopeless about finding a new job. Again, later, this man will decide whether or not he will actually quit his job; but right now, he needs to have the feelings that lead to his choice clarified.

In the next example, you label the feelings that are in conflict.

Speaker: I want to go with you all on the trip since it would be great to get away and relax, but I just can't stand Joe. He just irritates the hell out of me. I don't know what to tell you.

The feelings in conflict are:

_____ versus _____

Later, what might this person need to decide once he clarifies his feelings?

Throughout these examples, we have talked about the speaker's need to make a decision, at a later time in the helping process, about what she wants to do. This was done to separate out the feelings from the "wants" and/or action plans the speaker expressed. It is important to resist the urge to label conflicts in terms of simply wanting versus not wanting something, doing versus not

doing something, or feeling versus not feeling something about the same situation. For example:

Speaker: I don't know whether to leave school or not. I'm not doing that well. But to go away from here, and leave my friends, is pretty scary.

Listener: It sounds like you're pretty confused about whether or not to leave school.

This response is true, and accurate, and the speaker will probably go on to discuss his concern more fully. However, it does not add to the speaker's understanding of the conflict. It doesn't really clarify his feelings. A response that would be more likely to do so might be:

Listener: It sounds like on the one hand, you feel unsuccessful in school, but on the other hand, you're afraid to leave its familiarity.

Responding to the feelings that are in conflict, along with their sources, will facilitate the speaker's self-exploration, and give him more information to work with in problem-solving.

In summary, ambivalence causes psychological discomfort. The first step in dealing with this discomfort is to label the feelings that are involved in the conflict, along with each feeling's source. This will bring the conflict into focus, and clarify it. Then, using her more complete awareness of her feelings, the speaker can go on to consider alternative ways of acting to reduce or eliminate the discomfort.

As in the preceding sections, there is a scale with which we can evaluate responses to conflicts in speakers' feelings. Please read over and discuss this scale with your group.

Responding to Conflicts in Speaker's Feelings

LEVEL ONE--Listener does not respond to the conflicts in the speaker's feelings, but rather, responds to the situation.
--Listener points out conflicts in the speaker's feelings in a judgmental way.

LEVEL TWO--Listener recognizes and reflects the conflicting feelings the speaker expresses.

--Listener labels the conflict in speaker's feelings in terms of "wanting/not wanting" or "feeling/not feeling" something.
--Listener accurately points out the conflicts in a speaker's feelings in a non-judgmental way.

LEVEL THREE--Listener responds to conflicting feelings that were actually stated by the speakers, and goes on to point out undercurrent feelings the speaker appears to be having.
--Listener responds to feeling conflicts by using examples from experiences the speaker has described.

Owning of Listener Feelings

We've stressed the importance of being non-judgmental, non-possesively caring, and otherwise non-directive in responding to your speaker. Most of the time, this will probably not be too difficult for you as you use the skills you've learned. Sometimes, however, you may have a reaction to the speaker that impedes your ability to respond to her/him in a helpful way. The purpose of this section is to give you some guidelines for and practice in dealing with those kinds of reactions in a manner that continues to help your speaker.

Listener roadblocks are those situations that you come up against in which you have difficulty listening and/or responding empathically because of the impact that the speaker is having on you. Some examples of roadblocks are:

feeling unable to formulate a response
feeling confused about what the speaker is trying to tell you
feeling defensive when you respond
feeling very sympathetic toward the speaker

The root of a roadblock is a feeling you are experiencing. The first step in moving a roadblock is to own your feeling internally.

Let's look at an example:

Speaker: I really don't think my parents love me. They always put me down when I try to talk with them.

Listener: They must love you!

(That was a defensive response, I wonder what's going on with me? I know! Whenever anyone talks about their parents, I think about mine and that HURTS.)

Because the listener wasn't paying attention to his own feelings, he responded defensively. By being more aware of his feelings and labeling them for himself, his response could have been like this:

Speaker: I really don't think my parents love me. They always put me down when I try to talk with them.

Listener: (There are knots in my stomach, I wonder why? Ah ha! My parents do that too and it hurts me.) It sounds like it hurts you a lot when your parents don't listen to you.

Here, the listener paid attention to and labeled his own feelings, decided that his emotional response to the situation the speaker was describing was probably similar to her own feeling response and used his labeled feeling as an undercurrent feeling label in responding to the speaker. In this case, not only did the listener own his feeling, but he was able to use that in helping the speaker deal with her feelings.

In summary, when you have a feeling reaction to what your speaker is discussing, own the feeling, label it, and decide if he probably is experiencing this as an undercurrent. If so, try labeling the feeling as an undercurrent when you respond to the speaker.

If you think that your feeling reaction is basically personal and idiosyncratic, you can put your feeling aside and go on to listen and respond to what the speaker is saying he is feeling, rather than using your feeling reaction in responding.

Another type of listener roadblock occurs when a speaker says something that confuses you. For example:

Speaker: I can't seem to get out of this depression. Well, it's not a depression because. . .anyway, going to school and working at the same time. . .I never get to have, uh, well, I guess sometimes I do okay. It's just that I want to get away. . .no, not get away, just rest. Maybe I could quit school.

The moral of this story is: own your confusion and ask for clarification!

Finally, there is a class of roadblocks that can be pretty tricky to deal with. These roadblocks occur when you have a reaction to something the speaker is saying or doing here and now, and that reaction is getting in your way.

Speaker: I want you to give me some answer right now! That's why I came here.

Listener: (I feel like I'm getting a lot of pressure to solve the speaker's problem.) I'm feeling a lot of pressure from you to find some quick answers. I guess I want to check that out with you because it seems to be getting in the way of your working on your problem.

By labeling the feeling "pressured" and discussing the speaker's here and now impact on her, the listener was able to go on to share her reaction and put the focus back onto the speaker for finding answers to his problems.

A variation of this kind of roadblock occurs when you suspect that the listener has the same impact on other people in his life that he is having on you. In this situation, you can own your reaction, and ask the speaker to examine his style of interacting with you and/or others which may contribute to his concerns.

Speaker: (Loudly) I guess that my parents really hurt me a lot when they tell me they don't like the way I live!

Listener: I hear the pain coming from your parents, but I also hear that you're plenty mad at them, too.

Speaker: (Softly) No, I'm not angry, I just feel like my parents really hurt me a lot and I can't do anything. You know, they just keep putting me down.

Listener: It sounds like you feel pretty helpless.

Speaker: (Crying) Sure. I mean, how would you feel if your parents didn't love you? I just hurt all the time.

Listener: I'm feeling like I really want to protect you now because you seem so helpless. I wonder if that's the way you relate to other people?

Finally, a listener roadblock that often occurs when we're just starting to respond empathically is expecting ourselves to be perfect, and being overly critical of any mistakes we make. Give yourself room to be less-than-perfect; recognize your mistakes without being harshly judgmental of yourself as a listener. When you make a mistake as a listener, the speaker will usually try to help you out by clarifying what she said or meant. You will get another chance to label the feeling or conflict accurately!

Now, we are going to give you some practice in owning your feelings as a listener. Close your eyes and listen to each of the speakers on the tape your trainers will play. Pretend that each speaker is talking directly to you: that you said something to them, and this is their immediate response to you. Then, own your feelings, using the "Owning of Feelings Scale" as a guide. The following questions may help you to own your feelings:

What did the speaker say?
What did s/he feel toward me?
What are my symptoms?
What feeling labels would I put on these symptoms?
What's the source of my feeling?

Once you've owned your feeling, decide what you would say to the speaker. Some questions to consider in formulating your response are:

Will it help our interaction if I own my feelings?
Can I own my feelings and put the focus back on the speaker?
Is the speaker trying to manipulate me?
Do I think it would be valuable for the speaker, or me, to discuss the impact s/he is having on me?

Discuss your feelings, and your responses to the speaker, with your group.

Is Help Helpful?

by

Jack R. Gibb

People in the service profession often see themselves as primarily engaged in the job of helping others. Helping becomes both the personal style of life and a core activity that gives meaning and purpose to the life of the professional. The youth worker, the camp director, the counselor, the consultant, the therapist, the teacher, the lawyer--each is a helper.

