INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

Bell & Howell Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600

UMI®

THE UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

CBT, ICT, AND COMBINED TREATMENTS FOR DEPRESSED MARRIED WOMENT: A TWO YEAR FOLLOW-UP

A Dissertation

SUBMITTED TO THE FACULTY OF THE

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

in partial fulfillment of the requirements for the

degree of

Doctor of Philosophy

By

Scott Michael Miller
Norman, Oklahoma
2000

UMI Number: 9985569

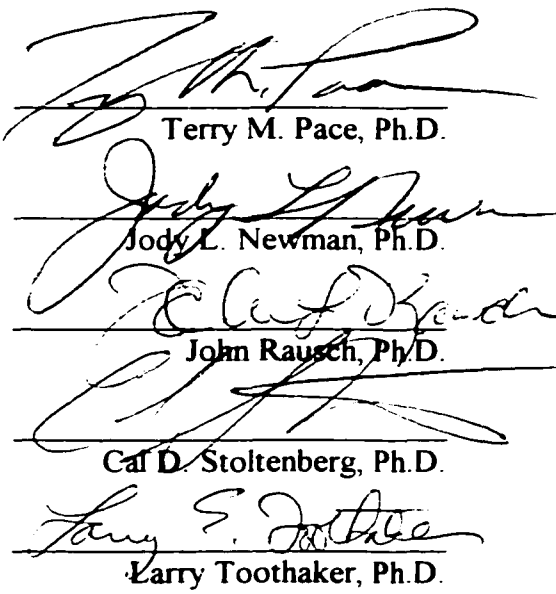
UMI Microform 9985569

Bell & Howell Information and Learning Company
300 North Zeeb Road
P.O. Box 1346
Ann Arbor, MI 48106-1346

CBT, ICT, AND COMBINED TREATMENTS FOR DEPRESSED MARRIED WOMEN: A TWO YEAR FOLLOW-UP

A Dissertation in Counseling Psychology APPROVED FOR THE DEPARTMENT EDUCATIONAL PSYCHOLOGY

BY



Terry M. Pace, Ph.D.

Jody L. Newman, Ph.D.

John Rausch, Ph.D.

Cal D. Stoltenberg, Ph.D.

Larry Toothaker, Ph.D.

ACKNOWLEDGEMENTS

Many individuals have assisted me in accomplishing something I once thought was not possible. First I wish to thank my advisor Dr. Terry Pace. You have guided me through the ups and downs of research with support, keen insight, and compassion. I have learned a great deal from you through these last four years of this project and this would not have been possible without your help.

I also wish to express my appreciation to the members of my committee who greatly assisted me with this project: to Dr. Cal Stoltenberg, whose knowledge and humor greatly shaped the final product; to Dr. John Rausch, who opened my eyes to the value of qualitative research; to Dr. Larry Toothaker, who supportively filled in the gaps in my statistical knowledge and was willing to be patient as I struggled to learn; and to Dr. Jody Newman, who was willing to be a part of the final stages and challenged me to think more globally. Without the help and input of my committee, this project would not have been possible.

My appreciation also extends to Dr. Maria Trapp, who was willing to trust me with the second phase of her hard work. Without her experiences, support and trust in me, I would not have been a part of this great learning experience. I also wish to thank Dr. Gerald Stone, my fellow intern and friend Scott McAward, and Dr. Carolyn Wanat, who assisted me in completing this project during my year in Iowa City.

Finally I wish to thank my family who believed in me and supported me throughout this exciting and challenging experience. Without you this would not have been possible. And to my wife Schelle, your contributions to this project were

immeasurable. You have been the most cherished part of this whole experience and I dedicate this dissertation to you.

TABLE OF CONTENTS

LIST OF TABLES

ABSTRACT

The current study is a two year follow-up of women who had received 12 sessions of either individual cognitive-behavioral therapy (CBT), conjoint integrative couples therapy (ICT) or a combined (CBT/ICT) treatment for depression. At the end of this treatment all three modalities resulted in significant and meaningful improvement in depression (BDI and HAM-D) and marital distress (DAS) with no differences between the three treatments. The results of the follow-up included both quantitative and qualitative analyses. All women were improved two years post-treatment when compared to pre-treatment level of adjustment. While each woman re-experienced feelings of depression, social support and willingness to seek future treatment differentiated between those who were considered to have relapsed and those who did not.

Chapter I

INTRODUCTION

Depression is one the most commonly diagnosed mental health disorders in adults (Craighead, Craighead, & Ilardi, 1998). Current empirical research suggests lifetime prevalence rates for unipolar depression to be 10-25% and 5-12% for women and men respectively, with these rates being relatively constant across the life span (American Psychiatric Association, 1994). Consistently, women experience serious depression at twice the rate of men (Brems, 1995). Significant advances have been made in the past 30 years in our ability to effectively treat clients presenting with issues of depression (Craighead, Craighead, & Ilardi, 1998).

Treatment of depression has included both pharmacological and psychosocial interventions. To date, Cognitive-behavioral therapy (CBT; Beck, Rush, Shaw & Emery, 1979) has received a great deal of research attention and support (Craighead, Craighead, & Ilardi, 1998; Gloaguen, Cottraux, Curcherat, & Blackman, 1998). In addition, Interpersonal Psychotherapy (IPT; Klerman, Weissman, Rounsaville, & Chevron, 1984) and behavioral approaches have been researched and received support as well (Elkins et al., 1989; Jacobson, Dobson, Fruzetti, Schmaling, & Salusky, 1991; O'Leary & Beach, 1990, Shea et al., 1992). Given the empirical support for CBT and IPT, both have been established as empirically validated treatments for depression (Chambless et al., 1997).

Research has also supported the use of behavioral marital therapy in treating depression due to the fact that depression and marital distress have been shown to be highly associated (Beach, Arias, & O'Leary, 1987; Coleman & Miller, 1975; Craighead, Craighead, & Ilardi, 1998). Marital distress has been shown to be the most common

precipitating event to depression (Paykel et al., 1969) and research suggests about 50% of women referred to address depression also have significant marital problems (Emmelkamp, 1994). Weissman (1987) found that individuals in discordant marriages are 25 times more likely to suffer from major depression than similar individuals in non-discordant marriages. Other research has suggested that women who experience marital distress early in their marriage are at greater risks for experiencing symptoms of depression (Markman, Duncan, Storaasli, & Howes, 1987). Depression is also more likely to reoccur in the presence of marital distress (Hooley & Teasdale, 1989).

Several studies have recently examined the efficacy of using marital therapy in treating major depression, one using a conjoint Interpersonal approach (Foley, Rounsaville, Weissman, Sholomskas, & Chevron, 1989) and three applying behavioral marital therapy (Beach & O'Leary, 1992; Jacobson, Dobson, Fruzzetti, Schmaling, & Salusky, 1991; O'Leary & Beach, 1990). Each of these studies provided varying amounts of support to the idea that marital therapy is effective in addressing the concerns of depressed, maritally discordant clients. The Jacobson et al. (1991) study additionally employed a combined approach which included both individual and couples modalities. Collectively these studies provide support for behavioral marital therapy (BMT; Jacobson & Margolin, 1979), and possibly its newer version integrative couple therapy (ICT; Jacobson & Christensen, 1996), being an effective alternative to individual psychotherapies for the treatment of depression in distressed married women.

Less is known about the long-term effectiveness of both individual and couples treatments of depressed, maritally distressed women specifically, and psychotherapy generally. Long-term follow-up studies are particularly valuable when treating

depression given the relatively high relapse rates. It is estimated that 50%-60% of individuals diagnosed with a single episode of depression will experience a second one (American Psychiatric Association, 1994). However, several researchers have reported a paucity of long-term follow-up studies (Alexander, Holtzworth-Munroe, & Jameson, 1994; Emmelkamp, 1994).

More is known concerning the long-term effects of CBT, however, the research to date has been difficult to interpret. Some studies suggest that CBT may reduce the risk of relapse following termination (Evans et al., 1992; Kovacs, Rush, Beck, & Hollon, 1981; Shea et al., 1992) and these clients are half as likely to need additional treatment when compared to pharmacotherapy (Hollon et al., 1991). Other authors suggest that even those individuals treated successfully with CBT are at significant risk of future episodes (Hollon & Beck, 1994). The study by Shea et al. (1992) indicated only 30% of participants successfully treated during the study maintained these gains over the course of the 18 month follow-up period.

The follow-up studies involving BMT have produced mixed results as well. Alexander, Holtzworth-Munroe, and Jameson (1994) assert that less is known about the long-term effects of BMT because the majority of studies have not included follow-up periods. The authors asserted the findings to date suggest that gains made during the course of therapy are difficult to maintain over time and that stressful life events were associated with decreases in marital satisfaction. Craighead, Craighead, and Ilardi (1998) stated that the follow-up studies to date have not employed follow-up procedures that allow the field to determine whether the long-term benefits of BMT are greater than those shown by individual CBT.

The earlier treatment phase (Trapp, 1997) of this follow-up study sought to remedy gaps in our research knowledge. Specifically it attempted to incorporate the newer version of BMT, ICT, in the treatment of depression in married women. Additionally the study served to replicate the promising results of Jacobson et al.'s (1991) combined treatment approach for depressed married women. This current study, therefore, is an attempt to remedy similar gaps in this area of research. First of all, it is an attempt to address the overall lack of follow-up studies examining the treatment of depression in married women. Secondly, it intends to identify whether women are able to maintain gains made during treatment and if not, to identify what factors contribute to relapse or reoccurrence of depressive symptoms.

The following research questions will be examined during this study: 1) Were the participants able to maintain gains made during the treatment phase over the course of the two year follow-up? 2) Are there any differences between treatments (CBT, ICT, or Combined CBT/ICT) that emerge during the follow-up period? 3) What were the reasons for the participants maintaining these gains during the follow-up? 4) What contributed to the participants who were unable to maintain lower levels of depression present at the completion of treatment? 5) Do women who maintain lower levels of depression exhibit different behaviors than women who are unable to maintain gains made during treatment?

Chapter II

RELATED LITERATURE

Depression

Hollon and Carter (1994) note that depression is not only one of the most prevalent, but also one of the oldest recognized disorders. People have recorded illustrations of depression since early history. Instances of depression appear in many of our ancient documents. Kaplan and Sadock (1998) cite that descriptions of depression are found in the Old Testament story of King Saul, as well as the description of Ajax's suicide in Homer's Illiad. In addition, Hippocrates in the 4th century B.C. used the notion of physical and mental health as resulting from a balance of humors and melancholia to describe a mental disturbance similar to what we now refer to as depression (Beck, 1967; Hunt, 1993).

The term melancholia was used again by scholars such as Galen in the second century A.D. when he described this state as the result of an excess of black bile (Hunt, 1993). The causes of the early conceptualizations of melancholia were unknown, but evidence suggests that their speculations were similar to ours today. For example, while the humoral theory of personality has since been discarded, its premise that there is a biological component to psychological disorders has been confirmed.

Throughout the past twenty years, only a handful of disorders have been as "extensively and successfully studied as depression" (Hollon & Carter, 1994, p. 89). Today, our descriptions of depression are not that much different from those of our early ancestors. Hippocrates and other early thinkers described individuals with disturbed mood, suicidality, feelings of guilt, and physical symptoms (Beck, 1967). Our current

diagnostic criteria for depression contain many of the same descriptions, however the introduction of the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 1st edition, 1952) has allowed mental health professionals to use a more standardized symptom criteria for which to diagnose clients. These criteria have since undergone limited refinement in regard to non-bipolar Major Depressive Disorder culminating in the current criteria outlined by the DSM-IV (American Psychiatric Association, 4th edition, 1994). The criteria for the diagnosis of depression is marked by either a depressed mood (flat affect, feelings of sadness or emptiness) or a loss of interest or pleasure in daily activities nearly every day. These essential features must be present for a minimum 2 weeks and represent a change from previous functioning. Associated indicators include: significant weight loss or weight gain (e.g. more than a 5% unplanned change in weight in a given month), insomnia or hypersomnia, psychomotor agitation or retardation which is observed by others, fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, diminished ability to think or concentrate, and recurrent thoughts of death (American Psychiatric Association, 1994).

In order to be diagnosed with depression, not all of these symptoms must be present at the same time. However, at least five of the above symptoms must occur during a given two-week period. Additionally, the client must not exhibit any manic symptoms, the symptoms must cause clinically significant distress in social functioning, not due to the physiological effects of a substance or a general medical condition, and the symptoms are not better accounted for by bereavement. In assessing a client for depression, it is important not to include symptoms that are clearly associated with a

general medical condition nor any delusions or hallucinations. Once a depressive episode has been established, it is important to indicate the level of severity (mild, moderate, or severe) and the type (chronic or melancholic).

While the prevalence of depression in our society is frequently debated, adolescent and adult women have been shown to be twice as likely to suffer from depression as compared to their male counterparts. Other research suggests that these statistics are even higher and that women may even be as much as three times more likely to suffer from depression (Hollon & Carter, 1994). The prevalence rates for unipolar depression in community samples varies from 5-12% for males and 10-25% for females. Depression occurs in the highest frequency in men and women aged 25 to 44, with the average age of onset being 20 (recent research suggests the average age of onset is decreasing for those individuals born more recently). In addition, rates appear to be unrelated to income, education, and ethnicity (American Psychiatric Association, 1994).

Depressive episodes can range in severity from only mild disturbances to psychotic episodes. Suicide is closely associated with depression, where roughly 15% of individuals with severe depression die of suicide (American Psychiatric Association, 1994). Current empirical evidence suggests that initial single depressive episodes tend to be limited in duration and their symptoms will eventually remediate themselves, even in cases where treatment is not provided (Hollon & Carter, 1994). This does not suggest that services are not critical. In fact, depression tends to be recurrent and the majority of individuals who become depressed once will experience multiple episodes during their lives (Zis & Goodwin, 1979, as cited in Hollon & Carter, 1994). Those results are supported by studies cited in the DSM-IV that suggest that approximately 50-60% of

individuals who have had a single episode of depression are likely to have a second episode (American Psychiatric Association, 1994). Empirical evidence suggests that episodes of depression can be treated effectively in as little as 12-16 weeks and this treatment may have the benefit of protecting individuals from experiencing a relapse of symptoms (Craighead, Craighead, & Ilardi, 1998; Hollon & Beck, 1994).

A typical episode of depression generally lasts about 6 to 9 months in an outpatient population and 9 to 12 months in inpatients (Beck, 1967). Roughly, one-fourth to one-third of all depressed individuals will exhibit chronic depression such that the individual will experience little to no symptom relief (Hollon & Carter, 1994). In those clients that experience recurrent depression, its course will be variable. Some individuals may experience only isolated episodes, while others may have frequent clustering. In addition, some evidence suggests that intervals of remission are longer earlier in the course of the disorder (American Psychiatric Association, 1994). However, it is clear that an individual is more likely to experience future episodes of depression if that individual has experienced numerous previous episodes. The consequences of untreated depression are varied and include such problems as: suicide, substance abuse/dependence, poorer general health, divorce, and unemployment (Kaelber, Moul, & Farmer, 1995).

The cause of onset for depressive episodes is less clear. Some episodes are marked by a specific event while others lack any clear marker. The most commonly found precipitants and risk factors include: biological, genetic, and psychosocial factors (Kaplan & Sadock, 1998). In addition, general medical conditions and substances dependence has also been discussed in the literature pertaining to etiology (American Psychiatric Association, 1994). The potential risk factors include such things as: being

divorced or separated, poor general health and other medical illnesses, adverse life events, social isolation, unemployment, low education, and a family history of depression (Kaelber, Moul, & Farmer, 1995). The causal factors associated with depression are less well known than the course of the disorder. Evidence for genetic transmission has been stronger for bipolar depression than for unipolar depression, where the findings have been more uncertain (Hollon & Carter, 1994). It is important to note that considerable variability is apparent with respect to the symptoms, course, and response to treatment of depression (Craighead, 1980).

Knowledge concerning the treatment of depression, and more importantly the effectiveness of psychotherapy, has increased a great deal in the past twenty years. Identifying a study which supported the efficacy of psychotherapy in treating depression was not possible as early as the middle 1970's (Hollon & Beck, 1978; Weissman, 1979). During the same period, no study indicated that therapy was better than pill-placebos when examining acute symptom reduction (Hollon & Carter, 1994). Since that time, the majority of studies that examine cognitive-behavioral interventions as compared to medications find equivalence or superiority for psychotherapy (Lambert & Bergin, 1994). While cognitive-behavioral therapy is the most widely used treatment modality in studies that compare psychotherapy to medications, other studies have also shown many forms of psychosocial interventions to be at least as effective as antidepressants (Hollon & Beck, 1986; Lambert & Bergin, 1994). While the field does not consider the results from studies examining cognitive-behavioral interventions in the treatment of depression to be conclusive, psychological treatments of depression have been shown to be a major advance in our ability to address our clients who present with depression.

Cognitive Theory and Cognitive-Behavioral Therapy

The underlying philosophical assumptions of cognitive theory can be traced back to Stoic philosophers. One of the earliest recorded writings which reflects cognitive theory was written by Epictetus who wrote, "Men are disturbed not by things but by the views which they take of them." Eastern thought, as reflected in Taoism and Buddhism, also reflect many of these ideas as well (Beck, 1979). The cognitive model of depression we use today was developed by Beck (1967) and was an outgrowth of his personal clinical experience and experimental testing with depressed patients.

This cognitive model emphasizes three specific concepts: (a) the cognitive triad, (b) schemas, and (c) cognitive errors. The cognitive triad, as the name implies, is broken into three cognitive patterns that impel the client to view himself, his experiences, and his future in a peculiar way (Beck, 1979). The first pattern, the client's negative view of himself, results in the individual perceiving himself as deficient and incompetent. Any unpleasant experiences are perceived to be the result of personal defects. Based on these perceived deficits, the individual feels he lacks the qualities that will allow him to find happiness (Beck, 1979).

