UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

THE INTERACTION OF COGNITIVE-BEHAVIORAL THERAPY WITH INTEGRATED COUPLE THERAPY FOR THE TREATMENT OF DEPRESSION IN WOMEN

A Dissertation

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

degree of

Doctor of Philosophy

By

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Norman, Oklahoma
1997

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THE INTERACTION OF COGNITIVE-BEHAVIORAL THERAPY WITH INTEGRATED BEHAVIORAL COUPLE THERAPY FOR THE TREATMENT OF DEPRESSION IN WOMEN

A Dissertation APPROVED FOR THE DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

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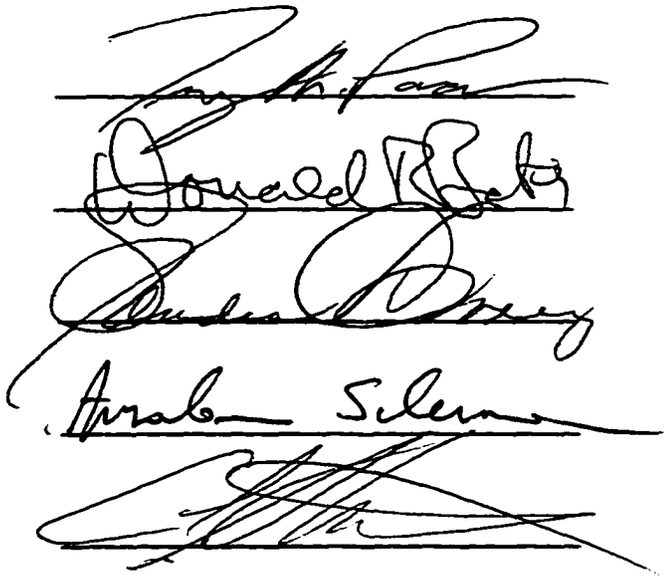

ACKNOWLEDGMENTS

This doctoral journey has been filled with joy and challenge. There have been many patient and supportive individuals who have assisted me along this educational passage. Each person has enabled me to continue to pursue this dream and make it a reality. My husband, Chris, has been the most important single person throughout this experience. He has provided unending care and concern even in the face of many frustrations and difficulties. Terry Pace, my committee chairperson, has been my mentor for many years. Without his guidance and tutelidge, this would not have been accomplished. Cai Stoltenberg has provided many hours of supervision and assistance which were invaluable. I am thankful to the rest of my committee members, Sandra Choney, Donald Baker, and Avriham Scherman, for their support.

To my colleagues who conducted the therapy, George Blair, Sid Dickson, Camron Joiliff, Laura Goodheart, Charlie Bass, Janelle Jacobs, Denise Beasley, Michael Loescher, Marci Leveridge, Thomas Brooks, and Kathy Laster, thank you so very much. I am grateful to Scott Miller who afforded me the opportunity to continue to work from Dallas because he was willing to assist with the project while in Norman. No task was too small nor too large for him to accomplish. Thanks to Debbe Moon and Dana Beake who conducted the manipulation checks along with Scott. And lastly, but certainly not least, thank you Art Gillaspy who assisted me with the statistics for this project. He was always patient, optimistic and willing to run the numbers no matter how many times it had been done before. Thank you one and all.

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Abstract

This project examined the efficacy of differing approaches of intervention for depressed married women. The modalities used were Cognitive-behavioral Therapy (CBT), Integrated Couple Therapy (ICT) or a combined treatment (CO). Participants were 29 depressed married women. The Beck Depression inventory (BDI), Hamilton Rating Scale for Depression (HAM-D), and Structured Clinical Interview for Diagnosis (SCID-P) were used to assess depression. Marital distress was determined by the Dyadic Adjustment Scale (DAS). Participants engaged in 12 weeks of therapy with one of the modalities.

A 4 x 3 ANOVA indicated significant clinical improvement in depression and marital satisfaction due to time involved in therapy. The treatment conditions were not significantly different in their efficacy from one another. in examining significant changes during the process of therapy, all dependent measures demonstrated substantial improvements between pretreatment and post-treatment, between pretreatment and the 4th session and between the 8th session and post-treatment. Replication with a larger sample size would improve power and substantiate these findings.

The Interaction of Cognitive-Behavioral Therapy with Integrated Couple Therapy for the Treatment of Depression in Women

Chapter I

INTRODUCTION

Depression has been reported to be one of the most prevalent mental illnesses seen by health care professionals in the United States (Weissman, et al., 1988). It is estimated that approximately 20 million people will suffer from depression on a yearly basis. Women are prone to experience depression more frequently than men. It is estimated that one in four women will suffer from depression at some point in their lifetimes as compared to one in ten men. The prognosis for those individuals suffering from depression who seek treatment is encouraging. There is support that a high percentage of clients experience relief with intervention (Reiger et al., 1988). A recent study focusing on depression treatment found evidence of both statistical and clinical significance for treatment of depression with short-term cognitive therapy, when compared to no treatment intervention (Pace & Dixon, 1993). Research conducted by the National Institute of Mental Health (NIMH) has indicated that their participants experienced a 51% improvement in depression symptoms using Cognitive-Behavioral Therapy (CBT) (Elkin et al., 1989). This

percentage is in keeping with other reported recovery rates and exceeds the 29% recovery rate of the control group. Although there is no definitive information regarding prevention from a relapse, the methods of cognitive restructuring, such as increasing positive thoughts about the self and decreasing negative cognitive distortions that are utilized in Cognitive-Behavioral Therapy may have a prophylactic effect (Evans et al., 1990).

Marital distress is one of the most prevalent indicators of the recurrence of a depressive episode (Hooley & Teasdale, 1989). Marital disruption is also the most common precipitator to depressive episodes (Paykel et al., 1969). Marital discord is an important issue for many couples in our society as evidenced by increasing divorce rates. The rate of divorce in the United States involving families with children is approximately 50%. It is estimated that 75% of divorced mothers and 80% of divorced fathers will remarry. The rate of divorce in these second marriages is even higher than that of the first marriages. Of those marriages experiencing difficulty, more than 50% of them include at least one spouse who is experiencing depression (Beach, Jouriles, & O'Leary, 1985).

Behavioral Marital Therapy (BMT) has been researched and indicated to be effective in the treatment of couples experiencing marital distress. Most recently, Jacobson and Christensen (1996) have attempted to improve and further develop BMT. They have developed Integrated Couple Therapy (ICT) which is posited as an improved version of BMT. ICT was

built from the foundations of traditional BMT. Preliminary research indicates that through its improvements ICT will be an equally successful, if not a better, treatment intervention.

Research by Coleman and Miller (1975) implicate the impact of depression on marital therapy. The results of their study indicate that there is an inverse relationship between marital satisfaction and depression. To the extent that marital satisfaction improves through the progress of therapy, there is an inverse relationship between improved marital satisfaction and the recurrence of depression (Rounsaville, Weissman, Prusoff, & Hercog-Baron, 1979). Marital distress and depression can create a cyclical interaction, each feeding off of the other, further entrenching the difficulties. Therefore, depression and marital distress are often experienced concurrently.

Treatment for depression and marital distress have been traditionally approached and researched independently. In light of the prevalent indications of concurrent diagnosis, it follows logically that the joint influence of each treatment on the concurrent issues bears exploration.

This study examined the effects of Cognitive-Behavioral Therapy and Integrated Couple Therapy treatments (both individually and jointly) on the reduction of depression and the increase of marital satisfaction of women.

It was anticipated that Cognitive-Behavioral Therapy would be a more effective treatment modality than Integrated Couple Therapy for

depression when performed separately. Similarly, Integrated Couple Therapy would be more effective than Cognitive-Behavioral Therapy for increasing marital satisfaction when used individually. A combined treatment methodology (CO) would be more effective than either component treatments in treating concurrent diagnoses of marital distress and depression, than either individual component treatment. Further, the combined treatment methodology was expected to culminate in enhanced marital satisfaction and decreased depressive symptomology.

Chapter II

RELATED LITERATURE

Depression

Philosophers and physicians have been witnessing and writing about depression for more than 2,000 years. Depression, or as it is often referred to in historical writings, melancholia, was clinically described by Hippocrates in the 4th century B.C. (Beck, 1967). There has been substantial knowledge acquired about depression, but there is continued controversy as to it's precise causes and processes. As a result, several theories and hypotheses have been postulated and, in some cases, supported with empirical studies.

The current principal symptoms and indicators of depression that psychologists and physicians use for diagnostic purposes closely parallel the descriptions that are found in ancient writings. Hippocrates and others wrote about disturbed mood, self-debasing behaviors, self-castignations, suicidality, physical and vegetative symptoms, and extreme feelings of guilt without a reprieve (Beck, 1967). Depression is one of the very few psychopathologies that have remained relatively constant in its description over the centuries.

Although descriptive indicators of depression have been uniform, mental health professionals of today require a more standardized criteria

from which to render a diagnosis. This is accomplished through pervasive utilization of the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-4) (American Psychiatric Association, 1994). The criterion for a diagnosis of depression according to the DSM-4 is marked with either a depressed mood (flat affect, apparent apathy, ambivalence) or a loss of investment or pleasure in activities that have previously held interest for the individual. At least one of these essential features of depressive symptomology must be present most of the day for a minimum of two weeks. They must represent a deviation from previous functioning for the individual. Associated indicators are weight loss or weight gain, insomnia or hypersomnia virtually every day. Other indicators are psychomotor agitation or retardation, feelings of fatigue or loss of energy, excessive feelings of worthlessness or guilt that cannot be reduced, lack of concentration and suicidal ideations or gestures. All of these symptomatic features do not have to be present simultaneously for a diagnosis of depression. However, at least five characteristics must be represented for the two-week minimum time period. Another diagnostic criterion that must be evaluated is that the disturbance is not traceable to an organic factor that has initiated the symptoms or be a normal reaction to bereavement. The depressive symptoms cannot be associated with delusions or hallucinations, nor identified with a delusional or psychotic disorder. The diagnosis of depression carries with it the indication of level of severity

(mild, moderate, or severe) and type (chronic or melancholic).

The absolute prevalence of depression in our society is debated. Research by Reiger et al. (1988) cited prevalence rates at 3% of the general population of the United States. This percentage was established over a 6-month time period. The percentage jumps to 5.8% when examined for the lifetime period. Reiger and his colleagues (1988) interviewed more than 20,000 people from five regionally diverse locations and extrapolated the information to create a general percentage for the United States population. Myers et al. (1984) found a similar 3% prevalence rate for the United States population at large. Studies utilized in the DSM-4 (1994) found a higher prevalence rate with a range of 9% to 26% for females and 5% to 12% for males. When these proportions were examined for current diagnosis only, they dropped to 4.5% to 9.3% for females and 2.3% to 3.2% for males.

These studies indicate that women suffer from depression more frequently than men. This is inclusive of women of all ages (Radloff, 1980). Even with what appear to be obvious prevalence rates, there is some controversy as to whether women truly do suffer from depression more frequently or whether these ratios are a methodological artifact (Corob, 1987). Hypotheses that are postulated to account for these ratio numbers representing a methodological artifact are that women are more willing to acknowledge difficulty and seek assistance more readily than men. Or the

possibility that the incidences of depression are equally divided but that men express their depression in different ways that are not diagnosed as depression such as turning to alcohol. Weissman and Kierman (1977) performed a thorough review of the available research literature and found no base of substantiation for the higher rate of women experiencing depression to be merely a methodological artifact. The research indicates that significantly more women experience depression than men.

Cognitive Theory

There have been several theories of depression expostulated. These theories include Cognitive Models, The Interpersonal Model, Intrapsychic Models, and Neurobiological Models (Mann, 1989). One of the most prevalent and widely accepted models of depression is Beck's Cognitive Model published in 1967 (Mann, 1989). Aaron Beck developed his theory through many years of clinical experience treating clients with depression (Beck, 1964). The most basic premise of his model is that cognitions motivate behaviors and feelings. He came to realize that his clinically depressed clients were absorbed with negative thoughts about themselves, their environments and their future. He further perceived a consistency among these patients in that their negative self-perceptions were solidly based in their internal self-schemata (Beck, 1967). The third feature he consistently found in these depressive individuals was their usage of faulty logic without realization of their participation in this type of

self defeating thinking. They were unable to see the irrational assumptions on which they based much of their life's perceptions.

The Cognitive Model attempts to explain the phenomenon of depression in terms that are observable both empirically and clinically. Other theorists have hypothesized concepts that are much more abstract and don't lend themselves well to empirical validation. They can be laborious and difficult to demonstrate their efficacy (Beck, 1967). Examples of such theories may be found in Freud's conceptualization of depression as an attack by a part of the ego against the love-object. This concept is unobservable and cannot be validated (Beck, 1967). Classical psychoanalysis espouses the notion that depression is a result of unfulfilled unconscious wishes. In this therapy, once the individual recognizes their unconscious wishes, which underlie their difficulties, they will choose other coping strategies that are more effective. Often what may occur instead, is the depressed individual may use this realization as further "proof" of his lack of worth. She may then become more depressed (Beck, 1979).

Beck maintained that people have "automatic thoughts". These are cognitions that occur spontaneously in a given situation. An individual will relate some personal message to himself about the event. These cognitions color the way an individual will feel and/or behave in that particular situation. Beck makes a distinction between socially objective definitions of events (public) and the private interpretations that an

individual will generate regarding an event. The discrepancy between the public and private meanings of a situation is the differentiation between "rational" cognitions and "distorted" thoughts. It is the focus on distorted thinking that the Cognitive Model has its roots (Jarrett & Rush, 1988). Cognitive distortion is the principal feature of depression according to the Cognitive Model. An example of a distorted thought may be "I can't do anything right" when a glass accidentally falls and breaks. That cognition is extreme and outside the realm of reality. The glass failing is accidental and the breaking is unfortunate. Neither situation was a result of lack of competency. There are behaviors which some individuals do not perform well, but certainly not everything. The cognition is distorted to encompass all of life with a negative view of oneself. Some examples of depressed automatic cognitions come from Holion and Kendall's (1980) Automatic Thoughts Questionnaire:

I'm no good.

No one understands me.

I wish I were a better person.

I'm so disappointed in myself.

I feel like I'm up against the world.

Nothing feels good anymore.

Beck's Cognitive Model identifies three elements cardinal to the psychopathology of depression. These are 1) the negative triad;

2) silent assumptions; and 3) logical errors (Mann, 1989). The negative triad encompasses how the depressed individual views herself, her world and her future in negative terms. The previously mentioned automatic thoughts are often within the negative triad. They assume that these three areas are fundamentally lacking in some component(s) that are prerequisite for happiness. The depressive may view herself as inadequate, unworthy and inept. Her world may seem overly demanding and without support from others. She may see her future as hopeless and painful. The second element is silent assumptions. These are private rules that govern the emotional, behavioral and cognitive patterns of the depressed individual. These are psychological constructs that organize and interpret incoming stimuli for the individual. These silent assumptions promote automatic thoughts. They are usually stated as "if-then" premises. An exampie would be "If a person asks for help, then it is a sign of weakness" or "People will think less of me if i make a mistake" (Weissman, 1979). The Cognitive Model for depression posits that these silent assumptions or distorted thoughts are triggered more often than the rational, logical thoughts. These distorted thoughts become more and more frequent as depression becomes more severe; despite objective indications that would contradict their illogical view. These illogical views from the distorted thoughts are the third element of depression according to the Cognitive Model. A logical error may be identified by examining the

automatic thoughts of the depressed individual regarding a specific event. Beck has classified several types of logical errors. One example is selective attention. This occurs when the depressed individual attends to certain information and details and ignores others. Certainly all people on occasion may utilize selective attention, but the depressed individual emphasizes the negative detail that supports their views of themselves, their world and/ or their future to the point of negating and ignoring information that would support a positive viewpoint (Burns, 1989).

Cognitive-Behavioral Therapy

Cognitive-Behavioral Therapy is a broad category of therapies that contain components from both areas of theory (cognitive and behavioral). It does not specify unto itself the type of psychopathology best suited for effective treatment. It may be used for a myriad of issues, dictating a variety of methodology and techniques. Cognitive Therapy (Beck, 1979) is one type of therapy inclusive in the classification of Cognitive-Behavioral Therapy (Dobson & Block, 1988). For purposes of this study, the terms Cognitive-Behavioral Therapy and Cognitive Therapy will be used interchangeably and CBT will denote either of them.

The role of Cognitive-Behavioral Therapy in treating depression emanates from the Cognitive Theory of depression. The focus is to assist the client to alter their negative triad, silent assumptions and logical errors. The therapist endeavors to join with the client in a collaborative enterprise.

The relationship becomes one of teamwork to explore and discover areas of client distortions. In the course of treatment, the client will experience improved symptomology and periodic 'setbacks'. With the aid of a joint effort attitude, these improvements may be analyzed for features which tend toward success and these improvements are positively reinforced by the therapist. Concomitantly, when the 'setbacks' occur, the client is urged to utilize the information surrounding the temporary increase of symptomology as a learning tool for the future regarding situations that may exacerbate depression. The client is requested to practice learned tools for dealing with these issues. Most clients appear to learn most effectively while depression or critical events are occurring as opposed to retrospectively (Beck, 1979). Continued self exploration is encouraged after treatment is terminated to guard against a relapse.

The techniques used to accomplish the transformation of cognitions assist the client with developing a more positive, rational point of view. The therapy advances in stages with small steps toward improvement with constant vigilance toward challenging and invalidating dysfunctional cognitions.

Therapeutically, a main goal in the initial session is to begin to decrease depressive symptoms. The expectation is for the client to leave the very first session feeling better. This immediate improvement aids in creating a collaborative alliance and allowing the client to experience some hope for

her future through immediate improvement.

The specific techniques Beck (1979) developed are regarded as behavioral and cognitive. They are considered behavioral because the client will be dynamically pursuing activities which may decrease some symptoms. The therapist helps to devise 'experiments' with the client which can successfully counteract their distorted thoughts. An example may be in the event a client reports they cannot accomplish anything in their day. The therapist may instruct the client on usage of a daiiy activity schedule which is used to plan activities the client desires to accomplish. The client is asked to only agree to initiate the activity to protect against failure and the client's expected negative judgement regarding any outcome. If they are able to complete more of the activity, that is reinforced but not expected, initially. If the client fulfills the 'homework' assignment of completing the activity chart, she may quickly realize that she does indeed accomplish many activities in the day. Another behavioral technique is the recording of the client's feelings of mastery or pleasure on a one to five scale for the activities completed. These activities may be getting out of bed, brushing teeth, or grocery shopping. The techniques are considered cognitive because a prominent concentration is on the client's thinking (Beck, 1979). These techniques and others are used as a springboard to negating overwhelming negative cognitions.

The therapy is primarily not focused on delving into the client's past and attempting to right past wrongs, but to deal with the present and facilitate the client in alleviating their depressive symptomology and becoming more satisfied with their current life. This is not to say that Cognitive-Behavioral Therapy ignores the influence of a person's past on their present, but the focus is not to alter the past. Once the person can elevate their mood and alter their cognitions, then they may be more able to examine their past issues and painful experiences with more clarity and productivity.