Helping is a central social process. The den mother, the committee chairman, the parent, the personal friend, the board member, the dance sponsor--each is a helper.

Help, however, is not always helpful. The recipient of the proffered help may not see it as useful. The offering may not lead to greater satisfaction or to better performance. Even less often does the helping process meet a more rigorous criterion--lead to continued growth on the part of the participants.

To begin with, a person may have varied motivations for offering help. He may wish to improve performance of a subordinate, reduce his own guilt, obtain gratitude, make someone happy, or give meaning to his own life. He may wish to demonstrate his superior skill or knowledge, induce indebtedness, control others, establish dependency, punish others, or simply meet a job prescription. These conscious or partially conscious motivations are so intermingled in any act of help that it is impossible for either the helper or the recipient to sort them out.

Depending upon his own needs and upon the way he sees the motives of the helper, the recipient will have varied reactions. He may feel helpless and dependent, or jealous of the helper who has the strength or resources to be in the helper role. He may feel indebted, or pressured to conform to the perceived demands or beliefs of the helper.

We have all noticed that in certain cases the recipient of the help becomes more helpless and dependent, less able to make his own decision or initiate his own

actions, less self-sufficient, more apathetic and passive, less willing to take risks, more concerned about propriety and conformity, and less creative and venturesome. We have also seen circumstances in which, following help, recipients become more creative, less dependent upon helpers, more willing to make risk decisions, more highly motivated to tackle tough problems, less concerned about conformity, and more effective at working independently or inter-dependently. Help may or may not lead to personal growth and organizational health.

Under certain conditions both the giver and the receiver grow and develop. In general people tend to grow when there is reciprocal dependence--interdependence, joint determination of goals, real communication in depth, and reciprocal trust. To the degree that these conditions are absent, people fail to grow.

From the standpoint of the organization, help must meet two criteria: the job or program must be done more effectively, and the individual members must grow and develop. These two criteria tend to merge. The program and the organization are effective only as the participants grow. The same conditions that lead to organizational health lead to personal growth. The following table presents a theory of the helping relationship. Seven parallel sets of orientations are presented. One set of conditions maximize help and a parallel set of conditions minimize help.

TABLE 1--The Helping Relationship

Orientations that help	Orientations that hinder
1. Reciprocal trust (confidence, warmth, acceptance)	1. Distrust (fear, punitiveness, defensiveness)
2. Cooperative learning (inquiry, exploration, quest)	2. Teaching (training, advice giving, indoctrinating)
3. Mutual growth (becoming, actualizing, fulfilling)	3. Evaluating (fixing, correcting, providing a remedy)
4. Reciprocal openness (spontaneity, candor, honesty)	4. Strategy (planning for maneuvering, gamemanship)
5. Shared problem solving (defining, producing alternatives, testing)	5. Modeling (demonstration, information giving, guiding)
6. Autonomy (freedom, interdependency, equality)	6. Coaching (molding, steering, controlling)
7. Experimentation (play, innovation, provisional try)	7. Patterning (standard, static, fixed)

Reciprocal Trust. People accept help from those they trust. When the relationship is one of acceptance and trust, offers of help are appreciated, listened to, seen as potentially helpful, and often acted upon. The receiver accepts help from one whose perceived motives are congenial to him. He tends to reject offers from people whose offering is seen as a guise for attempts to control, punish, correct, or gain power. "Help" is most helpful when given in an atmosphere in which people have reciprocal feelings of confidence, warmth, and acceptance. When one feels that his worth as a person is valued he is able to place himself in psychological readiness to receive aid.

Distrust. When people fear and distrust each other, even well-intended help is resisted, resented, or seen as unhelpful. Offers of help are sometimes given in service of motivations that are unacceptable to the receiver. That is, one offers help in order to place the other person in a dependent position, elicit expressions of gratitude, assert one's superiority, or punish him. In distrust the recipient's guard is up. He is likely to project his distrusts into the helper and to resist or resent the help.

One often gives help to camouflage or assuage his desire to change another person--change his character, habits, or misconceptions. The desire to change another person is essentially hostile. At a deep level, one who genuinely accepts another person does not wish to change him. A person who is accepted is allowed to be, to become, determine his own goals and follow them at his own pace. The person who genuinely wishes to help offers the help that the recipient wishes. Genuine help is not foisted upon the receiver. Neither the punisher nor the child really believes that the punishment is given "for the good of the child." Punishment or censure may be given with a conscious desire to help but usually is accompanied by a deep component of retaliation, or by a desire to hurt, control, or assert superiority. The giver often speaks of his act as "helpful" in order to rationalize to himself and to the receiver acts that are done for other motivations.

Cooperative learning. People are helpful to each other when they are engaged in a cooperative quest for learning. The learning atmosphere is one of joint inquiry and exploration. Needs for help and impulses to give help arise out of the demands of the common cooperative task.

Help is thus reciprocal. The helper and helpee roles are interchangeable. Each participant has the intent to learn and feels he can learn from the partners and from the common task. The boss and the subordinate, the teacher and the student, the professional worker and the youth--all are most helpful when each member of the pair sees the relationship as a quest with potential learning for each. An effective project team is guided by the task and not by the teacher. It is motivated by the shared potential for learning.

Teaching. When one participant in a project sets out to teach, train, advise, persuade, or indoctrinate the other members or is seen as wanting to do so, the learning of each member is reduced. People cannot be taught. People must learn. People cannot be trained. They grow and develop. The most deeply helpful relationship is one of common inquiry and quest, a relationship between co-learners and co-managers in which each is equally dependent upon the other for significant help and in which each sees and accepts this relationship.

Mutual Growth. The most permanent and significant help occurs in a relationship in which both members are continually growing, becoming and seeking fulfillment. Each member participates in a mutual assessment of progress, accepts this reality of growth, and participates in a way that will maximize the growth of both participants. In a fundamental sense one can only help himself. The helper can only participate with another in an effort to create a climate in which growth can occur.

Evaluating. Growth is often hindered when one member of the helping team sets out to appraise or remedy the defects in the other member. Help is most effective when it is seen as a force moving toward growth rather than as an effort to remove gaps, remedy defects or bring another person up to a standard criterion. The limits of growth of any person are extremely difficult to foresee or to assess. The potential for growth is consistently underestimated by both participants in helping relationships.

Reciprocal openness. One of the essential conditions for effective human learning is the opportunity for feedback of knowledge of progress. Feedback is essential in acquiring skills, knowledge, and attitudes. In the areas where professional help is most commonly sought or given, the essential progress in learning and growth is

blocked most often by the failure to obtain adequate data on people's feelings and perceptions of each other. In order to do effective work, one must know how others feel and how they see things. In the usual situations in which professional helpers find themselves, there are many pressures which camouflage or distort the relevant data necessary for efficient work and best learning. Many factors reduce the availability of the relevant data; differential status, differential perceived power, and fears that one can hurt or be hurt.

Strategy. When some part of the helping process is closed or unavailable to all participants, people are likely to become anxious, resentful, or resistant. Neither participant in the helping process can "use" the other for his own needs. The helping process is most effective when one plans with another, not for another. One is not helped when he is maneuvered into some action which he does not understand. Gamesmanship and gimmicks are antithetical to the helping process.

Shared Problem Solving. The productive helping relationships focus upon the problem to be solved. Problem solving involves a joint determination of the problem, continual redefinition of the problem as successive insights are gained, joint focus upon possible alternative solutions, joint exploration of the data, and continual reality testing of the alternatives. The expertness and resources of each person are shared. The aspect of the behavior about which help is given is seen as a shared problem--not as a defect to be remedied or as something to be solved by the helper as consultant.

Modeling. A common image of the helping relationship is one where the helper offers a model for the advisee to follow. The expert gives a demonstration of how the recipient may solve his problems. The problem is defined by the expert. Diagnosis is made by the expert. The expert is challenged to offer additional alternatives to the solution of the problem and perhaps even to test the solutions. The process in uni-directional. The limitations of modeling are many. Dependency is increased. The pupil seldom gives better than the model. The worker tries to conform to the image of the supervisor. Growth is limited.

Autonomy. The ideal relationship for helping is an interdependent one in which each person sees the other as both helper and recipient in an exchange among equals.