The second pattern describes the depressed individual's tendency to interpret experiences in a negative manner. The individual views the world as being too demanding for him to be successful. The hallmark of this pattern is that the individual will choose negative interpretations even in the face of several other alternatives that may be more plausible.

Finally, the third aspect involves a negative view of the future. The cognitive model asserts that depressed individuals make long-term assumptions and firmly believe

their current difficulties will continue indefinitely (Beck, 1979). This means that the depressed individual expects to fail whenever she undertakes a new task. This model sees the other symptoms of depression as a consequence of these negative patterns. To operationalize this assertion, if a depressed individual thinks she is socially isolated then she will react as if this is the actual case regardless of whether or not it is.

A client's lack of motivation, increased dependency, and physical symptoms are all explained by this idiosyncratic thinking. A depressed individual who sees life as insurmountable will lack the motivation to try. Suicide is an extreme example of this idea. For the suicidal person, taking one's own life is the only escape from a world that is filled, and will be constantly filled, with hardship. An individual who feels incompetent will likely seek the assistance of others whom they perceive as possessing greater competence. Finally, psychomotor retardation and fatigue are the likely result of any individual who sees life and their ability to cope with it as hopeless (Beck, 1979).

The second specific component of Beck's cognitive model of depression was taken directly from the field of cognition. Beck (1967) uses the concept of schemata to explain how and why a depressed individual maintains his "self-defeating" attitudes. The field of cognition refers to this type of schema as scripts which are defined as, "event schemas which people use to reason about prototypical events" (Anderson, 1995, p. 164). A schema refers to stable cognitive patterns that result from an individual selectively attending to a given stimulus and conceptually ordering that situation. Even though individuals conceptually order situations differently, any single individual will conceptualize similar stimuli in the same manner (Beck, 1979).

Whenever an individual experiences a given situation, assuming that situation has been encountered before, a given schema will be activated. Considering what Beck's model asserts about the idiosyncratic thinking of a depressed client, that individual's schemata will be idiosyncratic as well. Additionally, the activation of a schema when presented by a specific stimuli directly determines how the person will respond (Beck, 1979). In an individual who is depressed, the particular schema that is activated will color the present situation in a negative manner as well. In addition, as a schema becomes more active, it will be triggered by a greater degree of situations which are less and less related to them (Beck, 1979).

In milder cases of depression, the client is better able to see the negative distortions he is making. However, as the level of depression increases and the constant activation of negative schemata occur, this objectivity is lost. The client is no longer able to see that his negative thoughts are merely subjective interpretations of relatively benign events. As Beck (1979) states, "The depressive cognitive organization may become so independent of external stimulation that the individual is unresponsive to changes in his immediate environment" (p. 13).

The third and final component of Beck's cognitive model includes faulty information processing (Beck, 1979). Beck used this component to refer to the way that the thinking occurs in a depressed individual. He refers to the depressed individual's way of thinking as "primitive" and contrasts this with the more "mature" way that non-depressed individuals think about their environment (Beck, 1979). This primitive way of processing information is categorized by being negative, categorical, absolute and judgmental. It is not only the negative nature of these thoughts, but also the view that

one's actions are irreversible character flaws that make depression so difficult to live with. In contrast, a more mature way of interpreting events allows for more complexity, variability, and reversibility in interpreting negative events (Beck, 1979).

The cognitive model of depression has been supported in various empirical studies (Dobson, 1989; Haaga, Dyck, & Ernst, 1991). Not only has the cognitive model of depression been validated in research studies but it also provides the framework for cognitive and cognitive-behavioral therapy. For the purposes of this presentation, cognitive and cognitive-behavioral therapies will be used interchangeably and will be referred to as (CBT). However it is important to note that while today the terms are used interchangeably, they do have separate developmental histories (Hollon & Beck, 1994). Cognitive therapists have a history as being dynamically trained and focusing on meaning, while cognitive-behaviorists were originally trained as behaviorists. More recently the two camps have borrowed ideas from each other and this led to the blurring of boundaries between them (Hollon & Beck, 1994).

The goals of cognitive-behavioral therapy are to help the client correct difficulties in processing information and to modify schemas that are presently maintaining maladaptive behaviors. Symptom relief is the initial focus, however, changing the systematic biases in the processing of information is the ultimate goal (Beck & Weishaar, 1995). At the foundation is the concept that change is ultimately the result of beliefs being used as testable hypotheses which are examined through real-life behavioral experiments (Beck & Weishaar, 1995). Any cognitive-behavioral intervention emphasizes the importance of cognition in initiating and maintaining change in the client.

It is important to note, however, that this change is not achieved without the client being willing to take personal risks throughout the course of therapy.

The therapeutic relationship within this modality is collaborative. This means that the counselor sees the client as someone who has a problem and not that the client is inherently the problem. The counselor must be flexible during the course of therapy. At times the therapist may have to be more directive than at others (this is particularly true in working with a depressed client who may have low energy and feelings of hopelessness). While at other times the counselor must allow the client the freedom to create the structure within the session as well as to direct the therapeutic goals. At all times, however, the client shares the responsibility for setting the agenda of each session (Beck & Weishaar, 1995). This idea of collaboration is encourage throughout the therapy by asking the client to provide feedback as to what they are experiencing and by providing the client with a rationale before each new intervention (cognitive or behavioral) is implemented.

In working with clients, the therapist uses warmth, accurate empathy, and genuineness to understand the client (Rogers, 1951). It is important to note that while the cognitive-behavioral perspective finds these attributes necessary, they are not sufficient in producing the therapeutic change that is required (Beck & Weishaar, 1995). In addition, the therapist must not only be flexible in being more or less directive, it also is necessary to be flexible when choosing to use both behavioral and cognitive techniques. The choice of these techniques must not be arbitrary or mechanical but must be chosen based on the client's personality and the issue at hand. For example, Beck and Weishaar (1995) note that the "inertia of depression" is best addressed with behavioral techniques, while

suicidal ideation and the pessimism associated with depression are best addressed using cognitive ones.

Three important terms used in this modality are: collaborative empiricism, Socratic dialogue, and guided discovery (Beck & Weishaar, 1995). Collaborative empiricism is similar to what has been described already in that it emphasizes the importance of the therapist and client determining the goals of treatment together, as well as becoming jointly involved in investigating difficulties. It involves the process of gathering and examining evidence and incorporates the idea that collaboration is paramount to this model.

The second important term, Socratic dialogue, is evidence that questioning is used as a major technique. The therapist is required to carefully structure questions so as to encourage learning. The intent of the questions is to clarify problems and identify thoughts as well as the consequences of retaining certain maladative thoughts and behaviors (Beck & Weishaar, 1995).

Guided discovery is the third important term and it encompasses the process of modifying the maladaptive cognitions. This is achieved by identifying problems and designing behavioral experiments to bring about new learning. Guided implies that the therapist takes an active role in helping the client to identify problems and set up specific hypotheses that can be effectively tested.

During the initial sessions the focus is on establishing a relationship with the client and gathering essential information. A typical way to begin the first session is to ask questions concerning how the client feels about counseling, and what, if any, expectations are present. The therapist should also orient the client as to what cognitive-

behavioral therapy is and what types of things the client should expect. Early information gathering should focus on past history, present life circumstances, and attitudes and motivation concerning therapy itself. It should be expected that gathering information concerning the problem should take several sessions (Beck & Weishaar, 1995).

An additional focus of the initial contact should be to provide clients with some relief from their current symptoms (Beck et al., 1979). Beck and his colleagues (1979) assert that early symptom relief helps to establish the therapeutic relationship, collaboration, and confidence that the current therapy can be effective. This also helps the clients to feel as if they have worked through a problem effectively and increases the likelihood that they will complete future homework assignments. Initial relief can be achieved by focusing on a specific problem and demonstrating some strategies for how this problem could be handled effectively (Beck et al., 1979).

During the early portion of therapy the therapist plays more of an active role by gathering information, conceptualizing the client's problem, and providing information to help explain the process of therapy. In addition, homework is assigned during the very beginning of therapy. These early homework assignments should be designed to help the client think in terms of recognizing the connection between affect and behavior (Beck & Weishaar, 1995). This can be accomplished by teaching the client to self-monitor by recording automatic thoughts or counting thoughts when they do occur. Homework not only helps the client learn important new skills, but also helps to speed up the course of therapy (Beck & Weishaar, 1995).

A problem list is also generated during the early sessions. Included in the problem list is often information concerning symptoms, behaviors, or common problems

the client encounters (Beck et al., 1995). Each of the problems listed are rated and prioritized as targets of future sessions. The decision for the priority of problems are based on the level of distress the problem causes, likelihood for progress, severity of the symptoms, and the pervasiveness (Beck & Weishaar, 1995).

As the therapy progresses, the focus changes from symptoms to the specific patterns of thinking (Beck & Weishaar, 1995). Early sessions highlight the connections between thoughts, emotions, and behavior, achieved by examining the client's automatic thoughts. Once this has been accomplished, later work should focus on the underlying assumptions and patterns that create the automatic thoughts. Generally, at this point, behavioral techniques are decreased and cognitive techniques are increased (Beck & Weishaar, 1995). The general pattern that precipitates this is that through the course of identifying automatic thoughts, general themes emerge. These themes, once recognized, become powerful topics for discussion. The validity, adaptiveness, and usefulness of these themes can be explored and if needed, these assumptions can be modified (Beck & Weishaar, 1995).

Toward the end of therapy the client takes on more of the responsibility to identify problems, creating solutions, and determining weekly homework assignments. This process stems from the belief that the ultimate goal of therapy is to have the client learn to use this technique on their own without the assistance of counseling (Beck & Weishaar, 1995). The typical duration of this type of intervention for unipolar depression is generally 15 to 25 sessions.

Various cognitive techniques are used in cognitive-behavioral therapy. A main reason for the importance of cognitive techniques is because assumptions are more

difficult to identify than are automatic thoughts. As cited before, assumptions are only seen, and in many cases inferred, by examining a pattern of automatic thoughts. Once an assumption is identified, the counselor asks questions of the client in order for the client to explore the validity of the assumption. Techniques such as decatastrophizing, reattribution, redefining and decentering are used to help modify a maladaptive assumption (Beck & Weishaar, 1995). Each of these techniques help the client to reexamine the situation after automatic thoughts have been identified. Then, the client can approach the situation with more objectivity.

Behavior techniques are a crucial component of this modality as well. As with cognitive techniques, behavioral techniques are used to modify automatic thoughts and assumptions (Beck & Weishaar, 1995). These techniques are also integral in providing the client with additional skills to monitor their behaviors and gain success at dealing effectively with their depression. Homework is a behavioral technique discussed already that is a staple of any intervention based upon this model. Homework assignments generally ask the clients to observe and monitor their own behavior in a systematic manner.

Additional behavioral techniques include the use of hypothesis testing which requires the client to gather information to dispute maladaptive automatic thoughts and assumptions. Behavioral rehearsal and role-playing are other techniques that allow the client to practice new skills and behaviors that will ultimately be used in real life situations. Activity scheduling is yet another technique where the client is provided with a structured way to chart daily activities and rate their enjoyment. This is used with depressed clients to get them to see that there are activities that they enjoy, but that these

activities take effort on their part to initiate. Another technique is referred to as graded task assignment that entails the client to initiate an activity in a non-threatening arena and then gradually increase the risk involved (Beck & Weishaar, 1995).

The effectiveness of cognitive-behavioral therapy has been shown in several empirical investigations (Hollon & Beck, 1994; Dobson, 1989). Recently, the Division 12 Task Force on empirically validated treatments listed cognitive-behavioral therapy as an effective treatment of depression (Chambless et al., 1997). To date it appears to be as effective in reducing acute distress when compared to pharmacotherapy, and may even be superior in reducing subsequent risk (Hollon & Beck, 1994). While there are some discrepancies in the empirical findings, it is clear that cognitive-behavioral therapy has been shown to be an effective way in which to treat unipolar depression, as well as a variety of other psychological disorders.

Couples Distress and Integrative Couple Therapy (ICT)

Couples distress is often characterized by frequent arguments, communication difficulties, lack of intimacy, and sexual dissatisfaction (Waltz & Jacobson, 1994). Not only are these individuals having difficulties in their relationship, an increasing amount of evidence suggests that these individuals are also more susceptible to a variety of other physical and psychological disorders (Cordova & Jacobson, 1993). Couples present for counseling with problems which are multifaceted and report various behavioral and affective difficulties. Individuals in distressed relationships will frequently be experiencing anxiety or depression and seek treatment for those symptoms with relationship difficulties being a secondary issue (Waltz & Jacobson, 1994).

Distressed couples frequently exhibit problems in the areas of communication, attributions made about their partners behavior, interaction patterns, and ways of handling conflict (Waltz & Jacobson, 1994). Marital distress is marked by a pattern of negativity that becomes a part of most interactions. Initial interactions between partners are categorized by reinforcing and positive interactions, however over time, the interactions of distressed couples become more and more negative (Margolin, 1981). Couple distress is marked by a decreasing number of reinforcing behaviors (Jacobson & Margolin, 1979).

Communications between distressed couples become more negative both verbally and nonverbally (Waltz & Jacobson, 1994). Distressed couples make more negative attributions about their partner's behavior as compared to non-distress couples. In addition, distressed couples are more likely to attribute negative occurrences to their partner's behavior than to the situation itself. Non-distressed couples attribute negative partner behavior to more innocuous occurrences (Waltz & Jacobson, 1994). In addition, distressed couples are more likely to respond to negative statements with another negative statement, while nondistressed couples are less likely to do so (Gottman, 1979). Another difference between distressed and nondistressed couples is that negative events have a greater impact on distressed couples and result in more negative effects (Jacobson, Follette, & McDonald, 1982). Finally, couples in distress have more difficulties handling conflict and are more likely to exhibit defensiveness and withdrawal when faced with conflict (Waltz & Jacobson, 1994).

Behavioral marital therapy (BMT) was an approach developed by Jacobson and Margolin (1979) which used both social learning and behavioral exchange principles in treating distressed couples. The focus of BMT was on changing current contingencies

within which ongoing relationship problems were occurring (Jacobson & Margolin, 1979). The empirical research suggested that this approach was effective in helping two-thirds of treated couples (Jacobson, Schmaling, & Haltzworth-Munroe, 1987). However, there were several types of couples who did not respond to behavioral techniques which include: severely distressed couples (Baucom & Hoffman, 1986), older couples (Baucom & Hoffman, 1986), emotionally disengaged couples (Hahlweg, Schindler, Revenstorf, & Brengelmann, 1984), and couples who were incompatible (Jacobson, Follette, & Pagel, 1986).

Based on the fact that BMT was unable to help a certain proportion of couples, Jacobson and Christenson (1996) developed Integrative Couple Therapy (ICT). The development of ICT, formerly known as Integrative behavioral couple therapy (IBCT), combines strategies promoting emotional acceptance with the more traditional strategies aimed at promoting behavioral change. The term "integrative" was used to reflect the integration of acceptance with the traditional focus of change. "Couple therapy" has replaced "marital therapy" so as to include all dyads and not simply married heterosexual couples. In total, the evolution in marital therapy was the result of both empirical findings and clinical experiences that suggested that traditional behavioral marital therapy was unable to assist the more distressed couples.

Integrative couple therapy remains reliant on several behavioral principles. One such principle is the difference between arbitrary and natural reinforcement. This distinction is important, as natural reinforcement is much more likely to be generalized outside of therapy and is important for the therapist to use this type of reinforcement. For example, if a couple discovers that having intimate conversations results in greater

relationship satisfaction, then the couple is much more likely to engage in this type of conversation. It is important for the therapist to utilize natural reinforcement whenever possible, as this type of intervention will lead to greater generalizability and maintenance of therapeutic gains.

Another important behavioral principle involves the distinction between rule-governed and contingency-shaped behavior. Roughly defined, rule-governed contingencies refer to behavior being directed by verbal contingencies and contingency-shaped behavior refers to non-verbal contingencies (Cordova & Jacobson, 1993). Cordova and Jacobson (1993) use an example of a person not becoming involved in extramarital affairs because our society teaches us verbally that this is not appropriate. As a result an individual never has to have had an affair to learn that this behavior is detrimental to a relationship. However, rule-governed contingencies only prove lasting if it eventually becomes controlled by nonverbal contingencies (Skinner, 1974). An example of this is when a therapist instructs a couple to use effective communication skills. The couple must discover that these skills help them communicate more effective, as they will not continue to use these skills simply because their therapist instructed them to (Cordova & Jacobson, 1993). As a result, the ICT therapist must promote contingency-shaped behavior if treatment gains are to be lasting.

A final behavioral concept central to ICT is the distinction between private and public behavior. Some have suggested this concept to be paramount to effective ICT (Cordova & Jacobson, 1993). Traditional BMT approaches emphasized directly observable change and were less concerned about private behavior. The belief was that if observable behavior could be changed, then private behavior would eventually change as

a result. In this discussion private behaviors generally refer to an individual's thoughts and public behavior generally refer to the individual's observable behaviors. As Cordova and Jacobson (1993) note, "The distinction we make between change and acceptance is primarily the distinction between the effects of verbal behavior on private verses public behavior" (p. 485). ICT continues to focus on several behavioral tenants in order to produce change, and in addition, it employs several techniques that focus on acceptance to address such concepts as the importance of private behaviors.