In a recent meta-analysis conducted by Dobson (1989), Cognitive Therapy was shown to be a more effective treatment intervention for depression than strict behavior therapy, pharmacotherapy, no therapy and other therapeutic modalities. The meta-analysis examined studies since 1976 which used Cognitive Therapy compared to another method for treating depression. In order to allow for appropriate comparisons, the studies all used the Beck Depression Inventory as a measure of change. Other research has also supported Cognitive Therapy as an effective short term intervention for the treatment of depression (deRubeis & Beck, 1988; Williams, 1984; Pace & Dixon, 1993). It should be noted, however, that practitioners of other theoretical orientations argue that the CBT benefit is actually an artifact of the types of outcome measures used.

Marital Distress

Marital distress is an important and prevalent issue in our society as evidenced by increasing divorce rates. The rate of divorce involving families with children is approximately 50% of marriages. It is estimated that 75% of divorced mothers and 80% of divorced fathers will remarry. The rate of divorce in these second marriages is even higher than those of first marriages.

Literature addressing the development and process of marital discord has been garnering increased interest (Weiss & Heyman, 1990). There are a multitude of areas and issues that contribute to dissatisfaction among couples. A common factor in areas of discord is the negativity that becomes inherent in the couple's relationship interactions. A relationship that initially began with a balance of reinforcing and positive interactions becomes severely skewed toward a consistently negative trend (Margolin, 1981). The rate of reinforcing behaviors diminishes (Jacobson & Margolin, 1979) and hypersensitivity toward negative exchanges increases (Jacobson, Foliete, & McDonald, 1982). Spouses tend to expect and attend to the negative interactions, and then respond in a like manner. A complicating factor in marital distress is that problem solving skills and communication deteriorate. The dissatisfied spouse is more confident in their negative evaluations and hence less likely to negotiate or compromise than a less distressed spouse (Noller & Venardos, 1986).

This confidence translates into frustrating episodes of attempts to resolve conflicts. The deterioration of communication and problem solving skills and the persistence of unresolved problems result in increased behaviors of nagging, disapproval and demands. The recipient of these behaviors may respond with increased withdrawal, avoidance and alienation or may reciprocate disappointing and demanding behaviors (Christensen, 1987). Marital distress becomes characterized by a cyclical interaction process with the ineffective behaviors of each spouse creating more negativity and distress in the other. In the light of such negativity, efforts to break the cycle may feel hopeless and fatigued.

Another important factor that occurs as the cycle develops and crystallizes is the decrease, and in some cases removal, of acceptance of emotional expression which is a facet of social support (Beach, Sandeen, & O'Leary, 1990). In the course of choosing a mate, reciprocal reinforcement provided during the courtship is an intervening variable that influences the outcome of selection (Jacobson & Christensen, 1996). During courtship, the individual is reinforced by the opportunity to express their emotions and receive understanding and acceptance (Lehman, Ellard, & Wortman, 1986). In a marriage, the spouse is the person who is most commonly expected to continue that role of social supportiveness. The spouse is typically the one who is turned to and yieids the most opportunities for the expression of emotions. As distress progresses, social support is

decreased. Acceptance of emotional expression is tainted by negative judgements and substituted with lack of understanding. The lack of support by a spouse only acts to increase the demands and nagging of the other spouse. The increased nagging and demands only acts to increase withdrawal of support and avoidance. Subsequently, the behavior of each spouse acts to support the negative cycle of marital distress.

Reciprocal reinforcement during courtship in terms of demonstrations of love that are positively reinforcing such as caring notes, surprise gifts or unsolicited thoughtful gestures require alteration as the marriage continues. The spouse develops satiation to these types of gestures. The satiation leads to lack of reinforcement (Jacobson & Margolin, 1979). The same demonstrations of caring no longer produce the same effects. This may cause distress in some couples in the event that change does not occur to promote continued positive reinforcement.

Another developmental process that potentially fosters marital discordance is the incompatibilities that arise through increased and continued contact. Life's events are different for each spouse and as a result of personal upbringing and background, these events will be experienced differently. The incompatibilities may come simply from constant exposure to the other person or from differing experiences or perspectives on life (Jacobson & Christensen, 1996).

Integrated Couple Therapy (ICT)

Integrated Couple Therapy (iCT) is a behavioral approach for treating marital discord. It is built on the foundations of Behavioral Marital Therapy. Behavioral Marital Therapy was developed by Jacobson and Margolin (1979). Realizing the narrow application implied by "Marital" in the title of the therapy, BMT became Behavioral Couple Therapy (BCT). BMT and BCT will be used synonymously in this study. BMT has been extensively researched, with affirmative results indicating it to be an effective treatment for couple distress (Hahlweg & Markman, 1988).

The course of therapy using BMT is significantly structured and didactic. Relationship skills are systematically taught to the couple using a preprescribed format. The rationale for each skill is thoroughly explained to the couple at the beginning of instruction. "Behavioral rehearsal" is a technique used in therapy and includes the provision of feedback, modeling of germane skills by the therapist, and the opportunity for the couple to practice new skills. This is a component of BMT that contributes to the changes in the couples interactions, which is the essential goal of BMT (Jacobson & Margolin, 1979). Although the format and procedures are systematic, the target problems of the couple are the focus of intervention. The skills are taught to alter the target behavior problems. BMT places emphasis on generalizing the skills to the couple's everyday interactions outside of therapy. In an attempt to facilitate generalization,

'homework' assignments are given weekly for the expressed goal of supporting the couple to become autonomous from the therapist.

Traditional BMT begins with an initial interview. The goals of the interview are for the couple to build trust for the therapist, create positive expectancies and extinguish hopelessness. In the initial interview, the therapist gives a brief introduction to therapy. The rest of the interview will be spent gathering information from the couple regarding the development of their relationship and the courtship period and their decision to marry. Emphasis will be placed on previous positive experiences and interactions. This reminiscing tends to refresh the couple to the positive reinforcements they received at the beginning of their marriage.

The next several sessions are focused on assessment. The purpose is to gather adequate information to understand the problems, identify the controlling variables, select appropriate intervention strategies and set goals in order to recognize when treatment has been successful. During the assessment process cognitive factors are included. The utilization of standard inventories and interaction charts are employed to gather more information. The therapist seeks to understand how the couple is currently attempting to affect change in their relationship and the level of success that is accomplished.

The session following assessment is the interpretative session. The interpretation should include their strengths, confidence in their abilities to change and control behaviors, explanation of their skill deficits and reinforcement erosion due to satiation of previous reinforcers. The therapist will request a verbal contract with the couple for an agreement to complete all the work assigned. As a prophylactic precaution, the couple will be warned of the challenges and hard work which will characterize therapy.

Therapy will consist of two major features: Behavioral Exchange (BE) and Communication-Problem-solving Training (CPT). BE is primarily in the form of homework assignments to facilitate the generalization of behaviors into the couple's everyday interactions. The homework is directed toward increasing positive behaviors and decreasing punishing behaviors. The therapy sessions are used to analyze the success of the homework and generate new assignments. CPT teaches skills in session to assist in conflict resolution. The goal is for the couple to be competent in the skills so they may resolve issues at home without the mediation of the therapist (Jacobson, 1992).

ICT represents two changes or additions to traditional BMT. Although ICT envelops all aspects of the foundations of BMT, ICT is not narrowed by client marital status. ICT was developed for utilization with all people that are engaged in a committed, romantic relationship (Jacobson &

Christensen, 1996). This may include marrieds, individuals living together whether they be heterosexual, lesbian or gay. Deletion of 'marital' exclusivity allows ICT to approach a greater number of dyads than only married couples.

The second improvement is an addition to the concepts and techniques used with traditional BMT. Through continued empirical and clinical exploration, BMT was found to be effective but not prophylactic against relapse. Of couples who did receive benefit from BMT intervention, 30% relapsed to a clinically significant degree within one to two years (Jacobson, Schmaling, & Holtzworth-Munroe, 1987). In another study by Snyder, Wills, and Grady-Fletcher (1991) when a 4 year follow up was conducted with couples who were distressed and had been treated with BMT, 38% of those couples had experienced divorce. These works and some Jacobson's own research created the empirical stimulus for changes from BMT to ICT. Jacobson (1992) has also reported that BMT appeared to be effective in only about 50% of those treated. The other 50% either did not receive any relief or the effects seemed to be transient. ICT adds the idea of acceptance of behavior and individual differences. Previously, traditional BMT emphasized behavioral change without regard to the notion that some behaviors cannot be changed. ICT places an equal emphasis on change and acceptance. The treatment focuses on areas that can be changed and teaches techniques for acceptance for areas which cannot.

With the introduction and implementation of acceptance skills, ICT may more fully equip the couple to enjoy continued relief from distress.

Concurrent Treatment

Studies in the professional literature have consistently documented that there seems to be a relationship between depression and marital discord (Jacobson et al., 1991; Coleman & Miller, 1975; Beach, Arias & O'Leary, 1986). The literature indicates that the two frequently co-occur (Crowther, 1985; Coyne, 1988; Beach, Sandeen, & O'Leary, 1990). Concordance rates between depression and marital distress have been reported to be as high as 50% (Beach, Jouriles, & O'Leary, 1985). This would indicate that there is approximately a 50% overlap between depression and marital discord. The precise causal relationship between the two is unclear. Research has tended to support results indicating that individuals who are experiencing marital distress may manifest a depressive episode or maintain an already developed episode (Beach, Sandeen, & O'Leary, 1990; Hooley & Teasdale, 1989). There is also support for the reverse to occur. Positive interactions and support from an intimate relationship may minimize or even prevent depression (Beach & O'Leary, 1992; O'Leary & Beach, 1990; Jacobson, et al., 1993). Rounsaville, Weissman, Prusoff, and Hercog-Baron (1979) found during the progression of psychotherapy, improvements in marital satisfaction were affiliated with decreases in depressive symptomology. In the event that improved marital functioning was not associated with

decreased depressive symptoms, depression relapse is probable (Hooley, Orley, & Teasdale, 1986).

Research clearly indicates that there is a reciprocal link between depression and marital discord in many individuals. Until recently, treatment has focused on one or the other issue, without consideration of the concomitant focus of both. CBT has been indicated to be effective in the treatment of depression, as has BMT for the treatment of marital discord. There is a preliminary study utilizing both treatment modalities that has shown optimistic results in the concurrent treatment of both depression and marital dissatisfaction (Jacobson et al., 1991). The researchers did not use ICT which may enhance the treatment success and prevent reoccurrence of marital distress therefore, preventing future depressive episodes. With the utilization of CBT and ICT the reciprocal link between depression and marital discord may potentially be severed.

Chapter III

METHOD

Participant Recruitment

Some current research have used effect sizes of 1.0. For this study an effect size of 1.25 was used instead. Results of a power analysis using an effect size of 1.25 standard deviation, an alpha level of .05, power of .75 with 3 levels of intervention determined the appropriate number of participants per cell to be 10. This power analysis assisted to optimize detection of significant differences in treatment effects. The participants for this study were 30 married women who met the Diagnostic and Statistical Manual for Mental Disorders (4th edition, DSM-IV; American Psychiatric Association, 1994) criteria for major depression. The Structured Clinical Interview for DSM-III-R-Patient Edition (SCID-P; Spitzer, Williams, Gibbon & First, 1990) was used to assist in determining if DSM-IV criteria was met. Criteria for diagnosing Major Depression Disorder has not significantly changed from DSM-III-R to DSM-IV. Additionally, the sample group was requested to take a Beck Depression Inventory (BDI; Beck, Rush, Shaw & Emery, 1979). A score on the BDI of 20 or greater was used for inclusion in this study. The participants' spouses had to agree to participate for participant inclusion.

The participants presented with requests for services to treat depression. Clients who were assessed with suicidal intentions were

excluded and offered immediate services. Further, scores on the Hamilton Rating Scale for Depression (HAM-D; Hamilton, 1960) were used as additional information regarding depression severity completed by the designated therapist after the first session of therapy. The appointed therapist was selected to complete all HAM-D instruments to avoid scoring inconsistencies for the given participant.

Exclusionary criteria included current participation in any other psychotherapeutic treatment. If the participant positively endorsed the question on the demographics survey inquiring whether they were currently engaged in therapy, they were asked to suspend the other treatment during their participation in the study. This was the situation for 10.0% of the sample. Information regarding the current usage of psychotropic medications was requested but not employed as inclusion nor exclusion criteria so the sample would more easily generalize to the population at large. Age, years of marriage, number of marriages, number of children, education level, SES, and prior diagnostic history was requested for demographic purposes but not considered as inclusionary or exclusionary criteria. The MMPI-2 was also administered at the beginning of therapy as supplemental information on all participants.

The participants were recruited through the University of Oklahoma Counseling Psychology Clinic, solicited through local mental health agencies via flyers and letters, and in several newspaper articles offering

free treatment as part of a research project. Letters of recruitment were sent to all local General Practice physicians as well as OB/GYN physicians. Exposure from the newspapers produced the most participant responses for intake appointments. When screening criteria was met but participants were unwilling to participate, spousal refusal to be active in therapy was the most cited reason. Participants were interviewed for intake appointments for inclusion assessment by the author or two other interviewers who were trained on the standardized inclusion criteria.

Participant Demographics

The participant pool overall had a mean age of 37.48 (SD = 9.87), 1.23 children living with each couple in the household (SD = 1.28), an average of 1.63 marriages (SD = .77) with a mean of 9.07 years of marriage in the current relationship (SD = 9.51). The participant's average level of education was 1 - 2 years of college and an annual family income between $15,000 - $45,000. The participants reported that 73.3% drank alcohol, which was acknowledged as socially averaging from 1 - 2 drinks per month, 50.0% had not been diagnosed with depression previously, 60.0% were taking medications, such as antidepressants and various other medications, and 73.3% had previously participated in psychotherapy. In the area of cultural background, all identified themselves as Caucasian except for two women. One of the two identified herself as American-Indian and the second endorsed the "other" category. On the initial DAS,

83.3% of the participants met the criteria cutoff to be in the maritally distressed range. Appendix A features demographic information for the participant pool data by treatment cell.

The MMPI-2 indicated that 93% of the protocols for the participant pool had significantly elevated Depression Scales. These clinically elevated protocols ranged from a high of 92 to a low of 66 with the majority between 70 to 80. Of the 27 completed MMPI-2 instruments, only one participant protocol was a valid normal profile. For the overall pool, CBT, and ICT groups, the depression scale was the most elevated on the mean profile for each. On the mean profile for CO, the Hypochondriacal scale was the most escalated. Figures 1 - 4 summarize this data by illustrating the mean profiles for the overall participant pool and each treatment group.

Measures

Structured Clinical Interview for DSM-III-R-Patient Edition (SCID-P). The SCID-P is a structured interview that provides diagnoses consistent with the DSM-III-R. The criteria for the diagnosis of Major Depression has not significantly changed from DSM-III to DSM-IV. The SCID-P was administered by graduate level interviewers who were trained to utilize it. Couples were excluded if there were issues of physical abuse in the previous year.

Hamilton Rating Scale for Depression (HAM-D). The HAM-D was developed by M. Hamilton (1960). It is a clinician rated scale that has been

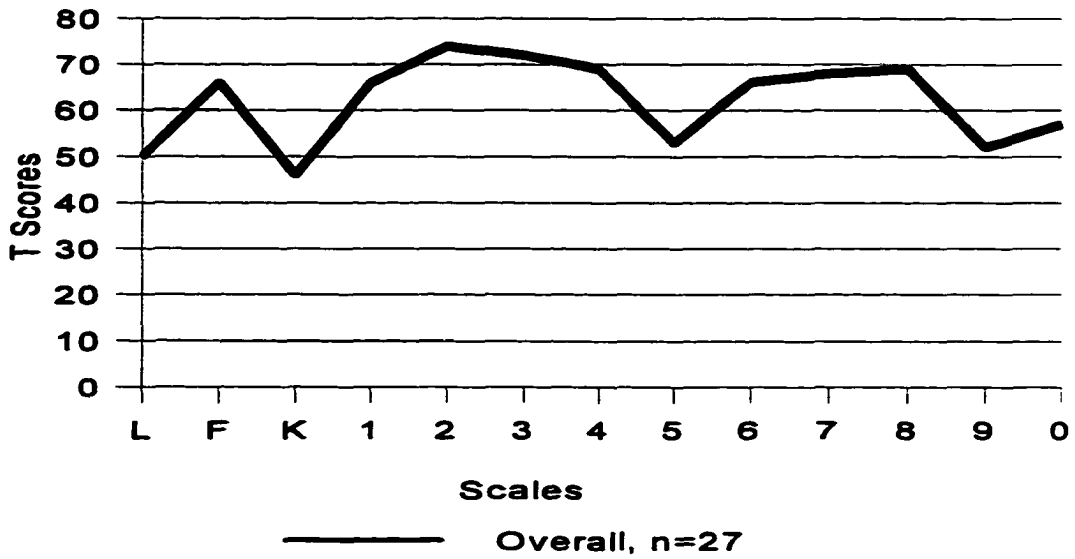

Figure 1. MMPI-2 mean profile for overall participant pool

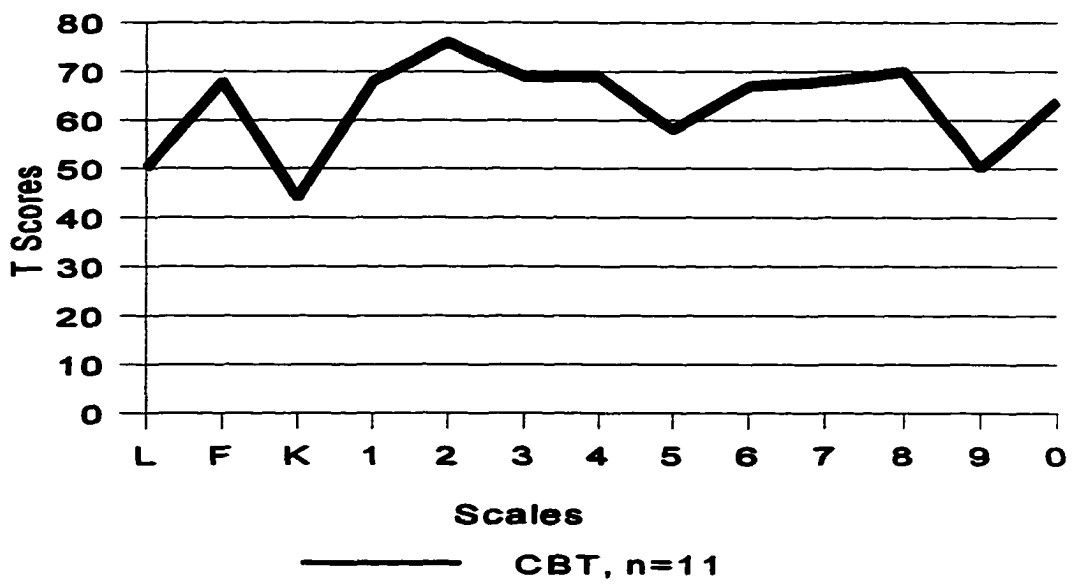

Figure 2. MMPI-2 mean profile for CBT group.

