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SELF-HELP PREFERENCES FOR THE ALLEVIATION OF DEPRESSION

A Dissertation

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Degree

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DEDICATION

This dissertation is dedicated to my mother, Enola Story Brandon (1924-1983), and to my brother, Edward Dennis Brandon (1943-1987).

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ABSTRACT

The purpose of this study was directed toward answering the question: Is one self-help approach preferable to another for relieving depression? It was hypothesized that equal numbers of people would select the affective, behavior, cognitive, and eclectic categories as their preferred self-help approach for the alleviation of depression. Five hundred subjects were interviewed. The sample included 306 females and 194 males. The age range was from 12 - 70. There were 197 students in the study and the remainder of the subject ($\underline{N}$ = 303) were classified as professionals and managerial, semiprofessionals and small business owners, skilled, and semi-skilled.

Data were collected using a phenomenological interview and a survey form based on Simon's (1978) Values Clarification Grid. Subjects were asked the question: When you are feeling depressed, what are your methods for improving the situation? Following the completion of the survey and interview, the subjects chose their preferred self-help approach (i. e., affective, behavior, cognitive, and eclectic).

The main finding of this study was that the hypothesis was rejected. A slight preference was expressed for the affective category. However, there was enough

representation in each category to support the idea that counselors and psychotherapists should be skilled in using treatment procedures from all categories.

Additional findings included a significant effect of gender and occupational level on self-help preference. Age was not found to have an effect on self-help preference for the alleviation of depression.

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CHAPTER I

INTRODUCTION

Statement of the Problem

Harper (1959) reported that 36 systems of psychotherapy were documented in the literature. By 1984, the number of systems exceeded 250 (Corsini, 1984). Implicit in each system is a theory of why people feel depressed and what is needed to alleviate depressed feelings. However, disagreement exists among the theorists as to whether the best avenue for alleviating depression is through cognitive restructuring, behavior change, affective exploration, or some combination of the three (Ellis, 1962; Glasser, 1965; Rogers, 1951). Therefore, the present study was directed toward answering the question: Is one self-help approach preferable to another for relieving depression?

Hypothesis

It was predicted that there would be no significant differences among the frequencies of people choosing affective, behavior, cognitive, and eclectic self-help techniques for relieving depression.

Assumptions

This research was based on the assumption that individuals can identify their preferred self-help approach and categorize that approach as an affective, behavior, cognitive, or eclectic approach. Equally important was the assumption that a goodness-of-match may exist between the preferred self-help approach of an individual seeking counseling and the approach used by the counselor.

Rationale

In comparison studies of psychotherapies, no one form of psychotherapy has emerged as a preferred treatment for depression and other problems (Luborsky, Singer, & Luborsky, 1975; Shapiro & Shapiro, 1982; Smith & Glass, 1977). A range of structured psychological treatments, often based on different underlying theories and emphasizing different therapeutic components, has been shown to be effective. As yet, none of the treatments have been shown to be consistently more effective than the others (Teasdale, 1985).

One possible reason for the lack of an identified superior approach to counseling may be that people differ in their preferred self-help approaches toward problem solving and an individual's preferred self-help approach may

be the most appropriate approach to use in the counseling setting. Heppner (1978) wrote that individuals have an optimal orientation (mental set) or an inferred predisposition toward problem solving. More specifically, Rippere (1980) has stated that individual preferences for approaches for the alleviation of depression are so diverse that treatment should be tailored to the individuals own particular needs.

Tailoring treatment to the particular needs and preferences of the individual has not been a widely practiced procedure. Traditionally, treatment procedures are determined a result of an allegiance, by the counselor, to a particular theorist and therapy. For example, those who align themselves with Glasser believe that a behavior change should be the focus of therapy. Glasser (1965) believes that depression is best eliminated by positive action on the part of the client. Rogers (1951), from a different perspective, supports the view that exploration of the affective domain should be the focus. He contends that depressed people should be encouraged to share feelings and ideas leading to such introspective techniques as exploration, understanding, and acceptance of self. A third focus comes from Ellis (1962) who wrote that cognitive restructuring must occur before an affective and/or behavior change can take place. Treatment of depression involves helping the client restructure the self-defeating ideas

creating the depression thereby leading to better feelings. Goldfried (1980) concluded that allegiance to one theoretical camp over another seems to be based more on "who" is right and not "what" is right and strict adherence to one theory may lessen the effectiveness of counselors and therapists.

Problem-solving researchers have also suggested that the nature of the problem contributes significantly to the problem-solving approach chosen. They stressed the importance of the counselor and the client fully exploring and understanding the problem. They have also stressed the need for researchers to focus more on "real-life" problems rather than the more frequently used laboratory problems.

In summary, although psychotherapy has been shown to be effective, no one approach has been shown to be consistently more effective. Some researchers have suggested that perhaps important dimensions of the counseling process have been neglected. More specifically, problem-solving researchers have stressed the need to know more about the client's preferred self-help approach to problem solving and the effectiveness of matching the treatment used by the counselor to the preferred self-help approach of the client. Forcing clients to adapt to the counselor's preferred approach may be antitherapeutic (Goldfried, 1980).

It is also suggested that the problem-solving approach used by the client is determined by the nature of the

problem. Therefore, counselors need to explore the nature of the problem as well as the preferred approach of the client. The data collected for this research was limited to preferred problem-solving or self-help approaches for the alleviation of depression. Approaches were categorized as affective, behavior, cognitive, or eclectic. The results of this study have implications for the question of whether or not an eclectic orientation should be employed in counselor training programs.

Definition of Terms

Affective

The affective approach was described as dealing directly with feelings, expression, and/or exploration of feelings, e.g., talking to others about feelings, prayer, meditation.