ICT begins with an assessment phase. The first stage provides the therapist with an overview of the couple's current difficulties, whether ICT is the appropriate treatment, and whether treatment should initially focus on change or acceptance. During the assessment, the counselor seeks to clarify several questions: how distressed is the couple, how committed is the couple to the relationship, what are the issues that divide them, how do these issues manifest themselves within the relationship, what are the strengths holding them together, and what can treatment do to help them (Jacobson & Christensen, 1996). In addition, a therapeutic impact during the assessment period, as with cognitive-behavioral therapy, will improve the couple's commitment to the process. Ideally, the assessment process consists of two couples sessions and one individual session with each member of the couple.

The information gathered during the initial sessions will assist the counselor in designing the appropriate course of therapy. A functional analysis of the couple's behavior is important for the counselor to understand what is reinforcing and maintaining their current behavior. Much of the information gathered during this portion of therapy is gathered through questions concerning their current difficulties, relationship history, and

observations of how the couple interacts. In addition, inventories such as the Dyadic Adjustment Scale (DAS; Spanier, 1976), Marital Satisfaction Inventory (MSI; Snyder, 1979), and Marital Status Inventory (Weiss-Cerreto, 1980) are helpful in gathering additional information about the couple. An investigation of possible violence is also important as ICT is inappropriate in cases where domestic abuse is present.

The formulation is an important component in the organization of ICT (Jacobson & Christensen, 1996). It consists of three components: a theme, a polarization process, and a mutual trap. Formulations within ICT are not absolute and must only be helpful to the clients. The theme is basically a shorthand description of the couple's primary conflict. It is believed that for any given couple, there is one theme that applies to the majority of their conflict (Jacobson & Christensen, 1996). Different themes include: closeness-distance; control-responsibility; you don't love me-Yes I do-It is you who doesn't love me; artist-scientist; and conventionality-unconventionality.

The second component, the polarization process, results as each partner attempts to change the other partner during conflict. This natural and inevitable process, however, results in the partners becoming more polarized in their view of the problem over time. An example of this might include a hypothetical couple who is arguing about spending time together. In this example the wife may be upset because her husband is spending, what she perceives to be, too much time with his friends. The wife would likely be concerned about convincing her husband that her perceptions of the situation are accurate and a fight would ensue every time he goes out with his friends. In response to this constant conflict, the husband would spend even more time with his friends to avoid their constant fighting and would likely resist what he perceives as his wife's attempt to change

his behavior. In this example each member of the couple has become more extreme in their own personal views regarding the conflict. While this pattern is common, it is also a destructive interaction that results in each individual's dissatisfaction with the relationship. The goal of therapy is to change this type of interaction and establish a more collaborative approach to perceiving difficulties.

The final component, the mutual trap, is the outcome of the polarization process (Jacobson & Christensen, 1996). This results in partners feeling stuck, helpless, and desperate. It is generally a private experience of each partner and the individual generally has no idea that his or her partner feels the same way. Each partner feels that they have done everything they can to bring about change in their partner and is left with a feeling of hopelessness. This concept also includes two additional components: the minefield and the credibility gap. The minefield describes the buttons that are pushed by each partner and serve to escalate the conflict, while the credibility gap describes the point in the argument where an impasse is reached. The goal of therapy is to help each individual develop empathy for the other person. As the couple works towards acceptance they often feel as if their initial trap is no longer important anymore.

The assessment period ends with the feedback session. During this stage the counselor answers each of the six questions outlined by Jacobson and Christensen (1996). The six questions are used as an outline for the session and feedback is elicited from each partner. The counselor describes what has been observed during the course of the assessment period and outlines for the couple what they can expect during the course of therapy. For example, the level of collaboration between each member of the dyad will determine whether therapy begins with emotional acceptance or behavioral change, with

those couples with low levels of collaboration needing to begin with an acceptance focus. The feedback session should end with a focus on the strengths that the couple has exhibited. This focus on strengths helps the session to end on a positive note and helps the couple to feel as if progress can be made.

The treatment phase consists of both acceptance and change (behavioral exchange and communication/problem solving training) components. The couple generally determines what issues are to be focused on each week, as this increases their levels of interest and motivation. Initial issues should be ones that the couple can be successful in addressing and continuity should be apparent between sessions.

The goal of acceptance work is to turn problems into situations where intimacy can be increased. The polarization and the mutual trap suggest that couples often feel the need to change the behavior of the other person. Successful acceptance work aims to have couples value their differences as well as their similarities. One technique is called empathetic joining around the problem where couples make "it" the problem and refrain from making accusations of their partner. Unified detachment is another technique that enables the couple to separate themselves from the problem and learn to develop an objective view regarding the conflict.

Tolerance building is another strategy within the acceptance work. When tolerance interventions are successful, the couple would rather the conflict not exist, and the conflicts that do occur are less distressing. It is important to note that successful tolerance does not lead to increased intimacy as do the other acceptance techniques described above. Tolerance consists of four major strategies that include, pointing out features of negative behavior, practicing negative behaviors in the therapy session, faking

negative behaviors between sessions, and self care. Tolerance building allow couples to interrupt conflict-causing situations, keep the effects of conflict to a minimum, or to recover more quickly from conflict when present (Jacobson & Christensen, 1996).

The behavioral exchange component consists of identifying behaviors reinforcing to each person and increasing the frequency of those behaviors. Initial behaviors should include those that are easier for each individual to perform and those that do not require learning new skills. The goal of behavioral exchange is to produce change in the current relationship in a positive direction. It is based on the premise that each member must work hard to make the relationship more satisfactory for the partner. This set of techniques generally consists of homework assignments that are discussed in sessions and implemented at home. Behavioral exchanges require collaboration on the part of the couple and must be used after this has been established. If during the course of this component, progress is not being made, greater acceptance work may need to be done.

Communication and problem solving has been a part of this modality of marital therapy since its inception (Jacobson & Margolin, 1979). These skills are taught to the couple in total, as research has shown that only teaching components does not lead to skill acquisition (Jacobson & Christensen, 1996). The components of training consist of: instructions, behavioral rehearsal, feedback and continued practice until mastery, practice at home, and fading therapist control (Jacobson & Christensen, 1996). These techniques are designed to help clients to communicate and deal with problems more effectively.

Research concerning the effectiveness of BMT/ICT is promising. Hahlweg and Markman (1988) conducted a meta-analysis of 17 studies and found BMT to be more effective than either no treatment or a placebo treatment. In their conclusion they cited

that no further studies comparing BMT with no treatment or placebo controls need to be conducted as the efficacy of BMT in these studies has been clearly established. Other studies have found similar results when comparing BMT to control groups (Baucom & Hoffman, 1986; Gurman et al., 1986). Jacobson and Addis (1993) went as far as stating that BMT is the closest thing to an established treatment for marital distress.

Studies examining the clinical significance of BMT, often referring to the percentage of couples which move from the distressed to nondistressed range on self-reported marital adjustment, are less promising, suggesting less than half the couples exhibit clinically significant improvements (Baucom & Hoffman, 1986; Hahlweg & Markman, 1988; Jacobson, Follette, Revenstorf, Baucom, et al., 1984). When compared to other marital modalities, BMT was generally no more effective (Baucom & Hoffman, 1986; Hahlweg & Markman, 1988).

In addition, several studies have been conducted which suggest ICT is an effective treatment for depressed, married woman (Jacobson, Dobson, Fruzzetti, Schmaling & Salusky, 1991; Koerner, Prince & Jacobson, 1994; O'Leary & Beach, 1990; Waring, 1994). These studies indicate that ICT reduced depressive symptoms in married women, especially in women also reporting marital discord (Jacobson et al., 1991; O'Leary & Beach, 1990). To date, this body of research suggests that marital therapy appears to decrease levels of depression, increase marital satisfaction, and decrease negative marital communication. Additionally, marital therapy appears to decrease the likelihood of a relapse in symptoms following treatment (Hooley & Teasdale, 1989).

Combined Treatment: ICT and CBT

Several research studies to date have consistently demonstrated a link between depression and marital distress (Jacobson et al., 1991; Koerner et al., 1994). Coleman and Miller (1975) suggest that an inverse relationship exist between marital satisfaction and depression. Weissman (1979) has even suggested that a model for a depressed client is a married woman experiencing relationship distress. Research has also indicted that marital distress and depression overlap in approximately 50% of those individuals seeking services (Beach, Jouriles, & O'Leary, 1985). The precise causal relationship between depression and marital distress has not been discovered. The body of literature suggests that support from positive intimate relationships may serve as a buffer from, or even prevent, depression (Beach & O'Leary, 1992).

Due to the link between depression and marital discord, researchers have utilized both CBT and ICT as viable approaches to treat these clients. O'Leary and Beach (1990) conducted a study that compared marital therapy, cognitive therapy, and wait-list control conditions. Their results suggested that marital therapy might be the most effective way in which to treat marital distress with co-occurring depression.

Jacobson et al. (1991) conducted an important study that not only involves CBT and BMT components, but also looks at an approach combining the two. The results indicated that BMT was less effective than CBT in addressing depression in nondistressed couples, however, both approaches were equally effective with distressed couples. The combined approach did not exhibit better outcomes than either component treatment in treating depression. With regards to marital satisfaction, BMT was more

effective in increasing marital satisfaction in distressed couples, while the combined approach was more effective with non-distressed couples. It is important to note that while this study suggests promising results, BMT was used as opposed to the more current version of ICT that may in fact increase treatment outcomes. Further research is needed to identify whether or not the combined approach will have greater efficacy in treating depressed married woman than either component treatment alone.

Follow-up Research

Follow-up research has been an important part of counseling research. The results from these studies provide evidence for the stability of changes produced over time. Our interventions need to not only be effective in producing change in a client's life at the end of treatment, but over time as well. This type of research is valuable, however, it can be very difficult to perform as subjects must agree to involve themselves for several years. The result is that we often know more about what produces change (results at the end of treatment) then we do about what maintains those changes.

Understanding what maintains change over a period of time is always valuable. It is particularly important when working with depressed clients (given what we know about the chronic nature of the disorder). As cited previously, 50-60% of individuals who experience a single episode of depression is likely to experience a second episode (American Psychiatric Association, 1994). Given the recurrent nature of depression, it is important for our research to monitor these clients after treatment in order to learn more about a given treatment's ability to maintain changes post-treatment. An important distinction in terminology for this type of research is relapse versus recurrence. Relapse

refers to the return of symptoms of the treated episode, while recurrence is the onset of a new episode of depression (Evans et al., 1992).

Several studies have been conducted to date that indicate that psychotherapy can be effective in the prevention of relapse in depressed individuals (Gallagher-Thompson et al., 1990; Shapiro & Firth-Cozens, 1990; Weissman & Kasl, 1976). However, therapy has not always been shown to be effective in follow-up studies. Weissman, Kasl, and Klerman (1976) conducted a study and found that over half of the individuals experienced a recurrence of symptoms at a one-year follow-up. Their conclusions were that psychotherapy did not prevent relapse but did improve social functioning in those individuals who completed treatment without relapsing.

Cognitive-behavioral therapy has been studied in numerous follow-up studies. Several of these studies have compared CBT with pharmacological treatments (Evans et al., 1992; Hollon et al., 1991; Shea et al., 1992). Our current understanding suggests that medications appear to prevent depression so long as they are continued (Hollon, Evans, & DeRubeis, 1990). Research appears to support that CBT may reduce the risk of relapse following treatment (Kovacs, Rush, Beck, & Hollon, 1981). Evans and colleagues (1992) also compared pharmacotherapy and CBT and concluded that CBT does appear to prevent relapse during a 2-year follow-up. This study also concluded that CBT was as effective in preventing relapse as the continuation of medications.

The 18 month follow-up study of the National Institute of Mental Health Treatment of Depression Collaborative Research Program did not support the efficacy of CBT in preventing relapse (Shea et al., 1992). The results of this study suggest that 16

weeks were insufficient for subjects to achieve recovery and lasting remission. The findings also indicated that CBT did not show any benefit over the placebo plus clinical management condition. The authors noted that all subjects were "at a fairly high risk of relapse" (Shea et al., 1992, p. 786). The study did cite previous research that reported better outcomes for CBT and suggested that these studies have been sufficiently consistent as to encourage optimism for the effectiveness of CBT in the prevention of relapse.

While clinical research has reported the efficacy of CBT in preventing relapse, studies have not determined if the prevention of new symptoms is also possible (Evans et al., 1992; Kovacs, Rush, Beck, and Hollon, 1981). Each of these authors calls for additional studies to determine whether or not the prevention of new symptoms can be achieved with CBT.

Less is known concerning the long-term impact of BMT. Alexander, Holtzworth-Munroe, and Jameson (1994) note that few of the studies conducted have included follow-up studies. One study that included a follow-up found that at 2 years post-treatment, 30% of the couples had relapsed (Jacobson, Schmaling, & Holtzworth-Munroe, 1987). Another study found a 38% divorce rate during a 4-year follow-up (Alexander, Holtzworth-Munroe, & Jameson, 1994). In a recent study comparing behavioral couple therapy, cognitive-behavioral therapy, and a combination of the two, Jacobson et al. (1993) found that all conditions exhibited "relatively low" relapse rates. Importantly, the study did not include measures of marital satisfaction and only monitored levels of depression during the course of the follow-up period. The authors had predicted

that behavioral couple therapy would produce greater effectiveness in preventing relapse. While more follow-up studies are needed investigating the long-term effects of ICT, current research suggests that the "initial positive effects of BMT may be difficult to maintain over time" (Alexander, Holtzworth-Munroe, & Jameson, 1994, p. 599).

No research to date has included ICT follow-up studies. Jacobson and Christensen (1996) and others believe that the introduction of acceptance techniques may improve the results of ICT in follow-up studies, however, this question cannot be answered until this type of research is performed. It is hoped that the results from the present study, as well as other follow-up studies, will provide more data on the long-term effects of depressed, married clients treated with ICT and CBT.

Treatment Phase

The present study is a two-year follow-up to a treatment study conducted by Trapp (1997). The treatment phase included 30 women ranging in age from 23 to 65 years with a mean age of 37.48 (SD = 9.87). All participants met criteria for non-bipolar, non-psychotic Major Depressive Disorder as assessed by the Structured Clinical Interview for DSM-III-R-Patient Edition (SCID; Spitzer, Williams, Gibbon, & First, 1990). In addition, participants had to score 20 or greater on the Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979). The Dyadic Adjustment Scale (DAS; Spanier, 1976) was also administered prior to treatment to measure levels of marital distress. Participants had a mean BDI score of 28.47 and DAS score of 78.50 at pre-treatment. Participants also had to have their spouse be willing to participate for inclusion.

The participants who met the inclusion criteria were then randomly assigned to one of three treatment conditions. All women completed 12 sessions of individual CBT, conjoint ICT, or combined CBT and conjoint ICT. The therapists who conducted the sessions were currently enrolled full-time graduate students in an APA accredited Counseling Psychology program and trained in each treatment modality. Therapists also participated in weekly supervision, provided by two licensed Ph.D. psychology professors with expertise in ICT and CBT treatments, throughout the treatment phase. During the course of treatment, data were collected for the depressed women participants only. The BDI and DAS scores collected at the intake were used as pre-treatment measures. Therapists completed the Hamilton Rating Scale for Depression after the initial session (HAM-D; Hamilton, 1960). Repeated measures with the BDI, DAS, and HAM-D were completed after sessions 4, 8, and 12, however, due to missing data at sessions 4 and 8, only scores at pre-treatment and post-treatment were analyzed.

Results indicate that overall levels of depression improved for all participants in all treatment conditions as measured by BDI and HAM-D scores. No significant differences were found between treatments. Mean post-treatment BDI scores were found to be 9.13 (SD = 7.25) which is just below the clinical cut-off score of 10 for mild depression. Similarly, HAM-D scores suggest lower levels of depression with scores changing from a pre-treatment mean of 17.17 (SD = 9.93) to post-treatment mean of 6.76 (SD = 6.79). Marital distress, as measured by the DAS, did not reveal significant differences between groups but did suggest improvement in marital satisfaction between pre-treatment and post-treatment mean scores.

Response to treatment also was measured by looking at the percentage of women whose scores on each of the outcome measures dropped below the standardized cut-off scores. These results of the BDI scores indicated that 21 of the 30 participants (70%) no longer met criteria for depression at post-treatment. HAM-D post-treatment scores indicated that 18 of the 29 participants (62%) no longer met criteria for depression. Also, 11 of the 29 participants (38%) no longer met criteria for marital distress as reflected by their DAS scores. Client satisfaction with treatment also was measured using a researcher-devised satisfaction survey. Results of this survey suggested that no differences existed between treatment groups with respect to participant satisfaction and all participants reported a very high level of satisfaction to the treatment they received. Therefore, this study is to determine the 2 year outcome of these participants.

Chapter III

METHOD

Research Design

The design of the study incorporated both quantitative information gained from validated instruments and qualitative analysis of semi-structured follow-up interviews. Threats to internal validity were the result of history, testing, and mortality. Attempts were made to control for the effects of history by conducting semi-structured interviews that identified events that may happen to each participant during the two-year follow-up that may have impacted their results. Threats that may have resulted from repeated testing were addressed by systematically changing the order of administration. In addition, a clinician rated level of depression was used and served to identify discrepancies between self-reported and observed levels of depression. Given the follow-up nature of the study, attrition was present. Attempts were made to identify and incorporate differential attrition rates between groups in order to determine the influence of attrition on the results. Threats to external validity were not problematic given that the study was conducted in a community outpatient clinic with clients presenting with difficulties of depression and marital distress. The participants will were representative of clients seen in other agencies. However, given the relatively small sample size of the study, replications will be necessary before strong conclusions can be drawn.