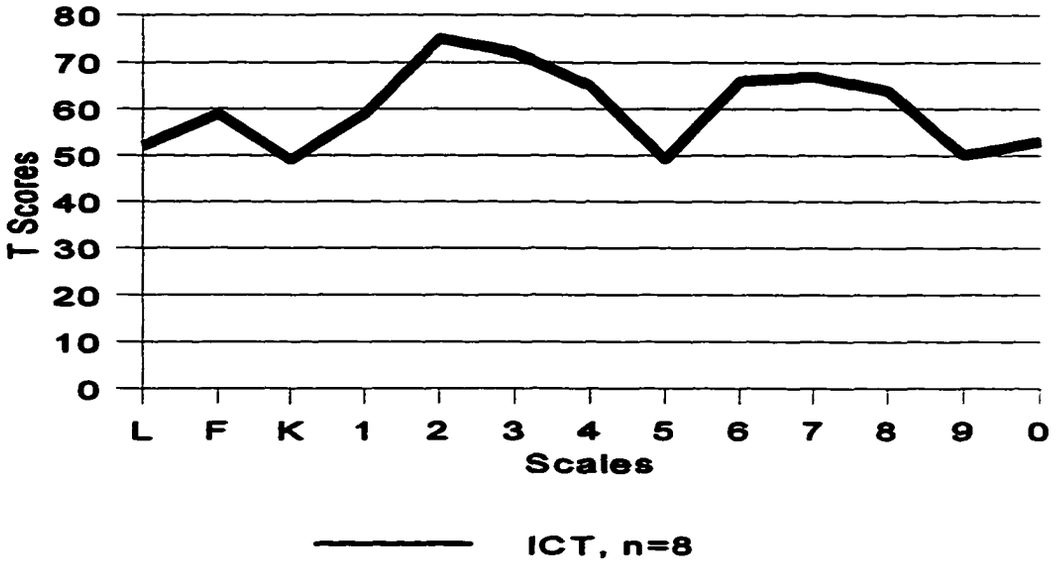

Figure 3. **MMPI-2 mean profile for ICT group.**

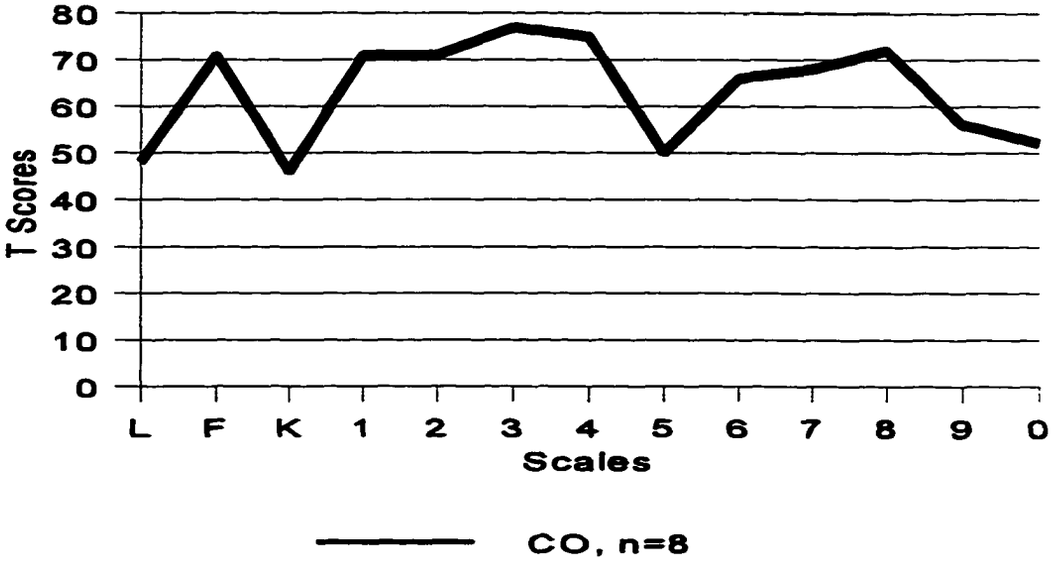

Figure 4. **MMPI-2 mean profile for CO group.**

widely used in clinical research to measure symptoms and severity of depression. The HAM-D is a 25 item instrument with a possible score range from 0 to 74 with variable scoring between 0-2 and 0-4. Traditional cutoff criteria has been 25 or greater indicating severe depression (inpatients), 18-24 indicates moderate depression (outpatient), 7-17 indicates mild depression and 6 or less for no depression (Endicott, Cohen, Nee, Fleiss, & Sarantakos, 1981). Research indicates that the HAM-D was shown to correlate .88 with 'global' judgements of depression (Bech et al., 1975). Interrater reliability for total scores range from .87 to .95 (Burrows, Foenander, Davies, & Scoggins, 1976; Robins, 1976).

Beck Depression Inventory (BDI). The BDI is the most extensively used self-report instrument for depression screening (Beck, Steer & Garbin, 1988). The original BDI was developed by Beck, Ward, Mendelson, Mock & Erbaugh (1961) and was revised by Beck, Rush, Shaw & Emery (1979). The BDI has 21 items that are rated on a 4-point Likert scale (0-3), reflecting increasing symptom severity. The BDI is simply scored by totaling the highest response for all items. Total scores range from 0-63. Guidelines for interpreting scores are generally as follows: 0 to 9 - no depression; 10 to 19 - miid depression; 20 to 29 - moderate depression, and 30 or higher - severe depression (Kendall, Hollon, Beck, Hammen & Ingram, 1987). In a major review, Beck, et al. (1988) concluded that the BDI has been shown to have acceptable reliability and validity, with typical reliability results

showing one week test-retest to be in the .70's and validity results indicate the BDI characteristically correlates in the .60's with expert clinical diagnosis.

Dyadic Adjustment Scale (DAS; Spanier, 1976). The DAS is a frequently used self report measure of marital satisfaction. Whisman and Jacobson (1991) have shown the DAS to have high internal consistency and discriminant efficiency. This instrument contains 32 items which may be scored from 0 to 5. The global adjustment score is calculated by adding all scores together. Total scores of 99 or less are classified as distressed. Individuals with a combined score greater than 99 are classified as nondistressed. When the DAS has been compared to other measures of global marital satisfaction, it was shown to be sensitive to treatment effects.

Measurement Procedures

The SCID-P, BDI, DAS, and MMPI-2 were completed prior to the first session of treatment. The HAM-D was completed by the therapist after the first treatment session. Repeated measures with the BDI, DAS, and HAM-D were completed after sessions 4, 8 and 12. A self-report satisfaction with treatment survey was also completed by all participants following the 12th session. All therapists were asked to complete a satisfaction survey regarding their training and research experience in this study. These surveys were completed by 7 of the 11 therapists after completion of their

cases. The remaining four therapists completed the survey after participating in the study for 16 months although they were not completely finished with some of their cases.

Therapists

The 11 therapists were recruited from the University of Oklahoma Counseling Psychology Clinic. Therapists were 6 females and 5 males ranging in age between 24 to 43. Ten of the therapists were Caucasian and one was American Indian. They were solicited by the author through a presentation of the study with an invitation to participate. Explanations of the training and data collection procedures were included. The students were graduate students with at least one year of practicum experience. Therapists were trained through a 12 week seminar executed by the author with assistance from Terry M. Pace, PhD and Cal Stoltenberg, PhD. A syllabus for the training procedure is in Appendix B.

Therapist order for assignment of cases was determined by their readiness to accept cases. The treatment modality was assigned to the therapist in a rotational order so that each therapist had the opportunity to conduct therapy with at least two of the three modalities. Clients were assigned to the therapist and modality in the order that they completed their paperwork and were accepted into the study. Weekly group supervision and as needed individual consultation was provided by the author and Drs. Pace and Stoltenberg for all therapists throughout the

course of treatment.

Treatment Conditions

Cognitive-Behavioral Therapy (CBT). This treatment program consisted of twelve sessions of individual psychotherapy for depression based on Beck's 20-session plan for cognitive therapy (Beck et al., 1979). Treatment included assessment and modification of cognitions regarding depression, situation specific automatic thoughts, underlying beliefs and attitudes focusing on depression and behavioral aspects of depression. A CBT treatment manual was followed. Appendix C contains the treatment manual.

Integrated Couple Therapy (ICT). The treatment program consisted of twelve conjoint couples sessions. Treatment began with emphasis on behavioral exchange. It then moved to communication skills and problem solving techniques for conflict resolution for issues regarding finances, sex, affection and parenting. Emotional acceptance was included with equal focus. Both spouses were required to attend. An ICT treatment manual was followed. The treatment manual is in Appendix D.

Combined Therapy (CO). The combined program consisted of twelve sessions as suggested by recent research by Jacobson, Dobson, Fruzzetti, Schmaling & Salusky (1991). The treatment modality had a minimum of four individual CBT sessions and four conjoint ICT sessions. The nonspecified sessions were flexible and left to the therapist to determine

the most beneficial modality between the two of interest. The only directives for session type determination was that the first session utilize the CBT modality with the second session utilizing ICT. This was thought to be beneficial to the therapeutic relationship so as to guard against actual or perceived bias by the clients on the part of the therapist. The patterning of the remaining sessions was also left to the therapist's discretion. For the ICT sessions the spouse was required to attend, whereas for CBT sessions, only the depressed wife attended. Sequencing of the sessions was fairly evenly distributed with 57% CBT sessions and 43% ICT sessions. In most of the termination sessions or 78, therapists chose the ICT modality to end treatment. All third sessions, except one, utilized the CBT modality. Exact sequencing of the CO modality sessions by participant can be found in Appendix T. A combined treatment manual was developed, followed and is contained in Appendix E. All sessions were 50 minutes for all treatment modalities.

Manipulation Check

A 45 item rating scale was utilized to measure treatment adherence. In this scale 15 items represent behaviors that are supposed to occur in CBT, 15 items represent behaviors that should occur in BMT, and 15 items of general nonspecific clinical skills (Jacobson et al., 1991). The BMT area of the manipulation check scale was modified to include ICT's behavioral acceptance component. This enhancement served to verify the adherence

to ICT. All sessions were videotaped. Three graduate students were trained and served as raters for interrater reliability. The raters were blind to the treatment condition. One randomly chosen session from each treatment case was viewed for manipulation check excluding sessions one and 12 since these consisted of introductions to therapy and termination. The tapes were cued to the beginning of the session of interest and distributed to each rater with a manipulation check form. Two of the raters were used for analysis with the third serving as a calibrator in the event of a discrepancy. The two raters were randomly selected at the beginning of the manipulation check process. The raters were trained to a 92% interrater agreement level comparing simple proportions. Comparison of the completed manipulation check forms indicated an 77% interrater agreement. The manipulation check form is contained in Appendix K.

Treatment Distribution

The alternating dispersion of the treatment modalities resulted in the CBT cell containing 11 participants; the ICT cell containing 10 participants; and the CO cell including 9 participants. All therapists conducted treatment utilizing at least two of the three modalities except for one therapist, who's time constraints only allowed for her to participate with one case. Six of the 11 therapists conducted therapy applying all three treatment modalities. The total case assignments per therapist ranged from one case to five.

Participant Attrition

Attrition was based on participant withdrawal from the study. Withdrawal was defined as leaving the study any time after the first session was completed. Of the 42 that began the study, 30 completed the 12 session protocol resulting in 71% completion. Within the 29% of those participants who began the treatment protocol but did not finish, 44% dropped out of the CBT modality, 33% from the ICT modality and 22% from the CO modality. The timing of the attrition was fairly evenly divided at 54% prior to session 4 and 46% after session 4. The earliest withdrawal occurred after session 1 and latest occurred after session 9. The reasons for early termination varied from moving out of the area to spousal refusal to continue therapy. No one reason was pervasive for those who gave this type of information. Attrition was widely distributed among therapists and did not seem to be impacted by any specific therapist.

Independent T tests were conducted on the entire participant pool comparing means of those who completed the treatment protocol and those who terminated prematurely. There were no significant differences between the attrition group and the completer group on any of the three instruments at pretreatment, BDI: t (12.82) = -.57, p < .580; HAM-D: t (14.04) = .32, p < .757; DAS: t (11.91) = -.39, p < .700. Independent T tests were also executed comparing the two groups by treatment modality at pretreatment by instrument. Again, no significant differences emerged.

The results for CBT were as follows: BDI: t (5.65) = -.19, p < .860; HAM-D: t (6.44) = .92, p < .393; DAS: t (3.72) = .71, p < .520. The results for ICT for the BDI were as follows: t (5.23) = -.81, p < .454. Results for the HAM-D were t (4.71) = -.14, p < .898; and for the DAS: t (4.45) = .11, p < .915. And finally the t test results for CO were for the BDI as follows: t (4.25) = -.37, p < .729; for the HAM-D: t (1.76) = -.57, p < .634; and for the DAS: t (8.19) = -1.06, p < .320.

Chapter IV

RESULTS

The primary measures of depression were the BDI and HAM-D. Marital Satisfaction was assessed through the DAS. Each dependent variable was tested for significant differences at pretreatment utilizing one way analysis of variance (ANOVA). For the BDI, the results indicated that the pretreatment measures were not significantly different between groups regarding treatment modality, F (2, 27) = .1354, p < .8740. The HAM-D scores at pretreatment were not significantly different, F (2, 26) = .5576, p < .5793. And again the results for the DAS were not significant either, F (2, 27) = .3347, p < .7185. Therefore, this study consisted of a 4 (pretreatment, 4th session, 8th session, 12th session) x 3 (CBT, ICT, CO) repeated measures factorial design. The following describes the results from each dependent variable.

Depression

Beck Depression Inventory

The BDI had a reliability coefficient alpha of .7339 for administration at pretreatment. The reliability coefficient alphas for administration after session 4 = .8410; after the 8th session = .8962; and at post-treatment = .8834. The results for this reliability coefficient alpha analysis are contained in Appendix R. Table 1 features the cell means and standard deviations for the BDI at pretreatment, after the fourth, eighth and twelfth

sessions by treatment group. At pretreatment, these BDI means are all near the cut-off score of 30, indicating a severe level of depressive symptoms in this sample. Inspection of the means revealed a decline in depressive symptoms after session 4 and at post-treatment.

A 4 x 3 repeated measure analysis of variance (ANOVA) was executed for the BDI. There were no significant differences due to treatment group, F (2, 26) = 1.40, $p < .264$. The ANOVA for time in the study was highly significant, F (3, 78) = 63.41, $p < .000$. Interaction between treatment group and time did not reveal any significance, F (6,78) = 1.51, $p < .187$. The results of this ANOVA are contained in Appendix O.

Due to the exploratory nature of the study and small n, post hoc t tests were used instead of Scheffee analysis. T tests for paired samples were conducted to determine at which points of administration significance between the means was present. The mean BDI score at pretreatment was 28.6 and after the 4th session was 10.0 which was a significant difference, t (29) = - 9.70, $p < .000$. For the 8th session administration, the mean was 11.5. Results for comparison between the pretreatment score and 8th session were significant, t (28) = - 8.84, $p < .000$. The mean at post-treatment was 9.13, which was significantly different from the pretreatment mean, t (29) = 10.13, $p < .000$. There were no significant differences between the means after the 4th session and after the 8th

Table 1

Means and Standard Deviations for the Beck Depression Inventory

Times	Treatment Groups		
	CBT (n=11)	ICT (n=10)	CO (n=9)
Pretreatment	28.0 (6.6)	29.6 (8.2)	28.1 (8.4)
4th session	14.27 (11.1)	6.6 (8.5)	8.4 (10.4)
8th session	16.0 (10.7)	7.8 (5.0)	10.6 (6.8)
12th session	11.2 (7.3)	7.7 (7.2)	8.2 (7.5)

Note. Means are represented by the first number in each cell, standard deviations are in parentheses. Lower means = less self-reported depression and higher means = greater self-reported depression.

session, t (28) = - .87, p < .393. There were also no significant differences between the means at the 4th session and post-treatment, t (29) = .57, p < .572. In examining the mean after the 8th session as compared to the mean at post-treatment, significant differences were indicated, t (28) = 2.29, p < .030. The results of these t tests are contained in Appendix S.

Hamilton Rating Scale for Depression

The reliability coefficient alpha for the HAM-D at pretreatment administration was .8597. The coefficient after the 4th session = .8645;

after the 8th session = .8463; and after the 12th session = .8786. The reliability coefficient alpha table is provided in Appendix R. The HAM-D cell means and standard deviations are contained in Table 2. At pretreatment, all means are above the cutoff criteria for mild depression, and CBT and CO means are above the criteria cutoff for moderate depression. Inspection of the means clearly demonstrates a decline in depressive symptomology as treatment progressed and at post-treatment.

A 4 (pretreatment, after the 4th, 8th, and 12th sessions) x 3 (CBT, ICT, and CO) repeated measures analysis of variance (ANOVA) was conducted for the HAM-D. There was no significant difference attributable to the treatment modality, F (2, 25) = .39, p < .679. As is consistent with the BDI results, the time factor in the study was highly significant, F (3, 75) = 24.84, p < .000. Again as with the BDI results, the interaction of treatment with time was not significant, F (6,75) = .96, p < .458. The results of this ANOVA are contained in Appendix O.

T tests for paired samples were conducted to compare the means of the various administrations of the HAM-D to determine any significant differences. The mean at pretreatment was 17.6 and after the 4th session was 13.4. These means were significantly different, t (27) = -4.11, p < .000. The mean after the 8th session was 9.4 which was significantiy different from the pretreatment mean, t (28) = -5.60, p < .000. The mean at

Table 2

Means and Standard Deviations for the Hamilton Rating Scale for Depression

Times	Treatment Groups		
	CBT (n=11)	ICT (n=10)	CO (n=9)
Pretreatment	19.6 (10.5)	15.1 (6.2)	18.8 (13.1)
4th session	15.5 (10.4)	12.4 (4.9)	12.4 (8.2)
8th session	12.6 (6.9)	7.6 (4.9)	9.2 (8.1)
12th session	7.0 (5.2)	7.5 (9.5)	7.0 (6.7)

Note. Means are represented by the first number in each cell, standard deviations are in parentheses. Lower means = less clinician rated depression and higher means = greater clinician rated depression.

post-treatment was 6.6, and also was significantly different from the pretreatment mean, t (28) = 6.10, p < .000. The means were significantly different between the 4th session and 8th session, t (28) = -3.18, p < .004, and also between the 4th and the post-treatment, t (28) = 4.37, p < .000. And finally, mean HAM-D scores also differed significantly between the 8th session and at post-treatment, t (29) = 2.60, p < .014. Results of these t

tests are contained in Appendix S.