Behavioral

The behavioral approach was described as active participation, deliberate behavior change directed toward alleviating depression, accomplishing something worthwhile, being productive (in other words, any task-oriented method as opposed to defense-oriented or avoidance method such as taking drugs, excessive sleeping, eating, withdrawing, etc). (Coleman & Glaros, 1983).

Cognitive

The cognitive approach was described as thinking strategies, e. g., self-thoughts, self-statements, thinking/ analyzing problem, planning.

Defense Orientation

Defense orientation was described as any method directed toward temporary relief and putting problems on hold.

Depression

Depression has been defined in many ways. Hall (1986) discussed the range of depression from mild (a down feeling caused by some sort of disappointment that lasts for a few hours to a couple of days) to moderate (a longer lasting period caused by a trauma of up to one year), to severe and incapacitating (generally considered clinical depression). Symptoms of depression include low energy levels, feelings of inadequacy, decreased productivity, and tearfulness (DSM III, 1980); self-depreciation, gloomy thoughts, and dejection (English and English, 1958); and feelings of unworthiness, discouragement, and sadness (Coleman & Glaros, 1983). This study was directed more toward mild depression, generally experienced by most individuals at some point in their life. There was no problem defining depression for the subjects participating in this study. The fact that

very few subjects asked for a definition was consistent with Rippere's (1977c) findings. She found that individuals with no formal training in psychology could recognize and describe depression in themselves and what to do to alleviate depression.

Eclectic

The eclectic approach was described as any method that involves two or more of the above methods, e. g., some may exercise (behavioral) and explore their feelings (affective) at the same time.

Phenomenological Interview

The process of collecting descriptive data about the human experience. Data are collected by posing to the subject appropriate questions which would elicit data that tap a description of the individual's experience of the topic being investigated (Colaizzi, 1978).

Task Orientation

Task orientation was described as any method directed toward solving the problem.

Limitations

The sample of subjects used in the present study was limited to volunteer subjects in the East Tennessee area. Any generalization of the data from this study is limited to populations likely to submit to an interview upon request.

CHAPTER II

REVIEW OF LITERATURE

Little research has been done in the area of self-help approaches directed toward the alleviation of depression. No research was found in which self-help approaches were analyzed and categorized in a way relevant to counselors (i. e., affective, behavior, cognitive, or eclectic). A review of related literature included; treatment comparison research in psychotherapy, comparison research for the treatment of depression, problem-solving research, and self-help research.

Treatment Comparison Research

Psychotherapy is taken to mean the informed and planful application of techniques derived from established psychological principles, by persons qualified through training and experience to understand these principles and to apply these techniques with the intention of assisting individuals to modify such personal characteristics as feelings, values, attitudes, and behaviors which are judged by the therapist to be maladaptive or maladjusted (Meltzoll & Kornreich, 1970). According to theorists, psychotherapies differ not only in therapists' mental operations but also in the therapists' verbal and nonverbal techniques and that

these technical prescriptions follow systematically from each theorist's view of human nature and personality change, and each theory is generally to be applied across large classes of clients (Stiles, Shapiro, & Elliott, 1986). However, despite clear demonstrations by process researchers of systematic differences in therapists' techniques (DeRubeis, Hollon, Evans, & Bemis, 1982; Luborsky, Woody, McLellan, O'Brien, & Rosenzweig, 1982) most reviews of the effectiveness of different therapeutic approaches show little or no differential effectiveness. Therefore, "unconditional judgements of superiority of one type or another of psychotherapy, and all that these claims imply about treatment and training policy are unjustified" (Smith & Glass, 1977, p. 760).

Traditionally, therapists have operated from within a given theoretical framework, often to the point of being completely blind to alternative conceptualizations and potentially effective intervention procedures (Stiles, et al., 1986). However, contemporary research indicates that there is a slight, but clearly growing trend toward questioning whether all the answers may be found within any given school of therapy. Therapists are beginning to ask themselves such questions as: (1) Where does our approach fail, (2) what are the limits to our paradigm, and (3) do other approaches have something useful to offer? (Goldfried, 1980).

We do not know whether there are psychotherapies that produce substantially better results and are especially suited to certain clients. We need to focus on particular forms of therapy that work exceptionally well with a few clients and seek to define the characteristics of both the therapy and the clients that lead to successful results (Frank, 1979). It seems probable that verbal, psychologically-minded people who have motivation for insight do well with insight therapies whereas those who are oriented to solving their problems by actions may do better with behavior approaches. Classifying clients in terms of categories more relevant to different forms of therapy is a promising area of goodness-of-match between the client and therapist. In summary, researchers need to determine what treatment, by whom, is most effective for what individual with what specific problem, under which set of circumstances (Frank, 1979).

Theories of Depression

Depression was chosen as the problem to be addressed in this study. Theories of depression reflect the theorist's views about the nature of depression and the most appropriate treatment for the alleviation of depression. The causes and preferred treatment of depression for affective, behavior, and cognitive theories will be discussed. A short discussion of the pharmacological

approach is included because of the predominant use of drugs in the treatment of depression.

Behavioral and reality based therapies. Behavioral theorists have suggested that depression amounts to a reaction to loss or anticipated loss (Glasser, 1965; Lewinsohn, Teri, & Hoberman, 1983; Seligman, 1975). Glasser (1965) stated that people who are depressed have lost the ability of meet their needs: (1) to love and be loved, and (2) to feel worthwhile. Healthy individuals fulfill these needs by maintaining a satisfactory standard of behavior. Irresponsible behavior leads to the inability to fulfill these needs and many familiar psychological symptoms appear from mild discomfort through anxiety and depression to complete withdrawal from the world around us. As a result of the pain or discomfort experienced, individuals become motivated to engage in some activity to try to relieve the pain. They deny the reality of the world around them and engage in behavior that is irresponsible, inadequate, and unrealistic. Thus, they are unable to fulfill their essential needs and become "ill." Behavior must be evaluated, and having evaluated it, it must be improved to meet satisfactory standards, or the needs to love and be loved and to feel worthwhile will not be fulfilled. People must learn to correct themselves when they do wrong and to credit themselves when they do right.