Participants

The participants were 30 married women who originally met the Diagnostic and Statistical Manual for Mental Disorders (4th edition. DSM-IV. American Psychiatric Association. 1994) criteria for major depression as assessed by the Structured Clinical Interview for Diagnosis (SCID-P). Participants also had to score 20 or above on the Beck Depression Inventory (BDI: Beck. Rush. Shaw & Emery. 1979). Spousal participation was also necessary inclusion criteria. The participants were comprised of those women who had successfully completed the treatment phase. The 30 women were evenly divided among each of the three treatment groups. Originally these women were recruited through the University of Oklahoma Counseling Psychology Clinic. solicited through local mental health agencies, newspapers, and TV offering free treatment as part of a research project. The participants had a mean age of 37.48. 1.23 children living in the household. an average of 1.63 marriages with a mean of 9.07 years of marriage in their current relationship. In addition. the participants had a mean of 1-2 years of college and an annual family income between $15,000 - $45,000. Ninety-three percent (93%) of the women identified their ethnicity as Euro-American. 3% identified an American Indian cultural background. and 3% identified themselves as "Other". Attrition during the course of follow-up was anticipated. Demographic information and dependent measures were analyzed to determine if any systematic differences exist within the attrition group.

Measures

Hamilton Rating Scale for Depression (HAM-D). The HAM-D is a clinician rated scale used to measure the symptoms and severity of depression originally developed by M. Hamilton (1960). It is a 25-item instrument with a scoring range of 0-74 and variable scoring between 0-2 and 0-4. Traditional classification of scores have been 25 or greater indicating severe depression, 18-24 indicating moderate depression, 7-17 indicating mild depression, and 6 or less indicating no depression (Endicott, Cohen, Nee, Fleiss, & Sarantakos, 1981. Bech and colleagues (1975) indicate that the HAM-D was shown to correlate .88 with general decisions regarding depression. Total scores have been shown to have an interrater reliability range from .87 to .95 (Burrows, Foenander, Davies, & Scoggins, 1976; Robins, 1976).

Beck Depression Inventory (BDI). The BDI was originally developed by Beck, Ward, Mendelson, Mock, & Erbaugh (1961), and was revised by Beck, Rush, Shaw, & Emery (1979). This scale is currently in its third revision, however, the original study utilized the second version, and this version was used during the follow-up so that useful comparisons could be made. The BDI is the most extensively used self-report instrument in screening for depression (Beck, Steer, & Garbin, 1988). The BDI has 21 items that are rated on a 4-point Likert scale (0-3), with higher scores reflecting increasing symptom severity. Total scores range from 0-63. Interpretation of scores are generally: 0-9, no depression; 10-19, mild depression; 20-29, moderate depression; and 30 or higher, severe depression (Kendall, Hollon, Beck, Hammen, & Ingram, 1987). In a review of relevant literature, Beck, et al. (1988) concluded that the BDI has been shown to have acceptable

reliability and validity. One week test-retest reliability were in the .70's and the BDI correlates in the .60's with expert clinical diagnoses.

Dyadic Adjustment Scale (DAS). The DAS (Spanier, 1976) is a frequently used self-report instrument measuring marital satisfaction. The instrument consists of 32 items scored on a 0 to 5 scale. Overall global adjustment is determined by adding all possible scores together. Couples classified as nondistressed are identified by overall scores of greater than 99, while distressed couples are identified by scores of 99 or less. When compared to other measures of global marital satisfaction, the DAS has been shown to be sensitive to treatment effects. Reliability estimates of .90 and higher have been found consistently in research studies (Stuart, 1992)

Treatment Conditions

Cognitive-Behavioral Therapy (CBT). This treatment condition consisted of twelve sessions of individual therapy based on Beck's 20 session plan for cognitive therapy (Beck et al., 1979). The CBT modality included assessment and modification of cognitions regarding depression, situation specific automatic thoughts, as well as behavioral aspects of depression that included the use of positive activity scheduling.

Integrated Couple Therapy (ICT). The treatment program consisted of twelve sessions based on the work of Jacobson and Christensen (1996). Treatment began with relationship assessment and behavioral exchange. It then progressed to communication skills and problem solving techniques for conflict resolution. Behavioral and emotional acceptance were included with equal focus. Both spouses were required to attend.

Combined Therapy (CO). The combined program consisted of twelve sessions and was based on recent research by Jacobson, Dobson, Fruzzetti, Schmaling, & Salusky (1991). The treatment had a minimum of four CBT sessions and four ICT sessions. The four non-specified sessions were flexible. The first session was CBT and the second was ICT. The patterning of the remaining sessions was left to the therapist's judgment. For the ICT sessions, spouses were required to attend, whereas for the CBT sessions, only the woman attended. Trained and supervised graduate students with at least two years of practicum experience conducted all sessions within the treatment phase.

Procedure

Consent for participation in this follow-up study was obtained from participants following their final session of the treatment phase. Their counselor was responsible for recruiting their participation. Clients were contacted and asked to return for administration of the BDI, DAS, HAM-D, and structured follow-up interview, at 3, 6, 12, and 24 months post-treatment. However, pragmatic accommodations to researcher and client schedules resulted in follow-up at 3, 6, 15, and 27 months post-treatment. Additionally, data collection errors that included technical difficulties recording sessions and follow-up intervals not occurring within appropriate time periods resulted in the 6 month follow-up being dropped prior to the analysis of the data. The author conducted all scheduling, interviews, and instrument administration/scoring. Each participant was asked to return for a structured interview and administration of each measurement at each interval. The structured interview consisted of questions assessing the client's perception of her overall functioning at the time of the interview, after the final counseling session,

and prior to therapy. The assessment also included information regarding whether counseling was helpful and what components were specifically helpful to them. Areas such as health, depression, marriage, work/school, and interactions between these categories were specifically targeted. All follow-up interviews were both audio and video taped so as to allow for qualitative analyses of participant responses. Selected interviews were identified by quantitative analyses and were transcribed and coded using the constant comparative method (Glasser & Strauss, 1967; Strauss & Corbin, 1990).

Data Analysis Procedures

Descriptive statistics were used to analyze the quantitative data. In addition, the dependent measures for depression and marital distress were analyzed using a 3 (CBT, ICT, Combined) X 4 (post-treatment, 3, 15, 27 month follow-up) repeated measures analysis of variance (ANOVA). Post hoc comparisons were conducted if levels of significance existed for any of the variables. Analysis of attrition and divorce rates were analyzed. The constant comparative method was used to analyze interview data (Glasser & Strauss, 1967; Strauss & Corbin, 1990). This type of qualitative inquiry allowed the researcher to break the data into pieces that could then be analyzed and organized in a manner that began to develop a theory about the topic under investigation. One woman from each treatment group was selected for qualitative analysis who maintained treatment gains throughout the follow-up period (i.e., lower scores on the BDI and HAM-D and higher scores on the DAS). These women were compared with one woman from each treatment group who did not maintain treatment gains during the follow-up period (i.e., higher scores on the BDI and HAM-D and lower scores on the DAS).

The first stage of the qualitative analysis included open coding. This involved the labeling of discrete statements or events and provided a way for the data to be broken down into smaller pieces. For example, all subjects may report an important part of therapy as being their relationship with the therapist. All statements that reflect this relationship were coded similarly in order to identify this important component of treatment. Open codes were then verified by another researcher with training in this method of analysis in order to ensure that these codes accurately reflect the data. Similar codes were then combined in larger and more complex conceptual categories (i.e., all codes which reflect the therapeutic relationship will be combined together under a larger category). Selective coding was then used to understand how these categories relate to each other and to the core category (i.e., the core category of depression). Identification of important concepts in the transcripts and an understanding of how these concepts related to one another was used to initiate the development of a grounded theory concerning the effects of treatment for depression two years post treatment.

Chapter IV

RESULTS

Quantitative Analysis

Depression was assessed using the BDI and HAM-D while marital satisfaction was assessed using the DAS. The study consisted of a 4 (post-treatment, 3 month, 15 month, 27 month) x 3 (CBT, ICT, CO) repeated measures factorial design. Below is a description of the results for each dependent variable.

Participant Attrition

Of the 30 participants who completed the treatment phase, 14 completed all follow-up periods resulting in a 47% completion rate. For the 16 women (53%) who did not complete all of the follow-up sessions, 7 were in the CBT group (44%), 4 were in the ICT group (25%), and 5 were in the CO group (31%). As a result, CBT had a 36% completion rate, ICT had a 60% completion rate, and CO had a 44% completion rate. Reasons for attrition included moving out of the area and being unwilling to return for follow-up sessions. Not being willing to complete the follow-up sessions was the most frequent factor in participant attrition.

In order to determine if completers differed in any systematic way from drop-outs, independent t-tests were performed on certain demographic variables and outcome measures. Demographic variables that were looked at were: age, number of marriages, years in the current marriage, total number of children, and education level. In addition,

analysis was completed for post-treatment BDI, HAM-D, and DAS scores. No significant differences were found for any of the demographic variables nor outcome measures. The results did indicate, however, a possible clinically meaningful difference between completers and non-completers on mean post-treatment DAS scores, t (26) = 1.94, $p < .064$. This result suggests that completers may have exhibited a difference in mean DAS scores at post-treatment, with drop-outs reporting greater levels of marital distress. Also, crosstabs chi squares were utilized comparing completers and non-completers for previous use of psychoactive drugs, previous psychotherapy, prior diagnosis of depression, presence of another significant illness, and treatment assignment. Results of these crosstabs chi squares revealed no significant differences between the drop-out group and completer group on these variables.

Depression

Beck Depression Inventory

The internal consistency reliability for the BDI at the post-treatment administration was .88; .90 at the 3 month follow-up period; .78 at the 15 month follow-up period; and .84 at the 27 month follow-up period. Results of this internal consistency reliability analysis are contained in Appendix G. Cell means and standard deviations for the BDI by treatment group at post-treatment, 3 month, 15 month and 27 month follow-up periods are contained in Table 1. Mean scores rose for all treatment groups at 3 months, and were lower at 15 months when compared to 3 month scores. At 27 months mean scores were lower for the ICT group, roughly equivalent for the CBT group, and higher for the CO group when compared to post-treatment means.

A 4 x 3 repeated measures analysis of variance (ANOVA) was computed to examine changes in BDI scores during each of the follow-up periods. The were no significant differences due to treatment group, F (2, 11) = .859, p < .450. The ANOVA for time in the study was not significant either, F (3, 33) = 2.081, p < .122. In addition, interaction between treatment group and time did not reveal any significant differences, F (6, 33) = .124, p < .993. The results of this ANOVA is contained in Appendix F.

Hamilton Rating Scale for Depression

The internal consistency reliability for the HAM-D at the post-treatment administration was .88; .68 at the 3 month follow-up period; .77 at the 15 month follow-up period; and .72 at the 27 month follow-up period. Results of this internal consistency reliability analysis are contained in Appendix G. Cell means and standard deviations for the HAM-D by treatment group at post-treatment, 3 month, 15 month and 27 month follow-up periods are contained in Table 2. Mean scores for the CBT group consistently rose slightly throughout the course of the follow-up. In contrast, scores for the ICT consistently fell slightly and mean scores for the CO group remained roughly consistent during the follow-up period.

A 4 x 3 repeated measures analysis of variance was computed to examine changes in HAM-D scores during each of the follow-up periods. There were no significant differences in HAM-D scores as a result of treatment group, F (2, 11) = .535, p < .600. In addition no significant differences were found for the time factor in the study, F (3, 33) =.261, p < .853, nor the interaction of treatment group with time, F (3, 33) = .876, p < .523. Results of the repeated measures ANOVA can be found in Appendix F.

Table 1

Means and Standard Deviations for the Beck Depression Inventory (BDI)

Times	Treatment Groups		
	CBT	ICT	CO
Post-Treatment	11.2 (7.3) (n=11)	7.7 (7.1) (n=10)	8.2 (7.4) (n=9)
3 Month	16.2 (9.5) (n=7)	12.1 (10.6) (n=8)	12.6 (11.0) (n=9)
15 Month	9.2 (2.2) (n=4)	8.6 (5.2) (n=6)	9.1 (7.0) (n=7)
27 Month	11.0 (4.5) (n=4)	6.8 (5.1) (n=6)	14.5 (10.2) (n=4)

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

Given that both the BDI and HAM-D are instruments designed to assess for depressive symptoms it would be expected that the two instruments have a reasonable level of correlation. Any correlation between the BDI and HAM-D should not be a perfect correlation because of their differing means of administration (client rated vs. clinician rated) and the fact that the HAM-D places a larger emphasis on somatic

Table 2

Means and Standard Deviations for the Hamilton Rating Scale for Depression (HAM-D)

Times	Treatment Groups		
	CBT	ICT	CO
Post-Treatment	7.0 (5.2) (n=11)	7.5 (7.5) (n=10)	7.0 (6.7) (n=9)
3 Month	9.4 (4.9) (n=7)	7.4 (5.4) (n=8)	6.4 (4.0) (n=9)
15 Month	9.0 (2.7) (n=4)	6.3 (3.6) (n=6)	6.3 (5.5) (n=7)
27 Month	9.5 (3.9) (n=4)	4.5 (3.0) (n=6)	7.5 (5.4) (n=4)

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

complaints. A Pearson correlation coefficient was conducted for these two instruments at each follow-up interval. The BDI and HAM-D had a correlation of .69 at the post-treatment interval, .79 at 3 months, .78 at 15 months, and .81 at 27 months. This suggests

that both clients and clinician were rating levels of depression in a similar fashion and this agreement increased during the course of the follow-up period.

Marital Distress

Dyadic Adjustment Scale

The internal consistency reliability for the DAS at the post-treatment administration was .94; .97 at the 3 month follow-up period; .96 at the 15 month follow-up period; and .96 at the 27 month follow-up period. Results of this internal consistency reliability analysis are contained in Appendix G. Cell means and standard deviations for the DAS by treatment group at post-treatment, 3 month, 15 month and 27 month follow-up periods are contained in Table 3. Mean scores for the CBT group fell slightly at 3 months but, were higher than post-treatment mean scores at 15 and 27 months. Mean scores for the ICT and CO groups consistently fell at 3 and 15 months and rose at 27 months but, were slightly lower when compared to post-treatment mean scores.

A repeated measures analysis of variance (ANOVA) was performed to examine changes in DAS scores during the course of the follow-up period. As with the instruments for depression, no significant differences were observed for treatment groups, F (2, 11) = .269, p < .769. No differences existed based on time in the study, F (3, 33) = .869, p < .467, or for the interaction of time by treatment groups, F (6, 33) = .444, p < .844. The results for this ANOVA are found in Appendix F.

Table 3

Means and Standard Deviations for the Dyadic Adjustment Scale (DAS)

Times	Treatment Groups		
	CBT	ICT	CO
Post-Treatment	83.1 (22.8)	96.2 (22.8)	101.2 (14.9)
	(n=10)	(n=10)	(n=9)
3 Month	80.1 (32.4)	88.0 (30.5)	94.0 (30.1)
	(n=7)	(n=8)	(n=9)
15 Month	96.5 (24.9)	83.8 (27.8)	88.1 (34.6)
	(n=4)	(n=6)	(n=7)
27 Month	95.8 (27.1)	92.7 (27.7)	97.0 (16.5)
	(n=4)	(n=6)	(n=4)

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

Treatment Outcomes

Treatment Change Scores

In order to examine trends in the data across the course of the follow-up, change scores were computed by treatment modality. These change scores were calculated by

taking the difference of the scores at post-treatment from the scores at the 27 month follow-up period for each inventory. The mean score was then computed for each instrument and the results are reflected in Table 4. The results suggest client self-reported depression decreased slightly for the ICT group but increased slightly in the CBT and CO groups. Clinician-rated levels of depression also increased slightly for the CBT group and decreased slightly in the ICT and CO groups. Finally the results indicate self-reported marital distress increased slightly across all treatment groups.

Table 4

Mean Change Scores Across Treatment Groups by Assessment Instrument

Instrument	Treatment Groups		
	CBT	ICT	CO
BDI	1.5 (7.5)	-1.3 (0.5)	3.8 (5.2)
HAM-D	3.2 (7.0)	-1.3 (4.9)	-1.8 (2.1)
DAS	-4.25 (7.5)	-7.0 (42.7)	-6.5 (3.4)

Note. Negative scores for BDI and HAM-D indicate a decrease in depression while negative scores for the DAS indicate an increase in marital distress.

Clinically Significant Responses to Treatment

A method for examining treatment outcome during the course of the follow-up period is to identify those individuals who responded to treatment versus those

individuals who did not respond. For this purpose, individuals who are considered responders are those whose scores on the BDI, HAM-D, and DAS indicated they no longer met criteria for depression or marital distress. Scores of below 10 on the BDI, below 8 on the HAM-D, and above 99 on the DAS are scores that indicate individuals are in the normal range for each instrument. Non-responders were defined as those individuals who still met criteria for either depression and/or marital distress. Percentages were calculated to determine responders versus non-responders for each treatment group at each follow-up interval. The results indicate a possible slight superiority for the ICT treatment in facilitating continued treatment gains in levels of depression. On measures of marital distress, the result indicates a slight advantage for ICT at post-treatment and 3 month follow-up. The CO treatment appears to have been more effective at sustaining treatment gains in marital distress at 15 months and CBT appears slightly better at the 27 month follow-up. Table 5 contains the percentages of responders versus non-responders.