It is essential that each participant preserve his freedom and maintain his autonomous responsibility for guiding himself toward his own learnings, growth, and problem solving. The helper must work himself out of the helping job. The supervisor, youth worker, and counselor must become decreasingly necessary to the people being helped. Psychological weaning, however painful to both helper and recipient, must continue if help is to be truly helpful.

Coaching. The coach molds, steers, or controls the behavior of the recipient, much as a tennis coach or physical education director molds the behavior of the athlete or skill-directed recipient of help. This is another uni-directional process in which the coach is assumed to have special diagnostic and observational powers which he applies in a skilled way to the behavior of the recipient, who puts himself in the hands of the coach. The recipient of help is encouraged to maintain respectful dependency upon the coach, to not challenge his coaching or expertness, to put implicit trust in his abilities and powers, and to receive from the coach motivational or inspirational guidance. Both coach and pupil suffer under this pattern. Each may gain in skill. Neither grows as a person.

Experimentation. Tentativeness and innovative experimentation are characteristic of the most productive helping relationship. There is a sense of play, excitement, and fun in the common exploratory quest for new solutions to continually changing problems. The helping process is viewed as a series of provisional trials. Each participant joins in the game and adds to the general excitement. Errors can be made--and are perhaps expected. Help is a search. Finding creative solutions to newly defined problems is a game--full of zest and intrinsic drives that keep the game going.

Patterning. Help is limited when the process is seen as an attempt on the part of one person to help another meet a prescribed standard, come up to a criterion, or reach a goal specified in advance. Helping is a creative synthesis of growth and a continual search for new forms.

"Help" is not always helpful--but it can be. Both the helper and the recipient can grow and learn when help is given in a relationship of trust, joint inquiry, openness, and interdependence. Growth-centered helping processes lead to healthy groups and effective organizations.

Communication

Some general aspects of communication are:

1. You can't communicate. You are always sending out messages.
2. Message sent is not necessarily message received.
3. Communication is a complex process. There are three main aspects of communication:
   a. The content. What the words are.
   b. Process. How the words were said.
   c. Context. Where and to whom the words are said.

Eight Communication Hang-Ups

These hang-ups result in communication break-downs:

1. Incongruence between levels of communication.
   a. Verbal-nonverbal. Saying one thing with your words and another with your tone of voice and body.
   b. A statement made in the form of a question: "Don't you really think that you're being unreasonable about this?"
   c. A statement in the form of a joke. Not really saying what you mean but giving a dig in the form of a joke.

2. Vague and unclear communication.
   a. A shift in time, place: "I don't like that," but saying, "we don't like that." A shift back to something that happened before when dealing with something that is going on between two persons now.
   b. Vague statements like "you know how I feel." "I've told you about that."

3. Not giving feedback.
   a. What I hear you saying is this. . .is that what you are saying?
   b. You are coming across to me like this. . . .

4. Not acknowledging that a message has been sent.
   "I see that you want to say something but can't get to it right now."
   "I'll come back to it."
   "I hear you."

5. Not distinguishing between fact and opinion; almost nothing about interpersonal relationships is a fact.
   "Why are you so unreasonable?"
   "Why are you so insensitive?"

6. Not owning your feelings, thoughts and behaviors. This results in the "blame game." If you just share how you feel (think) so that the other person can then deal with whether he really wants you to feel (think) that way. For example, say "I am beginning to feel bad," rather than "you make me feel bad," which results in the blame game. "You make me angry." "You are getting me upset." "It is your fault that I act this way." "You make me do that."

7. Disqualification of another's thoughts, feelings, beliefs or behavior which really is a way of saying you do not count as a person because I can pretend that you do not exist. "How can anyone belong to that political party?" Ignoring that another person is trying to get your attention to ask for something. "You really don't hate me" (disqualification of feelings).

8. Not checking out assumptions.
   a. Assuming why another person is acting a certain way--<u>not</u> checking it out--and then acting on it.
   b. Assuming how another feels without really finding out.

Summary of Basic Communication Skills For Improving Interpersonal Relationships

1. PARAPHRASE: Letting the speaker know what meaning his remark conveys to you.

   Examples: "Do you mean. . .(this)?" "Is this. . . (statement). . .an accurate understanding of your idea?" "Would this be an example of your point?. . . (then stating a specific example)."

2. BEHAVIOR DESCRIPTION: Describing specific, observable actions of others as contrasted with stating inferences, accusations or generalizations about their motives, personality or character traits.

   Example: "Jim and Harry have done nearly all the talking and the rest of us said very little," NOT "Jim and Harry just have to have the spotlight on them all the time."

3. DESCRIPTION OF FEELINGS: Identifying feelings by (a) name, (b) simile, or (c) action urge.

   Describing your own feelings.

   Example: "I feel embarrassed." (naming)
   "I'm very fond of you." (naming)
   "I feel like a tiny frog in a huge pond." (simile)
   "I'd like to hug you and hug you." (action urge)

   Perception check: Describing what you perceive the other is feeling in order to check whether you do understand what he feels.

   Examples: "You look like you felt hurt by my comment. Did you?"
   "I get the impression you'd like to change the subject. Is that accurate?"
   "You seem to be feeling more at home now."

To Understand the Other as a Person

--Check to make sure you understand his ideas, information and suggestions as he intended them. (skill: paraphrase)

--Check to make sure you accurately understand what he feels. (skill: perception check)

To Help Others Understand You as a Person

--Describe what others did that affects you personally or as a group member. (skill: behavior description)

--Let others know clearly what you are feeling. (skill: description of your own feelings)

--John Wallen

Paraphrase

A Basic Communication Skill for Improving Interpersonal Relationships

The Problem

Tell somebody your phone number and he will usually repeat it to make sure he heard it correctly. However, if you make a complicated statement most people will express agreement or disagreement without trying to insure that they are responding to what you intended. Most people seem to assume that what they understand from a statement is what the other intended.

How do you check to make sure that you understand another person's ideas, information, or suggestions as he intended them? How do you know that his remark means the same to you as it does to him?

Of course, you can get the other person to clarify his remark, by asking, "What do you mean?" or "Tell me more," or by saying, "I don't understand." However, after he has elaborated you still face the same question: "Am I understanding his idea as he intended it to be understood?" Your feeling of certainty is no evidence that you do in fact understand (see "On Misunderstanding").

The Skill

If you state in your own way what his remark conveys to you, the other can begin to determine whether his message is coming through as he intended. Then if he thinks you misunderstand, he can speak directly to the specific misunderstanding you have revealed. I will use the term "paraphrase" for any means of showing the other person what his idea or suggestion means to you.

Paraphrasing, then, is any way of revealing your understanding of the other person's comment in order to test your understanding.

An additional benefit of paraphrasing is that it lets the other know that you are interested in him. It is evidence that you do want to understand what he means.

If you can satisfy the other that you really do understand his point, he will probably be more willing to attempt to understand your views.

Paraphrasing, thus, is crucial in attempting to bridge the interpersonal gap. (a) It increases the accuracy of communication, and thus the degree of mutual or shared understanding. (b) The act of paraphrasing itself conveys feeling--your interest in the other, your concern to see how he views things.

Learning to Paraphrase

People sometimes think of paraphrasing as merely putting the other person's ideas in another way. They try to say the same thing with different words. Such word-swapping may merely result in the illusion of mutual understanding as in the following example.

Sarah: Jim should never have become a teacher.
Fred: You mean teaching isn't the right job for him?
Sarah: Exactly! Teaching is not the right job for Jim.

Instead of trying to re-word Sarah's statement Fred might have asked himself, "What does Sarah's statement mean to me?" In that case the interchange might have sounded like this.

Sarah: Jim should never have become a teacher.
Fred: You mean he is too harsh on the children? Maybe even cruel?
Sarah: Oh, no. I meant that he has such expensive tastes that he can't ever earn enough as a teacher.
Fred: Oh, I see. You think he should have gone into a field that would have insured him a higher standard of living.
Sarah: Exactly! Teaching is not the right job for Jim.

Effective paraphrasing is not a trick or a verbal gimmick. It comes from an attitude, a desire to know what the other means. And to satisfy this desire whether it matches the meaning he intended to convey.