Although the BDI and HAM-D were administered using the standardized differing methodology (clinician rating versus self report) and examining differing aspects of depressive symptomology, it would be expected that they would have a reasonable level of correlation. A Pearson correlation coefficient was conducted on each instrument by time of administration. The BDI and HAM-D have a coefficient of -.0248 at pretreatment. This may be attributable to the novelty of the therapeutic relationship since the HAM-D is a clinician rating form, the perceived differences between the clinician and participant regarding symptom severity and/or the differences in the instruments themselves. The HAM-D tends to focus on somatic complaints more so than the BDI. As the therapeutic relationship grew, the correlation coefficients increased; after the 4th session = .4730; after the 8th session = .5922; and after the 12th session = .6900. By the end of treatment, the clinician and participant appeared to see the symptoms in a more parallel fashion.

Marital Distress

Dyadic Adjustment Scale

The reliability coefficient alpha at pretreatment for the DAS was .9356. Administration of this instrument after the 4th session had a reliability coefficient alpha of .9291; after the 8th session = .9407; and after the 12th session = .9383. The reliability coefficient alpha table is provided in

Appendix R. Table 3 represents the cell means and standard deviations for the DAS by treatment condition at pretreatment, and after sessions 4,8, and 12. At pretreatment, all modality means were below the cutoff criteria for marital distress, indicating distress in this sample. Again, inspection of the means indicates an increase in marital adjustment as treatment progressed.

A 4 (pretreatment, after the 4th session, after the 8th session and after the 12th session) x 3 (CBT, ICT, and CO) repeated measures analysis of variance (ANOVA) was executed for the DAS. The results indicated no significant differences accountable by treatment modality, F (2, 22) = 1.04, p < .267. The results showed the time in the study was highly significant, F (3, 66) = 13.46, p < .000. Again as with the previous two instruments, the interaction between time and treatment was not significant, F (6, 66) = 1.31, p <.265. The results for this ANOVA are contained in Appendix O.

T tests for paired samples were also conducted on the DAS means to determine significant differences between administrations. The mean at pretreatment was 78.5 and after the 4th session it was 87.7. The t tests resulted in significance between these two means, t (29) = 3.37, p < .002. The mean after the 8th session was 88.4. As was parallel with the previous instruments, the t test comparing pretreatment with session 8

Table 3

Means and Standard Deviations for the Dyadic Adjustment Scale

Times	Treatment Groups		
	CBT (n=11)	ICT (n=10)	CO (n=9)
Pretreatment	74.5 (21.6)	82.5 (20.2)	79.1 (26.2)
4th session	78.6 (24.3)	98.4 (18.0)	87.0 (19.9)
8th session	77.8 (23.2)	94.0 (18.6)	94.1 (21.8)
12th session	83.1 (22.8)	96.0 (24.2)	101.2 (14.9)

Note. Means are represented by the first number in each cell, standard deviations are in parentheses. Lower means = greater self reported marital distress and higher means = less self reported marital distress.

was significant, t (25) = 3.22, p < .004. Comparison of the pretreatment and post-treatment means was significant with a post-treatment mean of 93.1, t (27) = -4.67, p < .000. The t test between the 4th and 8th sessions was not significant, t (25) = -.09, p < .931. The t test comparing the means of the 4th and post-treatment were also not significant, t (27) = - 2.03, p < .052. Lastly, the means of session 8 and at post-treatment were significantly different, t (24) = - 2.32, p < .029.

Treatment Outcomes

Treatment Change Scores

An approach used to examine the data was comparing the trends of the change scores across time by treatment modality. Change scores were calculated as the difference between scores from the pretreatment to after the 12th session administration of each instrument. Then a mean score for each group was computed. It is apparent in Table 4 that scores changed in the desired direction of decreased symptomology as treatment progressed.

Still another method of examining the treatment outcome from the BDI, HAM-D and DAS scores was to calculate simple percentages of responders versus nonresponders. For this analysis, responders were defined as those participants who's score dropped below 10 for the BDI, below 8 for the HAM-D, and rose above 99 for the DAS. These ranges were used because they indicated that the participant no longer met the criteria to be considered depressed or maritally distressed. Nonresponders were defined as those participants who maintained scores outside of the above mentioned ranges. The scores used for overall participant pool comparison were after the 12th session or post-treatment. In examining the scores on the BDI, 55% of CBT participants, 80% of ICT participants, and 78% of CO participants met criteria to be classified as responders to treatment. Post-treatment scores on the HAM-D showed results of 55% of CBT participants, 70% of ICT participants, and 78% of CO participants were

Table 4

Means for change scores of treatment groups by assessment instrument

Test	Treatment Groups		
	CBT	ICT	CO
BDI	16.8 (8.5)	21.9 (11.3)	19.9 (12.2)
HAM-D	12.5 (10.3)	7.6 (9.2)	13.3 (9.7)
DAS	-10.9 (8.1)	-14.4 (21.5)	-22.1 (21.2)

Note. Means are represented by the first number in each cell, standard deviations are in parentheses.

considered responders. And lastly looking at scores for the DAS, 30% of CBT participants, 50% of ICT participants, and 33% of CO participants were classified as responders to treatment and therefore maritally nondistressed. Figure 5 contains the results of this part of the analysis.

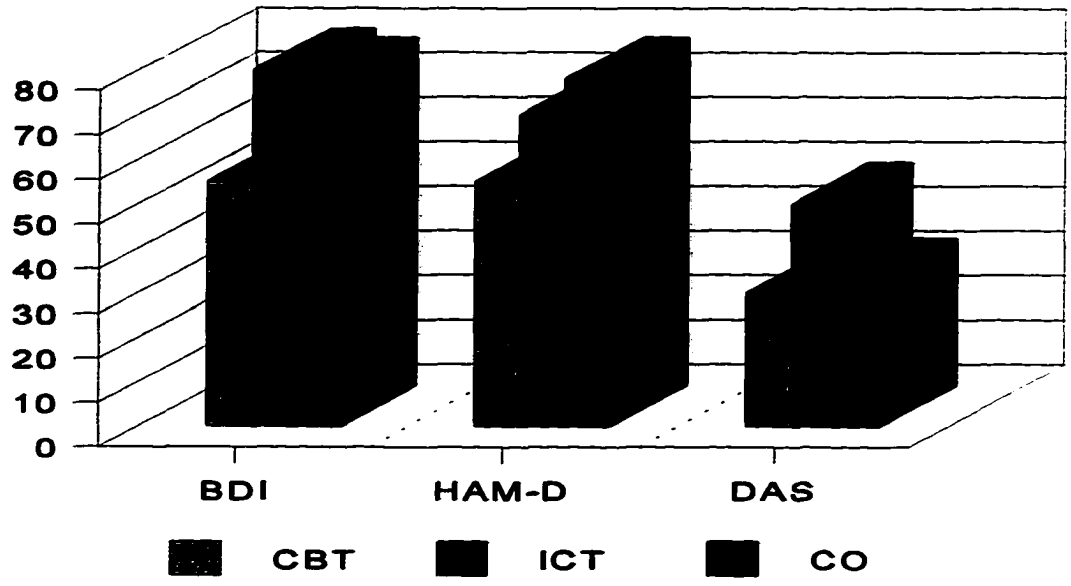

Figure 5. Percentage of responders to therapy at post-treatment

Clinically Significant Responses to Treatment

Treatment outcome may also be addressed by examination of the percentage of clients who respond to treatment as indicated by scores that move into the normal (non-distressed vs. distressed) range on each treatment measure. Overall, the percent of responders gradually increased as treatment progressed. In the case of the BDI after the 4th session, the percentage of responders to CBT was 9% with 20% for ICT and 0% for the CO group. Percentages of responders on the HAM-D were also modest at the 4th session with 20% for CBT, 10% for ICT, and 33% for CO. Parallel to the previous results but with slightly better outcomes at the 4th session,

percentages of responders on the DAS were 27% for CBT, 40% for ICT, and 33% for CO. Percentages notably improve after the 8th session administration of each instrument. The CBT group has 40% responders, the ICT group has 80%, and the CO group has 67% responders according to results calculated from BDI scores. After session 8, scores on the HAM-D also improved with 27% for CBT, 60% for ICT, and 50% for CO meeting responder criteria. Percentage of responders on the DAS after the 8th session appear variable, with fewer responders for CBT and ICT, and more responders for CO as compared to the 4th session percentages. For the DAS, the CBT group has 22%, the ICT group has 33%, and the CO group has 50% responding to therapy. Results indicated that the percentage of responders to therapy after the 12th session on the BDI were 55% for CBT, 80% for ICT, and 78% for CO. Results for the HAM-D were 55% for CBT, 70% for ICT, and 78% for CO. Percentages of responders as demonstrated by the scores on the DAS were 30% for CBT, 50% for ICT, and 33% for CO. Table 5 contains these percentages by treatment modality and time of administration. Figures 6,7,& 8 represent this information as line graphs to facilitate interpretation.

Client Satisfaction with Counseling

At the end of treatment, participant's were asked to return a confidential survey regarding their perspectives toward their therapy. The surveys were developed for each treatment modality specifically. The

Table 5

Percentages of responders to therapy by treatment and time

Test	Treatment Groups								
	CBT			ICT			CO		
	4th	8th	12th	4th	8th	12th	4th	8th	12th
BDI	9%	40%	55%	20%	80%	80%	0%	67%	78%
HAM-D	20%	27%	55%	10%	60%	70%	33%	50%	78%
DAS	27%	22%	30%	40%	33%	50%	33%	50%	33%

Note: 4th, 8th, and 12th denote session number prior to administration.

reliability coefficients for each modality surveyed were calculated. The results indicated that for the CBT survey, Cronbach's alpha was .9327; for the ICT survey it was .8929; and Cronbach's alpha for the CO survey was .9398. There were 14 questions for CBT and ICT and 18 for CO. The survey questions utilized a 7 point Likert scale with 1 representing strongly agree to 7 indicating strongly disagree. Of the 30 surveys sent to participants, 26 questions utilized a 7 point Likert scale with 1 representing strongly agree

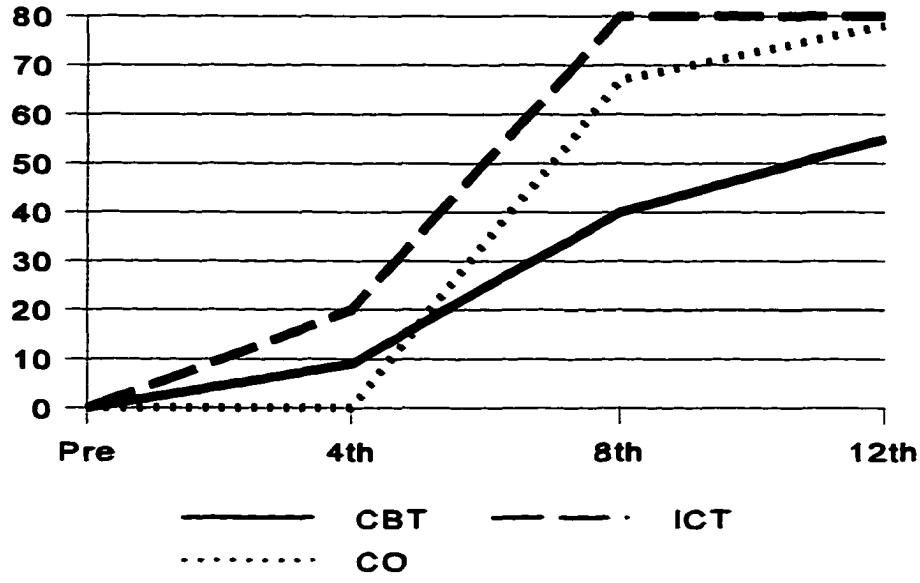

Figure 6. BDI: Percentage of responders to treatment

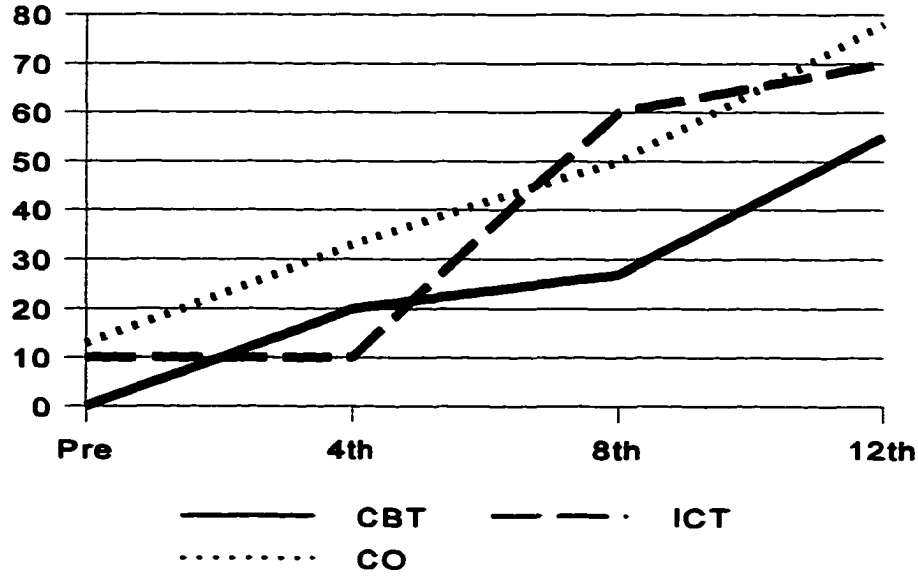

Figure 7. HAM-D: Percentage of responders to treatment

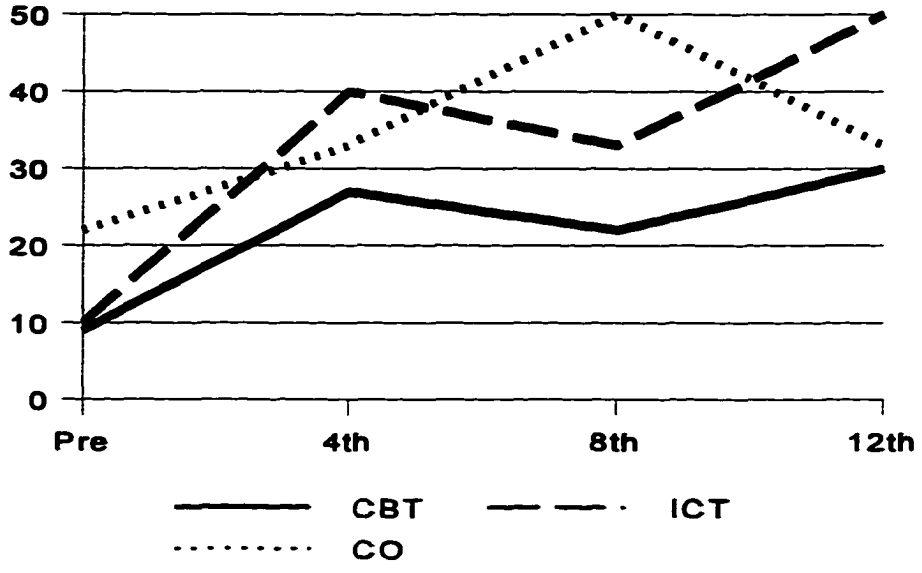

Figure 8. DAS: Percentage of responders to treatment

to 7 indicating strongly disagree. Of the 30 surveys sent to participants, 26 were returned equaling an 87% response rate. The three surveys which were not returned were evenly divided among the three modalities. Results appear to reflect a high level of satisfaction with therapy across all three treatment modalities. Respondents to the CBT treatment survey indicated an overall mean satisfaction of 1.91 (SD=.81). Responses to the ICT survey indicated an overall satisfaction mean of 2.50 (SD=1.13). And participants responses to the CO treatment survey demonstrated an overall satisfaction mean of 1.94 (SD=.98). Appendix P contains the means and SD for each question by survey.

The information requested in the surveys can be broken down into three general categories: therapy techniques (e.g. learning to exchanging pleasing behaviors), counselor attributes (e.g. trustworthy and professional), and overall counseling experience (e.g. overall, I found this counseling experience to be helpful). An examination of the data with regards to these categories using the overall mean for each modality as cutoff points demonstrated that the means for all questions tapping into perspectives about counselor attributes were skewed in the positive direction from the means for the ICT and CO groups. Participants in these two groups were highly satisfied with their counselors. However, while still quite positive, satisfaction with counselors was somewhat lower for CBT. In the CBT modality, only two of the four counselor attribute means were positively oriented from the overall modality mean.

The CBT group had means better than the overall survey mean for four of the five counseling experience questions. This was the area where this group had the most satisfaction relative to the other categories and to the other modalities. The category of therapy techniques was scored the poorest across all three modalities. Only three questions out of 19 regarding therapy techniques across all modalities ranked positively. In the case of CBT and CO, the worst performer was contained in this category. The least satisfied mean for the ICT survey was in the overall counseling experience category. Although some categories scored

negatively from the modality mean, the least satisfied response means were still within one SD deviation away from the modality mean for both CBT and CO. In the case of ICT, the least satisfied mean was 1.34 SD away from the modality mean.

The four open ended questions were the same for each survey across modalities. Two questions asked about what the participant liked most and least about their counselor and the other two questions asked what they like most and least about the entire counseling experience. The responses varied by modality and within each modality group. In 63% of the CBT group, a frequent response to what they liked most about their counseling experience centered around the communication interactions with the counselor. Improving some aspect of interactions with their spouse was a salient feature to 50% of the participants in ICT. In the CO treatment modality, responses were too diverse to compiie into a general theme. Responses to what the participants liked least about counseling generated themes of paperwork and homework assignments in CBT and ICT, while responses from the CO group were more varied.

CBT participants described their counselors as caring and professional with 63% citing this as what they iiked best about their counselor, whereas only 38% of the ICT and 50% of the CO groups responded as such. In examining what was ieast liked about their counselor, 75% of the CBT group responded with "nothing" or left the space blank. In a parallel

manner, 50% of the CO group responded similarly. The responses from the ICT group were too diverse to categorize. Two pervasive themes emerged across all three modalities in the other comments space provided. These were focused on either positive feedback about the overall benefits of their counseling experience or positive comments about their counselors abilities and potential future.

Counselor's Satisfaction Survey

All 11 counselors anonymously completed the satisfaction survey. Cronbach's reliability coefficient for the survey was .7837. The questions were both open ended as well as discrete. The discrete data was formulated on a seven point Likert scale. Questions focused on both benefits received from participating in the study as well as areas of disappointment. It also explored the therapists attitudes toward outcome research and their feelings of competency regarding usage of the modalities. The discrete questions were answered on a Likert scale from one to seven with one indicating strongly agree to seven representing strongly disagree. All questions were asked in an affirmative manner except question two. With the exception of number two, the means for the responses ranged from 1.55 to 3.27 with an overall mean of 2.11. Question two had a mean of 6.45 and SD of 1.51. Open ended questions were answered with overwhelmingly positive responses with a 91% approval rate. Approval rate is defined as positive versus negative responses and

calculated for the response percentage to the whole. The means and SD for the Likert scaled questions and the open ended questions can be found in Appendix Q.

In this survey the most positively endorsed question was whether the counselors would recommend this experience to a peer with a mean of 1.55 and SD of .93. Another area that the counselors reported very high levels of satisfaction was in the training they received with a mean of 1.64 and SD of .67. They also reported feeling more competent and skilled in this type of treatment. The highest mean (3.27) and SD (1.49) were results of a question asking whether the counselor's views of assessment had changed through this experience. Although this is the highest mean and SD indicating the lowest positive endorsement level, no conclusions can be made as to whether they collectively had a high regard for assessment previously or if they did not enhance their view of assessment.