Qualitative Analysis

This study focused on the experiences of women receiving treatment for depression during a 2-year follow-up period. Six women were selected for qualitative analysis based on their scores on each of the outcome measures for depression and marital distress. Two women were selected from each of the three treatment groups. One of these women had scores that indicated consistently low levels of depression and high levels of marital satisfaction throughout the follow-up period (i.e., non-relapsed). The other woman had scores that reflected higher levels of depression and higher levels of marital distress (i.e. relapsed). Prior to treatment, the three women in the non-relapsed

Table 5

Percentage of Responders During Course of Follow-up by Treatment and Time

Instrument	Treatment Groups											
	CBT				ICT				CO			
	Post	3	15	27	Post	3	15	27	Post	3	15	27
BDI	55	28	50	25	80	62	50	67	78	44	57	50
HAM-D	55	43	25	25	70	62	83	83	78	44	57	50
DAS	30	28	50	75	50	50	33	50	33	44	57	50

Note. Numbers in table represent percentages.

group were experiencing greater levels of depression compared to the three women in the relapsed group, as indicated by scores on the BDI and HAM-D. However, women in the relapsed group were reporting greater levels of marital distress prior to treatment than women in the non-relapsed group, as reflected by scores on the DAS. Qualitative analysis was used to understand the experiences of the women during the follow-up period. Attempts were made to identify behaviors and life experiences that contributed to the maintenance of treatment gains or a relapse of depressive symptoms. Through the analysis process, categories that discriminated between those women whose feelings of

depression worsened (i.e., relapsed) and those women whose treatment gains continued during the course of the follow-up (i.e., non-relapsed) were identified.

While the women fit generally into two groups, relapsed and non-relapsed, these women shared several things in common. This background section will serve to identify those things that were common across all participants. This section will be followed by a discussion of the two major themes that emerged during the data analysis. The first identified theme involved the role of social support and how this support contributed to continued positive adjustment or to relapse in depressive symptoms. The second theme that emerged was entitled, help seeking behavior, and includes the women's willingness to seek future mental health services. Each of these themes will be explore further later in this section.

Similarities

Commitment to Marriage

All of the women included in the qualitative analysis were married and described strong commitments to their marriages. Even in cases where the women were dissatisfied with their relationships, they reported a strong sense of commitment to remaining married. In a discussion of her marriage Christine reported:

> I feel a strong, strong commitment to marriage. I don't feel its something you take lightly. .....It's not the relationship either of us wants but we're committed to each other. I mean we're good friends. That's probably the basis of it, we're good friends.

Denise was another participant who described a commitment to her relationship even though she was dissatisfied with her current marriage:

> It's not a marriage that I'm thinking of changing. I just wish that things were better. It was a struggle to get my husband to even have come to the counseling. Nothing that we learned has been implemented in our relationship and that's kind of frustrating for me but. I care about him and I don't want to break-up our family. I just have to go along the best I can with it. I guess it doesn't sound like a very good relationship.

Participants who continued to report little depression during the follow-up period also described strong marriages. For example, during her 3 month follow-up Barbara reported, "My marriage is always good. ....But mine was kind of, almost in spite of. I get really depressed from time to time in spite of the fact that I've got a good marriage, a good relationship with my husband". It was clear that each of these women viewed marriage as a serious commitment not to be taken lightly regardless of their satisfaction in their marriages.

Absence of Health Problems

As a group, these women were generally healthy. Five of the six women did not report any significant health concerns during the course of the follow-up. Several women described general health concerns such as high blood pressure, weight concerns, and back pain. For example Ellen reported, "Just main things, I get high blood pressure and I need to go and check on that. Just general things. Nothing that has gotten particularly worse". Similarly Amanda stated, "There are always my back problems which are beginning to get better, but nothing major other than that" and Ellen described, "Yeah it was about the same, nothing major just that I needed to monitor my own health, to watch my weight and

to watch my blood pressure". While these health problems did need to be monitored and contributed to limited amounts of stress, none of these women viewed their health problems as significantly impacting their overall adjustment. None of these women viewed their health problems as major factors in either their depression nor their marital satisfaction.

Employment

Employment was an important part of these women's lives. Five of the six women were employed during the follow-up and four of the six described work as being an integral part of their self image. In describing her work experiences, Christine reported, "Very busy, I'm working with lots of other kinds of people and I like myself better I guess. You know, I think interaction with people is positive and important. I feel useful so that really has been helpful".

Many of the participants described work as providing them with a sense of independence. "Well its given me some freedom and I'm working full time and I feel like I am more my own person". This sense of independence appeared to be helpful when the women were concerned about their marital relationships. Christine described this when she stated:

> I just felt like if my husband was going to divorce me, which he still could, I just felt like I had to take care of myself. I needed to get back into the work force and find something I could do.

Work also provided a sense of future planning and a way to invest their time working towards a future goal. Denise described this in stating:

> I've been trying real hard this year especially to improve my qualifications. I've attended seminars to try to build my experience up and eventually get to a point where I can earn more money because that would help us a lot if we could earn some more money. I've enjoyed that a lot. I've enjoyed being more involved. I've taken on a lot of new responsibilities just for that purpose, to try to increase my experience. That helps a lot. ....[Work] kept me interested and kept me looking to the future and thinking about the future and that really helps when you start getting down, is to try to make plans.

Work clearly served an important purpose in these women's lives. Work provided these women with a sense of independence, a focus towards the future, and played a central role in their self image.

Problems as Interrelated

Four out of six women saw their difficulties with their depression, marriage, work, and other areas of their lives as being interrelated. These women clearly came to view difficulties in one area of their lives as impacting several other areas. For example Amanda described:

> I think I am more aware of just the fact that the depression affects everything else rather than the other way, which I had always assumed believing that things are going on and therefore I am depressed. And it goes the other way too. I'm just more aware of that now.

This understanding of their difficulties as being interrelated appeared to be helpful in facilitating improvement in their lives. Amanda again verbalized how the realization of interrelationships between her depression and her marriage facilitated improvement:

> Just that I have been feeling more and more run down. It is just hard to do things so I would just come home and not want to do anything and complain about nothing being done around here and asking my husband why he's not doing more. And it's that I wasn't doing anything. Eventually when I realized that I wasn't doing anything, things got better.

For Amanda, realizing how her feelings of depression were impacting others and her perception of herself contributed to improvement. During counseling she was able to understand how her depression, marital difficulties, and health concerns were interacting. This process was similar for several other women in the study.

Continued Feelings of Depression

Interestingly, all six of these women experienced continued feelings of depression at some point during the follow-up regardless of their designation as either relapsed or non-relapsed. During her 12-month interview Gail stated:

> I would say I feel even better now. I have just changed so much and the baby and everything. So I think I am feeling better now than I did when I quit. Sometimes there is a down thing. It is an up and down and I am not used to that. I am used to it every month or so but, I am not used to it every couple of days or so.

The experiences of these women support the research suggesting that depression is recurrent in nature and can return even in cases where it was effectively treated through counseling and/or medication. Barbara described her experiences with depression in stating, "Well, you have to understand that for 10-15 maybe 20 years, maybe 15 years, from time to time every few years I have gone into counseling for a little while and it always helps a lot". Other women described feeling as if they were fighting their feelings of depression, "I'm really fighting it and I have been the rest of the summer. ....Very frustrating. ....A rollercoaster. It really has, I'm ready for it to change". Another woman described believing others would not recognize her current feelings of depression even though she was personally aware of these feelings:

> One would think if they looked at me, that I would be, I was pretty down in the dumps then, and they would say that I am close to being at the top of my game and career wise I would probably say that's true but, emotionally I don't think there's been much change.

It is clear that feelings of depression were present for all of the women at some point during the follow-up period. However, there were differences in how the women handled these feelings when they occurred (non-relapsed vs. relapsed) which accounted for the differences in their overall adjustment. These differences with be explored later in the discussion of major themes which occurred during the course of the follow-up.

Counseling as Helpful/Positive

Counseling was described as being a positive and helpful experience for the majority of these women. Gail stated, "Oh a lot better. I got a lot out of counseling and that is why I feel like I do today". Counseling was described as being useful in providing helpful feedback, needed direction, and identification of problem areas. Throughout the follow-up these women consistently described positive experiences. Christine identified how valuable it was to receive feedback through counseling:

> I think they were very effective. Very helpful. I didn't feel like they sided with either of us. I felt like they're, and another thing I liked about the counselors was that they gave good feedback or that they have good suggestions about what to do or what to read or what exercises to do. As opposed to just, um hmm, um hmm, and how do you feel now, and how does that feel.

Importantly, women in both the relapsed and non-relapsed groups found counseling to be positive and helpful. Four of the six women clearly identified the valuable impact counseling had in addressing their feelings of depression and marital dissatisfaction.

Additionally these women appeared to value the objectivity and clarity that the counseling services provided. "The counseling then helped to help me see things around me more clearly". Christine identified this point well in her statement:

> I think counseling helps a lot. I think you need an objective sounding board. I think the counseling helped me start thinking about what I was doing. You know, you can bury your head in the sand only so long and I think counseling forced me to take my head out.

During her 24 month follow-up session Gail described the importance of objectivity for her because her husband was struggling with similar issues and was unable to be objective:

> I was looking to get through the gray and I think counseling helped me get there. I just needed somebody because my husband was going through it too and my family. I couldn't tell them. So coming to counseling and having me not know her and telling her everything.

Ellen also described the usefulness of objectivity for her. Identifying the importance of an objective individual confirming her perceived problem areas:

> I think it helped me narrow down my feelings and my understanding, its like in the background I knew all the things I should be doing but sometimes it helps to have someone else tell you that that's what you need to be doing as well. Its easier to look at someone else and figure things out then it is to do it yourself because then you feel guilty because your taking off. Counseling doesn't make everything perfect but it helps make you think about what you should be doing for yourself, kind of mirroring your thoughts.

For Ellen, this clarity and confirmation of problem areas provided her with an ability to "take action" and work on her difficulties:

> It helped pinpoint things I needed to concentrate on and it helped me realize there weren't any miracles out there and somebody wasn't going to wave a magic wand and make everything okay. It kind of helped me narrow things down that I needed to work on changing. You need to take action.

Many of the women described processes similar to Ellen's. Objectivity and clarity was a necessary component that enabled them to "take action" and address their feelings of depression and marital discord.

Perceived Better Adjustment Post Treatment

A final similarity shared by each of these women was a sense of increased adjustment after counseling and during the follow-up period as compared to before counseling. Even those participants in the relapsed group perceived themselves as being better adjusted. These women made several statements reflecting increased adjustment such as, "Things have been overall, things have been really good for me lately", "I think I'm better. I think things are better" and "I think I am doing a lot better". Women who relapsed post-treatment also reflected increased adjustment however their statements were slightly different, "Seems to be a little better. ....I'm probably managing a little bit better. ....Not as good as I want it to be, but I think things will keep improving". In describing her improved adjustment Ellen stated:

> Well I think it's better. I learned some things in counseling that have helped me overcome those feelings and now the bad feelings are not as often. They kind of come at different times and I kind of recognize what is causing it.

For these women counseling appears to have improved their overall level of adjustment, even for those women who are still working to manage feelings of depression. Consistently, each of these women perceived counseling as helpful and reported that they would do the study all over again based on what they know now.

Major Themes

Two prominent themes, or categories, emerged during the analysis that appear to have accounted for the differing outcomes between the non-relapsed and relapsed groups. These themes were: the quality of the women's social support and their attitudes with regard to help seeking behavior. The two groups were strikingly different across these two domains. Each major theme will be described below with quotations from the women supporting the development and quality of these concepts.

Quality of Social Support

Non-relapsed Group

Consistent support and encouragement from spouses and children characterized the social support for the non-relapsed women. These women viewed their marital relationships positively and perceived their husbands to be encouraging and supportive. This positive view of their marital relationships was reflected by Barbara in her statement. "I think in the beginning of this study was, I think if I understand it correctly, was designed to analyze things specific to marital relationships and I have a good marriage. I'm a lucky woman". Each of these women had husbands who were actively involved in encouraging them to seek treatment and the husbands were willing to attend counseling sessions in cases where their participation was required. Amanda also identified the importance of her husband's patience during her depression. "Yeah he had incredible patience and realized I was not in a really good place in life".

For this group of women, their difficulties did not appear to originate from their relationships. While their relationships were impacted by the women's feelings of depression, these women saw their husbands as a source of support. For example Barbara stated:

> My marriage is always good. My doing this study is only, it's only a peripheral factor that I'm married. It has been from the beginning of going into the study. .... But mine was kind of, almost in spite of I get really depressed from time to time in spite of the fact that I've got a good marriage, a good relationship with my husband.

It was clear that their marriages were impacted as a result of their negative feelings. Amanda clearly described her relationship difficulties that she was experiencing prior to counseling:

> In my marriage my husband was really doing the work and got to the point where he said, "I want to be with you but I just can't handle this any longer". I think I was the one who finally said right at the beginning of this, around the second week we were here, I think it was a last ditch thing, I said, "If I'm not going to get better, I want out". He said that you can move on but you're going to be leaving me an orphan. It's like, I love you and if I can't get better, you need to worry about yourself and I'm out of here. It was really bizarre. I was unsure that it was going to work out okay. I was unsure if I was going to be able to get better while we were still together.

These husbands were actively involved in encouraging their spouse to seek treatment. For Amanda, her husband was actively involved in encouraging her to seek treatment in the first place, "I had just been struggling with things and they had gradually been getting worse. My husband finally convinced me that I had to do something about this". This type of active involvement was not uncommon for women who continued to sustain treatment gains achieved during the study.

As a result of the husbands' active involvement in the treatment process it was clear that these husbands learned skills or gained a new perspective which helped them adjust to their wives depression as well. The counseling experience appeared to provide their husbands with a greater understanding of depression and how they could be most helpful in assisting their wives with depression. Amanda described the impact on her husband by stating:

> He felt like he needed to change for me to get better. He would do things that I didn't do 'cause I wasn't feeling well and he became overwhelmed. So he was able to just step back and say, okay don't worry about anything until she starts to feel better.

Learning about the recurrent nature of depression appeared to be helpful as well. The husbands appeared able to assist their spouses in identifying when symptoms of depression were returning and, in Amanda's case, were instrumental in encouraging them to seek out services.

Children were also a large part of these women's support systems. Two of the three women in the non-relapsed group described the importance of their children as a source of support and a buffer from feelings of depression. Gail made this point most clearly when she remarked:

> They were the one place where I felt some sanity and where I didn't have to, whatever they needed I could give as opposed to the church and even my marriage, in-laws and all that stuff. They were just there for me. So that was the thing that kept me going.

For Barbara, her relationship with her eldest daughter was something that she valued. She described how much she enjoyed working in the same office with her daughter and how her relationship with her daughter was very important to her. Part of Barbara's

depression when she entered the study was connected to the death of her son several years earlier. She described how her daughter's adjustment to the death of her son allowed her to begin to cope more effectively as well. Barbara described an interaction with her daughter that happened during the anniversary of her son's death:

> So she told me about that and how she said, "well you know, I'm fine, we're all fine about that". It just made my heart sing, you know, that it was fine and knowing that it was fine with her made it that much more okay with me. I was fine.

This relationship with her daughter was one that provided Barbara with a great deal of social support and her daughter was an integral part of her social support system.

A connection with a strong and supportive social support system was a theme that was discussed throughout the course of the follow-up for the women who were able to maintain treatment gains. In describing the importance of Amanda's relationship with her husband she stated, "No I feel like there are still some things we need to work on but, its like we're going to work on it. We can handle it". For these women, a strong social support system allowed them to address their struggle with depression more effectively. On several occasions throughout the follow-up, Gail remarked:

> Of course my children, I'm really busy with them, they are 5 and under and they keep me sane, they really do. And of course my marriage is wonderful. So it is nothing at home that is the cause of it. .... That is not what gets me down, its what keeps me going.

These women consistently described their social support structures in positive terms throughout the follow-up period.

These women also appeared to have strong communication in their social support networks. In their marital relationships their husbands were aware of their spouse's feelings of depression and these husbands communicated a willingness to be helpful in addressing these negative feelings. Barbara and her husband communicated with each other so openly that she was surprised to learn new things about him during counseling:

> My husband and I both remind each other from time to time that a couple of times during that period either I mentioned, if we were here together, if it happened when he was here with me, I would mention something that would surprise him or he would do something that would surprise me and we would have never thought that there was anything that we would reveal or bring up in this circumstance that we wouldn't have brought up in ordinary everyday going along.

The ability to communicate effectively with their social support systems was a clear strength for these women.

Relapsed Group

The social support systems for the women who experienced a relapse in depression contributed to additional stress in these women's lives. The social support systems of these women were characterized by a general lack of support. Both husbands who were required to participate in couples counseling terminated their involvement prior to the end of the study. The third husband was required to travel frequently by his job, and that made communication and time together difficult in their marital relationship. In addition, two of the women described added stress as a result of their children and reported feelings of guilt if, and when, they prioritized time for themselves. These women consistently described problems with social support throughout the follow-up period.

In general these husbands were disengaged from their wives and were unwilling to acknowledge problems in their relationships. For two of the husbands this disengagement was reflected in their unwillingness to complete the couple sessions outlined in the study. Denise described, "Worried about my marriage, I would go back to counseling in a heartbeat if my husband would but, he has no interest at all in doing that". Not only did this unwillingness to participate lessen the effects of the couples sessions but also left their wives feeling frustrated, hopeless, and angry. Christine described her disappointment related to her husband's unwillingness to continue with counseling during her three-month follow-up:

> The only thing that disappointed me was my husband's reluctance to continue. But that had had nothing to do with the counseling I don't think. We were talking a little bit, getting a little bit into his dealing, using drugs and alcohol to anaesthetize his feelings, but I don't think that's really, my husband doesn't like discussing that. I think it was more. My husband decided that the counseling wasn't going to help him bully me into doing what he wanted me to do and so he realized it wasn't worth his time. I'm not sure, I would have to ask him. I asked him why he was quitting and he said, "You're the one who needs counseling and not me".

Christine reported perceiving his decision not to continue as a sign that their relationship was worsening, "Charlie didn't attend the last two sessions. So it was going down. It was in the process of going down". Denise's husband was also unwilling to complete his participation, and while she infrequently described anger, she did describe being upset with her husband during her three month interview, "Yeah I know, I think I'm more on the side of blaming my husband for not participating". In describing her frustrations related to her experience in joint counseling with her husband she stated:

> The thing about counseling, when I first signed up for this and I told him about it he just went crazy. He just didn't think a counselor needs to tell us how to solve

> our problems. The problem is that he won't solve them either and that was the main reason I signed up for it, for the marriage counseling part of it. I thought it really could have helped us and it would have if it would have been a joint effort. He only came, it was like I had to drag him. I don't feel like he really cared about it that much and really wanted it to help us.