Morals, standards, values, or right and wrong behavior are all intimately related to the fulfillment of our need for self-worth and a necessary part of Glasser's treatment, reality therapy. Individuals must be motivated to change their behavior by looking honestly at their own behavior to determine whether or not it contributes to the fulfillment of needs. It is the job of the therapist to help clients become more responsible so they will be able to satisfy their needs. To obtain help in therapy, individuals must gain or regain involvement first with the therapist and then with others. Reality therapy consists of: (1) involvement with the therapist, (2) rejecting irresponsible, unrealistic behavior, and (3) teaching clients better ways to fulfill their needs within the confines of reality. Clients, rather than the therapist, must decide whether or not their behavior is irresponsible and whether they should change it. Clients must open up their lives, talk about new horizons, expand their range of interests, and become aware of life beyond their difficulties. Reality therapists do not ask "why" but "what." The therapist points out the reality of what individuals are now doing to help bring about more conscious and responsible control. After clients admit their behavior is irresponsible, relearning occurs. Behavior gradually changes from irresponsible to responsible. Therapy is successful when clients are able to give up denying the real world and recognize that reality

not only exists but their needs must be fulfilled within reality's framework. In summary, the basic job of the therapist is to become involved and get the client to face reality.

Self-help therapies. Self-help therapies for depression are an extension of the behavior approach. Self-management therapies are based on the idea that when individuals become aware that their behavior is not producing the desired or expected positive reinforcement, they can then engage the three stage sequence of behaviors (i.e., self-monitoring, self-evaluation, and self-reward) which act as a feedback loop to modify the behavior in question (Rehm, 1984). A modification of this model (Rehm, 1984) adds a self-attribution component. The assumption is that self-evaluation cannot occur unless individuals attribute the cause of the behavior to themselves. This model assumes that people can modify their own behavior in the same way in which one person might modify the behavior of a second person (Rehm, 1984). This model hypothesizes that the important core behaviors in depression could be described in terms of deficits in the various stages of the self-control sequence. Self-control is concerned with behavior which people engage in when they perceive a change in reinforcement contingencies or available reinforcements. Thus, the model may be particularly applicable to situations

which have been linked to depression, such as loss or perception of loss of reinforcement. Lewinsohn and Arconad (1981) view depression specifically as a response to a loss or lack of response contingent positive reinforcement.

Elements of the self-control model parallel and draw from other behavior and cognitive models of depression. Beck's conception of cognitive distortion is represented, Seligman's (1975) concept of learned helplessness is incorporated in the self-attributional components, and Lewinsohn and Arconad's behavior model (1981) is supplemented by the self-control model in that it assumes that both self-administered as well as externally administered reinforcement may be influential in producing depressive overt behavior (Rehm, 1984).

Cognitive and cognitive-behavioral based theories.

According to cognitive theorists, the root of depression is a negative cognitive set. Depressed individuals are seen as having a negative view of self, the world, and the future (Beck, 1967; Ellis, 1962). Depressed people see themselves as deficient and inadequate, they consistently construe their experiences in negative ways, and believe their current difficulties will continue indefinitely. According to this view, hopelessness and helplessness represent the central features of human depression and it emphasizes the

role that disturbances in thinking play in determining emotional states (Shaw, 1977).

Treatment involves altering the negative cognitive set with the expectation that remaining symptoms and behaviors characteristic of depression will be eliminated (Shaw, 1977). The overall treatment objective is the systematic modification of faulty patterns of thinking. Initially, treatment focuses on clients "automatic thoughts" (Beck, 1967). After the clients learn to identify these depressant cognitions they are trained to challenge the validity and alter the cognitions that are distorted or dysfunctional. As therapy continues, clients' assumptions underlying the depressant cognitions are examined and modified. Clients are persuaded to adopt a more realistic appraisal of self and environment.

Recent years have seen an integration of Beck's definition of depression with that of the behavioralists'. Treatment includes both an attempt at helping clients obtain a more realistic appraisal and practical homework assignments to give clients an opportunity to try themselves out. The best known of the cognitive-behavioral therapies is rational-emotive therapy (RET) developed by Albert Ellis (1962). The basic rationale for cognitive-behavioral therapy is that emotional distress is a result of self-defeating irrational thoughts with which individuals continue to reindoctrinate themselves. Negative emotional

reactions to events are caused not by the events themselves but rather by the interpretation of the events. The goals of the cognitive-behavioral therapist are fundamentally those of helping clients to perceive maladaptive cognitions, realize their detrimental impact, and replace them with more appropriate and adaptive thought patterns (Ellis, 1962; Graff, Whitehead, & LeCompte, 1986). In summary, cognitive, cognitive-behavioral therapies focus on clients' thoughts in an attempt to help clients to alter their self-thoughts.

Person-centered theory. According to person-centered theorist Carl Rogers (1951), the incongruence between self and experience leads to psychological maladjustment. Inner feelings are denied and trust in those feelings rejected. There is a discrepancy between the way in which people view themselves and their actual experience. Defenses of denial and distortion are developed to deal with resulting tension, confusion, and depression that occurs when individuals' perceptions of self-worth is not congruent with inner feelings. Discordant or incomprehensible behavior will follow, producing vulnerability, anxiety, or threat.