Chapter V

DISCUSSION

General Effectiveness of Treatments

On an overall basis, participants improved in terms of both depressive symptoms and marital satisfaction. improvement was not only statistically significant, but also met criteria for clinical significance, especially for depression with success for two of the three treatments dropping into the normal, nondepressed range. These results are congruent with findings in the literature for both depression and marital satisfaction (Dobson, 1989; Hawlweg & Markman, 1988).

Possible Superiority of ICT and CO over CBT

According to the analyses of attrition, percent of responders, trends in change over treatment, and client satisfaction with treatment, while not reflected in the main experimental analyses, these relative levels of improvement were variable contingent upon the treatment modality. Consistent with past research (O'Leary & Beach, 1990; Jacobson, Dobson, Fruzzetti, Schmaiing, & Salusky, 1991) individual therapy and marital therapy were both effective in improving depression, and iCT was the most effective in enhancing marital satisfaction. iCT had the lowest rates of attrition, the greatest improvements in mean depression scores, and the highest percentage of responders for depression and marital distress. This study diverges from most past research in that it utilizes ICT as

opposed to BMT. It would follow, that the enhanced ICT is likely to be equally effective, if not more effective, in increasing dyadic satisfaction. These results continue to build the stable foundation of intervention efficacy for psychotherapy. Individuals have the opportunity to improve their lives through utilization of therapy and specifically CBT, ICT, and CO for depression and marital distress.

The treatment modalities were disparate when the issue of marital distress was addressed. Across all modalities, distress significantly decreased but when examining the treatment groups, it becomes obvious that the ICT group out performed the other groups in terms of responders to therapy as is consistent with other literature findings (O'Leary, Riso, & Beach, 1990). This treatment group had a notably higher percentage of participants who improved into the nondistressed level. O'Leary, Riso & Beach (1990) postulate that marital therapy may be necessary at some point in treatment in order to achieve optimal benefits when depression and marital distress comorbidly exist. This symptom reduction may in part be due to the impact of 'behavioral exchange' which was one of the first techniques prescribed for the couple according to the treatment manual. This technique often brings rapid symptom reduction. This reduction may have also been influenced by the participant's expectation of improvement and hope for the relationship due to the spouses involvement.

In terms of post-treatment group means which were out of the

distressed range, ICT was 4 points short and CO was the only group that had a mean score in the nondistressed range. Interestingly, the CO group also had the largest level of mean change in marital satisfaction as well as having the lowest pretreatment mean on the DAS. Although the ICT group has the best response percentages to treatment across all dependent variables for both issues of concern, the CO group is the only group at post-treatment whose means are indicative of both nondistress and no depression. Explanations for this may range from the notion that CO is more flexible in addressing the distress for whichever issue, marital distress or personal depression, appears to be more clinically salient for the participant. This would also be supported by the O'Leary, Riso, & Beach (1990) study in that they found that women received more benefit from therapy for depression when it approached their problems from their perspective of what was causative of the depression. In this study, the participant gave information to the clinician in some fashion which allowed him/her to make a decision of which aggravating features were more salient from the participant's point of view. This was necessary to determine the number and order of CBT and ICT sessions for the CO approach.

Another possible explanation for the improvements in both the ICT and CO groups may be the common feature of marital therapy in each. A study by Finchman & Bradbury (1993) suggest that discretely alleviating spousal

depression may not be enough to enhance marital satisfaction as is indicated in the results of this study. It is unknown how these results and tentative findings would generalize to women who are married and nondistressed, single but in a significant relationship, single without a relationship or men. However, in a study by Heim and Snyder, results indicated that marital disaffection was the best predictor of depressive symptomology in both husbands and wives. O'Leary, Riso and Beach (1990) indicate some findings which suggest that marital therapy is not as effective in alleviating depression in nondistressed, married women. That information is beyond the scope of the current analysis and study.

The mean change scores supported ICT as exhibiting the most profound change on the BDI, but this did not hold true for the other two instruments. The mean change scores in the DAS for the ICT and CO group were similar to DAS change scores in other literature using marital therapy (O'Leary, Riso, & Beach, 1990). The CO group demonstrated more overall change on the HAM-D and DAS. As in the case of the above mentioned conclusions, CBT accounts for the least amount of change, percentage of responders to therapy, improvement of depression, and maritai enhancement. In looking at the global picture for counseling depressed married women, it appears that ICT and CO approaches are both more beneficial than CBT. Which of these two modalities is more efficacious appears to depend on the method of comparison. It is unclear why CBT was inferior even in alleviating

depression.

This further supports the emerging literature regarding the impact of the marital relationship on depression in women. The marital relationship tends to be linked in such a way that the treatment of depression in married women must have a marital therapy component in order to be most efficacious for the client. This is not to postulate which aspect, depression or marital distress, is causative nor curative, but to highlight the counseling methodology most effective. This is again parallel to several of the studies previously mentioned (e.g. Jacobson, Fruzzetti, Dobson, Schmaiing, & Salusky, 1991; Jacobson, Hoitzworth-Munroe, & Schmaling, 1989).

Client Satisfaction with Treatment

With regards to participant satisfaction with counseling, all of the group means indicated high levels of overall satisfaction with both treatment and counselors. Considering the Likert scale had a median score of 4 with descending values demonstrating higher levels of satisfaction, the modality means ranged from 1.94 to 2.50 supporting the previous statement. This high level of satisfaction potentially further champions the validity of counseling interventions since these results were obtained from an outwardly heterogenous group of counselors with training and modalities in common.

Trends in Treatment Outcome over Time

Turning focus to the administration times in which significance emerged, according to scores on all three dependent variables, symptoms improved dramatically from sessions one to four. in like terms, improvement was noted between sessions one to eight and one to 12 as would be expected since there was significance already established between pretreatment and post-treatment. Interestingiy, on all three instruments, significant improvement was demonstrated between sessions eight and 12 in ail three treatment groups. This may have particularly interesting ramifications on what benefits the client receives in therapy terminating at or before session eight. A study by Smith, Glass, and Miller (1980) reported that the majority of therapeutic impact occurs in the first six to eight sessions and is greatly reduced after that. The outcomes of this study were in direct contrast to these previous results. It would appear that the client may be shortchanged on valuable improvements which are only a few more sessions away. It may be either that this significant improvement between sessions eight and 12 may be prophylactic and/or simply continued enhancement of their life. in either circumstance, this progression is evident and due clients who wish to receive maximum benefits from therapy.

No conclusions can be drawn from benefits beyond session 12, although some research has indicated continued change up to at least

sessions 20 - 30. This was consistent with the meta-anaiysis conducted by Howard, Kopta, Krause, and Orlinsky (1986) which concluded that by session 26, 75% of the participants in the analysis had improved. The percentages of responders to therapy were at a mean of 66% by session 12 of this study specifically when examining the ICT group of participants. Responders were at an overall mean of 63% for CO and 51% for CBT at the 12th session.

Differential Rates of Attrition

Although it is difficult to conclude why participants terminated prematurely, the CBT group experienced the most profound percentage rate of attrition. Expectations regarding therapy may have played a roie in their decision making process. Perhaps they had desired spousal participation in some fashion and when they found this was not part of their treatment, decided to terminate. And yet, the percentages were almost evenly split between attrition prior to session four and after. It would intuitively be reasonable that by session three or four, their expectations could have adjusted appropriately. So regarding client expectations, they may have become disillusioned or found therapy more disconcerting in some manner when working individually.

Increasing Congruence of Therapist and Client Views over Time

Also in the examination of which sessions produced significant improvements on which assessment instrument, another outcome requires

discussion. The results on the HAM-D indicated significant change at each point of measurement unlike the BDI and DAS. This is the only clinician rated instrument. This result leads to several speculations. One perspective dictates that perhaps clinicians have a personal need to validate their work as valuable and enhancing. This is not to propose that it is done with conscious forethought or intention, but rather as a result of the helping type of individuals which choose counseling as a profession. This could speak to our need to be helpful and impact those we work with. While only speculation, it may be important to note that the trends of improvement reflected in figures 6 - 8 all appear to be continuing in a positive upward direction when data collection and treatment ended in this study at session 12. These results could suggest that additional treatment would produce further improvement. Such possibilities deserve attention in future research.

Secondly, this result may have some connection to the disparity between what the counselor views as improvement and the client's perspectives of improvement. The client may be more enmeshed in the symptomology and take longer to see the actual changes and improvements that a more objective evaluator may detect. Also, counselors may see change as a process level. Process, for this purpose, may be defined as client's abiiity to keep appointments, attempt homework, openly discuss concerns and difficult issues in sessions and other more

pragmatic components of the therapeutic process. These observations of therapeutic engagement in the process of change may be reflected in lower symptom scores by the counselor.

Another possibility to this outcome may be the type of symptoms that each measure was examining. Perhaps the somatic concerns associated with depression decline more quickly or readily than the perceived emotional concerns. Scores on the HAM-D would have decreased more rapidly and hence show significant change at each interval more readily than the BDI.

The increasing congruence between therapist's HAM-D ratings and client's BDI self-reports may also be a reflection of the development of a working alliance or collaborative set which is characterized by empathy and a shared perspective of the client's needs. The increase in congruence between counselor and client perspectives on depressive symptoms may reflect the generally positive development of a therapeutic relationship.

Counselor Satisfaction from Study Participation

Counselors who participated in this study have demonstrated overwhelmingly positive perspectives of their experience. Not only has this been established through an empirical method via the highly affirmative responses to the survey, but many of the counselors have independently and without solicitation given verbal feedback to this

investigator. The consistent theme of the feedback has been how valuable they have regarded this experience. It can be surmised from the verbal feedback, open ended questions and discrete questions that these graduate student therapists found great value in learning a specific method of intervention and then utilizing it with clients while being supervised. It allowed for the abstract, theoretical nature of most graduate learning experiences to be translated into a more practical, pragmatic hands on experience. They were able to more fully comprehend the intervention theory and tools in a clinical experience while using supervision and client feedback as moderating factors. Such approaches as this, that integrate treatment research with therapist training may prove to be valuable additions to the standard training methods in professional psychology. Such approaches may also be effective ways to train psychologists in empirically validated treatments.

Limitations

A limitation of the study is the small participant pool. The N per treatment modality had insufficient power to detect significant differences between treatments and treatment by time interaction. Replication with a larger sample would not only increase the chances of significant results, but strengthen the conclusions of this study.

Another limitation is the lack of opportunity for the counselor's to have practice sessions in each modality. This may have been beneficial for

increasing comparable competency for all counselors as well as increasing each counselors perceptions of their own competency. Future research may incorporate practice sessions as well as survey the perspectives toward outcome research of the participating counselor's prior to the study experience and then conduct a comparison of their post-study perspectives. This may shed some light on the counselor's process of perceived competence and development within each modality.

Replication of the study is essential in order to further document and demonstrate the value of a marital component in treating married women with depression. Replication with a larger sample may also include an extended therapy version to 20 sessions to further explore the possible benefits which continue to manifest past the 12th session.

Lastly, generating a sample which would be more generalizable to women experiencing depression as a whole would be valuable. This study cannot draw any conclusions to women who are not married, so extending the sample to unmarried women who are in a significant relationship would continue to build our understanding of efficacious interventions. Extending this research to men is also an important task for researchers.

Conclusions

In summary, the major findings that were clearly demonstrated included significant improvement in terms of both depression and marital satisfaction influenced by time the participant was in therapy. Treatment

modalities which appeared to be most efficacious were either ICT or CO depending on the type of comparison method utilized. Both of these modalities were very close in all comparisons. CBT was obviously less effective in enhancing marital satisfaction, as expected, but also in alleviating depressive symptoms. Again this highlights the complexity and depression/relationship link inherent in depression which may need to be addressed in therapy before effective treatment can be completed.

Participants reported overwhelmingly positive responses to their experiences to treatment. They reported some modest differences between modalities, but with no real departure from the favorable outcomes to the satisfaction surveys.

Results not only found significant improvement from pretreatment to post-treatment, but also between session eight and 12 across all modalities and dependent variables. This leads to some concern that therapy that is too brief may result in a lack of complete intervention. This may raise questions about the point of termination in briefer treatment and the development of the therapeutic relationship. A client may not be as willing to reenter treatment during occasions of future stress if termination occurred during a divergent period in the working alliance. The therapists and participants demonstrated increased congruence of therapeutic views as time in the study progressed.

Attrition was most profound in the CBT group. The rate of early termination was almost evenly divided between those departing prior to session four and those departing after session four.

Counselors responded favorably regarding their experiences in the study. The reported that they viewed themselves as more competent and knowledgeable about the modalities and treatment. They also asserted that they would recommend this experience to a peer.

The development of research questions for future studies is plentiful as a consequence of the various results demonstrated in this study. Further exploration seeking insight and replication with refinement to substantiate findings is undoubtedly essential. Future research may examine the CO modality sequencing by comparing these results with a predetermined selection of modality pattern such as six CBT and then 6 ICT sessions. Also future studies could vary the length of the session to accommodate the treatment modality. Such as 90 minutes for couple therapy to allow for the therapeutic relationship to possibly develop more fully in light of the increased complexity of three people in therapy. Among the most important needs in future research are the need for larger samples of sufficient diversity and for post-treatment follow-up studies. A follow-up study is now being conducted for the client's in this study with evaluations planned for three months, six months, 12 months and 24 months after the termination of treatment.

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Appendix A

Summations of Demographic and Participant Variables

According to Group Assignment

Summation of Demographic and Participant Variables According to Group Assignment

VARIABLES	OVERALL SAMPLE (N = 30)
Age:	37.48 yrs; range 23 - 65
Gender:	100% female
Marital Status:	100% married
Number of Marriages:	1.66; range 1 - 4
Yrs. of Current Marriage:	9.07; range 1 - 44
Number of Children from Current marriage:	1.07; range 0 - 4
Number of Children Total (own):	1.67; range 0 - 4
Number of Children in Household:	1.23; range 0 - 4
Number of Years of Education (self):	1 - 2 yrs. college; range less than HS - Master's
Number of Years of Education (spouse):	1 - 2 yrs. college; range less than HS - Master's
Family Income:	$ 30,000 - 45,000; range $ 0 - 90,000
Your Income:	$ 0 - 15,000; range $ 0 - 60,000

Spouse's Income:	**$ 15,000 - 30,000;**
	range $ 0 - 90,000
Cultural Background:	**93% Caucasian;**
	3% American Indian; 3% Other
History of Counseling:	**73.3% yes; 26.7% no**
Currently In Other Therapy:	
(prior to group assignment)	**10.0% yes; 90.0% no**
Taking Medications:	**60.0% yes; 40.0% no**
Consume Aicohol:	**73.3% yes; 26.7% no**
Any Medicai Illness:	**33.3% yes; 66.7% no**
History of Depression Diagnosis:	**50.0% yes; 50.0% no**

VARIABLES	CBT GROUP (N = 11)
Age:	38.28 yrs; range 23 - 65
Gender:	100% female
Marital Status:	100% married
Number of Marriages:	1.46; range 1 - 4
Yrs. of Current Marriage:	12.10; range 1 - 44
Number of Children from Current marriage:	1.28; range 0 - 4
Number of Children Total (own):	1.82; range 1 - 4
Number of Children in Household:	1.09; range 0 - 3
Number of Years of Education (self):	1 - 2 yrs. college; range less than HS - BA
Number of Years of Education (spouse):	3 - 4 yrs. college; range less than HS - BA
Family Income:	$ 15,000 - 30,000; range $ 0 - 60,000
Your Income:	$ 0 - 15,000; range $ 0 - 45,000
Spouse's Income:	$ 0 - 15,000; range $ 0 - 60,000
Cultural Background:	90.0% Caucasian; 10.0% other
History of Counseling:	63.6% yes; 36.4% no

Currently in Other Therapy:	
(prior to group assignment)	**18.2% yes; 81.8% no**
Taking Medications:	**45.5% yes; 54.5% no**
Consume Alcohol:	**72.7% yes; 27.3% no**
Any Medical Illness:	**36.4% yes; 63.6% no**
History of Depression Diagnosis:	**36.4% yes; 63.6% no**

VARIABLES	ICT GROUP (N = 10)
Age:	35.70 yrs; range 24 - 50
Gender:	100% female
Marital Status:	100% married
Number of Marriages:	1.60; range 1 - 2
Yrs. of Current Marriage:	7.10; range 1 - 18
Number of Children from Current marriage:	.50; range 0 - 2
Number of Children Total (own):	.90; range 0 - 2
Number of Children in Household:	.70; range 0 - 2
Number of Years of Education (self):	1 - 2 yrs. college; range less than HS - Master's
Number of Years of Education (spouse):	1 - 2 yrs. College; range less than HS - Master's
Family Income:	$ 30,000 - 45,000; range $ 0 - 90,000
Your Income:	$ 15,000 - 30,000; range $ 0 - 60,000
Spouse's Income:	$ 15,000 - 30,000; range $ 15,000 - 90,000
Cultural Background:	100% Caucasian

History of Counseling:	**80.0% yes; 20.0% no**
Currently in Other Therapy:	
(prior to group assignment)	**10.0% yes; 90.0% no**
Taking Medications:	**60.0% yes; 40.0% no**
Consume Alcohol:	**70.0% yes; 30.0% no**
Any Medical Illness:	**40.0% yes; 60.0% no**
History of Depression Diagnosis:	**70.0% yes; 30.0% no**

VARIABLES	CO GROUP (N = 9)
Age:	38.44 yrs; range 24 - 48
Gender:	100% female
Marital Status:	100% married
Number of Marriages:	1.89; range 1 - 3
Yrs. of Current Marriage:	7.56; range 1 - 17
Number of Children from Current marriage:	1.44; range 0 - 3
Number of Children Total (own):	2.33; range 0 - 4
Number of Children in Household:	2.00; range 0 - 4
Number of Years of Education (self):	1 - 2 yrs. college; range less than HS - Master's
Number of Years of Education (spouse):	BA degree; range less than HS - Master's
Family Income:	$ 30,000 - 45,000; range $ 0 - 90,000
Your Income:	$ 0 - 30,000; range $ 0 - 60,000
Spouse's Income:	$ 15,000 - 30,000; range $ 15,000 - 90,000

Cultural Background:	**93% Caucasian;**
	3% American Indian
History of Counseling:	
(prior to group assignment)	**77.8% yes; 22.2% no**
Currently in Other Therapy:	**100% no**
Taking Medications:	**77.8% yes; 22.2% no**
Consume Alcohol:	**77.8% yes; 22.2% no**
Any Medical Illness:	**22.2% yes; 77.8% no**
History of Depression Diagnosis:	**44.4% yes; 55.6% no**

VARIABLES	ATTRITION GROUP (N = 9)
Age:	36.50 yrs; range 26 - 54
Gender:	100% female
Marital Status:	100% married
Number of Marriages:	1.50; range 1 - 4
Yrs. of Current Marriage:	10.00; range 2 - 28
Number of Children from Current marriage:	.63; range 0 - 2
Number of Children Total (own):	1.25; range 0 - 6
Number of Children in Household:	.38; range 0 - 1
Number of Years of Education (self):	1 - 2 yrs. college; range less than HS - Master's
Number of Years of Education (spouse):	BA Degree; range less than HS - Master's
Family Income:	$ 15,000 - 30,000; range $ 15,000 - 45,000
Your Income:	$ 0 - 15,000; range $ 0 - 45,000
Spouse's Income:	$ 30,000 - 45,000; range $ 15,000 - 45,000
Cultural Background:	87.5% Caucasian; 12.5% Other
History of Counseling:	37.5% yes; 62.5% no

Currently in Other Therapy:	
(prior to group assignment)	**100% no**
Taking Medications:	**75.0% yes; 25.0% no**
Consume Alcohol:	**37.5% yes; 62.5% no**
Any Medical Illness:	**37.5% yes; 62.5% no**
History of Depression Diagnosis:	**37.5% yes; 62.5% no**

Appendix B

Syllabi for Training Seminars

Syllabus: *Section 1*

The Interaction of Cognitive-Behavioral Therapy

with Integrated Couple Therapy for the

Treatment of Depression in Women

Thursday, 1- 2 p.m.