If the other's statement was general, it may convey something specific to you.

Larry: I think this is a very poor textbook.
You: Do you mean it has too many inaccuracies?
Larry: No, the text is accurate, but the book comes apart too easily.

Possibly the other's comment suggests an example to you.

Laura: This text has too many omissions; we shouldn't adopt it.
You: Do you mean, for example, that it contains nothing about the Negro's role in the development of America?
Laura: Yes, that's one example. It also lacks any discussion of the development of the arts in America.

If the speaker's comment was very specific, it may convey a more general idea to you.

Ralph: Do you have 25 pencils I can borrow for my class?
You: Do you just want something for them to write with? I have about 15 ball point pens and 10 or 11 pencils.
Ralph: Anything that will write will do.

Sometimes the other's idea will suggest its inverse or opposite to you.

Stanley: I think the Teacher's Union acts so irresponsibly because the administration has ignored them so long.
You: Do you mean that the T.U. would be less militant now if the administration had consulted with them in the past?
Stanley: Certainly. I think the T.U. is being forced to more and more desperate measures.

To develop your skill in understanding others, try different ways of (a) conveying your interest in understanding what they mean, (b) revealing what the other's statements mean to you. Find out what kinds of responses are helpful ways of paraphrasing for you.

The next time someone is angry with you or is criticizing you, try to paraphrase until you can demonstrate that you understand what he is trying to convey as he intends it. What effect does this have on your feelings and on his?

--John L. Wallen

Behavior Description

A Basic Communication Skill for Improving Interpersonal Relationships

The Problem

If you and another person are to improve the way you get along together, you must be able to convey what each does that affects the other. This is not easy. Most of us do not describe behavior clearly enough for others to know what actions we have in mind. Instead, we usually state what we infer about his motivations, attitudes and personality traits; often we are not even aware we are inferring rather than describing. Because we are so used to inferring we may not even know what the other did that led to our inferences.

The skill of behavior description, then, depends upon accurate observation which, in turn, depends upon being aware of when you are describing and of when you are inferring.

The Skill

A statement must pass two tests to be a behavior description.

1. A behavior description reports specific, observable actions rather than inferences or generalizations about the person's motives, feelings, attitudes or personality traits. It states what was observed. It does not infer about why.

Behavior Descriptions	Inferences
Fran walked out of the meeting 30 minutes before it was finished.	Fran was annoyed. Fran had an appointment elsewhere.
Bob's eyes filled with tears.	Bob had a cold. Bob felt sorry for himself.
Becky did not say anything when Bill asked her a question.	Becky did not hear Bill. Becky resented Bill's question. Becky was embarrassed.

2. A behavior description is non-evaluative: it does not say or imply what happened was good or bad, right or wrong. Evaluative statements (such as name calling, accusations, judgments) usually express what the speaker is feeling and convey little about what behavior he observed.

Behavior Descriptions	Evaluative Statements
Jim talked more than others on this topic. Several times he cut others off before they finished.	Jim is rude. Jim wants to hog the center of attention.
"Bob, you've taken the opposite of most statements Harry has made today."	"Bob, you're just trying to show Harry up."
Fran walked out of the meeting 30 minutes before it was finished.	Fran is irresponsible. Fran doesn't care about others.
"Sam, you cut in before I finished."	"Sam, you deliberately didn't let me finish."

The word "deliberately" implies that Sam knowingly and intentionally cut you off. All anybody can observe is that he did cut in before you had finished.

As an example of the difference a behavior description may make, let's suppose you tell me I am rude (a generalized trait) or that I don't care about your feelings (an inference about my motivation). Because I am not trying to be rude and because I feel I do care about your feelings, I don't know what the basis is for your negative evaluation of me. We certainly have not moved closer to a shared understanding. However, if you point out that several times in the past few minutes I have interrupted you and have overridden you before you could finish what you were saying, I get a clearer picture of what actions of mine were affecting you.

Several members of his group had told Ben that he was too arrogant. Ben was confused and puzzled by this judgment. He was confused because he didn't know what to do about it; he didn't know what it referred to. He was puzzled because he didn't feel arrogant or scornful of the others. In fact, he admitted he really felt nervous and unsure of himself. Finally, Joe said that Ben often laughed explosively after Ben made a comment that seemed

to have no humorous aspects. Others immediately agreed this was the behavior that led them to perceive Ben as looking down on them and, therefore, arrogant. Ben said he had not been aware of this.

The pattern, thus, was as follows. When he made a statement of which he was somewhat unsure, Ben felt insecure. . . .Ben's feelings of insecurity expressed themselves in an explosive laugh after he made the statement. . . .the other person perceived Ben as laughing at him. . .the other person felt put down and humilitated. . . the other's feeling of humiliation was expressed in the accusation that Ben was arrogant. Note that Ben had no awareness of his own behavior (the laugh) which was being misread until Joe accurately described what Ben was doing. Ben could then see that his laugh was a way of attempting to cope with his own feelings of insecurity.

To develop skill in describing behavior you must sharpen your observation of what actually did occur. You must force yourself to pay attention to what is observable and to hold inferences in abeyance. As you practice this you may find that many of your conclusions about others are based less on observable evidence than on your own feelings of affection, insecurity, irritation, jealousy, or fear. For example, accusations that attribute undesirable motives to another are usually expressions of the speaker's negative feelings toward the other.

--John L. Wallen

Description of Feelings

A Basic Communication Skill for Improving Interpersonal Relationships

The Problem

To communicate your own feelings accurately or to understand those of others is difficult.

First, expressions of emotion take many different forms. Feelings can express themselves in bodily changes, in action, and in words (see attached diagram).

Second, any specific expression of feeling may come from very different feelings. A blush, for example, may indicate that the person is feeling pleased, but it may also indicate that he feels annoyed, or embarrassed, or uneasy.

Likewise, a specific feeling does not always get expressed in the same way. For example, a child's feeling of affection for his teacher may lead him to blush when she walks around the room, to tell her "you're nice," to bring his pet turtle to show her, etc.,--different forms of expression for the child's feeling of affection.

Communication of feelings, thus, is often inaccurate or even misleading. What looks like an expression of anger, for example, often turns out to result from hurt feelings or from fear.

A further obstacle to the accurate communication of feelings is that your perception of what another is feeling is based on so many different kinds of information. When somebody speaks, you notice more than just the words he says. You note his gestures, voice tone, posture, facial expression, etc. In addition you are aware of the immediate present situation--the context in which the interaction is occurring. You are aware of whether somebody is watching, for example. And so you make assumptions about how the situation influences what the other is feeling. Beyond all of this you also have expectations based on your past experiences with the other.

You make inferences from all of this information--his words, nonverbal cues, the situational context, your expectations of the other. These inferences are influenced by your own current emotional state. What you perceive

the other to be feeling, then, often depends upon what you are feeling (e.g., to be afraid of or wishing for) than upon the other person's actions or words. For example, if you are feeling guilty about something, you may perceive others as angry with you. If you are feeling depressed and discouraged about yourself, others may seem to be expressing disapproval of you.

And so--communicating your own and understanding the feelings of others is an extremely difficult task. And yet, if you wish others to respond to you as a person, you must help them understand how you feel. Likewise, if you are concerned about the other as a person and about your relationship with him, you must try to understand his emotional reactions.

The Skill

Although we usually try to describe our ideas clearly and accurately, we often do not try to describe our feelings clearly. Feelings get expressed in many different ways, but we do not usually attempt to identify the feeling itself.

One way to describe a feeling is to identify or name it. "I feel angry." "I feel embarrassed." "I feel comfortable with you." However, we do not have enough names or labels to emcompass the broad range of human emotions, and so we invent other ways to describe our feelings, such as the use of similes. "I feel like a tiny frog in a huge pond." A girl whose friendly overture had just been rebuffed said, "I feel like I have just had an arm amputated."

A third way to describe a feeling is to report what kind of action the feeling urges you to do. "I feel like hugging and hugging you." "I'd like to slap you." "I wish I could walk off and leave you."

In addition, many figures of speech serve as descriptions of feeling. "I just swallowed a bushel of spring sunshine."