Treatment of depression involves the process of introspection. The therapist helps clients become aware of, understand, and accept inner feelings. The focus of therapy is on the therapeutic relationship of the client and therapist. Rogers (1951) wrote that the trusting

relationship established between client and therapist provides the safe, supportive atmosphere necessary for the client to engage in self-exploration of feelings. This atmosphere is created by the therapist who shows empathy, positive regard, and genuineness. As clients begin to explore and understand feelings, there is no longer any need for distortion or denial. Clients learn to trust their own values. As clients experience themselves and discover their emotional reactions, they begin to have a positive liking for themselves and discover the capacity for self-control. Clients explore thoughts and feelings and their effects on behavior and personal growth. Ideas are shared about life and life's problems, conscious awareness is expanded, and clients are able to reorganize feelings, thoughts, and behavior with more congruency, and openness to experience. In summary, the main goal of the therapist is to help clients become more autonomous, spontaneous, and confident. The major technique in doing this is active listening.

Pharmacological theories. Some theorists support the notion of a biological theory of depression as a result of a chemical imbalance in the brain. Much of the theorizing has dealt with the neurotransmitters norepinephrine, serotonin, and dopamine. Debate continues as to whether it is too much or too little of these neurotransmitters that results in depression.

Treatment by antidepressants and monoamine oxidase inhibitors is used to regulate the production and level of neurotransmitters in the brain (Weissman, 1979, 1984). Electroconvulsive therapy (ECT) is also used. A jolt of electricity is applied to the individual creating a similar reaction in the brain to that of a naturally-occuring epileptic seizure. Although most agree that some kind of psychotherapy enhances the effects of pharmacotherapy, there continues to be a steadily increasing reliance on the use of drugs for the alleviation of depression (Weissman, 1979, 1984).

In summary, Glasser supports a behavioral approach for depression, Rogers, an affective approach, and Ellis, a cognitive approach. Biological theorists explain and treat depression with a physiological approach designed to remediate chemical imbalances within the patient.

Research on Treatment of Depression

Reviews of the efficacy of psychotherapeutic treatments and depression are hampered by the limited research in particular therapy orientations. To date, studies have focused on antidepressant medications and verbal interviews (behavioral, cognitive, and nondirective). Little research exists for the psychodynamic, humanistic, or existential treatments for depression (Weissman, 1979, 1984). Although a variety of behavioral approaches were represented in the

literature, no research was found comparing Glasser's reality therapy with other treatments.

To date, no research has been done comparing self-help preference and the use of that preference in a formal counseling setting for the treatment of depression or other problems. Researchers have focused on the effectiveness of different therapeutic approaches in which random assignment was used to determine the treatment each subject would receive. There has been no indepth attempt to determine the approach most appropriate for each subject or client. A study by Skinner (1984) gave individuals an opportunity to select their preferred approach following a written description of different treatment approaches, or audio-, video-taped simulated counseling sessions using different treatment approaches. Skinner found that matching clients with their stated preference showed support for the self-selecting process over random selection when choosing a treatment. Perhaps self-selections would be more effective following a comprehesive analysis of individuals usual problem-solving or self-help approaches. The following review of literature relating to the effectiveness of different counseling approaches for the alleviation of depression is mostly limited to studies of random treatment assignment.

Comparison studies for alleviating depression are inconclusive. While cognitive therapy for depression

probably has the most consistent evidence for effectiveness with clinical populations, it does not stand clearly apart from other alternative approaches (Teasdale, 1985).

A study by Taylor and Marshall (1977) compared cognitive, behavioral, and a sequential cognitive and behavioral treatment and found the sequential treatment was better than either treatment alone and that cognitive and behavioral treatments did not differ between themselves. At follow-up the differences were maintained. The authors determined that for mildly depressed people, cognitive and behavioral treatments were both effective and beneficial.

Shaw (1977) compared cognitive-behavioral, behavioral (social skills training), non-directive and a waiting list control group. He found that the cognitive-behavioral approach resulted in significantly fewer depressive symptoms after treatment than all other groups. However, at follow-up, Shaw found all three active treatments to be equal. Shaw found that the nondirective approach was as effective as the behavioral approach. Based on this study, discussing one's difficulties with interested persons, as Rogers (1951) suggested, seems to have a powerful treatment effect (Shaw, 1977).

Zeiss, Lewinsohn, and Munoz (1979) compared the effects of three treatments on depression. The three treatments included interpersonal skills training, pleasant activities schedules, and cognitive training. In general, patients

became less depressed as a result of treatment. However, patients did not improve differentially, dependent on the kind of treatment they received.

Skinner (1984) compared cognitive-behavioral therapy with behavioral therapy (social-skills training) in the reduction of depression and found no significant differences between the interventions. However, this study did find that comparison between self-selection of treatment and random assignment of subjects to treatments showed strong support favoring the superiority of the self-selecting process when choosing an intervention.

A study by Wilson, Goldin, and Charbonneau-Powis (1983) found that both cognitive and behavioral treatment (social-skills training) had equivalent beneficial effects on depression. Both types of intervention were found to be similarly effective in reducing the severity of depression in the first four sessions of therapy, leading the authors to conclude that neither treatment had any advantage in the rapidity with which effects are obtained. Treatments were found to be equally effective at follow-up.

Eaton (1986) compared the effects of cognitive and nondirective group psychotherapy on the depression of assaulted wives. The hypothesis was that beneficial properties of group therapy would significantly decrease depression and increase self-esteem. An increase in self-esteem was found in both the cognitive and non-directive

groups as compared to the waiting list control group. However, participants in the cognitive group evidenced significantly higher self-esteem than the non-directive group.