Sept. 07 - Introduction

History of CBT

Role of Emotions in CBT

Sept. 14 - The Therapeutic Relationship

Structure of the Therapeutic Interview

Initial Interview

Sept. 21 - Application of Behavioral Techniques

Cognitive Techniques

Focus on Target Symptoms

Sept.. 28 - Depressogenic Assumptions

Integration of Homework into Therapy

Technical Problems

Oct. 05 - Problems Related to Termination and Relapse

Competency Criteria

Oct. 12 - History of ICT

Marriage and Marital Distress from a

Social Learning Perspective

General Considerations

Oct. 19 - Initial Interview

Assessment of Relationship Dysfunction

Oct. 26 - Persuasion Influence and the Collaborative Set

Increasing Coupies' Positive Exchanges

Nov. 02 - Communication and Problem-Solving Training

Contingency Contracting

Nov. 09 - Acceptance Training

Nov. 16 - Integration of CBT & ICT

Nov. 30 - Integration of CBT & ICT

Explanation and Organization of Data Collection

Syllabus: Section 2

The Interaction of Cognitive-Behavioral Therapy

with Integrated Couple Therapy for the

Treatment of Depression in Women

Thursday, 10-12 p.m.

Sept. 14 - Introduction

History of CBT

Role of Emotions in CBT

Sept. 21 - The Therapeutic Relationship

Structure of the Therapeutic interview

Initial interview

Sept. 28 - Application of Behavioral Techniques

Cognitive Techniques

Focus on Target Symptoms

Oct. 05 - Depressogenic Assumptions

Integration of Homework into Therapy

Technical Problems

Oct. 12 - Problems Related to Termination and Relapse

Competency Criteria

Oct. 19 - History of ICT

Marriage and Marital Distress from a

Social Learning Perspective

General Considerations

Oct. 26 - Initial Interview

Assessment of Relationship Dysfunction

Nov. 02 - Persuasion Influence and the Collaborative Set

Increasing Couples' Positive Exchanges

Nov. 09 - Communication and Problem-Solving Training

Contingency Contracting

Nov. 16 - Acceptance Training

Nov. 30 - Integration of CBT & ICT

Dec. 07 - Integration of CBT & ICT

Explanation and Organization of Data Collection

Appendix C

Cognitive Behavioral Therapy Treatment Manual

(modified from Beck, et al, 1976)

RESEARCH PROTOCOL FOR OUTCOME STUDY

AT CENTER FOR COGNITIVE THERAPY (MODIFIED)

A. Preliminary Evaluation

1. Complete clinical Evaluation: mental status, history of patient illness, past history.
2. Diagnosis according to Diagnostic Interview Schedule (DIS).
3. Clinical Scales: Hamilton Rating Scale for Depression (HAM-D).
4. Psychometric Tests: Minnesota Multiphasic Personality Inventory - 2 (MMPI-2), Beck Depression Inventory (BDI).
5. Special Scales: Dyadic Adjustment Scale (DAS)

B. Assignment of client to therapist

C. First therapeutic interview

D. Frequency and duration of interviews of treatment: 12 sessions over a 13 week period; duration of each interview, 50 minutes; interviews scheduled on a once a week basis.

FIRST INTERVIEW

1. Establish rapport
2. Inquiry regarding expectations of therapy

3. **Elicitation of negative attitudes regarding self, therapy, or therapist**
4. **Pinpointing most urgent and accessible problem (e.g., hopelessness, suicidal wishes, severe dysphoria)**
5. **Explanation of cognitive-behavioral strategies with emphasis on the rationale for behavioral assignments and homework**
6. **Review form for recording activities until next session**
7. **Inquiry regarding reaction to interview. Note: Most clients feel better by the end of the first interview; if not, therapist should probe for reasons for adverse reaction.**

SECOND INTERVIEW

1. **Inquiry regarding effect of first interview**
2. **Review of form for recording schedule of activities**
3. **Discussion of problems and accomplishments since previous interview**
4. **Scheduling of activities until next session**
5. **Discussion of recording "Mastery" and "Pleasure" ratings on schedule for recording activities**

6. Preparation of agenda and focus on the problem(s) to be discussed
7. Inquiry to reactions toward present interview

THIRD INTERVIEW

1. Preparation of agenda
2. Inquiry regarding effects of first interview
3. Review of homework assignments
4. Discussion of reaction to previous interview
5. Discussion of automatic negative thoughts
6. Demonstration of the wrist counter for clicking negative automatic thoughts (optional)
7. Preparation of homework assignments
8. Feedback regarding today's session
9. Request that client write a biographical sketch or autobiography for next interview

FOURTH INTERVIEW

1. Follow the same general format as in third interview
2. Further instruction in identifying negative automatic thoughts (use "induced fantasy" or role-piaying if indicated)

3. Explanation of how these automatic thoughts represent distortions of reality and are related to other symptoms of depression
4. Elicitation of automatic thoughts, specifically relationship to homework assignments

FIFTH INTERVIEW

1. Follow same general format as previous interview
2. Review schedule of activities with special reference to mastery and pleasure
3. Review and discuss automatic negative thoughts
4. Demonstrate to the client way of evaluating and correcting cognitive distortions (automatic thoughts)
5. Instruction in using the Daily Recording of Dysfunctional Thoughts, explain columns 4,5 and 6 ("Rational Response", etc.)
6. Use wrist counter for monitoring automatic thoughts

INTERVIEWS 6 AND 7

1. Same format as above
2. Continue to remove psychological blocks to return to premorbid level of functioning

3. Continue to identify negative automatic thoughts
4. Further demonstration of rational responses to automatic thoughts
5. Further homework assignments
6. Discussion of the concept of Basic Assumptions

INTERVIEWS 8, 9 AND 10

1. Increasing delegation of responsibility for setting the agenda to the client
2. Increase responsibility of homework to the client
3. Identification and discussion of Basic Assumptions. Testing validity of the assumptions

INTERVIEWS 11 & 12

1. Preparation of client for termination of therapy
2. Emphasis on continuation of homework assignments and practicing other strategies after the termination; emphasis on psychotherapy as a learning process that continues throughout the individual's life
3. Delineating of anticipated problems and rehearsal of coping strategies

Appendix D

Integrated Couple Therapy Manual

(modified from Jacobson & Christensen, 1996)

RESEARCH PROTOCOL FOR OUTCOME STUDY

FOR INTEGRATED COUPLE THERAPY

A. Preliminary Evaluation

1. Complete clinical evaluation: history of patient illness, past history.
2. Clinical Scales: Hamilton Rating Scale for Depression (HAM-D).
3. Psychometric Tests: Minnesota Multiphasic Personality Inventory - 2 (MMPI-2), Beck Depression Inventory (BDI).
4. Special Scales: Dyadic Adjustment Scale (DAS).

B. Assignment of Client to Therapist

C. First Therapeutic Interview

D. Frequency and Duration of Interviews: 12 sessions over a 13 week period; duration of each interview, 50 minutes; interviews scheduled on a once per week basis.

FIRST INTERVIEW: INITIAL INTERVIEW

1. Establish rapport
2. Ascertain reason for seeking treatment
3. How are the current problems conceptualized and how have they been attempted to be resolved.

4. Developmental history of the relationship
5. Foreshadowing of current problems
6. Explain ICT approach to therapy
7. Explanation of expectations
8. Contract for 12 week treatment period

SECOND INTERVIEW: ASSESSMENT SESSION

1. What is daily life like
2. What is reinforcing to each person
3. How have they attempted problem solving previously
4. How committed is the couple to change
5. What are their strengths
6. Functional analysis of problem maintenance
    * reinforcement decay
    * learned incompatibilities through greater exposure
    * generation of incompatibilities via shared lives
    * experiences in individual life events
7. Explain what treatment can do to help
8. Initiate attempts at increasing positive behaviors/feedback

THIRD INTERVIEW: INTERPRETIVE/FEEDBACK SESSION

1. Give feedback regarding collected data

2. Identify 2-3 major themes, problem areas
3. Detail interactions and how they generate distress
    * mutual trap (limited strategies)
    * minefieid (push buttons)
    * credibility gap (no longer trust/believe each other)
4. Emphasize strengths
5. Emphasize acceptance and change
6. Push for collaborative set

INTERVIEWS 4 - 10: TREATMENT PHASE

1. The couple decides the issues each week
2. Utilize the following strategies per clinical judgement:

A) Behavior Exchange

1) identify desired behaviors that are reinforcing
2) increase frequency
3) minimal "cost" behaviors
4) giver determines what will improve relationship (make a list)
5) love days or caring days
6) receiver initiated requests, but giver determines choice

B) Communication and Problem Solving

1) instruction
2) feedback

3) behavioral rehearsal

4) fading

C) Emotional Acceptance

1) learn language of acceptance (feelings, thoughts, "soft feelings", some active listening skills)

2) therapeutic conversations

* general discussions of basic differences

* discuss upcoming events that may trigger problem

* discuss recent events where problem occurred

* discuss recent positive event

* empty chair for problem or therapist

3) Tolerance Building

* positive features of negative behaviors

* role-playing or behavioral rehearsal of negative behaviors

* faked incidents of negative behavior

4) Greater Self-Care

* alternate means of need satisfaction

* self care in face of negative situation (leave situation, seek solace from others, assertively altering the situation, define the situations differently)

D) Trouble - shooting

1) induce dispute

2) interrupt process

* elaborate thoughts and feelings

* elicit meaning, unexpressed affect

* other sits and listens

3) therapist identifies themes and factors accounting for cognitions and feelings

INTERVIEWS 11 & 12

1. Preparation of couple for termination of therapy
2. Emphasis on continuation of increased positive reinforcing behaviors, emotional acceptance and other strategies after the termination
3. Delineating of anticipated problems and rehearsal of coping strategies

Appendix E

Combined (CBT & ICT) Treatment Manual

RESEARCH PROTOCOL FOR OUTCOME STUDY FOR COMBINED THERAPY TREATMENT

A. Preliminary Evaluation

1. Complete clinical evaluation: history of patient illness, past history.
2. Clinical Scales: Hamilton Rating Scale for Depression (HAM-D).
3. Psychometric Tests: Minnesota Multiphasic Personality Inventory - 2 (MMPI-2), Beck Depression Inventory (BDI).
4. Special Scales: Dyadic Adjustment Scale (DAS).

B. Assignment of Client to Therapist

C. First Therapeutic Interview

D. Frequency and Duration of Interviews: 12 sessions over a 13 week period; duration of each interview, 50 minutes; interviews scheduled on a once per week basis.

FIRST INTERVIEW: PARTICIPANT PRESENT ONLY

1. Establish rapport
2. Inquiry regarding expectations of therapy
3. Elicitation of negative attitudes regarding self, therapy, or therapist

4. Pinpointing most urgent and accessible problem (e.g., hopelessness, suicidal wishes, severe dysphoria)
5. Explanation of cognitive-behavioral strategies with emphasis on the rationale for behavioral assignments and homework
6. Review form for recording activities until next session
7. Inquiry regarding reaction to interview. Note: Most clients feel better by the end of the first interview; if not, therapist should probe for reasons for adverse reaction

SECOND INTERVIEW: COUPLE PRESENT

1. Establish rapport
2. Ascertain reason for seeking treatment
3. How are the current problems conceptualized and how have they been attempted to be resolved.
4. Developmental history of the relationship
5. Foreshadowing of current problems
6. Explain CO approach to therapy
7. Explanation of expectations
8. Contract for treatment period explaining some sessions will participation of both and others will only require the participant

INTERVIEWS 3 - 10

1. **Each treatment modality must have a total of 4 sessions**
2. **Discuss and determine whether depression or marital discord is a more salient concern**
3. **Do not blend modalities within single session**
4. **Use prescribed approach for modality during session**
5. **The sequence arrangement of these sessions is left to the clinician's judgement**

INTERVIEWS 11 & 12

1. **Preparation of couple and individual for termination of therapy**
2. **Emphasis on continuation of increased positive reinforcing behaviors, emotional acceptance and other strategies after the termination**
3. **Emphasis on continuation of homework assignments and practicing other strategies after the termination; emphasis on psychotherapy as a learning process that continues throughout the individual's life**
4. **Delineating of anticipated problems and rehearsal of coping strategies**

Appendix F

Informed Consent Form

(Participant & Spouse)

UNIVERSITY OF OKLAHOMA, NORMAN CAMPUS

INFORMED CONSENT FORM

TITLE OF PROJECT:

THE INTERACTION OF COGNITIVE-BEHAVIORAL THERAPY WITH INTEGRATED COUPLE THERAPY FOR THE TREATMENT OF DEPRESSION IN WOMEN

INVESTIGATOR(S): Maria Trapp, M.Ed., doctoral student, Terry M. Pace, Ph.D., Assistant Professor, Department of Educational Psychology, 325-5974.

INVITATION TO PARTICIPATE: You are invited to participate in a study focusing on the interactive benefits of Cognitive-Behavioral Therapy and Integrated Couple Therapy for depression.

PURPOSE OF THE STUDY: This study will assess the responses and changes made by depressed women who receive Cognitive-Behavioral Therapy, Integrated Couple Therapy or a combination of both for depression.

DESCRIPTION OF THE STUDY: This project is a study concerned with how depressed women respond to counseling with differing approaches of intervention. Each focused intervention has been shown to be beneficial for depression with new attention given to a combination treatment of Cognitive-Behavioral Therapy with Integrated Couple Therapy. The

combination appears to help break the cycle between depressive symptoms and marital discord which appear to contribute to depression in women.

Participants in this study will be given treatment for depression free of charge. Which treatment utilized will be unknown to the participant. In some situations, spouses will be required to attend and participate in therapy also. Participants and their spouses' will be requested to attend weekly sessions with a trained counselor for 12 weeks. All counseling sessions will be held at the OU Counseling Psychology Clinic in Norman. All participants and their spouses will be asked to complete some objective evaluations of depression, their marital satisfaction, and personality functioning. Some questions of a demographic nature will also be included.

RISKS OF PARTICIPATION: The risk involved may be the potential for depression to worsen for the participant. Sometimes at the beginning of therapy it is possible for depression to seem worse as one begins to examine and explore their life and the possible basis for the depression.

BENEFITS OF PARTICIPATION: Cognitive-Behavioral Therapy for depression is one of the most well substantiated approaches to the treatment of depression. Integrated Couple Therapy is also well researched in the improved marital satisfaction of couples which appears to be linked to depression in women. Participants have a reasonable

opportunity to achieve meaningful progress toward overcoming current depression and being able to resist future depression. Some participants and their spouses also have the opportunity to enhance their marital relationship which may counteract depressive symptoms and prevent future depression.

THERAPEUTIC ALTERNATIVE: Prospective participants or spouses who choose not to participate in this study, but nevertheless, desire therapy for depression may contact the following campus service:

Counseling Psychology Clinic

2709 Lawrence Avenue

Norman, OK 325-2714

PARTICIPANT ASSURANCES:

Conditions of Participation: Participation is voluntary and refusal to participate or withdrawal from participation at any time will in no way effect the participant or alter their relationship with the University of Oklahoma. The participant may discontinue participation at any time without penalty or consequence. I understand that I will become a regular client of the Counseling Center and will be required to sign the Center's consent form agreeing to audio and video recording of any counseling session in which I participate. I understand that by signing the informed consent for this

research project, the conditions of the research consent form take precedence over any other forms or any other agreements that have been made related to clinical practice or service provision within the Counseling Center. Once the research has ended, all other forms go back into effect.

Confidentiality: All information gathered in this study will be kept confidential. Your name or other identifying data will not be associated with any of the gathered data beyond completion of the study. Participant identification numbers will be used to code all gathered data.

Contacts for Questions: If you have any questions, please do not hesitate to ask. If you think of questions later or need to report any adverse effects during this study, please feel free to contact Maria Trapp, Department of Educational Psychology: 325-5974 or Terry Pace, Director of the Counseling Psychology Clinic: 325-2914. Or you may write to either of us at:

OU Counseling Psychology Clinic

2709 Lawrence Avenue

Norman, OK. 73019.

SIGNATURES:

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Investigator **Date**

UNIVERSITY OF OKLAHOMA, NORMAN CAMPUS

INFORMED CONSENT FORM (SPOUSE)

TITLE OF PROJECT:

THE INTERACTION OF COGNITIVE-BEHAVIORAL THERAPY WITH INTEGRATED COUPLE THERAPY FOR THE TREATMENT OF DEPRESSION IN WOMEN

INVESTIGATOR(S): Maria Trapp, M.Ed., doctoral student, Terry M. Pace, Ph.D., Assistant Professor, Department of Educational Psychology, 325-5974.

INVITATION TO PARTICIPATE: You are invited to participate in a study focusing on the interactive benefits of Cognitive-Behaviorai Therapy and integrated Couple Therapy for depression.

PURPOSE OF THE STUDY: This study will assess the responses and changes made by depressed women who receive Cognitive-Behavioral Therapy, Integrated Couple Therapy or a combination of both for depression.

DESCRIPTION OF THE STUDY: This project is a study concerned with how depressed women respond to counseling with differing approaches of intervention. Each focused intervention has been shown to be beneficial for depression with new attention given to a combination treatment of Cognitive-Behavioral Therapy with Integrated Couple Therapy. The

combination appears to help break the cycle between depressive symptoms and maritai discord which appear to contribute to depression in women.

Participants in this study will be given treatment for depression free of charge. Which treatment utilized will be unknown to the participant. In some situations, spouses will be required to attend and participate in therapy also. Participants and their spouses' will be requested to attend weekly sessions with a trained counselor for 12 weeks. All counseling sessions will be held at the OU Counseling Psychology Clinic in Norman. All participants and their spouses will be asked to complete some objective evaluations of depression, their maritai satisfaction, and personality functioning. Some questions of a demographic nature will also be included.