Describing Your Own Feelings

You try to make clear what feelings you are experiencing by identifying them. The statement must (a) refer to "I," "me," or "my," and (b) specify some kind of feeling by name, simile, action urge or other figure of speech.

The following examples show the relation between two kinds of expressions of feeling: (a) those that describe what the speaker is feeling, and (b) those that do not. Notice that expressions of feeling which describe the speaker's emotional state are more precise, less capable of misinterpretation, and thus, convey more accurately what feelings are affecting the speaker.

Expressing feeling by describing your emotional state	Expressing feeling without describing your emotional state
"I feel embarrassed." "I feel pleased." "I feel annoyed."	Blushing and saying nothing.
"I feel angry!" "I'm worried about this." "I feel hurt by what you said."	Suddenly becoming silent in the midst of conversation.
"I enjoy her sense of humor." "I respect her abilities and competence." "I love her but I feel I shouldn't say so."	"She's a wonderful person."
"I hurt too much to hear any more." "I feel angry with myself." "I'm angry with you."	"Shut up!!!"

Where emotional states express themselves simultaneously in words, in actions, through physiological changes, a person may convey contradictory messages about what he is feeling. For example, his actions (a smile or laugh) may contradict his words (that he is angry). The clearest emotional communication occurs when the speaker's description of what he is feeling matches and, thus, amplifies what is being conveyed by his actions and other nonverbal expressions of feeling.

The aim in describing your own feelings is to start a dialogue that will improve your relationship with the other. After all, others need to know how you feel if they are to take your feelings into account. Negative feelings are indicator signals that something may be going wrong in a relationship with another person. To ignore negative feelings is like ignoring a warning light that indicates that an electrical circuit is overloaded.

Negative feelings are a signal that the two of you need to check for misunderstanding and faulty communications.

After discussing how each of you sees the situation in your relationship, you may discover that your feelings resulted from false perceptions of the situation and of his motives. In this case, your feelings would probably change. However, the other may discover that his actions are arousing feeling in you that he wasn't aware of--feelings that others beside you might experience in response to his behavior--and he may change.

In short, describing your feelings should not be an effort to coerce the other into changing so that you won't feel as you do. Rather you report your inner state as just one more piece of information that is necessary if the two of you are to understand and improve your relationship.

Perception Check

You describe what you perceive to be the other's inner state in order to check whether you do understand what he feels. That is, you test to see whether you have decoded his expressions of feeling accurately. You transform his expressions of feeling into a tentative description of his feeling. A good perception check conveys this message, "I want to understand your feelings--is this (making a description of his feelings) the way you feel?"

Examples: "I get the impression you are angry with me. Are you?" (NOT: "Why are you so angry with me?" This is mind reading, not perception check.)

"Am I right that you feel disappointed that nobody commented on your suggestion?"

"I'm not sure whether your expression means that my comment hurt your feelings, irritated you, or confused you."

Note that a perception check (a) describes the other's feelings, and (b) does not express disapproval or aprpoval. It merely conveys, "This is how I understand your feelings. Am I accurate?"

--John Wallen

Emotions as Problems

The way we deal with emotion is the most frequent source of difficulty in our relations with others. Although each of us continually experience feelings about others and about himself, most of us have not yet learned to accept when others express strong feelings; in addition, most of us do not even recognize, much less accept many of our own feelings.

We know, intellectually, that it is natural to have feelings. We know that the capacity to feel is as much a part of being a person as is the capacity to think and reason. We are aware of incompleteness in the one who seems only to think about life and does not seem to feel--to care about, enjoy, be angered and hurt by what goes on around him. We know all this, and yet we feel that feelings are disruptive, the source of obstacles and problems in living and working with others.

It is not the feelings that are the source of difficulty in our relations with others but the way we deal with them, our failure to use them.

Because of our negative attitude toward emotions, because of our fear of and discomfort with our feelings we spend much effort trying, in one way or another, to deny or ignore them. Look around you and observe how you and others deal with feelings. Make your own observations and see if they support or contradict the point that our usual response is some variation of "don't feel that way."

To the person expressing disappointment, discouragement, or depression we say things like, "Cheer up!" "Don't let it get you down." "There's no use crying over spilt milk," "Things will get better." In short, "Don't feel that way." To the sorrowing or hurting person we advise, "Don't cry. Put your mind on something pleasant." We tell the angry person, "Simmer down. There's no point in getting angry. Let's be objective." To the person expressing joy and satisfaction in something he has done we caution, "Better watch out. Pride goeth before a fall." In various group meetings we counsel each other, "Let's keep our feelings out of this. Let's be rational."

Another sign of the difficulty we all experience with feelings is that the more distant and remote the feelings, the more comfortably we discuss them. Try to pay attention to yourself and others when talking about

feelings and ask, "How distant are these feelings?" I predict that you will find relatively few discussions of feelings that someone is having "right now" in comparison with a number of discussions about feelings they had in the past toward somebody else. Do you find that you talk more easily about feelings you had in the past than about feelings you have right now? Do you find that you talk more easily about feelings toward somebody else than about your feelings toward persons who are present? As you observe yourself and others discussing feelings, see whether the following scale roughly represents what you find.

Feelings are spontaneous reponses to factors over which we have little direct control. To control the arousal of our feelings, we attempt to arrange the environment so that it will evoke the feelings we desire and not those we wish to avoid. Much of the interaction between persons can be viewed as an effort by each to control which feelings will be aroused. That is, I try to get you to act in ways that will elicit feelings in me that I desire and not those I dislike. You, in turn, attempt to get me to act in ways that will have a similar effect on your feelings. Each of us, thus, tries to control the relationship (and the other's behavior) as a way of controlling his own feelings.

Others seem to have more control over what we feel that we ourselves have. People usually say, "You made me angry," rather than, "I've become angry." One popular song declared, "You made me love you. I didn't want to do it." Maybe our discomfort with our own feelings springs from a belief (a recognition?) that to feel something toward another is to surrender some of our control of self to him. Certainly, if we believe that the other "made" us angry or "made" us love him, he has some control over us.

Paradoxically, however, if we hold the other responsible for our anger, we probably expect that he should stop his annoying behavior <u>because</u> we feel angry. Our anger, then, is not just a felt inner state, but is felt as a claim against the other. Likewise, if we feel that the other "made" us love him, we will probably expect him to return our affection. Note your own tendency when somebody expresses affection for you to feel that you should reciprocate, a "you're-nice-too" effect.

I believe much of our discomfort with our own and others' feelings arises because interpersonal feelings

precipitate a struggle for control between persons. Which of us will succeed in defining what our relationship is to be? Which of us will yield and thus give up some of his own identity? Do I have control over you because I can make you angry? Do you have control over me because you get angry or hurt when I act in a certain way? You and I must come to some shared understanding of the meaning of your feelings of anger, of my feelings of being hurt, of your feelings of affection, of my feelings of inadequacy around you. Are the feelings each of us has about the other really claims on the other, obligations to be and act in a certain way? Or are our feelings phenomena to be accepted and then understood. Your anger may tell us something about you and about me, if we can understand it.

To interact with another is to risk having feelings aroused by him and to risk arousing feelings in him. You and he cannot turn on and turn off your feelings toward each other merely by wishing or deciding to. Unless you avoid each other totally and forever, you must each share some of yourself with the other. To feel something toward another--whether anger, disgust, fear, interest, enjoyment--is to become related, interdependent, with the other. Most of us seem to feel that to be interdependent with another is to lose some of our control over our own life. Feelings, thus, seem to threaten our voluntary, planful control over our own affairs.

The Interpersonal Effect of Various Responses

FREEING EFFECTS increase other's autonomy as a person; they increase one's sense of equality:

1. Increasing your understanding of the other as a person and conveying your understanding to him.

   Active attentive listening: Responsive listening, not just silence.
   Paraphrasing: Testing to insure that the message you got was the one he sent.
   Perception check: Showing your desire to relate to him and understand him as a person by checking out your perception of his inner state. Showing acceptance of feelings.
   Seeking information to help you understand him: Questions directly relevant to what he has said, not ones that introduce new topics.
   Offering information relevant to the other's concerns: But letting him use it or not without pressing him.