Graff, Whitehead, and LeCompte (1986) compared group treatment with divorced women using cognitive-behavioral and supportive-insight therapy. Both treatments were effective immediately after treatment. Clients in both had generally less depression. Four months after treatment, effects for the support-insight group were not as strong as for the cognitive-behavioral group.

Beach, and O'Leary (1986) compared individual cognitive therapy with conjoint behavioral marital therapy for couples experiencing marital discord and where the wife was experiencing depression. Wives receiving either treatment showed significant positive results in relieving depression.

Two studies were found comparing self-control therapy with other therapeutic approaches. In a study by Fuchs and Rehm (1977), a behavior program based on a self-control model of depression was evaluated against a nonspecific group therapy condition and a waiting list control. The nonspecific group therapy was developed around a nondirective framework. The self-control therapy procedure was clearly and consistently superior to the other two conditions. However, these differences between conditions appeared to dissipate somewhat at a 6 week follow-up.

This was due in large part to follow-up improvement by the subjects in the nonspecific therapy condition. It was reported that individuals in the nonspecific therapy condition tended to seek additional therapy following the conclusion of the study. However, the researchers concluded that a short-term therapy program based on a self-control model of depression can have a significant effect in alleviating moderate degrees of depression.

A study by Kornblith, Rehm, O'Hara, and Lamparski (1983) compared four treatment conditions to assess the efficacy of the treatments on depression. Treatment conditions included comprehensive self-control, self-monitoring plus self-evaluation, principles-only condition (behavior homework assignments) and psychotherapy. Significant improvement was found for all groups except the self-monitoring plus self-evaluation group as measured by the MMPI-D. Subjects who had evidenced improvement at posttesting generally maintained it at follow-up.

Perhaps the most unexpected and provocative finding has been the superiority of psychotherapy to drug therapy. Cognitive therapy has been found to be superior to tricyclic antidepressants among depressed patients attending general practice, but not in patients attending psychiatric clinics (McLean & Hakstian, 1979; Murphy, Simons, Wetzel, & Lustman, 1984). Rush, Beck, Kovacs, & Hollon (1977) found behavioral therapy to be more effective than antidepressant medication

on symptom reduction. Since 1979, there has been an increase in the number of studies that test psychotherapies in combination with drug therapy. These studies have found the combination of psychotherapy and drugs more effective than either treatment alone (McLean & Hakistan, 1979; Weissman, 1984).

One possible explanation for the success of cognitive and behavioral approaches is the fact that a great deal of structure is used and the counselor takes an active and direct role. These approaches place more emphasis on motivating clients to commitment and hard work. Another possible explanation is "homework assignments" typical of behavior and cognitive-behavior approaches. Many theorists advocate the use of self-directed homework assignments (Ellis, 1962; Glasser, 1965). Homework assignments involve specific assignments that encourages clients to think about and work on therapy between sessions (Zeiss, Lewinsohn, & Munoz, 1979). Graff et al. (1986) believed that therapists should provide training that has some significance to clients in handling their life. Therapists should emphasize the independent use of these skills by the client outside of therapy.

Weissman (1979) has cautioned that in the few existing studies of direct comparisons there has been a tendency for the treatment that is the usual modality of the research group to be shown as more efficacious by that group.

Undoubtedly, this is related to their greater experience with that particular treatment. It is natural to question whether or not, despite care in the design, the therapeutic alliance of the experimenters might in some way influence the results.

In summary, it appeared that psychological treatments were successful in alleviating depression, that fully behavioral treatments had a measurable effect and that this was enhanced by the addition of a cognitive component. It remains to be seen whether the success of these techniques depend upon the type of depression disorder manifested and whether they are applicable across a full range of verbal reasoning ability, educational level, and social-economic class. Further research is needed to ascertain whether these approaches are applicable to a wide variety of clients, or if the careful matching of client to treatment modality would yield more favorable results.

Problem-Solving Research

The area of problem-solving research has more specifically addressed the process of individual needs in the problem-solving process. Although preferences for individual problem-solving approaches dealing with real-life problems have been neglected, researchers have suggested that a preference for a problem-solving or self-help

approach exists and that the preferred approach is most likely determined by the nature of the problem.

Problem-solving refers to the process by which people discover or identify effective means of coping with problematic situations encountered in daily living (Nezu & Ronan, 1985). Assisting clients in coping with problematic situations is central to counseling and psychotherapy (Fretz, 1982; Heppner, 1978). Heppner (1978) stated that counseling is a problem-solving process and the counselor, as facilitator, helps the client to determine the approach for solving the problem (Heppner, 1978).

Evidence suggests that individuals may have an optimal problem-solving mental set (D'Zurilla & Goldfried, 1972). Neufeldt (1978) stated that:

> If individuals are accustomed to solving problems in particular ways, then they would be most comfortable in continuing to do so and it makes sense for counselors to assess the client's usual problem-solving strategies before determining a method of treatment. (p. 187)

Problem-solving mental sets or styles might be described as the unique manner an individual approaches, responds to and acts in a problematic situation (Phillips, Pazienza, & Ferrin, 1984). Researchers have found differences across problem-solving styles, specifically in

terms of cognitions, behaviors, and affect (Heppner, Hibel, Neal, Weinstein, & Rabinowitz, 1982). A range of cognitive, behavioral, and affective activities exist that increase or decrease the probability of cueing effective, task-oriented responses during a very complex chain of events. Research is needed to determine the frequency of various behavioral, cognitive, and affective responses across problem types and problem solvers.