RISKS OF PARTICIPATION: The risk involved may be the potential for depression to worsen for the participant. Sometimes at the beginning of therapy it is possible for depression to seem worse as one begins to examine and explore their life and the possible basis for the depression. Spouses of the participants may experience some distress in seeing increased symptomology.

BENEFITS OF PARTICIPATION: Cognitive-Behavioral Therapy for depression is one of the most well substantiated approaches to the treatment of depression. Integrated Couple Therapy is also well

researched in the improved marital satisfaction of couples which appears to be linked to depression in women. Participants have a reasonable opportunity to achieve meaningful progress toward overcoming current depression and being able to resist future depression. Some participants and their spouses aiso have the opportunity to enhance their marital relationship which may counteract depressive symptoms and prevent future depression. Some spouses who participate may receive a sense of fulfillment as a result of participating in intervention which aids in decreasing depressive symptoms in their wives.

THERAPEUTIC ALTERNATIVE: Prospective participants or spouses who choose not to participate in this study, but nevertheless, desire therapy for depression may contact the following campus service:

Counseling Psychology Clinic

2709 Lawrence Avenue

Norman, OK 325-2714

PARTICIPANT ASSURANCES:

Conditions of Participation: Participation is voluntary and refusal to participate or withdrawal from participation at any time will in no way effect the participant or alter their relationship with the University of Oklahoma. The participant may discontinue participation at any time without penalty or consequence. I understand that I will become a regular client of the

Counseling Center and will be required to sign the Center's consent form agreeing to audio and video recording of any counseling session in which I participate. I understand that by signing the informed consent for this research project, the conditions of the research consent form take precedence over any other forms or any other agreements that have been made related to clinical practice or service provision within the Counseling Center. Once the research has ended, all other forms go back into effect.

Confidentiality: All information gathered in this study will be kept confidential. Your name or other identifying data will not be associated with any of the gathered data beyond completion of the study. Participant identification numbers will be used to code all gathered data.

Contacts for Questions: If you have any questions, please do not hesitate to ask. If you think of questions later or need to report any adverse effects during this study, please feel free to contact Maria Trapp, Department of Educational Psychology: 325-5974 or Terry Pace, Director of the Counseling Psychology Clinic: 325-2914. Or you may write to either of us at:

OU Counseling Psychology Clinic

2709 Lawrence Avenue

Norman, OK. 73019.

SIGNATURES:

_____ _____

Signature of Spouse **Date**

_____ _____

Signature of Investigator **Date**

Appendix G

Counselor Satisfaction Survey

Counselor Satisfaction Survey

Please respond to the following questions regarding your participation/enrollment as a counselor in this study. Please feel free to use additional sheets of paper to give more detailed information than the allotted space.

1. Where did you learn/gain the most?

training:

_____

_____

supervision:

_____

_____

treatment:

_____

_____

2. Did your experience change the way you approach practice?

_____ **Explain:**

_____

_____

3. Anything unique about your experiences?

_____

_____

4. Do you feei more confident in your skills and knowledge in the areas covered?

YES 1 2 3 4 5 6 7 NO

5. Do you feel less confident in your skills and knowledge in the areas covered?

YES 1 2 3 4 5 6 7 NO

6. Were there any surprises during your experience?_____

Explain:

_____

_____

_____

7. Were there any disappointments regarding your experience?

_____ Explain:

_____

_____

_____

8. Do you have a different view of counseling research?

YES 1 2 3 4 5 6 7 NO

9. Do you have a different view of assessment?

YES 1 2 3 4 5 6 7 NO

10. Explain the best aspect of training?

_____

_____

_____

11. Explain the worst aspect of training?

_____

_____

_____

12. Expiain the best aspect of supervision?

_____

_____

_____

13. Explain the worst aspect of supervision?

_____

_____

14. Explain the best aspect of treatment?

_____

_____

_____

15. Explain the worst aspect of treatment?

_____

_____

_____

16. Explain any administrative/scheduling issues (good or bad):

_____

_____

_____

17. Explain any research issues (good or bad):

_____

_____

_____

18. Overall, how satisfied are you with the training you received?

Extremely 1 2 3 4 5 6 7 Extremely

Satisfied Dissatisfied

19. Overall, how satisfied are you with the supervision you received?

Extremely 1 2 3 4 5 6 7 Extremely

Satisfied Dissatisfied

20. Overall, how satisfied are you with your treatment experience?

Extremely 1 2 3 4 5 6 7 Extremely

Satisfied Dissatisfied

21. Overall, how satisfied are you with your involvement in this study/project?

Extremely Satisfied	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Extremely Dissatisfied**

22. Would you recommend this or a similar experience to your peers?

Yes	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**No**

THANK YOU VERY MUCH FOR ALL YOUR TIME, EFFORTS AND CONCENTRATED WORK!!

Appendix H

Participant Satisfaction with Counseling Survey -

Cognitive Behavioral Therapy (CBT)

Counseling Evaluation Form (CEF-CBT)

Please respond as honestly as you can to the following questions by circling the one number that best describes your perspective. Rate each item on the 7 point scale from totally agree to totally disagree.

1. Overall, I found this counseling experience to be helpful.

Totally Agree 1 2 3 4 5 6 7 **Totally Disagree**

2. Using the Weekly Activity schedule to examine and plan my activities was helpful.

Totally Agree 1 2 3 4 5 6 7 **Totally Disagree**

3. My counselor was really able to understand me and my concerns.

Totally Agree 1 2 3 4 5 6 7 **Totally Disagree**

4. Discussing my concerns during the sessions with my counselor was helpful.

Totally Agree 1 2 3 4 5 6 7 **Totally Disagree**

5. My counselor seems to be a caring and concerned professional.

Totally Agree 1 2 3 4 5 6 7 **Totally Disagree**

6. The assignments and suggestions my counselor gave me to try out on my own between our sessions was helpful.

Totally 1 2 3 4 5 6 7 Totally
Agree Disagree

7. Using the Daily Record of Thoughts to monitor my automatic thoughts was helpful.

Totally 1 2 3 4 5 6 7 Totally
Agree Disagree

8. My counselor seems to be a knowledgeable and competent professional.

Totally 1 2 3 4 5 6 7 Totally
Agree Disagree

9. I would be willing to see my counselor again if I had a need to see a counselor in the future.

Totally 1 2 3 4 5 6 7 Totally
Agree Disagree

10. I have a better understanding of myself and how to cope with my emotions and thoughts as a result of this counseling experience.

Totally 1 2 3 4 5 6 7 Totally
Agree Disagree

11. My attitude about counseling is more favorable now than it was before I started the counseiing.

Totally 1 2 3 4 5 6 7 Totally

Agree Disagree

12. My counselor seems to be an honest and trustworthy professional.

Totally 1 2 3 4 5 6 7 Totally

Agree Disagree

13. Learning to identify and alter my negative thoughts was helpful.

Totally 1 2 3 4 5 6 7 Totally

Agree Disagree

14. Working on doing positive things for myseif was helpfui.

Totally 1 2 3 4 5 6 7 Totally

Agree Disagree

15. The most heipful part of counseling was:

---

16. The least helpful part of counseling was:

---

17. The thing I liked best about my counselor was:

---

18. The thing I liked least about my counselor was:

---

19. Do you have any other comments about your counseling experience?

_____

_____

THANK YOU!

Appendix I

Participant Satisfaction with Counseling Survey - Integrated Couple Therapy (ICT)

Counseling Evaluation Form (CEF-ICT)

Please respond as honestly as you can to the following questions by circling the one number that best describes your perspective. Rate each item on the 7 point scale from totally agree to totally disagree.

1. Overall, I found this counseling experience to be helpful.

Totally Agree 1 2 3 4 5 6 7 Totally Disagree

2. Learning to exchange pleasing behaviors with my spouse was helpful.

Totally Agree 1 2 3 4 5 6 7 Totally Disagree

3. My counselor was really able to understand me and my concerns.

Totally Agree 1 2 3 4 5 6 7 Totally Disagree

4. Discussing my concerns during the sessions with my counselor was helpful.

Totally Agree 1 2 3 4 5 6 7 Totally Disagree

5. My counselor seems to be a caring and concerned professional.

Totally Agree 1 2 3 4 5 6 7 Totally Disagree

6. The assignments and suggestions my counselor gave us to try out on our own between our sessions was helpful.

Totally 1 2 3 4 5 6 7 Totally
Agree Disagree

7. Gaining greater understanding and acceptance of each other was helpful.

Totally 1 2 3 4 5 6 7 Totally
Agree Disagree

8. My counselor seems to be a knowledgeable and competent professional.

Totally 1 2 3 4 5 6 7 Totally
Agree Disagree

9. I would be willing to see my counselor again if I had a need to see a counselor in the future.

Totally 1 2 3 4 5 6 7 Totally
Agree Disagree

10. Learning to listen and communicate with each other was helpful.

Totally 1 2 3 4 5 6 7 Totally
Agree Disagree

11. I have a better understanding of myself and how to cope with my marital relationship as a result of this counseling experience.

Totally 1 2 3 4 5 6 7 Totally

Agree Disagree

12. My attitude about counseling is more favorable now than it was before I started the counseling.

Totally 1 2 3 4 5 6 7 Totally

Agree Disagree

13. My counselor seems to be an honest and trustworthy professional.

Totally 1 2 3 4 5 6 7 Totally

Agree Disagree

14. Discussing problem solving methods was helpful.

Totally 1 2 3 4 5 6 7 Totally

Agree Disagree

15. The most helpful part of counseling was:

_____

16. The least helpful part of counseling was:

_____

17. The thing I liked best about my counselor was:

_____

18. The thing I liked least about my counselor was:

_____

19. Do you have any other comments about your counseling experience?

_____

_____

THANK YOU!

Appendix J

Participant Satisfaction with Counseling Survey - Combined (CO)

Counseling Evaluation Form (CEF-CO)

Please respond as honestly as you can to the following questions by circling the one number that best describes your perspective. Rate each item on the 7 point scale from totally agree to totally disagree.

1. Overall, I found this counseling experience to be helpful.

Totally Agree 1 2 3 4 5 6 7 **Totally Disagree**

2. Learning to exchange pleasing behaviors with my spouse was helpful.

Totally Agree 1 2 3 4 5 6 7 **Totally Disagree**

3. My counselor was really able to understand me and my concerns.

Totally Agree 1 2 3 4 5 6 7 **Totally Disagree**

4. Discussing my concerns during the sessions with my counselor was helpful.

Totally Agree 1 2 3 4 5 6 7 **Totally Disagree**

5. Discussing problem solving methods was helpful.

Totally Agree 1 2 3 4 5 6 7 **Totally Disagree**

6. My counselor seems to be a caring and concerned professional.

Totally 1 2 3 4 5 6 7 Totally

Agree Disagree

7. The assignments and suggestions my counselor gave me to try out on my own between our sessions was helpful.

Totally 1 2 3 4 5 6 7 Totally

Agree Disagree

8. Using the Daily Record of Thoughts to monitor my automatic thoughts was helpful.

Totally 1 2 3 4 5 6 7 Totally

Agree Disagree

9. My counselor seems to be a knowledgeable and competent professional.

Totally 1 2 3 4 5 6 7 Totally

Agree Disagree

10. Learning to listen and communicate with each other was helpful.

Totally 1 2 3 4 5 6 7 Totally

Agree Disagree

11. I would be willing to see my counselor again if I had a need to see a counselor in the future.

Totally 1 2 3 4 5 6 7 Totally

Agree Disagree

12. I have a better understanding of myself and how to cope with my emotions and thoughts as a result of this counseling experience.

Totally Agree 1 2 3 4 5 6 7 Totally Disagree

13. My attitude about counseling is more favorable now than it was before I started the counseling.

Totally Agree 1 2 3 4 5 6 7 Totally Disagree

14. My counselor seems to be an honest and trustworthy professional.

Totally Agree 1 2 3 4 5 6 7 Totally Disagree

15. Learning to identify and alter my negative thoughts was helpful.

Totally Agree 1 2 3 4 5 6 7 Totally Disagree

16. Using the Weekly Activity schedule to examine and plan my activities was helpful.

Totally Agree 1 2 3 4 5 6 7 Totally Disagree

17. Working on doing positive things for myself was helpful.

Totally Agree 1 2 3 4 5 6 7 Totally Disagree

18. Gaining greater understanding and acceptance of each other was helpful.

Totally Agree 1 2 3 4 5 6 7 Totally Disagree

19. The most helpful part of counseling was:

_____

20. The least helpful part of counseling was:

_____

21. The thing I liked best about my counselor was:

_____

22. The thing I liked least about my counselor was:

_____

23. Do you have any other comments about your counseling experience?

_____

_____

THANK YOU!

Appendix K

Manipulation Checklist

MANIPULATION CHECKLIST

Therapist's Name:

Your Name:

Instructions: Please indicate with a check mark whether the therapeutic characteristic stated was included in this therapy session.

A.

_____**1. Therapist seemed to be saying what he/she really felt or meant (seemed honest or "real").**
_____**2. Therapist did not seem to be holding back impressions or information, or evading client's questions.**
_____**3. Therapist seemed open rather than defensive.**
_____**4. Therapist did not criticize, disapprove, or ridicule the client's behavior.**
_____**5. Therapist did not seem effusive, possessive, or overinvolved.**
_____**6. Therapist did not seem cold, distant, or indifferent.**
_____**7. Therapist communicated through his/her verbal and nonverbal behavior that he/she understood the client's feelings and was responding to them.**
_____**8. Therapist accurately summarized the client's most obvious emotions (e.g. sadness, anger, etc.)**
_____**9. Therapist accurately summarized more subtle nuances of feeling or implicit belief.**
_____**10. Therapist's tone of voice and nonverbal behavior conveyed confidence.**
_____**11. Therapist made clear statements without frequent hesitations or rephrasings.**

_____12. Therapist was in control of the session; he/she was able to shift appropriately between listening and leading.

_____13. Neither client or therapist appeared overly defensive, cautious, or restrained.

_____14. Flow of verbal interchanges were smooth.

_____15. Client and therapist seemed comfortable with each other.

B.

_____1. Specific automatic thoughts were identified.

_____2. Therapist helped client identify thoughts rather than repeatedly pointing out automatic thoughts in a didactic fashion.

_____3. Therapist used appropriate techniques to elicit automatic thoughts

_____ inductive questioning

_____ imagery

_____ moods shifts during session

_____ dysfunctional thought record

_____ role-playing

_____4. Therapist helped client recognize connection between affect and specific cognitions.

_____5. Questioned or Tested automatic thoughts in systematic manner.

_____6. Did not use exhortation or argument to "talk client out of automatic thoughts".

_____7. Helped client set up specific, testable hypotheses.

_____8. Helped client collect valid evidence systematically concerning hypotheses.

_____9. Helped client evaluate evidence and draw conclusion from evidence.

_____10. Specific underlying assumptions were identified.

_____11. Therapist helped client discover relevant assumptions from a joint analysis of automatic thoughts.

_____12. Therapist did not rely solely on didactic counterarguments to evaluate assumptions.

_____13. Therapist helped client analyze validity of assumptions (e.g. by inductive questioning or listing advantages and disadvantages).

_____14. Techniques used:

_____ reattribution
_____ alternative technique
_____ cognitive rehearsal
_____ activity scheduling
_____ mastery and pleasure ratings
_____ ascertaining the meaning of an event
_____ focusing and concentration practice
_____ graded task assignment
_____ role-playing
_____ diversion procedures
_____ assertive training
_____ other: specify

_____15. Instrument, materials, devices used:

_____ autobiographies
_____ Depression Inventory
_____ Daily Record of Thoughts
_____ activity schedule: planning
_____ activity schedule: summarizing
_____ diary
_____ reading assignment

C.

_____1. Therapist focused on pleasing behaviors for each person.

_____2. Therapist conducted a systematic analysis of problem behaviors.

_____3. Therapist sought and explored spousal attributions.

_____4. Therapist focused on increasing pleasing behaviors for each person.

_____5. Therapist modeled good communication skills with each person.

_____6. Therapist did not clearly and continuously align with one person over the other.

_____7. Therapist sought to attain and maintain a collaborative set.

_____8. Therapist coached each person to attend to the impact of his/her behavior on his/her spouse.

_____9. Therapist coached each person to positively reinforce pleasing behaviors.

_____10. Therapist maintained a positive and motivating attitude.

_____11. Therapist helped client to recognize negative tracking or negative attributions.

_____12. Therapist assigned homework or reviewed previously assigned homework.

_____13. Therapist accurately summarized couple's behavior problems.

_____14. Techniques used:

_____ iove days
_____ cookie jar
_____ SORC
_____ functional anaiysis
_____ companionship activities
_____ probiem solving
_____ communication training
_____ focus on cognition and emotion
_____ reading assignment
_____ emotional acceptance
_____ improved self care
_____ troubleshooting
_____ restructuring relationship rules
_____ other: specify

_____15. Instruments, materials, or devices used:

_____ DAS
_____ SOC
_____ list of pleasers
_____ MSI
_____ problem solving manual
_____ other: specify

Appendix L

Beck Depression Inventory (BDI)

Beck Depression Inventory (BDI)

Name:_____ **Date:**_____

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2, or 3) next to the statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all statements before making your choice.

1) **0** **I do not feel sad.**

1 **I feel sad.**

2 **I am sad all the time and I can't snap out of it.**

3 **I am so sad or unhappy that I can't stand it.**

2) **0** **I am not particularly discouraged about the future.**

1 **I feel discouraged about the future.**

2 **I feel I have nothing to look forward to.**

3 **I feel that the future is hopeless and that things cannot improve.**

3) 0 I do not feel like a failure.

1 I feel I have failed more than the average person.

2 As I look back on my life, all I can see is a lot of failures.

3 I feel I am a complete failure as a person.

4) 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 feei 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 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, 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 irritated all the time now.

3 I don't get irritated at all by the things that used to irritate me.

12) 0 I have not lost interest in other people.

1 I am less interested in other people than I used to be.

2 I have lost most of my interest in other people.

3 I have lost all of my interest in other people.

13) 0 I make decisions about as well as I ever could.

1 I put off making decisions more than I used to.

2 I have greater difficulty in making decisions than before.

3 I can't make decisions at all anymore.

14) 0 I don't feel I look any worse than I used to.

1 I am worried that I am looking old or unattractive.

2 i feel that there are permanent changes in my appearance that make me look unattractive.

3 I believe 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 1 - 2 hours earlier than usual and find it hard to get back to sleep.

3 I wake up several hours earlier than I used to and cannot get back to sleep.

17) 0 I don't get more tired than usual.

1 I get tired more easily than I used to.

2 I get tired from doing almost anything.

3 I am too tired to do anything.

18) 0 My appetite is no worse than usual.

1 My appetite is not as good as it used to be.

2 My appetite is much worse now.

3 I have no appetite at all anymore.

19) 0 I haven't lost much weight, if any, lateiy.

1 I have lost more than 5 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 physicai problems such as aches and pains; or upset stomach; or constipation.