2. Helping the other to understand you as a person.

   Sharing information that has influenced your feelings and viewpoints.
   Directly reporting your own feelings.
   Offering new alternatives: Action proposals offered as hypotheses to be tested, not as solutions you already know to be best.

BINDING EFFECTS diminish other's autonomy:

   Changing the subject without explanation: For example, to avoid encountering the other's feelings.
   Explaining the other, interpreting his behavior: "You do that because your mother always. . . ." This binds him to past behavior and may be seen as an effort to get him to change.
   Advice and persuasion: "What you should do is. . . ."
   Vigorous agreement: Binds him to present position--limits his changing his mind.
   Expectations: Binds to past--"You never did this before. What's wrong?" Or cues him to future

action--"I'm sure you will. . . ." "I know you can do it."

Denying his feelings: "You don't really mean that!" "You have no reason to feel that way!" Generalizations like "everybody has problems like that."

Approval on personal grounds: Praising the other for thinking, feeling, or acting in ways you prefer; that is, praising him for conforming to your standards.

Disapproval on personal grounds: Blaming or censuring the other for thinking, acting, or feeling in ways you do not want him to. Imputing unworthy motives to him.

Commands, orders: Telling the other what to do. Includes, "Tell me what to do!"

Emotional Obligations: Control through arousing feelings of shame and inferiority. "How can you do this to me when I have done so much for you?"

THE EFFECT OF ANY RESPONSE DEPENDS UPON THE DEGREE OF TRUST IN THE RELATIONSHIP. The less trust, the less freeing effect from any response. The more trust, the less binding effect from any response.

--John Wallen

By learning the skill of behavioral description we can be more accurate in communicating with another about the quality of the relationship. Once we are clear about the behavior, we can tell the other person how this behavior is affecting us. This is called feedback.

Feedback can have a number of helpful effects. It can:

1. Reinforce--feedback may confirm behavior by encouraging its repetition. "You really helped then when you clarified."

2. Correct--feedback may help bring behavior in line with intention. "It would have helped me more if you had stood up to talk."

3. Identify--feedback may help identify persons and their relationship. "Joe, I thought we were enemies, but we're not, are we?"

As well, there are a number of criteria for helpful feedback:

1. Intended to Help--It takes into account the needs of both the receiver and giver of feedback. Feedback can be destructive when it serves only our own needs and fails to consider the needs of the person on the receiving end.

2. Trust--A trusted non-threatening source who gives feedback directly and with feeling helps to make feedback more palatable. "Daddy, you're getting too fat" from your three-year-old daughter is more acceptable than from a forever-carping wife.

3. Descriptive--It is descriptive rather than evaluative. By describing one's own reaction, it leaves the individual free to use or not as he sees fit. By avoiding evaluative language, it reduces the need for the individual to react defensively, i.e., "Ralph, I want to be sure to hear you. Could you raise your voice a bit, please?" This gives a different feel from the statement, "Henry, you talk too low." The latter sounds condemning and puts all the responsibility on Henry. The former shares the situation between Henry and the speaker, and contains a complimentary rather than accusative note.

4. Specific--It is specific rather than general. To be told that one is "dominating" will probably not be

as useful as to be told that "just now when we were deciding the issue I felt forced to accept your arguments or face attack from you."

5. Timely and Recent--It is well-timed. In general, feedback is most useful when offered at the earliest opportunity after the given behavior (depending, of course, on the person's readiness to hear it, support available from others, etc.).

6. Not an Overload--Don't give too much feedback at the same time.

7. Usable--It is directed toward behavior which the receiver can do something about. Frustration is only increased when a person is reminded of some short-coming over which he has no control.

8. Requested--It is solicited, rather than imposed. Feedback is most acceptable when the receiver himself has formulated the question which those observing him can answer.

When you have reached the point in your relationship where it is possible to give serious feedback, it means that you are relating at a deeper, more mature level with your youth.

Confrontation

In addition to being aware of and communicating the impact of your youth's behavior on you, you will also want to be aware of the impact of the behavior on the youth himself/herself, especially in terms of whether these behaviors help bring about the youth's desired goals. When there are discrepancies between what a youth says he/she wants to accomplish and what he/she is actually feeling, doing, thinking, etc., you will want to use a skill called confrontation.

Confrontation is defined as the halting of any ongoing interaction for the purpose of assessing its intentions, consequences, or possible alternatives. It is an invitation to the youth to engage in self-examination, to explore his/her behavior, especially the discrepancies in his/her life.

The act of confronting is a learned behavior. The more practice one has, the more comfortable one will be

when confronting. In order to confront another person you must accept that you have the right to stop an interaction, that you have the right to interrupt. For this reason confronting is an assertive behavior.

Given that confronting is an assertive behavior, it is important to acknowledge the rights of the other people involved in the confrontation. If a person confronts nonassertively or assumes that the person being confronted can't accept a direct and appropriate confrontation, this will result in a padded confrontation. If a person confronts aggressively, he/she will accept his/her personal rights and ignore the other person's rights. This will result in a punitive confrontation.

Confrontation is generally not helpful for learning when received as condemnation. It is far more helpful within the confrontation to conclude the possibility that the confronter's interpretation of behavior might be badly distorted.

Possible Ways of Initiating a Confrontation of Discrepancies

1. Feedback: It is possible to stop an ongoing interaction by giving an individual feedback about the interaction. While giving the feedback it is important to remember the criteria for appropriate feedback.

(a) behavior oriented--something that can be changed.
(b) specific--the shorter the statement, the easier it is to hear
(c) timely--it helps if the behavior is fresh in both individuals' mind

In order to facilitate the confrontation, it may be helpful to add more criterion to the feedback model.

(d) consequences--telling the person you're confronting what you will or won't do if they continue certain behavior(s) allows for a more complete exploration of the behavior(s). Sharing the different perceived consequences of the behavior leads to exploring values behind the behavior and the confrontation. When sharing the consequences of a behavior, it is important to speak for yourself. You can't be sure how the behavior will affect others, therefore own what you say.

2. Self-disclosure: Confronting in an interaction by telling how you feel about that interaction may facilitate the exploration of certain behavior(s). Self-disclosure is similar to the "consequence" stage of feedback. However, when giving feedback a cause and effect statement regarding the behavior is presented. When self-disclosing you need not know the cause and effect relationship. You can label your feeling about the behavior(s) and then by exploring the behavior a cause and effect relationship may be established.

3. Questioning: Questioning an interaction may stop it to allow for further exploration. Questioning is an effective way to explore the assumptions, contradictions and values behind certain behavior(s). Appropriate questioning is not for the purpose of having an individual defend his/her behavior. Recognize an individual's personal rights when confronting by questioning.

Following Up a Confrontation

After a behavior displayed during an interaction has been confronted (by giving feedback, self-disclosing, or questioning), the next step in completing the confrontation is to explore intentions, consequences, and alternatives associated with the behavior. During this time it is important to use communication skills. Empathy, feedback, questioning, self-disclosure, and paraphrasing may all be helpful to complete the confrontation. Possible areas to explore about a behavior:

(a) values--behind the behavior and the confrontations
(b) assumptions--what assumptions are behind the behavior?
(c) feelings--what feelings are associated with the behavior?
(d) history--when does a person usually display the behavior?

When exploring the confronted behavior, it may be possible that one or both of the people involved may not feel resolved. This is something that has to be accepted. It may take awhile to resolve a confrontation.

Thus, confrontation of discrepancies is an important part of your relationship because it is a useful way of teaching your youth to be aware of his/her behaviors and the consequences that result. Yet, it might be one

of the scariest things that you do. It involves a lot of risk-taking--risking that your youth might become angry, feel hurt, etc. Yet, because giving feedback and confronting discrepancies makes your relationship an especially meaningful and effective learning situation, the risk you might have to take seems worthwhile. He/she may be doing destructive or contradictory behaviors that he/she is not aware of. Your honesty and sensitivity to your youth, your ability to give and receive feedback and be confronting are essential components of the model we are developing. This model involves the development of a helping relationship that is geared toward aiding the youth to solve his/her problems and in taking final responsibility for himself/herself.