Denise also identified her husband's unwillingness to even acknowledge that problems existed in their relationship, "He just does not want to admit there are problems. That happened with our son as well. It's really frustrating sometimes".

Each of these women discussed the difficulties they had coping with their husband's lack of involvement in their marriages. Both Christine and Denise described an unwillingness to collaborate in improving their marital relationships on the part of their husbands. In describing her perception of her husband's involvement Christine reported, "He contributes nothing to this relationship, he contributes nothing to maintaining the household. I mean other than finances and his finances have been a little sluggish as of late". When talking about her husband's lack of commitment, Christine described wondering if her husband did not have the motivation to change because the relationship may have been satisfactory for him, "Other than not being intimate, it may be an ideal relationship for him. So I guess this is living in a man's world".

For Denise, this lack of investment in their relationship from her husband was very difficult, "The only negative experience was my husband not coming with me. That was hard for me to accept, that he wouldn't even make an effort. I have some negative feelings towards him". During the course of the follow-up, finances became stressful in her family. These difficulties were another example for Denise of her husband's lack of involvement in their relationship:

> Finances are a big stress and I, the main reason is because my husband wants me to just handle everything and doesn't want to deal with any of it. I can't get the bills paid if he's wanting to buy this or buy that. ....He doesn't want to help me. In the summer I had the chance to take a course in financial management that included financial counseling and it was for a couple and he wouldn't go with me. I just went by myself.

This lack of involvement was a consistent pattern for these women and contributed to them perceiving a lack of support in addressing their marital problems.

Ellen experienced this lack of husband involvement in a slightly different manner, however, some of her negative feelings were similar to Christine and Denise. The lack of involvement in Ellen's relationship was the result of her husband's job that required extensive travel. This travel left Ellen feeling somewhat alone in her relationship:

> We have a good marriage but I guess it is. I would like to spend more time and when he's gone that much its hard when he's gone 5,6,7 nights a week or maybe he'll leave at 5 in the morning and get back at 8 at night.

For Ellen, her husband's absence was particularly difficult and was connected to her feelings of depression:

> I don't see the marriage as related to the depression except when he's gone and I am the only one to deal with the problems. I think the depression is mostly looking around and seeing how much needs to be done and I'm the only one that has to do it.

While this lack of involvement was different from either Christine or Denise, Ellen was still left managing without her husband's presence and this lack of involvement was clearly related to her feelings of depression.

This lack of involvement on the part of their husband's resulted in these women experiencing feelings of resentment towards their spouses. These negative feelings were

a marked difference for this group of women as compared to the non-relapsed women.

For Ellen these feelings were expressed when she stated:

> A few of them I guess between my son and my husband and I guess I didn't deal with the marriage because he was gone so I would find myself resenting him for being gone while I was trying to deal with all the problems.

In describing how she has sorted out her negative feelings related to her marriage she reported, "Yeah I think that was part of it, not really the marriage as much as just resenting me having to do everything". Ellen described feelings of jealousy towards her husband as well, ".... I realized I was jealous because he can just pack up and go and I'm still sitting here with our son and all of his faults and problems and trying to do that".

Christine described feelings of resentment and regret when reflecting on her marriage:

> Not regret about, there is some regret on my part for having spent all of this time. In talking with girlfriends when they talk about their relationships with men, I mean I look around and I say get what you can out of the relationship, just make sure it's a give and take situation. Stop doing so much for that relationship if they're not giving back in return. Because its not worth it if the sex isn't good, move on. I can't imagine putting up, if I had to do it over again I wouldn't put up with that all these years. If I knew what I knew now, that I wasn't going to have children I would have, I would not have married, period. At least not my current husband.

In Christine's case, these feelings of resentment resulted in her attempting to disengage from her relationship:

> Because for me that was my last straw, my last big effort for us to work as a couple and we kind of flushed it down the toilet and so I just don't have the strength or the energy or the information anymore to do it which just amazes me because it's the first time in my life that I have given up on anything.

Poor communication was also present in many of their current relationships. Difficult communication was most prominent in their marital relationships but was also

present in relationships with children. Denise described her communication problems most clearly during her follow-up sessions. She reported feelings of frustration and disappointment that her husband was not willing to discuss their problems:

> Well its not really bad it's just that we don't communicate like we should. When we were in counseling and he did come with me we had some wonderful ideas and some things I thought could really help us because the main problems we really have are communication but he won't do them and has no interest. He won't even talk to me about it.

The communication problems these women experienced were connected to their husbands unwillingness to discuss problems or even implement suggestions gained from their counseling. Again Denise described her husband's unwillingness to implement what she perceived as positive suggestions from her counseling:

> Well she talked to us about doing positive things for each other, sitting down and talking, just communicating with each other every day, even if it was just for a little while. Things like that mostly, the problems with our communication and you know one person can't do it by themselves.

For Ellen, many of her communication difficulties were with her son who reportedly struggles with Tourette's Syndrome, Attention-Deficit Disorder, and Obsessive-Compulsive Disorder. The communication difficulties Ellen experiences contribute to stress in her relationship and are connected to her continued difficulties with depression:

> Yeah I don't know how to reach him and he doesn't let me get too close. I did not have trouble with my other children but it is much harder with him. ....It seems like he wants to be close but he also rejects it at the same time. If he'll ever let me hug him or something than I can see that he would like that and he will accept that and he will talk. But he seems to try and close off to what you have to say.

Ellen consistently described how difficult it was for her to communicate with her son. In part, these difficulties were hard because she had raised two other children with whom she did not have any problems. Ellen described how she would blame herself for her problems in communication with her son. This attribution left her feeling overwhelmed and ineffective as a parent. For example, on one occasion she reported, "Yeah, when you're trying simply to do something nice or to tell him something and he yells at you, you almost want to crawl in a hole or something". She also described how counseling attempted to increase her self-esteem as a parent as a result of her difficult and stressful relationship with her son:

> We spent a lot of time making me feel like I was a good parent which I think I'm a good parent because I have two good kids but, my other son is still a good kid. But its very frustrating so I feel like a failure with him because I don't know how to reach him and I think I feel like a mother should be able to reach their children. I probably understand him better than anybody else does but I don't get any feedback from him. He only tells me what a failure I am and what a bad parent I am and it makes it hard to feel good about myself. Then he will turn around and tell me I did something well.

The two women with children both described difficulties they have taking time for themselves because of their role as mothers. Specifically they reported feeling guilty whenever they took time for themselves. These feelings were a unique experience for these women and were not described by the women in the non-relapsed group. Denise describe her struggle to join a weight loss support group to gain additional social support:

> Realizing that it's up to me to do something for myself, to do things that I want to do. That's really hard for a mom when you're being pulled in so many directions. It's really hard to say, I'm going to do this for me. It's a challenge even now after I know how much it helps me. One of the things I have done is join a weight loss support group that I started during the counseling. .... My family hasn't liked it but its been really good. .... It's hard to continue with it, my husband will try to keep me from going, but I just stick to my guns. .... I struggle at home to be able

> to do that, to be able to get that done. That's probably the main reason that I don't do it more, because it is so much trouble to try to get things taken care of at home so I can do things I want to. I don't have a very supportive family is what it is. They expect mom to do everything.

Ellen also described the difficulties she had prioritizing time for herself because of her responsibilities as a mother:

> Yeah, not as much as I hoped it would but then part of that is me. I have to still make changes but if I'm the only one there, you can't take time to go and do something else if you're the one who has to take the kids to school and home from school. So I still have all of those responsibilities that I have to try and work around.

During her final follow-up interview she described her difficulties prioritizing time for herself even though she became aware through counseling that self care is important:

> Yeah I think reinforcing what I already knew and things that I should be doing, taking time for myself. I still don't do that a lot but I do it more. I think that's hard for moms because they feel guilty if they are actually doing things for themselves. I think gradually I realized that's something I need to do, it in turn will benefit them.

A final consistent component part of these women's social support was their decision to remain in their marriages even though they described their spouses as being uninvolved and unwilling to change, their relationships were characterized by poor communication, and they described having negative feelings about their husbands. Regardless of these difficulties, each of these women in the relapsed group described their decisions to remain in their current relationships. Denise initially described remaining in her marriage as a result of being unsure what to do, "No he just really doesn't want to and I just really don't know what to do. I'm not ready to end my marriage over it. I just try to keep going on". However, during the follow-up period she

appeared to make a decision that remaining in the relationship was important to her and she was not willing to consider divorce:

> It's not a marriage that I'm thinking of changing. I just wish that things were better. It was a struggle to get my husband to even have come to the counseling. Nothing that we learned has been implemented in our relationship and that's kind of frustrating for me but. I care about him and I don't want to break-up our family. I just have to go along the best I can with it. I guess it doesn't sound like a very good relationship. .... It's either accept the way things are or get a divorce and I don't want to do that.

During her follow-up interview, Christine also described her decision making process to remain in the relationship:

> I didn't really want to change my living situation as such. I wasn't ready to do that. And I don't want to do that. And I don't want another man in my life. I really don't, not that I want a woman in my life or anything like that, its just that wasn't something I really wanted. I thought basically we could be good friends and were a good couple together because we know each other pretty well and we know what the other person likes and so forth and he really likes me taking care of him. So it's interesting to me that even having to give up the sex, it really wasn't an option for either one of us. I don't know what's going on with him sexually, whether he is going out and getting it or paying for what he's doing. I don't know that and I don't care to know that. As long as he wasn't going to emotionally, physically, or sexually really harass me, I didn't see any sense in it, in divorcing him at this stage. Marriage is a serious commitment. It's not something I did take [lightly] initially ever and its not something I would just throw away.

During her final interview she described her relationship as more of a friendship that she is comfortable in:

> I've come a long way in my relationship. I think that's what's happened is that when we decided we would just live together, that's about the extent of it. It's not the relationship either one of us wants but we're committed to each other. I mean we're good friends. That's probably the basis of it, we're good friends. I've always had the decision to stick it out. I don't know if my husband always did. I think that it has just taken time for him to settle into not having the relationship he wants and I think that if that relationship was available from another woman that he might leave the marriage. But he doesn't seem compelled to go out and find it

and you know he still likes me enough to want to stay with me. I guess that's part of it.

Each of these women acknowledges problems in their respective relationships and has made the decision to remain in their marriages. In making this decision they report that marriage is a serious commitment and a desire to not disrupt their respective family systems.

Help Seeking Behavior

A second major theme that appeared to differentiate the non-relapsed women from the relapsed women appeared to be the concept of help seeking behavior. Although not reflected in the quantitative inventories, all six of the participants described continued feelings of depression at some point during the 27 month follow-up period. All of the women reported feeling ambivalent about returning to counseling and each reported that they did not want to return to counseling or return to medication. The difference between these two groups existed in the fact that the non-relapsed women sought additional intervention, either resumed counseling or psychotropic medication, despite their ambivalent feelings. In contrast, women in the relapsed group also described ambivalence, however, this ambivalence kept them from seeking additional treatment when experiencing feelings of depression.

Non-Relapsed Group

Despite lower scores on each of the quantitative measures across each of the follow-up periods, women in the non-relapsed group did report continued feelings of depression at some point during the course of the follow-up. In Barbara's case she

continued taking medication during the majority of the follow-up period. When she did identify resumed feelings of depression prior to her 15 month follow-up she initially sought assistance from her family doctor who referred her for counseling:

> So, another thing since I saw you last is, I've been thinking, do you know Dr. Karen Swisher, Dr. Swisher? I've been seeing her once a week for the last couple of months. I went to see my doctor two or three months ago, and I hadn't been to the doctor for a long time so I had a long list of questions. I saw Dr. Neil over at the health center and he said that's nothing to worry about, that's nothing to worry about, that's nothing to worry about. Then he said, 'you know I think you're okay except that you're too anxious. Anyway he just decided that I was anxious instead of falling apart physically and so I was feeling really depressed and weepy and crummy. So he sent me to see Dr. Swisher and I've been going to see her, and I'm not making any correlation between seeing her because I'm not sure I'd go back to see her if I got to feeling really bad again but I do feel a lot better. Things are good at work. Things are good at home. I just feel very positive about things. She asked questions about how do you feel about your future, how do you feel about yourself and I feel good.

Two of the women described being surprised by the recurrence of depression in their lives. Amanda described, "I had to go back on the anti-depressants. Yeah, I just didn't expect that. I didn't realize how important the medication was. I realized I better keep taking it".

Amanda also reported a desire to seek additional treatment in the future as well, "I would be willing if things showed up to take care of it. I wouldn't want to let it get bad again". Barbara similarly described a willingness to seek future services:

> From time to time, there's always been before then and since then. Before January when I started and since then. There's always been the option, well if I really need some help I have no qualms about digging somebody up so you know. I know that its always there if I need it. I am fortunate in that I've lived here a long time. I know where the resources are but, I'm fine.

Interestingly she described belief in her ability to seek services when experiencing mild depression but, concern that she is unable to return for services when feeling severe depression:

> I may have mentioned before but, oh for the last, the first time I had any structured counseling was probably 15 or 20 years ago and ever since then I have a pretty good idea of what it can do for me. I have a pretty good idea, at least my own version of things getting so out of whack that I need to do this, I really need to do this for awhile, get somebody, drag somebody else into this for awhile. I get comfortable that it's a resource, I know its there all the time. I used to, when I'm really, really depressed then I know that its there but I don't think anything is going to help me. Its all hopeless and all horrible, useless and endless and but, when things are not quite that bad then I know that I don't have to worry about things getting really bad because I have this resource. Its just like having money in a savings account.

A willingness to seek future treatment was also reflected in Gail's behavior. Unlike Amanda or Barbara she remained with counseling after the study ended in order to address remaining marital issues:

> I never had a break. I've stayed with it. Tonight is my last night with her. So it has just been wonderful and I've had counseling before in the past and I was much younger, like teenage years but, I really needed it when I came and I really got a lot from it. .... Those sessions were about my own past. We did talk about the marriage some, we were only married about six years. My husband came for the past 2 ½ - 3 months and those sessions were centered pretty much on just us two.

It is important to acknowledge that each of these women did express ambivalence regarding future treatment. In Barbara's case she described not wanting to continue with her prescription for her anti-depressant:

> I tend to feel that way except that I don't like the idea that I can be behaviorally dependent on it number one, and number two, my insurance company doesn't reimburse for it. So its expensive. So every time I go to refill it I go, I don't have to do this.

Gail also described feelings of ambivalence reporting that she does not have time in her schedule to seek future services

> I miss the counseling. I really do. Its just a matter that I don't have the time for it. I have three little children and I have a first grader, she's my oldest, and she is just into new things. We live way out in the country so it is just so hard to find the time.

Despite these feelings of ambivalence, each of these women did seek treatment when feelings of depression did reoccur and this willingness to seek future services appeared to result in continued positive adjustment post-treatment.

Relapsed Group

Women in the relapsed group also reported feelings of ambivalence towards future services and these feelings kept them from receiving additional services when feelings of depression returned. Each of these women described feeling as if future services would be helpful but did not return. Christine described feeling as if future services could be helpful and reported being unsure why she has not continued with counseling:

> I know that counseling is available to me. I have mixed emotions about that, with continuing with counseling. I don't know why, I guess its just my independence. .... I don't know what it is. I don't know, I want to say its pride. I would say that its a, I learned a lot. I went in with the only expectation was that I always wanted to be in joint counseling with my husband and he agreed to do it and it was the first time that he ever had done that. That to me was good because I felt we needed an objective, some objective feedback, from a qualified individual listening to what was going on. I don't know why I'm hesitant and resistant at this point.

Denise also discussed her ambivalence regarding future treatment:

> Well, I don't feel like I've made much progress. Not many things have changed since my last session but, she suggested that I should continue with the counseling but I did not. Mostly because I didn't have the money to do it. Its hard to come down here because my husband works rotating shifts and during the summertime I didn't have my older daughters at home to watch my littlest one so that made it hard.

She also reported believing that continued counseling would be beneficial for her. "They've been about the same. I did not continue with the counseling. I think it probably would have helped if I had". When asked if she has thought about returning to counseling she reported, "I think about it occasionally. Things aren't real bad. Probably if they were I would do that". Despite acknowledging that continued counseling would be helpful, none of the women in the relapsed group sought out additional counseling or pharmacological services.

Chapter V

DISCUSSION

The purpose of the current study was to address the overall lack of follow-up studies examining the treatment of depression in married women. In addition, the study intended to identify whether women were able to maintain gains made during treatment and if not, to identify what factors contribute to relapse or reoccurrence of depressive symptoms.

Limitations

The current findings must be understood in the context of certain limitations. First, the sample size for the study is small, limiting the power of the statistical analyses and preventing the detection of differences between treatment groups if differences were, in fact, present. Replication is needed with a larger sample to confirm that the finding of no differences between treatments are reliable.

Secondly, it is not possible to precisely compare this study with other similar follow-up studies because the follow-up intervals are different from the standard practice intervals. While direct comparison is not possible, general comparisons are possible as this study did follow participants post-treatment for approximately two years. It is important to reinforce the implications of small sample size and the resulting low power when comparing the results of this study with other follow-up studies.

A third limitation involves the fact that the three women in the non-relapsed group of the qualitative analysis reported using psychoactive medications during the course of the follow-up. Women in the relapsed group did not report taking similar psychoactive medications during the follow-up. This difference presents a confound in interpreting the results of the qualitative analysis. It is not possible to determine what role the medication played with respect to symptoms of depression during the follow-up period.