Investigators maintained that the problem type is of utmost importance in solving a problem (Heppner, 1978; Maier, 1970; Michenbaum, Henshaw, & Himel, 1982). Strong support existed for a clear definition and understanding of the problem. Good problem solvers understood the essence of the problem and were able to translate vague or unfamiliar terms into simpler and more concrete terms (Heppner, 1978).

It has also been found that good problem-solvers approach rather than avoid their problem and were more systematic with their approach. They were more aware of their problem-solving processes and generated more alternative solutions to problem solving (Heppner, 1978; Heppner, et al., 1982). Some researchers suggested that specific training in judging alternatives increased one's ability to select better solutions (Heppner, 1978; Johnson, Parrott, & Stratton, 1968). Self assessment of one's behavior, knowledge, emotions, feelings, and environment helped individuals to identify the effectiveness or

ineffectiveness of their problem-solving approaches (Heppner, 1978).

For counselors who are interested in real-life problem solving with real-life consequences, problem-solving research appears to be generally irrelevant (Heppner, et al., 1982). Problem-solving research has focused on the processes of solving predetermined laboratory problems: situations that do not adequately represent real-life problem-solving processes (Heppner et al., 1982; Janis & Mann, 1977). Most problem-solving studies performed in psychological laboratories present the problem explicitly defined. Solving predefined laboratory problems may be different or less complex than how people solve real-life personal problems and subsequently offer little assistance for counselors in helping clients define vague and ambiguous problems (Heppner & Petersen, 1982). More research needs to be conducted in naturalistic settings with real-life problems (Heppner, 1978; Heppner et al., 1982; Heppner & Petersen, 1982).

The literature on problem solving and depression supports the idea that good problem solvers were less vulnerable to depression and experienced fewer symptoms of depression (Heppner, Baumgardner, & Jackson, 1985; Nezu & Ronan, 1985). Heppner et al. (1985) found that individuals who rated themselves as high on problem-solving confidence, use of approach behaviors, and personal control reported

fewer personal problems and depression. The Nezu and Ronan (1985) study indicated poor problem-solving skills were associated with higher levels of depression. The authors suggested that intervention based on existing problem-solving skills may prove fruitful in reducing vulnerability to depression.

Much remains unknown about the process of how people attempt to and actually do solve real-life problems (Heppner, et al., 1985; Nezu & Ronan, 1982). Problem-solving investigators have not provided an understanding of the psychological processes of people who approach problem solving differently (Heppner, Reeder, & Larson, 1983). We need to determine how a counselor can best facilitate the development of effective behaviors associated with the client's optimal mental set or problem-solving style. Little empirical evidence is available as to the effectiveness of various techniques, especially in comparison or conjunction with one another (Heppner, 1978). New models or theories may be needed to conceptualize the real-life, problem-solving process (Heppner et al., 1982).

In summary, problem-solving researchers have suggested that individuals may have an optimal problem-solving style or set and that differences exist across problem-solving styles in regard to cognitions, behavior, and affect affecting the problem-solving process. The approach used is

determined by the problem type and good problem solvers tend to experience less depression.

Self-Help Research

Ten million Americans a year suffer from depression. Most of these people try to cope with depression on their own (Bales, 1986; Rippere, 1976, 1977a, 1980). Self-initiated attempts to cope with depression appear to be frequent occurrances. Folkman and Lazarus (1980) found that research has focused on individuals who exhibit either pathology or superperson characteristics. Little attention has been paid to individuals in the general population who undertake self-help programs to control a problem behavior (Bales, 1986; Doefler & Richards, 1981; Folkman & Lazarus, 1980; Perri & Richards, 1977; Rippere, 1980).

Perri and Richards (1977) studied university students in an effort to determine those factors and methods crucial to successful self-help approaches used by these students for controlling smoking, overeating, studying, and dating. They found that students who are successful in controlling these areas of their lives reported using more techniques for longer periods of time, using self-reinforcement procedures, and using a wide variety of methods depending on the problem. The most dramatic difference between the successful and unsuccessful subjects was the use of covert and overt reinforcers. Reinforcers were used over three

times more frequently among successful self-controllers than among unsuccessful ones.

Doefler and Richards (1981) focused on the role of behavioral self-control techniques in self-initiated efforts to alleviate depression, specifically on the differences between people who had successfully coped with depression on their own and those who had not. No differences were found between the two groups in regard to whether or not they used standard self-control techniques, number of self-control attempts, or in duration of problem. However, there was a difference between groups in how they used self-control techniques. Successful subjects often made dramatic changes in their social environment, whereas few unsuccessful subjects did. The successful subjects reported making these changes with the explicit intention of alleviating depression, whereas none of the unsuccessful subjects reported this.

A series of studies by Rippere (1976, 1977a, 1977b, 1977c, 1980) was the largest body of research devoted to self-help methods for alleviating depression. Rippere stated that most contemporary research on depression gives the impression that depressed people might just well exist in a social and cultural vacuum. However, Rippere (1976) has found that first-year psychology students without previous academic instruction in abnormal psychology already

had cognitions about depression and antidepressive behavior of a high degree of complexity. Therefore, she concluded that people have socially-learned normative ideas about depression and what they can do about it when feeling that way.

In a study, Rippere (1977b) asked the question: What's the thing to do when you're feeling depressed? A substantial proportion of subjects concurred in naming a common core of behavior (i.e., environmental changes, activity and work, cognitive, and affective experiences). A substantial proportion of types of behavior (e.g., see a friend, think about reason for depression, go for a walk) were named by more than one subject independently. However, a great diversity of items were identified, suggesting that alleviation of depression is a complex process of generating novel solutions, tailored to the individual's own particular situation and the goals of that individual at any point of time. Rippere (1980) stated:

> If 'the' thing to do when feeling depressed depends on the person doing it, the reason for his depression, the type of depression it is, the length of time he's felt that way, the degree to which he feels it, where he is at the time, and who or what happens to be available, it is very unlikely that a unitary attribute will cover the multitude of the possibilities involved. (p. 190)

Rippere (1980) asked 50 adults: When you're feeling depressed, what sorts of things can make you feel worse?