Typical Gaffes and Faux Pas Common Among Beginning Counselor Trainees in Their Alarming Attempts to be Helpful and of Assistance to the Diverse Victims of Their Art, Being a Taxonomy which Categorizes, Identifies, and Isolates Them

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Counselors in training make many errors as they attempt to learn appropriate verbal responses to facilitate the helping relationship. These errors appear typically to involve a confusion of verbal aspects of counseling with techniques appropriate to conversational, teaching, or inquisitorial relationships in which people may also engage. Sometimes a misapplication of counseling theory comes out all wrong, and not infrequently the trainees own personality or authority needs get in the way. The following taxonomy of response errors has proven itself helpful in pointing up to counselor candidates the sorts of mistakes they are making, and seems to be useful in improving the student counselor's verbal behavior in his interactions with clientele.

CATEGORY I: THE EMPATHIC TRAP RESPONSE

Form A. The Sharer. The Counselor is compelled to share, and forgets who is in focus.

Couns: Gee, you really have a problem. I had a second cousin who had a problem just like yours, and. . . .

or

Couns: I know just how you feel, because this happened to me, and . . . .

Form B. The Conversationalist. The Counselor does not understand the differences between counseling and conversation.

Client: I just bought a new dress at Knapp's store.
Couns: Oh? I saw some very attractive skirts there.
Client: You can usually get good bargains.

Couns: But their jewelry department is awful.
Client: I know. Junk.
Couns: What do you think of Macy's?

CATEGORY II: THE NON-DIRECTIVE OBSESSIVE RESPONSE

Form A. General Type. The counselor has only one technique at his command.

Client: I feel awfully warm, can't you open the window?
Couns: You feel warm.

or

Client: Can you tell me how to find the restroom?
Couns: You want to find the restroom.

Form B. Perseverating Parrot Type. The counselor confuses reflection and repitition.

Client: I'm sorry I'm a little late today, but it's so beautiful outside that I stopped to look at the flowers, and the birds, and the trees, and the bushes.
Couns: You're sorry you're a little late today, but it's so beautiful outside that you stopped to look at the flowers, and the birds, and the trees, and the bushes.

CATEGORY III: THE INQUISITORIAL RESPONSE

Form A. True or False Type. The counselor demands a "yes" or "no" response.

Couns: Do you like school?

or

Couns: You're not going to fail again, are you?

Form B. Loaded Option Type. The counselor tells his client how to respond.

Couns: Don't you think you ought to get a good education so that you can amount to something? You're not really going to marry that clod!

or

Couns: Why are you talking about your mother like this? Everyone loves his mother, don't you love yours?

or

Couns: A big guy like you shouldn't be having trouble in gym, should he?

Form C. Multiple-Choice Type. The counselor delimits response options available to his client.

Couns: How did you feel? Did you feel good or bad?

or

Couns: How do you feel when your father hits you? Do you hate him or don't you feel anything?

Form D. Declaration of War Type. The counselor challenges his client to defend himself.

Couns: Why do you feel this way?

or

Couns: Where'd you ever get an idea like that?

Form E. Der Gestapointerrogationisch Type. The counselor wears jack boots and walks funny.

Couns: Have a seat. Name?
Client: Jones. John Jones. I feel. . . .
Couns: Address?
Client: Hm? Oh, I live in the dorm. It's no use. . . .
Couns: Your problem?
Client: I had a date with this girl. . . .
Couns: When was that? When was the date with the girl?
Client: Friday or Saturday. Saturday, I think. I never had a date before. . . .
Couns: Don't you like girls?
Client: Hm? Sure, but I never felt. . . .
Couns: M-hm. You never felt a girl.
Client: No! No! I felt comfortable, I. . . .
Couns: How old are you?
Client: Nineteen last month. No one ever sent me a birthday card.
Couns: Then actually you're a little over nineteen, aren't you?
Client: Well, about a month over. I need help. . .
Couns: Where is your home? Don't you have a father? What's wrong with your mother? Why is your shoe untied?
Client: I. . . .
Couns: Tell me what you did to the girl.

Client: Please, can't you turn off that light? It's in my eyes.
Couns: The girl. Tell me about it. Come on, tell me your sordid little story. I'm here to help you.

Form F. Focus on Minutae Type. The counselor has strong needs to gather data.

Client: (Sniffing) I'm going to have to get an abortion.
Couns: I didn't get the spelling of your last name. Would you repeat that, please?
Client: Fox. F-O-X. Like the furry little animal (weeping) in the woods, with its c-c-cubs. (Weeps copiously) My friend, June, had an abortion. (Bawling)
Couns: (Writing) F-O-X. June Fox.
Client: No, I'm Mary Fox. June is my friend. She damn near died. (Cries heavily)
Couns: How old are you?
Client: Hm? Twenty-two. I've already made the arrangements with that terrible little man and his ghastly nurse, but I just don't know if it's right. (Nearly hysterical)
Couns: And June?
Client: (Wailing) Huh?
Couns: How old is June?

CATEGORY IV: THE SAFETY DODGE RESPONSE

Form A. General Type. The counselor is frightened by his client's material, and withdraws to high ground.

Couns: So your homosexual problem really bothers you. What kind of grades did you make last year?

or

Couns: . . .and you're very concerned about your relationshipship with God. Well, lots of people are. Are you interested in athletics?

Form B. Diversionary Trap Type. The counselor responds to inappropriate material.

Client: Ever since Mother died I've been pretty depressed. I just don't think it's any use. What

point is there in going on? And my sister feels awful, too.
Couns: Your sister is upset.

or

Client: When my fiance and I broke up I was so angry and distraught that I went out and raced my car through the streets and screamed and screamed. I wrecked the car, and Daddy was furious.
Couns: Your father has a nasty temper.

Form C. Estranged Type. The counselor is a fool.

Client: Mother and Dad were fighting, and he was pounding on her and knocking her down, so I beat hell out of him and went out and had a steak.
Couns: How do you like your steak cooked?

Form D. Aborted Reflection Type. The counselor wants, properly, to communicate his understanding, but is afraid to stick his neck out. So he uses a question mark when a period is indicated.

Client: I'm going to run away from home.
Couns: You're going to run away from home?
Client: I'm going somewhere else to live.
Couns: You're going somewhere else to live?
Client: No one loves me.
Couns: No one loves you?
Client: I'm all alone.
Couns: You're all alone?
Client: Lonely.
Couns: Lonely?

Form E. Missing the Concealed-Inference Ploy. The counselor doesn't know what's going on.

Client: We have no money at all; my husband's an awful drunk and he spends the welfare check on beer and wine. My daughter's a prostitute, and my son's on dope. I can't go home to my folks because Ma throws knives around, and Pa chases me through the house. My brothers are in jail. My sister's a lesbian. The cops are always coming around and the windows are broken out and the roof leaks and they've cut off the gas and lights. But I'm really

a very lucky person and I don't have no right to complain. I'm actually very, very happy. I really am. Really.

Couns: Life is a bowl of cherries.

Form F. The "Aw Shucks" Type. The counselor lacks confidence in his profession and in his skills.

Client: I get nervous before tests.
Couns: Oh, dear. You'd better see your physician about that. I'm only a counselor.

or

Client: I'm having a problem with my mother. . . .
Couns: I should caution you that I'm not a real psychologist, and. . . .

or

Client: I'm wondering if I should quit going to church.
Couns: It's best that you consult your spiritual advisor about that.

Form G. Reassurance Type. The counselor insists that his client be strong.

Couns: Hell, everyone's had that problem. Don't let a little thing like that bother you. Stop crying.

CATEGORY V: THE BUFFALO STAMPEDE The counselor is not only incompetent but rude.

Client: I'm not sure if I should stay in school.
Couns: You're thinking you should do something else.
Client: Yes, that's right, I. . . .
Couns: You might stay in school, or you might. . .
Client: I could. . . .
Couns: . . .drop out and do something else, like. . .
Client: I. . . .
Couns: . . .get a job or grow a beard, or join the circus. . . .
Client: . . .I
Couns: . . .or draw welfare or something, but you're feeling guilty because everyone tells you to finish school. . . .
Client: No, I. . . .
Couns: . . .but you. . . .