The study did not specifically control for psychoactive medications and, as a result, it is not possible to address the role that these medications played in any definitive manner. Standard psychiatric practice suggests that patients who experience recurrent episodes of depression should remain on medications indefinitely. Studies comparing medications with psychotherapies have produced mixed results. Follow-up studies suggest that patients treated with either medications or psychotherapy are at risk for future difficulties (Jacobson & Hollon, 1996; Shea et.al., 1992). Treatment of these clients would benefit from future studies designed to examine the comparative efficacy of medication, psychotherapy and some combination of the two in maintaining treatment gains following treatment.

Finally, a possible interaction existed between this researcher's developmental growth in therapeutic skills and the length of the follow-up period. At the outset of this study, this researcher possessed entry level interview skills. By the time of the 27 month follow-up, these interviewing skills had developed and improved significantly. In coding the qualitative data, it became apparent that the transcripts were richer at 27 months as compared to the 3 month transcripts. As a result it is not possible to determine how the

information gathered during the follow-up sessions may have changed if it was gathered by a more experienced researcher.

Research Questions Addressed

The first question this study sought to address was whether participants could maintain treatments gains over the course of the two year follow-up period. With respect to symptoms of depression, both client-reported and clinician-rated, it appears as if the women who remained in the study were generally able to maintain treatment gains during the course of the 27 month follow-up period. At 27 months, women in the ICT treatment group did not meet criteria for depression as reflected in both BDI and HAM-D scores. Additionally these women had lower mean scores when compared to post-treatment mean scores. For these women, treatment change scores also reflected a slight drop in symptoms of depression as well. When viewed through the lens of clinically significant responses to treatment, 67% of these participants can be called responders based on their BDI scores and had an 83% response rate as reflected in their HAM-D scores (these response rates can be compared to 80% and 70% respectively at post-treatment).

Participants in the CBT group had comparable mean scores on the BDI at the 27 month follow-up as compared to their scores at post-treatment. Scores were slightly higher on the HAM-D during the follow-up period as well. These mean scores reflected scores in the lower end of the mild depression range. However, percentage scores for clinically significant responses to treatment reflect only 25% rate as reflected by scores on both the BDI and HAM-D at the 27 month follow-up period. This response rate is below

the 30-50% response rate reflected in the literature (Shea et al., 1992; Weissman et al., 1976).

Interestingly, mean scores on the BDI for the CO group increased the most at the 27 month follow-up period. However, results indicated that 50% of these participants are considered to have responded to treatment in a clinically significant manner. The group had a similar response rate based on HAM-D scores at the 27 month period as well. Mean scores for the HAM-D remained fairly consistent throughout the follow-up period and at the 27 month follow-up period they were comparable to scores at post-treatment.

In total, feelings of depression increased slightly over the course of the follow-up period as reflected by the participant's treatment change scores. However, these results suggest that participants, across treatment groups, remained considerably improved when compared to the amount of depression these women were experiencing prior to treatment. At the end of the follow-up period, participants in the ICT group were self-reporting symptoms that did not meet criteria for depression, while participants in the CBT and CO groups were endorsing mild levels of depression. Similarly, based on clinician report, participants in both ICT and CO groups did not meet criteria for depression and women in the CBT group were viewed as experiencing mild levels of depression.

Results of self-reported marital distress are more difficult to interpret. An analysis of variance did not find a significant difference in levels of marital distress over the course of the follow-up period. This finding of no difference is not surprising given the small sample size and limited power of the test. Means scores at the 27 month follow-up period were fairly similar across all three treatment groups. Participants in the ICT and

CO groups were reporting slightly greater marital distress at 27 months when compared to their scores at post-treatment. The mean scores for the CBT group suggests an increase in marital satisfaction at 15 and 27 months when compared to their scores at post-treatment. An examination of participant attrition suggests that the CBT marital satisfaction scores may have been affected by attrition as every participant that discontinued reported moderate to significant amounts of marital distress, and all of the participants reporting marital satisfaction remained throughout the course of the follow-up. In addition, treatment change scores suggest that all groups were reporting a negative mean change indicating increased levels of marital distress.

By contrast, in an examination of participants who were seen as responding to treatment, 75% of the CBT group and 50% of both the ICT and CO groups are considered to have responded to treatment at end of the follow-up period. When these response rates are compared to the percentages at the end of treatment (30% CBT; 50% ICT, 33% CO), the results suggest that as many, if not more, participants have responded to treatment. These percentages must be taken with caution as attrition impacted the percentages during each of the follow-up intervals. Given the fact that few follow-up studies have been completed examining the results of ICT, these results are difficult to place in context. The results of this study may not be as promising as the 70% of couples who continued to respond in another follow-up study (Jacobson et al., 1987).

These results suggest that the participants were able to maintain many of the gains they made during the course of treatment. While the change scores indicate that these women were reporting slightly more marital distress at 27 months, these women are

improved when compared to levels of self-reported marital distress prior to treatment. In total, all of the results indicate that the participants who completed the follow-up period were able to maintain many of the gains achieved during treatment.

The second research question involved whether differences between treatment groups emerged with respect to differential outcomes. As a result of the insufficient sample size and resulting lack of power, it is not possible to answer this question with any degree of certainty. This study would need to be replicated with a larger sample size in order to adequately address this question. As a result of the number of participants who responded to treatment, lower mean scores and slightly lower attrition rates, it is possible that ICT may have been more effective in treating these women's depression, however this inference is only tentative at best. Participants in the CO group also reflected response rates comparable to those found in other follow-up studies (Shea et al., 1992; Weissman et al., 1976). Both of these groups appeared to be more effective in treating symptoms of depression as reflected in mean scores of the clinician-rated HAM-D. Each of the groups appeared equally effective in treating the women's marital distress, however some evidence exists that attrition may have inordinately affected scores in the CBT group.

Two themes emerged during the course of the qualitative analysis which answer the final research questions involving: 1) the reasons for certain participants maintaining treatment gains during the follow-up period; 2) possible factors in other participants being unable to maintain treatment gains post-treatment; 3) and possible behaviors that contributed to certain women maintaining lower levels of depression 27 months post-

treatment. The first contributed as to why certain participants maintained gains while others did not involved the role and quality of the participant's social support systems. For the women who were able to maintain gains during treatment, their social support systems were characterized by husbands who were supportive of their difficulties and actively involved in addressing these difficulties. One way that these husbands were actively involved in their spouse's lives was by encouraging them to seek help for their problems. Not only did these spouses encourage their wives to seek help, but they were also willing to involve themselves in the treatment process. Through this process the husbands learned how to be more helpful by learning more about depression and what is needed to bring about remission of this disorder. These social support systems were also characterized by strong communication and the active involvement of children who were important figures in their mother's lives.

For the participants who were unable to maintain treatment gains, their social networks were characterized by a general lack of support. These husbands were generally disengaged from their spouses and unwilling to acknowledge the existence of problems. A striking example of this was that both husbands who were required to participate in their wife's treatment refused to attend the final counseling sessions. In addition, these support systems were characterized by poor communication. These women found it difficult to take needed time for themselves, consistently stating that if they did not take care of family responsibilities they would not get done. As a result, these women developed resentment towards their husbands in particular, and their whole support systems more generally.

The differences in these support systems was striking and emphasizes the importance of social support systems in maintaining treatment gains for depression. Women who had strong support systems were able to manage difficult life events without experiencing continued feelings of depression. For example, one of the women in the non-relapsed group had a tornado hit her house during the follow-up period. She described being able to deal with this difficult event because she had a family whom she loved and who loved her. In contrast, a participant in the relapsed group faced financial difficulties during the study. This problem was overwhelming and clearly related to her continued difficulties with depression. She described what made this particularly difficult was the fact that her husband was not willing to assist her in managing this problem. These findings are similar to previous research which found that a husband's facilitative behavior contributes to the maintenance of treatment gains post-treatment (Jacobson et al., 1993). This point was emphasized by one participant when she reported an ability to recognize the need for help when experience mild to moderate depression, but that she is unable to make accurate decisions when severely depressed. Husbands, as well as other members of a person's social support network, play a crucial role in encouraging their spouses to get help during times when the depressed individual is unable to think accurately. Clearly, social support is a major factor in either maintaining treatment gains or contributing to a relapse of depression.

A second notable difference between these two groups (relapse versus non-relapse) was the participants' help-seeking behavior. All of the participants expressed ambivalence regarding seeking future services. However, women who were able to

maintain treatment gains sought future services, or continued with treatment, despite these feelings of ambivalence. In contrast, the same feelings of ambivalence kept women who were unable to maintain treatment gains from seeking future treatment. This prominent behavioral difference was a clear factor contributing to those participants who were able to maintain treatment gains throughout the follow-up period.

Several interesting similarities were discovered during the qualitative analysis and are important to emphasize. Possibly the most interesting, and most surprising, was the fact that all of the participants in the qualitative analysis described continued difficulties with depression at some point during the follow-up period. For some, these feelings were not reflected in the standardized inventories and may have occurred between follow-up interviews. This clearly underscores the recalcitrant nature of depression and the challenges facing those who suffer from depression, as well as those individuals who work in the mental health field.

Another commonality among all participants was their commitment to their marriages. Each of the participants described a steadfast commitment to their marriages. This commitment was present in both satisfying and dissatisfying marital relationships. These women were also all employed and described their jobs as being integral parts of their self-images. Participants all viewed their health, depression, marriage, and work as being interrelated and were aware of how difficulties in one area negatively impacted other areas of their lives. Many of these women described learning how interrelated their problems were, and that learning this facilitated improvement during counseling. Finally, all the women viewed counseling as helpful and positive. Even participants who

continued to experience feelings of depression and/or marital distress described counseling as being useful in assisting them with their difficulties.

Conclusions and Future Implications

Given the overall lack of follow-up data in our field, this study provides unique and useful information regarding the treatment of depressed married women. First of all this study provides support for the idea that clients can maintain a significant amount of treatment gains two-years post-treatment. However, it also outlines how difficult depression can be to treat and that many women experience some level of continued difficulties.

Secondly, this study emphasizes the critical role of a strong social support system in maintaining treatment gains over time. In order for treatments of depression to be successful, treatment must work to establish and strengthen the social support networks of clients. Treatments like ICT and Interpersonal Psychotherapy (IPT) are likely to be especially effective in treating depressed married women as both treatments emphasize the importance of social support networks. Future research needs to focus on the specific role of social support systems in treating not only depressed married women, but also depressed individuals more generally. Clinical treatments of depression would likely benefit from incorporating the assessment and monitoring of social support as well as an emphasis on the role this support plays in maintaining treatment gains.

Finally this study reinforces the fact that mental health services must be destigmatized. Given the recurrent nature of depression, clients must be willing to return

for services in the future when feelings of depression reemerge. The participants in this study who were willing to return clearly benefited from additional services. However, it is important to emphasize that even these women were ambivalent about returning. These feelings are reflected in our society and the public continues to associate mental illness with those individuals who are "crazy". Clients would likely benefit from being educated regarding the importance of continued services in the future. This could be done by working to decrease client's ambivalence about returning and working with these individuals to identify markers which indicate that they would benefit from additional services. Members of the client's social support system should also be educated regarding signs of relapse or reoccurrence because family members also play an important role in the long-term adjustment of the client.

Most importantly, more follow-up studies are needed in order to provide more information regarding the impact of interventions over time. Many authors cite the lack of these types of studies in the mental health field as being a weakness (Alexander et al., 1994; Emmelkamp, 1994). It is clear that these studies are difficult to perform and it is difficult to get participants to agree to become involved in a study for many years. These studies are, however, crucial in understanding how our treatments impact our clients over time. Based on the results indicating the tentative favorability of ICT, this treatment should continue to be examined as an effective treatment of depressed married women.

The present study provides solid hypotheses for future research and clinical practice. Future research examining depression should focus on the role of social support in maintaining treatment gains. Clearly this study points to the importance of social

support systems in either facilitating the maintenance of treatment gains. In cases where strong social support systems did not exist, this additional stress appeared to be a factor in the reoccurrence of depression.

This study also highlights the critical need to educate clients about the importance of seeking future treatment if and when a relapse occurs. Every participant included in the qualitative analysis re-experienced symptoms of depression. The women who sought future treatment reported more positive adjustment during the follow-up period as compared to those that did not. Our treatments of depression need to include information related to relapse prevention due to the recurrent nature of this disorder. The differences between the non-relapsed women and the relapsed women in relation to social support and help-seeking behavior are further supported by the fact that the women in the non-relapsed group were experiencing greater levels of depression prior to entering treatment. Despite these increased levels of depression, women in the non-relapsed group were able to benefit from treatment and maintain these gains during the course of the follow-up period. Consistent with the qualitative findings regarding the value of social support, the relapsed women did have lower pre-treatment DAS scores, thus greater levels of marital distress than did the non-relapsed women. Future research examining social support and help seeking behavior using both quantitative and qualitative inquiry is indicated based on the results of this present study.

In conclusion, it is important for us as scientist-practitioners to take a step back and take a larger view of treatment. Far too often, we may focus only on the individual and the current difficulties that client is experiencing. The women in this study clearly

illuminate the importance of social support and the interpersonal system surrounding the client. In addition, we must think beyond the point at which our clients terminate services. Conducting future follow-up studies in these areas will impact not only our clinical practice but ultimately the long term welfare of our clients.

References

Alexander, J.F., Holtzworth-Munroe, A., & Jameson, P. (1994). The process and outcome of marital and family therapy: Research review and evaluation. In A.E. Bergin & S.L. Garfield (Eds.). Handbook of psychotherapy and behavior change (4th Ed.). New York: Wiley.

American Psychiatric Association. (1994). Diagnostic and statistical manual for mental disorders. (4th ed.). Washington, D.C.: Author.

Anderson, J.R. (1995). Cognitive psychology and its implications. (4th ed.). New York: W.H. Freeman and Company.

Baucom, D.H., & Hoffman, J.A. (1986). The effectiveness of marital therapy: Current status and applications to the clinical setting. In N.S. Jacobson & A.S. Gurman (Eds.). Clinical handbook of marital therapy (pp. 597-620). New York: Guilford Press.

Beach, S.R.H., Arias, I., & O'Leary, K.D. (1987). The relationship of marital satisfaction and social support to depressive symptomatology. Journal of Psychopathology and Behavioral Assessment, 8, 305-316.

Beach, S.R.H., Jouriles, E.N., & O'Leary, K.D. (1985). Extramarital sex: Impact on depression and commitment in couples seeking marital therapy. Journal of Sex and Marital Therapy, 11, 99-108.

Bech, P., Gram, L.F., Dein, E., Jacobson, O., Vitger, J., & Bolwig, T.G. (1975). Correlation between clinical assessment, Beck's self rating scale and Hamilton's objective rating scale. Acta Pstchiatr. Scand., 51, 161-170.

Beck, A.T. (1967). Depression: Clinical, experimental and theoretical aspects. New York: Harper & Row.

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). Cognitive therapy of depression. New York: Guilford.

Beck, A.T. & Weishaar, M. (1995). Cognitive therapy. In R.J. Corsini & D. Wedding (Eds.), Current psychotherapies. (5th ed.). Itasca, IL.: F.E. Peacock.

Bergin, A.E. & Garfield, S.L. (1994). Handbook of psychotherapy and behavior change. (5th ed.). New York: Wiley.

Coleman, R.E. & Miller, A.G. (1975). The relationship between depression and marital maladjustment in a clinic population: A multitrait-multimethod study. Journal of Consulting and Clinical Psychology, 43, 647-651.

Cordova, J.V. & Jacobson, N.S. (1993). Couple distress. In D.H. Barlow (Ed.), Clinical handbook of psychological disorders. (2nd ed.). New York: Guilford.

Corsini, R.J., & Wedding, D. (Eds). (1995). Current psychotherapies (5th ed.). Itasca, IL: F.E. Peacock.

Craighead, L.W., Craighead, W.E., Kazdin, A.E., & Mahoney, M.J. (1994). Cognitive and behavioral interventions: An empirical approach to mental health problems. Boston, MA.: Allyn & Bacon.

Craighead, W.E. (1980). Away from a unitary model of depression. Behavior Therapy, 11, 122-128.

Craighead, W. E., Craighead, L.W., & Ilardi, S.S. (1998). Psychosocial treatments for major depressive disorder. In P.E. Nathan & J.M. Gorman (Eds.), A guide to treatments that work, (pp. 226-239). New York: Oxford.

Dobson, K.S. (1989). A meta-analysis of the efficacy of cognitive therapy for depression. Journal of Consulting and Clinical Psychology, 57(3), 414-419.

Elkin, I., Shea, T., Watkins, J.T., Imber, S.C., Sotsky, S.M., Collins, J.F., Glass, D.R., Pilkonis, P.A., Leber, W.R., Fiester, S.J., Docherty, J., & Parloff, M.B. (1989). NIMH treatment of depression collaborative research program. Archives of General Psychiatry, 46, 971-982.

Emmelkamp, P.M.G. (1994). Behavior therapy with adults. In A.E. Bergin & S.L. Garfield (Eds.), Handbook of psychotherapy and behavior change, (4th ed., pp. 379-427.

Evans, M.D., Hollon, S.D., DeRubeis, R.J., Piasecki, J.M., Grove, W.M., Garvey, M.J., & Tuason, V.B. (1992). Differential relapse following cognitive therapy and pharmacotherapy for depression. Archives of General Psychiatry, 49, 802-808.

Foley, S.H., Rounsaville, B.J., Weissman, M.M., Sholomaskas, D., & Chevron, E. (1989). Individual versus conjoint interpersonal therapy for depressed patients with marital disputes. International Journal of Family Psychiatry, 10, 29-42.

Gallagher-Thompson, D., Hanley-Peterson, P., & Thompson, L.W. (1990). Maintenance gains versus relapse following brief psychotherapy for depression. Journal of Consulting and Clinical Psychology, 58 (3), 371-374.