2 I am very worried about physical problems and it's hard to think of much else.

3 I am so worried about my physical problems that I cannot think about anything else.

21) 0 I have not noticed any recent changes 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.

Obtained from the Psychological Corporation, 555 Academic Court, San Antonio, Texas 78204-0952.

Appendix M

Hamilton Rating Scale for Depression (HAM-D)

Hamilton rating Scale for Depression (HAM-D)

The HAM-D scale is designed fer use in assessing the symptoms of patients diagnosed with depression. While the scale contains 21 variables, evaluation of the severity of depressive symptoms is based on the patient's scores on the first 17 items.

1) **Depressed Mood (sadness, hopelessness, worthlessness)**

   - 0 **Absent**
   - 1 **These feeling states indicated only on questioning**
   - 2 **These feeling states spontaneously reported verbally**
   - 3 **Communicates feeling states nonverbally (facial expression, posture, voice, tendency to weep)**
   - 4 **Reports virtually only these feeling states in spontaneous verbal and nonverbal communication**

2) **Feelings of Guilt**

   - 0 **Absent**
   - 1 **Self-reproach, feels she has let people down**
   - 2 **Ideas of guilt or rumination over past errors or "sinful" deeds**
   - 3 **Present illness is a punishment; delusions of guilt**
   - 4 **Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations**

3) Suicide

0 Absent

1 Feels life is not worth living

2 Wishes she were dead or has any thoughts of possible death to self

3 Suicidal ideas or gestures

4 Attempts at suicide (any serious attempt rates "4")

4) Insomnia - Early

0 No difficulty falling asleep

1 Complains of occasional difficulty falling asleep

2 Complains of nightly difficulty falling asleep

5) Insomnia - Middle

0 No difficulty

1 Complains of being restless and disturbed during the night

2 Wakes during the night - getting out of bed rates a "2" (except for purposes of voiding)

6) **Insomnia - Late**

0 **No difficulty**

1 **Wakes in early hours of the morning but falls back to sleep**

2 **Unable to fall asleep again if she gets out of bed**

7) **Work and Activities**

0 **No difficulty**

1 **Thoughts and feelings of incapacity; fatigue or weakness related to activities, work or hobbies**

2 **Loss of interest in activity, hobbies or work - either directly reported by patient or indirectly in listlessness, indecision and vacillation (feels she has to push self to work or for activities)**

3 **Decrease in actuai time spent in activities or decrease in productivity**

4 **Stopped working because of present illness**

8) Retardation (slowness of thought and speech; impaired ability to concentrate, decreased motor activity)

0 Normal speech and thought

1 Slight retardation at interview

2 Obvious retardation at interview

3 Interview difficult

4 Complete stupor

9) Agitation

0 None

1 Fidgetiness

2 "Playing with" hands, hair, etc.

3 Moving about, can't sit still

4 Hands wringing, nail biting, hair pulling, lip biting

10) Anxiety - Psychic

0 No difficulty

1 Subjective tension and irritability

2 Worries about minor matters

3 Apprehensive attitude apparent in face or speech

4 Fears expressed without questioning

11) Anxiety - Somatic (physioiogicai concomitants of anxiety such as gastrointestinal: dry mouth, flatulence, indigestion, diarrhea, cramps, belching; cardiovascular: palpitations, headaches; respiratory: hyperventilation, sighing; urinary frequency; sweating)

0 Absent

1 Mild

2 Moderate

3 Severe

4 Incapacitating

12) Somatic Symptoms - Gastrointestinal

0 None

1 Loss of appetite, but eating; heavy feelings in abdomen

2 Difficulty eating without urging; requests or requires laxatives or medication for bowels or medication for GI symptoms

13) Somatic Symptoms - General

0 None

1 Heaviness in limbs, back of head; backache, headache, muscle ache; loss of energy and fatigability

2 Any clear cut symptoms rate a "2"

14) General Symptoms (i.e., loss of libido, menstruai disturbances)

0 Absent

1 Mild

2 Severe

15) Hypochondriasis

0 Not present

1 Self-absorption (bodily)

2 Preoccupation with health

3 Frequent complaints, requests for help, etc.

4 Hypochondriacal delusions

16) Weight Loss

0 No weight loss

1 Slight or doubtful weight loss

2 Obvious or severe weight loss

17) Insight

0 Acknowledges being depressed and ill

1 Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.

2 Denies being ill at all

18) Diurnal Variation

0 No variation

1 Miid; doubtful or slight variation

2 Severe; clear or marked variation; if applicabie, note whether symptoms are worse in the am or pm

19) Depersonalization and Derealization (feelings of unreality, nihilistic ideas)

0 Absent

1 Mild

2 Moderate

3 Severe

4 Incapacitating

20) Paranoid symptoms

0 None

1 Suspicious

2 Ideas of reference

3 Delusions of reference and persecution

4 Paranoid hallucinations

21) Obsessive/Compulsive Symptoms

0 Absent

1 Mild

2 Severe

Adapted from Hamilton, M. (1960). A rating scale for depression. Journal of Neurosurg Psychaitry, 23, 56-62.

Appendix N

Dyadic Adjustment Scale (DAS)

Dyadic Adjustment Scale (DAS)

Most pereons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each on the following list. Circle the star under one answer for each item. Note: scale for each item group is depicted prior to the item group because of space problems

	Almost			Almost	
Always	Always	Occasionally	Frequently	Always	Always
Agree	Agree	Disagree	Disagree	Disagree	Disagree
*	*	*	*	*	*

1. Handling family finances
2. Matters of recreation
3. Religious matters
4. Demonstrations of affection
5. Friends
6. Sex relations
7. Conventionality (correct or proper behavior)
8. Philosophy of life
9. Ways of dealing with parents or in-laws
10. Aims, goals, and things believed important

11. Amount of time spent together
12. Making major decisions
13. Household tasks
14. Leisure time interests and activities
15. Career decisions

All The Time	Most Of Time	More Often Than Not	Occasionaliy	Rarely	Never
*	*	*	*	*	*

16. How often do you discuss or have considered divorce, separation, or termination of your relationship?
17. How often do you or your mate leave the house after a fight?
18. In general, how often do you think that things between you and your partner are going weil?
19. Do you confide in your mate?
20. Do you ever regret that you married (or live together)?
21. How often do you and our partner quarrel?
22. How often do you and your mate get on each other's nerves?

Every Day	Almost Every Day	Occasionally	Rarely	Never
*	*	*	*	*

23. Do you kiss your mate?

All Of Them	Most Of Them	Some Of Them	Very Few Of Them	None Of Them
*	*	*	*	*

24. Do you and your mate engage in outside interests together?

Never	Less Than Once A Month	Once Or Twice A Month	Once Or Twice A Week	Once A Day	More Often
*	*	*	*	*	*

How often do the following occur between you and your mate?

25. Have a stimulating exchange of ideas

26. Laugh together

27. Calmly discuss something

28. Work together on a project

There are some things about which couples sometimes agree or disagree. Indicate if either item caused differences of opinions or were problems in the past few weeks.

29. Being too tired for sex Yes No

30. Not showing iove Yes No

31. The stars on the following line represent different degrees of happiness in your relationship. The middle point, happy, the degree of happiness of most relationships. Circle the star above the phrase which best describes the degree of happiness, all things considered, of your relationship.

* * * * * * *

Extremely Unhappy | Fairly Unhappy | A Little Unhappy | Happy | Very Happy | Extremely Happy | Perfect

32. Which of the following statements best describes how you feel about the future of your relationship/ Circle the letter for one statement.

A. I want desperately for my relationship to succeed, and would go to almost any length to see that it does.

B. I want very much for my relationship to succeed, and I will do all that I can to see that it does

C. I want very much for my relationship to succeed, and will do my fair

share to see that it does.

D. It would be nice if my relationship succeeded, but I can't do much more than I am doing now to keep the relationship going.

E. It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.

F. My relationship can never succeed, and there is no more that I can do to keep the relationship going.

Obtained from Multi-Health Systems, Inc., 906 Niagara Falls Blvd., North Tonawanda, NY 14120.

Appendix O

Analysis of Variance (ANOVA) Tables

ANOVA Table for the Beck Depression Inventory (BDI)

Source	SS	df	MS	F
Treatment	439.09	2	219.55	1.40
Error	4074.65	26	156.72	
Time	7591.83	3	2530.61	63.41***
T x T	360.87	6	60.14	1.51
Error	3112.84	78	39.91	

Note: *** $p < .001$

ANOVA Table for the Hamilton Rating Scale for Depression (HAM-D)

Source	SS	df	MS	F
Treatment	131.08	2	65.54	.39
Error	4168.10	25	166.72	
Time	2090.28	3	696.76	24.84***
T x T	161.56	6	26.93	.46
Error	2103.90	75	28.05	

Note: *** $p < .001$

ANOVA Table for the Dyadic Adjustment Scale (DAS)

Source	SS	df	MS	F
Treatment	4904.19	2	2452.10	1.40
Error	38446.07	22	1747.55	
Time	4337.36	3	1445.79	13.46***
T x T	844.98	6	140.83	1.31
Error	7088.92	66	107.41	

Note: *** $p < .001$

Appendix P

Item Results for the

Client Satisfaction with Counseling Survey

by Treatment Modality

Client Satisfaction with Counseling Survey (CEF) at Post-Treatment Completed by the Cognitive Behavioral Therapy Group (n = 10)

Discrete CEF Items	Mean	Mode	SD
1. Overall helpfulness of therapy	1.70	1.00	1.25
2. Helpfulness of the Weekly Activity Schedule	3.00	2.00	1.41
3. Perceived therapist understanding	2.10	2.00	1.20
4. Helpfulness of sessions	1.80	1.00	1.23
5. Perceived counselor caring	1.60	1.00	1.27
6. Helpfulness of homework	2.10	1.00	1.10
7. Helpfulness of Daily Record of Thoughts	2.50	2.00	1.08
8. Perceived therapist expertness	2.30	1.00	2.26
9. Willingness to see the same therapist in the future	1.70	1.00	1.57

Note: SD = Standard Deviation

Discrete CEF Items	Mean	Mode	SD
10. Increased self understanding	1.60	2.00	.51
11. Increased favorability in attitude toward counseiing	2.30	3.00	1.16
12. Perceived therapist trustworthiness	2.00	1.00	1.89
13. Heipfulness of alteration of negative thoughts	1.60	1.00	.70
14. Helpfulness of positive activities	2.00	1.00	.94

Open - Ended CEF Items

15. The most helpful part of counseling was:

16. The least helpful part of counseling was:

17. The thing I liked best about my counselor was:

18. The thing I like least about my counselor was:

19. Do you have any other comments about your counseling experience:

THANK YOU!

Client Satisfaction with Counseling Survey (CEF) at Post-Treatment

Completed by the Integrated Couple Therapy Group (n = 8)

Discrete CEF Items	Mean	Mode	SD
1. Overall helpfulness of therapy	2.75	1.00	1.58
2. Helpfulness of pleasing behaviors exchange	3.25	1.00	2.05
3. Perceived therapist understanding	2.50	3.00	1.31
4. Helpfuiness of sessions	2.13	1.00	1.46
5. Perceived counselor caring	1.63	1.00	.74
6. Helpfulness of homework	2.88	1.00	1.96
7. Helpfulness of increased coupie understanding	2.75	1.00	1.49
8. Perceived therapist expertness	1.62	1.00	1.06
9. Willingness to see the same therapist in the future	1.88	1.00	.83

Note: SD = Standard Deviation

Discrete CEF Items	Mean	Mode	SD
10. Helpfulness of increased couple communication	2.63	2.00	1.51
11. Increased understanding and marital coping skills	3.88	3.00	2.17
12. Increased favorability in attitude toward counseling	3.88	2.00	2.47
13. Perceived therapist trustworthiness	1.50	1.00	1.41
14. Helpfulness of problem solving methods	2.88	1.00	1.64

Open - Ended CEF Items

15. The most helpful part of counseling was:

16. The least helpful part of counseling was:

17. The thing I liked best about my counselor was:

18. The thing I like least about my counselor was:

19. Do you have any other comments about your counseling experience:

THANK YOU!

Client Satisfaction with Counseling Survey (CEF) at Post-Treatment

Completed by the Combined Therapy Group (n = 8)

Discrete CEF Items	Mean	Mode	SD
1. Overall helpfulness of therapy	1.38	1.00	.52
2. Helpfulness of pleasing behaviors exchange	2.63	1.00	2.13
3. Perceived therapist understanding	1.63	1.00	1.41
4. Helpfulness of sessions	1.38	1.00	.74
5. Helpfulness of problem solving methods	1.50	1.00	.76
6. Perceived counselor caring	1.38	1.00	1.06
7. Helpfulness of homework	2.00	1.00	.93
8. Helpfulness of Daily Record of Thoughts	2.38	1.00	2.00
9. Perceived therapist expertness	1.63	1.00	1.06

Note: SD = Standard Deviation

Discrete CEF Items	Mean	Mode	SD
10. Helpfulness of increased couple communication	2.63	1.00	2.13
11. Willingness to see the same therapist in the future	2.38	1.00	2.00
12. Increased self understanding	1.88	1.00	.99
13. Increased favorability in attitude toward counseling	2.00	1.00	1.07
14. Perceived therapist trustworthiness	1.38	1.00	.74
15. Helpfulness of alteration of negative thoughts	1.50	1.00	.76
16. Helpfulness of the Weekly Activity Schedule	2.38	1.00	1.85
17. Helpfulness of positive activities	2.13	3.00	.99
18. Helpfulness of increased couple understanding	2.88	1.00	1.96

Open - Ended CEF Items

15. The most helpful part of counseling was:

16. The least helpful part of counseling was:

17. The thing I liked best about my counselor was:

18. The thing I like least about my counselor was:

19. Do you have any other comments about your counseling experience:

THANK YOU!

Appendix Q

Item Results to the Counselor's Satisfaction Survey

Item Results from the Counselor's Satisfaction Survey (CSS)

Completed by Therapists (n = 11)

Discrete CSS Items	Mean	Mode	SD
4. More confident in skills and knowledge	1.91	2.00	.70
5. Less confident in skills and knowledge	6.45	7.00	1.51
8. Different view of counseling research	2.18	2.00	1.08
9. Different view of assessment	3.27	2.00	1.49
18. Satisfaction with training	1.64	1.00	.67
19. Satisfaction with supervision	2.64	3.00	1.21
20. Satisfaction with treatment experience	1.91	2.00	.83
21. Satisfaction with involvement	1.82	1.00	1.25
22. Recommend experience to peers	1.55	1.00	.93

Open - Ended CSS Items

1. Where did you learn/gain the most?

   Training:

Supervision:

Treatment:

2. **Did your experience change the way you approach practice?**

   Explain:

3. **Anything unique about your experiences?**

6. **Were there any surprises during your experience?**

   Explain:

7. **Were there any disappointments regarding your experience?**

   Expiain:

10. **Explain the best aspect of training?**

11. **Explain the worst aspect of training?**

12. **Explain the best aspect of supervision?**

13. **Explain the worst aspect of supervision?**

14. **Explain the best aspect of treatment?**

15. **Explain the worst aspect of treatment?**

16. **Explain any administrative/scheduling issues (good or bad):**

17. **Explain any research issues (good or bad):**

THANK YOU!!!

Appendix R

Reliability Table for All Measures

(BDI, HAM-D, DAS, CEF-CBT, CEF-ICT, CEF-CO, CSS)

Reliability Table for All Measures

Measure	N	Cronbach's alpha
BDI:		
pretreatment	30	.7539
post-treatment	30	.8834
HAM-D:		
pretreatment	30	.8597
post-treatment	30	.8786
DAS:		
pretreatment	30	.9356
post-treatment	29	.9383
CEF-CBT	10	.9327
CEF-ICT	9	.8850
CEF-CO	10	.9398
CSS	11	.7837

Note: BDI = Beck Depression Inventory; HAM-D = Hamilton Rating Scale for Depression; DAS = Dyadic Adjustment Scale; CEF-CBT = Client's Satisfaction with Counseling - CBT, ICT, or CO; CSS = Counselor Satisfaction Survey.

Appendix S

Paired Sample t Test Table for

Dependent Measures at Pretreatment,

Session 4, Session 8, and Post-Treatment

Paired Sample t Test Table for Dependent Measures at Pretreatment, Session 4, Session 8, and Post-Treatment Beck Depression Inventory

Measure	Comparison	df	t - value
BDI:			
	Pretreatment/ 4th	29	-9.70***
	Pretreatment/ 8th	28	-8.84***
	Pretreatment/ Post	29	10.13***
	4th / 8th	29	-.87
	4th / Post-treatment	29	.57
	8th / Post-treatment	28	2.29*

Note: *** $p < .000$; ** $p < .01$; * $p < .05$

Paired Sample t Test Table for Dependent Measures at Pretreatment, Session 4, Session 8, and Post-Treatment Hamilton Rating Scale for Depression

Measure	Comparison	df	t - value
HAM-D:			
	Pretreatment/ 4th	27	-4.11***
	Pretreatment/ 8th	28	-5.60***
	Pretreatment/ Post	28	6.10***
	4th / 8th	28	-3.18**
	4th / Post-treatment	28	4.37***
	8th / Post-treatment	29	2.60*

Note: *** $p < .000$; ** $p < .01$; * $p < .05$

Paired Sample t Test Table for Dependent Measures at Pretreatment, Session 4, Session 8, and Post-Treatment Dyadic Adjustment Scale

Measure	Comparison	df	t - value
DAS:			
	Pretreatment/ 4th	29	3.37**
	Pretreatment/ 8th	25	3.22**
	Pretreatment/ Post	27	-4.67***
	4th / 8th	25	-.09
	4th / Post-treatment	27	-2.03
	8th / Post-treatment	24	-2.32*

Note: *** $p < .000$; ** $p < .01$; * $p < .05$

Appendix T

Sequence of CO Group Sessions by Participant

	Sequence of Sessions 1 - 6 for CO Group					
1	CBT	ICT	CBT	CBT	ICT	CBT
2	CBT	ICT	CBT	CBT	ICT	CBT
3	CBT	ICT	CBT	CBT	ICT	CBT
4	CBT	ICT	CBT	CBT	ICT	CBT
5	CBT	ICT	CBT	ICT	CBT	CBT
6	CBT	ICT	CBT	CBT	CBT	CBT
7	CBT	ICT	CBT	ICT	CBT	ICT
8	CBT	ICT	CBT	ICT	CBT	CBT
9	CBT	ICT	ICT	CBT	CBT	CBT

Client	Sequence of Sessions 7 - 12 for CO Group					
1	ICT	CBT	CBT	CBT	CBT	ICT
2	ICT	CBT	ICT	CBT	ICT	ICT
3	CBT	ICT	CBT	CBT	CBT	ICT
4	CBT	CBT	CBT	CBT	ICT	ICT
5	ICT	CBT	CBT	ICT	ICT	CBT
6	CBT	CBT	ICT	ICT	CBT	ICT
7	CBT	ICT	ICT	CBT	ICT	ICT
8	ICT	ICT	ICT	ICT	CBT	ICT
9	CBT	ICT	CBT	ICT	ICT	CBT