Client: I. . . .
Couns: . . .don't really want to stay in school.
Client: M-hm.
Couns: And you're about to say, "The hell with it," but you really can't. . . .
Client: Hm. I. . . .
Couns: So that's the problem as you see it.
Client: M-hm.
Couns: Don't interrupt. I notice that you interrupt a good deal. I'm trying to understand your problem so that I can help you.

CATEGORY VI: THE LEAPFROG INTERPRETATION RESPONSE. The counselor gets far, far ahead of his client and shows off his psychological know-how.

Client: I was up late last night studying, and I'm pretty tired this morning.
Couns: I make you uncomfortable, and you're excusing this by blaming your masochistic study pattern.

or

Client: I wish my Dad would lose some weight.
Couns: You're suffering typical penis envy, complicated by Oedipal conflict and castration anxiety.

CATEOGRY VII: THE INVERTED RELATIONSHIP RESPONSE. The counselor allows his own interests or needs to dominate the interview or influence it significantly.

Client: I divorced my husband several years ago, and now that the kids are out of college and on their own I need to find something to occupy my time. I thought perhaps I could. . .
Couns: Tell me about your husband.
Client: Fred? Oh, I'm well rid of him. Better all around. But you see, I had an art major, and I thought perhaps I could. . .
Couns: You feel the divorce was best for everyone.
Client: That's ancient history. What would I have to do to get licensed as a teacher in this state?
Couns: Fred is unimportant to you.

Client: Also, I need to know if I'd be better in an elementary school or at senior high.
Couns: You've just about forgotten your husband.
Client: I suppose I'd have to get a master's degree, but am I too old to learn?
Couns: Your divorce is very painful to you and you resist talking about it.
Client: I could go to school full time.
Couns: How do you see yourself as a woman, having lost your husband, and all?
Client: What?

or

Client: I've been majoring in Psychology, but those mazes are getting to me.
Couns: M'hm.
Client: I've thought about changing to counseling. People, you know.
Couns: You prefer people to pigeons.
Client: Yeah. Fewer feathers.
Couns: Psych's a pretty rough course, isn't it?
Client: They have their own language.
Couns: Tough to learn?
Client: Oh, I don't know. Pretty tough. "Reinforcement schedule," "Rorschach," "biomodal distributions," funny words like that.
Couns: What are the profs like?
Client: They mumble a lot. You thinking of changing to psych?
Couns: I don't know. These damn <u>people</u> are getting <u>to me</u>.
Client: M-hm.
Couns: Do you think I could make it in psych?
Client: You're concerned about your inadequacy.

CATEOGRY VIII: <u>THE DEFENSIVE RESPONSE</u>. The counselor is protective of himself.

Client: Why won't you school people let me wear a beard?
Couns: Surely you don't blame me; that's the fault of those unfeeling administrators.

or

Client: That's an awful tie you're wearing.
Couns: I happen to like this tie very much. It's been my favorite tie for twenty years. <u>Lots</u> of people like nudes on their ties.

CATEGORY IX: THE FRIENDLY ADVISOR RESPONSE. The counselor has lots of good advice to offer.

Client: I'm really having trouble in history.
Couns: You should get to class on time, and pay attention, and take good notes, and ask intelligent questions.

or

Client: Tom keeps making passes at me.
Couns: Slap the S.O.B.

The Problem-Solving Process

or

How to Keep the Mountain from Falling Down on You

William C. Hinds

The last part of the helping relationship deals with problem-solving. It is during this final step that the listener can take a more active role, assuming the relationship is firm and the speaker feels he can trust the listener. The listener can begin to point out the places where the speaker's feelings, values and attitudes, and behavior may or may not fit together. The listener can begin to encourage the speaker to do some risk-taking (trying new ways of behaving) and can offer alternatives to ways the speaker has tried to deal with his problems in the past. The listener can also begin to share more of his own feelings and thoughts with the speaker. More information can be offered, and helpful questions can be asked.

CAUTION: The listener can take a more active part in the problem-solving process. However, his role is still NOT to try to solve the problem for the speaker. Advice giving takes away from giving the speaker a chance to solve his problem for himself.

In the problem-solving process, we are asking you to learn the steps to finding solutions. There will be no scales to follow. Instead, think of these steps as a series of questions the speaker must consider before he can solve his problem.

First, are six steps related to clearly identifying the speaker's problem (or, find out what part of the mountain is coming down on you).

1. The listener helps the speaker try to find out exactly what the problem is (the situation, the people involved, the events surrounding the problem), when it happens, how it happens (how the speaker behaves when his problem confronts him), and how often it happens.

2. The listener helps the speaker focus on his final problem-solving goal (how the situation will be changed once the problem is solved; how the behavior of the speaker and the people around him will be changed).

3. The listener helps the speaker identify the ways he avoids solving the problem (how he blames others for his troubles, how he puts off doing anything about it, what he tells himself so he won't have to work at solving his problem).

4. The listener helps the speaker understand the prices he pays for doing nothing about solving the problem.

5. The listener helps the speaker tune in on how the speaker feels about trying to solve the problem.

6. The listener helps the speaker tune in on the rewards he gets for not solving his problem.

Second, the speaker and listener explore the speaker's alternatives (or, how many different ways are there to stop that big rock from coming down on you?).

7. The listener helps the speaker identify alternative ways he can solve the problem.

8. The listener helps the speaker clarify the rewards and punishments attached to each alternative.

9. The listener helps the speaker tune in on how the speaker feels about each alternative.

We have found that just understanding the problem and discussing ways to solve it doesn't always help the speaker change. Hence, the next step is to encourage him to make some initial plans which will keep him motivated to change. In other words, making plans to change the problem.

10. The listener helps the speaker identify the initial change he wants to make in order that his final goal may be reached.

11. The listener helps the speaker identify the amount of success the speaker needs to achieve initially to keep him going in the problem solving process.

12. The listener helps the speaker explore what he will do should an alternative not work.

Finally, the listener helps the speaker think through how he will test out his plans (or, rehearsing your plans so opening night won't be a flop).

13. The listener helps the speaker organize the order of activities that need to be followed to carry out the solution to his problem.

14. The listener helps the speaker identify the things the speaker might do to defeat the testing-out process and thus maintain the problem.

15. The listener helps the speaker understand what kinds of things the speaker is afraid will happen in the testing-out process.

It is important to understand that you will probably not have to deal in depth with each of these considerations during actual helping interactions, particularly if the speaker has already been doing some work on his own. You should, however, check to make sure that point has been considered completely and appropriately by the speaker.

One of the things you'll have to watch out for when going through the problem-solving process is knowing when to stop encouraging the speaker to change. One of the helpful things about this process is that the speaker gets confronted with whether or not he really wants to change. Many times after looking at the problem, exploring alternatives and examining the payoffs and costs of the problem, the speaker decides he wants to keep things as they are. In other words, it will be even more painful to change. We can't change people. They have to want to change themselves. In clarifying the problem and exploring the alternatives, the speaker gathers more information about his problem, and many times this is enough to carry him through the tight spots. If the speaker decides he can solve his problem on his own, then we must trust that we as listeners have helped initiate change and the speaker is ready to deal with the problem on his own. If the speaker decides he does not want to solve his problem, then at least we have cleared up the haze enough to help the speaker know that he has made his choice on the basis of what he is ready to do at this point in his life.

APPENDIX O

GENERAL INSTRUCTIONS FOR ALL GROUPS

APPENDIX O

General Instructions for All Groups

Everyone in this group has agreed to a contract which requires them to participate actively in the workshop for a period of four weeks. In doing this, you have actually made a contract with the members of this group as well as with me. As you all know, the effects of this workshop are going to be evaluated two times in the future: at the conclusion of treatment and six weeks after treatment has ended. I want to emphasize that the purpose of the workshop is to help each individual in the group to overcome his or her own depression as well as to learn more about themselves.

This type of group has been used many times to help other depressed persons. The workshop itself is not experimental! It is based on scientific findings and I feel that each one of you could benefit from the workshop. I say could because the success will depend on your active participation (by following suggestions made in the group). I realize that you are all eager to begin, but first I would like to answer any questions about anything except the actual workshop procedures (for example, when the meeting times are, questions about the assessment procedures, etc.).

From Brian F. Shaw, University of Western Ontario

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