The most frequent replies were: being alone, inactivity, and thinking about the problem. However, the results also showed that in this heterogeneous group of young-to-middle aged adults there tended to be quite a variety of events, activities, and situations which typically make people feel worse. The fact that 38% of the items were mentioned by only one subject suggested that individual differences in this respect may be considerable.

The need exists for finding out what people already know about depression, and how they apply their knowledge in the course of their everyday lives if the psychology of depression that emerges from contemporary research efforts is to be maximally relevant to ordinary people. Instructions to increase any one abstract category of activities without regard to the way in which individuals habitually solve their problems, and the implicit devaluation of their own way of running their life that such instructions might carry, could itself be antitherapeutic. Unless the psychology of depression gives due weight to the ways in which humans differ by virtue of their language, culture, and long years of cognitive, emotional, and behavioral socialization, it is unlikely to be fully adequate as a psychology of human depression. The best way to find out what is likely to affect people would seem to be simply to ask them (Rippere, 1977a, 1980).

In summary, little has been done to study self-help programs in the general population. Rippere has found that individuals have a preconceived notion of depression and the kinds of things that make them feel better or worse. She suggested that individual therapists need information regarding clients' usual problem-solving approaches and that to suggest a treatment approach without this information could prove to be antitherapeutic.

Chapter Summary

Theorists' claims of superiority of their therapy over others for wide classes of people were not supported by the research. These findings indicated that therapists align themselves with a given theory based, not on research evidence but, on "who" is right and not "what" is right. This practice may eliminate potentially effective procedures found in other theories.

Theories of depression reflect the theorists' views of human nature and behavior change. Glasser believes irresponsible behavior is the cause of depression and supports relearning of responsible behaviors. Rogers stated that depressed people do not know or understand their feelings. His treatment involves an introspective process encouraging people to explore and accept their feelings in a supportive atmosphere. Ellis believes that depression is

the result of negative and defeating thoughts. He stresses cognitive restructuring as the method of treatment.

Psychotherapy is an effective treatment for depression. However, the paucity of comparison studies make a conclusion regarding the superiority of one psychotherapy treatment over another impossible. Researchers comparing psychotherapy with pharmacotherapy, alone and together, have concluded that the combined treatment is most effective.

Problem-solving researchers have suggested that important dimensions relating to the effectiveness of treatment have been neglected. They recommended more research on individual problem-solving approaches for specific real-life problems and the relationship of these individual preferences to formal counseling approaches.

It would appear that the best way to determine the approach most likely to affect a client would be simply to ask the client (Rippere, 1980). Such research is scarce. In the few studies that have been reported, it was clear that people can identify their self-help approaches that made depression better or worse. No attempt has been made to analyze individual approaches and to classify them in a way relevant to counselors. The way in which people usually solve their problems should be determined and considered in the choice of treatment. A promising goodness-of-match may exist between the client's preferred self-help approach and the therapist's treatment approach.

CHAPTER III

METHODS

Design

The purpose of this study was directed toward answering the question: Is one self-help approach preferable to another for relieving depression? Preferences are based on the individual's preferred self-help approach (affective, behavior, cognitive, or eclectic) for the alleviation of mild depression.

A phenomenological approach was used in the research design (Colazzia, 1978). This research was directed toward the personal perceptions and experiences of the subjects. In order to obtain this type of experiential information, a phenomenological interview must be conducted (Colazzia, 1978; Rogers, 1985). For example, we may be able to observe that an individual jogs when depressed, but to learn how that individual experiences jogging as helpful we must allow the individual to explore and explain the activity as he or she experiences it. The meaningfulness of experience cannot possibly be adequately studied by conventional empirical methods (Rogers, 1985). Even if the possibility exists that a self-perception may be wrong, counselors must work with

the self-perceptions their clients bring to the counseling setting.

In order to get this self-perception, a values clarification technique was used which was specifically designed to help people understand their self-help preferences for the alleviation of depression. People may do something and not really know why. The values clarification technique, better than other techniques, helped the participants to determine what they do and why. Specifically, Simon's (1978) Values Clarification Grid was used. This instrument has been widely used for helping people of all ages clarify their values and belief systems (Simon, Howe, & Kirschenbaum, 1978) (see Appendix A).

Two pilot studies were conducted. Refinements were made in the survey form, the structured interview, and interviewer training procedures before the final study was conducted. Data were obtained from a survey/interview process conducted by trained interviewers. The survey/ interview took approximately 30 minutes to complete. The survey question was: "When you feel depressed, what are your methods for improving the situation"? The participant was asked to list up to ten responses: however, less than 10 was acceptable. Participants were asked to provide additional information for each response (e.g., number of people involved, cost, time it takes to get started, time it takes to work, utilization rate in the past year, and task

or defense orientation) (see Appendix A). Following completion of the survey, interviewers reviewed with the subject, information included in the survey. Particular attention was given to the columns including rank of effectiveness, task/defense orientation, and self-help orientation of each method listed (see Flow Chart, Appendix B).

Subjects

The subjects were volunteers selected by the interviewers. Five hundred subjects were interviewed (306 females and 194 males). The age range was from 12-70. Occupational categories were based on Roe's (1956) six-level scheme for classifying occupations. There were 197 students in the sample. The remaining sample (N = 303) consisted of occupational levels including professional and managerial, semi-professional and small business owners, skilled, and semi-skilled (see Appendix C).