Glasser, B. & Strauss, A. (1967). The discovery of grounded theory. Chicago: Aldine Publishing Co.

Gloaguen, V., Cottraux, J., Cucherat, M., & Blackburn, I.M. (1998). A meta-analysis of the effects of cognitive therapy in depressed patients. Journal of Affective Disorders, 49, 59-72.

Gottman, J.M. (1979). Marital interaction. New York: Academic Press.

Gurman, A.S., Kniskern, D.P., & Pinsof, W.M. (1986). Research on the process and outcome of marital and family therapy. In S.L. Garfield & A.E. Bergin (Eds.), Handbook of psychotherapy and behavior change, (3rd ed., pp. 565-624). New York: Wiley.

Haaga, D.A.F., Dyck, M.J., & Ernst, D. (1991). Empirical status of cognitive theory of depression. Psychological Bulletin, 110 (2), 215-236.

Hahlweg, K. & Markman, H.J. (1988). The effectiveness of behavioral marital therapy: Empirical status of behavioral techniques in preventing and alleviating marital distress. Journal of Consulting and Clinical Psychology, 6, 276-296.

Hahlweg, K., Schindler, L. Revenstorf, D., & Brenglemann, J.C. (1984). The Munich marital therapy study. In K. Hahlweg and N.S. Jacobson (Eds.), Marital interaction: Analysis and modification (pp. 3-26). New York: Guilford.

Hollon, S.D. & Beck, A.T. (1978). Psychotherapy and drug therapy: Comparison and combinations. In S.L. Garfield & A.E. Bergin (Eds.), Handbook of psychotherapy and behavior change, (2nd ed., pp. 437-490). New York: Wiley.

Hollon, S.D. & Beck, A.T. (1986). Cognitive and cognitive-behavioral therapies. In S.L. Garfield & A.E. Bergin (Eds.), Handbook of psychotherapy and behavior change, (3rd ed., pp. 443-482). New York: Wiley.

Hollon, S.D. & Beck, A.T. (1994). Cognitive and cognitive-behavioral therapies. In A.E. Bergin & S.L. Garfield (Eds.), Handbook of psychotherapy and behavior change, (4th ed., pp. 428-466). New York: Wiley.

Hollon, S.D. & Carter, M.M. (1994). Depression in adults. In L.W. Craighead, W.E. Craighead, A.E. Kazdin, & M.J. Mahoney (Eds.), Cognitive and behavioral interventions: An empirical approach to mental health problems, (pp. 89-104). Boston, MA: Allyn & Bacon.

Hollon, S.D., Evans, M.D., & DeRubeis, R.J. (1990). Cognitive mediation of relapse prevention following treatment for depression: Implications of differential risk. In R.E. Ingram (Ed.), Psychological aspects of depression (pp. 117-136). New York: Plenum.

Hollon, S.D., Shelton, R.C., & Loosen, P.T. (1991). Cognitive therapy and pharmacology for depression. Journal of Consulting and Clinical Psychology, 59, 88-99.

Hooley, J.M., & Teasdale, J.D. (1989). Predictors of relapse in unipolar depressives: Expressed emotion, marital distress, and perceived criticism. Journal of Abnormal Psychology, 98 (3), 229-235.

Hunt, M. (1993). The story of psychology. New York: Anchor Books, Doubleday.

Jacobson, N.S., & Addis, M.E. (1993). Research on couples and couple therapy: What do we know? Where are we going? Journal of Consulting and Clinical Psychology, 61, 85-93.

Jacobson, N.S., & Christenson, A. (1996). Integrative couple therapy: Promoting acceptance and change. New York: W.W. Norton & Co.

Jacobson N.S., Dobson, K., Fruzzetti, A.E., Schmaling, K.B., & Salusky, S. (1991). Marital therapy as a treatment for depression. Journal of Consulting and Clinical Psychology, 59 (4), 547-557.

Jacobson N.S., Follette, W.C., & Pagel, M. (1986). Predicting who will benefit for behavioral marital therapy. Journal of Consulting and Clinical Psychology, 54 (4), 518-522.

Jacobson, N.S., Follette, W.C., Revenstorf, D. Baucom, D.H., Hahlweg, K., & Margolin, G. (1984). Variability in outcome and clinical significance of behavioral marital therapy: A reanalysis of outcome data. Journal of Consulting and Clinical Psychology, 52 (4), 497-504.

Jacobson, N.S., Fruzzetti, A.E., Dobson, K., Whisman, M., & Hops, H. (1993). Couple therapy as a treatment for depression: II. The effects of relationship quality and therapy on depressive relapse. Journal of Consulting and Clinical Psychology, 61 (3), 516-519.

Jacobson, N.S., & Margolin, G. (1979). Marital therapy: Strategies based on social learning and behavior exchange principles. New York: Brunner/Mazel.

Jacobson, N.S., Schmaling, K.B., & Holtzworth-Munroe, A. (1987). Component analysis of behavioral marital therapy: 2 year follow-up and prediction of relapse. Journal of Marital and Family Therapy, 13 (2), 187-195.

Kaplan, H. I., & Saddock B.J. (1998). Synopsis of psychiatry: Behavioral sciences/clinical psychiatry (8th ed.). Baltimore, MD: Williams & Wilkins.

Kaelber, C.T., Moul, D.E., & Farmer, M.E. (1995). Epidemiology of depression. In .E.E. Beckham & W.R. Leber (Eds.), Handbook of Depression, (2nd ed., pp. 3-35). New York: Guilford.

Klerman, G.L., Weissman, M.M., Rounsaville, B.J., & Chevron, E.S. (1984). Interpersonal Psychotherapy for Depression. New York: Basic Books.

Koerner, K., Prince, S., & Jacobson, N.S. (1994). Enhancing the treatment and prevention of depression in women: The role of integrative behavioral couple therapy. Behavior Therapy, 25, 373-390.

Kovacs, M., Rush, A.J., Beck, A.T., & Hollon, S.D. (1981). Depressed outpatients treated with cognitive therapy or pharmacotherapy: A one-year follow-up. Archives of General Psychiatry, 38, 33-39.

Margolin, G. (1981). Behavior exchange in happy and unhappy marriages: A family cycle perspective. Behavior Therapy, 12, 329-343.

Markman, H.J., Duncan, W., Storaasli, R., & Howes, P.W. (1987). The prediction and prevention of marital distress: A longitudinal investigation. In K. Hahlweg & M.J. Goldstein (Eds.), Understanding major mental disorder: The contribution of family interaction research. New York: Family Process.

O'Leary, K.D., & Beach, S.R.H. (1990). Marital therapy: A viable treatment for depression and marital discord. American Journal of Psychiatry, 147 (2), 183-186.

Paykel, E.S., Myers, M.J., Dienelt, M.N., Klerman, G.L., Lindenthal, J.J., & Pepper, M.P. (1969). Life events and depression: A controlled study. Archives of General Psychiatry, 21, 753-760.

Robinson, L.A., Berman, J.S., & Neimeyer, R.A. (1990). Psychotherapy for the treatment of depression: A comprehensive review of controlled outcome research. Psychological Bulletin, 108, 30-49.

Rogers, C. (1951). Client-centered therapy. Boston, MA: Houghton Mifflin.

Shapiro, D.A., & Firth-Cozens, J. (1990). Two-year follow-up of the sheffield psychotherapy project. British Journal of Psychiatry, 157, 389-391.

Shea, M.T., Elkin, I., Imber, S.D., Sotsky, S.M., Watkins, J.T., Collins, J.F., Pilkonis, P.A., Beckham, E., Glass, D.R., Dolan, R.T., & Parloff, M.B. (1992). Course of depressive wymptoms over follow-up: Findings form the National Institute of Mental Health Treatment of Depression Collaborative Research Program. Archives of General Psychiatry, 49, 782-787.

Skinner, B.F. (1974). About behaviorism. New York: Knopf.

Snyder, D.K. (1979). Multidimensional assessment of marital satisfaction. Journal of Marriage and the Family, 41, 813-823.

Snyder, D.K., Wills, R.M., & Grady-Fletcher, A. (1991). Long-term effectiveness of behavioral versus insight-oriented marital therapy: A 4-year follow-up study. Journal of Consulting and Clinical Psychology, 59 (1), 138-141.

Spanier, G. (1976). Measuring dyadic adjustment. Journal of Marriage and the Family, 38, 15-28.

Strauss, A., & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage.

Stuart, R.B. (1992). Review of the dyadic adjustment scale. In J.J. Kramer & J.C. Conoley (Eds.), The eleventh mental measurements yearbook (pp. 297-298). Lincoln, Nebraska: The University of Nebraska Press.

Trapp, M.D.C. (1997). The interaction of cognitive-behavioral therapy with integrated couple therapy for the treatment of depression in women. Unpublished doctoral dissertation, University of Oklahoma.

Waltz, J., & Jacobson, N.S. (1994). Behavioral couples therapy. In L.W. Craighead, W.E. Craighead, A.E. Kazdin, & M.J. Mahoney (Eds.), Cognitive and behavioral interventions: An empirical approach to mental health problems. Boston, MA: Allyn & Bacon.

Waring, E.M. (1994). The role of marital therapy in the treatment of depressed married women. Canadian Journal of Psychiatry, 39, 568-571.

Weiss, R.L., & Cerreto, M.C. (1980). The marital status inventory: Development of a measure of dissolution potential. American Journal of Family Therapy, 8, 80-85.

Weissman, M.M. (1979). The psychological treatments of depression: Research evidence for the efficacy of psychotherapy alone, in comparison and in combination with pharmcacotherapy. Archive of General Psychiatry, 36, 1261-1269.

Weissman, M.M., & Kasl, S.V. (1976). Help-seeking in depressed out-patients following maintenance therapy. British Journal of Psychiatry, 129, 252-260.

Weissman, M.M., Kasl, S.V., & Klerman, G.L. (1976). Follow-up of depressed women after maintenance treatment. American Journal of Psychiatry, 133 (7), 757-760.

Zis, A.P., & Goodwin, F.K. (1979). Major affective disorder as a recurrent illness: A critical review. Archives of General Psychiatry, 36, 835-839.

Appendix A

Informed Consent Form

UNIVERSITY OF OKLAHOMA

INFORMED CONSENT FORM

TITLE OF PROJECT:

INTERACTION OF COGNITIVE-BEHAVIORAL THERAPY

WITH INTEGRATED BEHAVIORAL COUPLE THERAPY FOR THE

TREATMENT OF DEPRESSION IN WOMEN

(FOLLOW UP)

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

INVITATION TO PARTICIPATE: You are invited to participate in a follow up study for the current study you have been a participant in. The follow up will focus on the success and maintenance of treatment goals derived from interactive benefits of Cognitive-Behavioral Therapy and Integrated Behavioral Couples therapy for depression.

PURPOSE OF THE STUDY: This project is a follow up study concerned with how women who have received counseling for depression maintain decreased symptoms 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 Behavioral 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 asked to complete objective evaluations of depression and marital satisfaction. Also each participant will be asked to respond to questions focusing on their views of personal therapeutic success and continued improvement. These follow up contacts will be made at 3, 6, 12 and 24 months after treatment has been completed.

RISKS OF PARTICIPATION: The risk involved may be the potential for depression to reemerge for the participant.

BENEFITS OF PARTICIPATION: Follow up contacts may be utilized as booster sessions to treatment. These interviews may facilitate continued mental health and marital satisfaction.

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 from 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 make 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 the Investigator Date

Appendix B

Beck Depression Inventory (BDI)

Beck Depression Inventory (BDI)

Name:_____Marital Status:_____Age:_____Sex:____

Occupation:_____Education:_____

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 one 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 the statements in each group before making your choice.**

1. 0 I do not feel sad.

   1 I feel sad.

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

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

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

   1 I feel discouraged about the future.

   2 I feel I have nothing to look forward to.

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

3. 0 I do not feel like a failure.

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

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

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

4. 0 I get as much satisfaction out of things as I used to.

   1 I don't enjoy things the way I used to.

   2 I don't get real satisfaction out of anything anymore.

3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.

1 I feel guilty a good part of the time.

2 I feel quite guilty most of the time.

3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.

1 I feel I may be punished.

2 I expect to be punished.

3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.

1 I am disappointed in myself.

2 I am disgusted with myself.

3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.

1 I am critical of myself for my weaknesses or mistakes.

2 I blame myself all the time for my faults.

3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.

2 I would like to kill myself.

3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.

1 I cry more now than I used to.

2 I cry all the time now.

3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I ever am.

1 I get annoyed 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 that I look ugly.

15. 0 I can work about as well as before.

1 It takes an extra effort to get started at doing something.

2 I have to push myself very hard to do anything.

3 I can't do any work at all.

16. 0 I can sleep as well as usual.

1 I don't sleep as well as I used to.

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

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

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

1 I get tired more easily than I used to.

2 I get tired from doing almost anything.

3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.

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

2 My appetite is much worse now.

3 I have no appetite at all anymore.

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

1 I have lost more than 5 pounds.

2 I have lost more than 10 pounds.

3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes _____ No _____

20. 0 I am no more worried about my health than usual.

1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation

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

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

21. 0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

Beck Depression Inventory, Psychological Corporation, 555Academic Court, San Antonio, Texas 78204-0952.

Appendix C

Hamilton Rating Scale for Depression (HAM-D)

Hamilton Rating Scale for Depression (HAM-D)

The HAMD-D scale is designed for 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, helplessness, worthlessness)

   0 Absent

   1 These feelings states indicated only on questioning

   2 These feeling states spontaneously reported verbally

   3 Communicates feeling states nonverbally (i.e. 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 he/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 he/she were dead or has any thoughts of possible death of 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 he/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 for activities)

3 Decrease in actual 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 "Paling with" hands, hair, etc.

3 Moving about, can't sit still

4 Hand 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 (physiological 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 Genital Symptoms (i.e., loss of libido, menstrual 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 hypochondrical 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

1 No variation

2 Mild: doubtful or slight variation

3 Severe: clear or marked variation: if applicable, note whether symptoms are worse in AM__ or PM__

19 Depersonalization and Derealization (feelings or 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 or persecution

4 Paranoid hallucinations

21 Obsessive/Compulsive Symptoms

0 Absent

1 Mild

3 Severe

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

Appendix D

Dyadic Adjustment Scale (DAS)

Dyadic Adjustment Scale (DAS)

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. Circle the star under one answer for each item.

Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always 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	Occasionally	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 well?

19. Do you confide in your mate?

20. Do you ever regret that you married (or live together)?

21. How often do you and your 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 love Yes No

31. The stars on the following line represent different degrees of happiness in your relationship. The middle point, "happy," represents 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 will do all 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. I 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.

Dyadic Adjustment Scale, Multi-Health Systems, Inc., 906 Niagara Falls Blvd., North Tonawanda, NY 14120.

Appendix E

Interview Guide for Follow-up Booster Session

Interview Guide for Follow-up Booster Session

Note: Be sure to audio and video record each session and correctly label them. Also, be sure to complete the structured case note after the interview.

1. Female only, spouse interview is available if requested.
2. Administration of: DAS, BDI, HAM-D
3. Assess symptoms specific to HAM-D during interview
4. Overall, how are you now?
    a.) health
    b.) depression
    c.) marriage
    d.) other areas (work, school, etc.)
    e.) how do these areas of your life relate to each other or influence each other
5. How were you doing when you completed your final (12^{th}) counseling session?
    a.) health
    b.) depression
    c.) marriage
    d.) other areas (school, work, etc.)
    e.) how do these areas of your life seem to relate to each other or influence each other
6. Are you doing better now, than before the counseling? How? Describe?
    a.) health
    b.) depression
    c.) marriage
    d.) other areas (school, work, etc.)

e.) how do these areas of you life seem to relate to each other or influence each other

7. If doing better now, what has changed? Do you think counseling worked for you? Was it helpful? Any harm? How did counseling help? (Get specifics on views)

8. General wrap-up, summary and ask. "Is there anything else we can help you with right now?" Do you have any questions about depression, marital issues, counseling?

9. Call us if needed with any questions or concerns. Next follow-up in 3 months (6 months after the second follow-up interview) and then again at 1yrs and 2yrs. Should be in contact and notify us if you move within that time.

Appendix F

Repeated Measures Analysis of Variance (ANOVA) Tables

ANOVA Table for the Beck Depression Inventory (BDI)

Source	SS	df	MS	F	p
Treatment	254.32	2	127.16	.859	.450
Error	1627.90	11	147.99		
Time	284.34	3	94.78	2.08	.149
Time x Trtmnt	33.93	6	5.66	.124	.972
Error	1502.85	33	45.54		

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

Source	SS	df	MS	F	p
Treatment	66.75	2	33.38	.535	.600
Error	686.75	11	62.43		
Time	10.22	3	3.41	.261	.853
Time x Trtmnt	68.68	6	11.45	.876	.523
Error	431.25	33	13.07		

ANOVA Table for the Dyadic Adjustment Scale (DAS)

Source	SS	df	MS	F	p
Treatment	962.22	2	481.11	.269	.769
Error	19637.58	11	1785.24		
Time	779.18	3	259.73	.869	.452
Time x Trtmnt	796.71	6	132.79	.444	.814
Error	9860.42	33	298.80		

Appendix G

Reliability Table for All Measures

(BDI, HAM-D, DAS)

Reliability Table for All Measures

Measure	N	Cronbach's alpha
BDI:		
post-treatment	30	.8834
3 month	24	.8978
15 month	17	.7757
27 month	14	.8459
HAM-D:		
post-treatment	30	.8786
3 month	24	.6843
15 month	17	.7700
27 month	14	.7237
DAS:		
post-treatment	29	.9383
3 month	22	.9738
15 month	17	.9645
27 month	13	.9583