Procedures

Interviewers were graduate students enrolled in counseling theories and techniques classes at The University of Tennessee. Interviewers received verbal and written instructions regarding the purpose, nature, and procedures

of the survey and structured interview (see Appendix E). Interview procedures were demonstrated with interviewers acting as participants.

Each interviewer conducted 10 interviews. Two audiotapes from each interviewer were reviewed and evaluated to determine consistency in the administration of the survey and interview process. Tapes were reviewed and evaluated by other interviewers involved in the study (see Appendix D), as well as by this researcher. Inter-rater reliability was 100% agreement.

The purpose of the survey was explained to each participant and each interview was conducted individually. The participants entered the information on the survey as the interviewer used a structured interview to guide them through the survey. Following completion of the survey, the interviewer and participants discussed each method in terms of how the participant experienced each method. The interview was conducted as a mini-counseling session. Interviewers were instructed to ask questions that clarified column information, such as: Can you tell me a little more about why you chose that response? or, How is that method task (defense) oriented? Responses by the interviewer were limited to summarizing the responses of the participant. Each method was categorized as affective, behavior, or cognitive (see Appendix E). If more than one category was given for a method, the interviewer requested participants

to determine which category stood out as being more important than the other(s). Following completion of this step for each method listed, the participants chose their preferred self-help approach for the alleviation of depression (i.e., affective, behavior, cognitive, or eclectic). Those with no predominant method were classified as eclectic. This information was reported on the survey form and the interview was terminated.

Data Analysis

The single sample chi-square test was used to determine whether a significant difference existed among an observed number and the expected number of responses falling into each of 4 categories: affective, behavior, cognitive, and eclectic. Chi-square contingency tables were used to determine whether any relationships existed among age, gender, occupational level, and category choice.

CHAPTER IV

RESULTS

Introduction

The results of the study are presented in Chapter IV. A chi-square test (Yuker, 1958) using the .05 level of significance was conducted to analyze the data for the purpose of testing the hypothesis that no significant difference would exist among the frequencies of people selecting affective, behavior, cognitive, and eclectic self-help methods for relieving depression. Additional analyses were done using chi-square contingency tables (Yuker, 1958) to determine what effect age, gender, and occupational level might have on the chosen self-help preferences.

Findings

Chi Square Test of Significance for Self-Help Choice

The main finding of the study was that the hypothesis was rejected. Frequencies of people selecting the affective, behavior, cognitive, and eclectic categories were significantly different from the equal frequencies that might be expected by chance, X^2 (3, $\underline{N}$ = 500) = 8.75, p.<.05.

There were 144 people in the affective category, 136 in the behavior category, 119 in the cognitive category, and 101 in the eclectic category. Frequencies were higher than expected for the affective category and lower than expected for the eclectic category (see Table 1).

Additional Findings

Additional analyses were conducted to determine if age, gender, and occupational level had an effect on self-help preferences. Results of the chi-square contingency tables are reported here.

Effect of Age on Self-Help Preference

Age was not found to have an effect on self-help preferences, X^2 (12, $\underline{N}$ = 500) = 17.86, p.>.05 (see Table 2). Attempts to predict appropriate treatment procedures based on the age range of 12 to 70 was not supported by the findings of this study.

Effect of Gender on Self-Help Preference

Gender was found to have an effect on self-help category choice, X^2 (3, $\underline{N}$ = 500) = 13.39, p.<.05. Females had higher than expected frequencies in the affective category and lower than expected frequencies in the cognitive

Table 1. Observed and Expected Frequencies of Self-Help Preferences with X^2 Values for Each Preference.

	Self-Help Categories				
	Affective	Behavior	Cognitive	Eclectic	X^2 Total
Obs.	144	136	119	101	
Exp.	125	125	125	125	
X^2	2.88	.96	.28	4.60	8.75*

a. df = 3

* p.<.05

Table 2. Observed and Expected Frequencies with X^2 Values for Self-Help Preferences Based on Age.

	Self-Help Categories				
Age Groups	Affective	Behavior	Cognitive	Eclectic	X^2 Totals
12-19					
Obs.	23	8	17	13	
Exp.	18	17	14	12	
X^2	1.65	4.45	.43	.03	6.58
20-29					
Obs.	55	48	57	44	
Exp.	59	55	49	41	
X^2	.24	1.01	1.45	.19	2.90
30-39					
Obs.	40	50	28	27	
Exp.	42	39	35	29	
X^2	.07	2.85	1.22	.18	4.33
40-49					
Obs.	16	20	10	8	
Exp.	15	15	13	11	
X^2	.01	1.91	.65	.77	3.34
50+					
Obs.	10	10	7	9	
Exp.	10	10	9	7	
X^2	.01	.004	.29	.39	.71
X^{2a} Total					17.86

a. df = 12

p>.05

category. Males had higher than expected frequencies in the cognitive category, and lower than expected frequencies in the affective category (see Table 3).

Effect of Occupational Level on Self-Help Preference

Occupational levels were based on Roe's (1956) six-level scheme for classifying occupations (see Appendix C). Occupational level was found to have an effect on self-help preferences for the alleviation of depression, X^2 (12, N = 500) = 31.94, p.<.05. Those in the professional and managerial group had higher than expected frequencies in the behavior category, and lower than expected frequencies in the affective and cognitive categories. Those in the semi-professional and small business owners group had higher than expected frequencies in the affective category and lower than expected frequencies in the behavior category. Skilled workers had higher than expected frequencies in the affective category, and lower than expected frequencies in the cognitive category. Semi-skilled workers had higher than expected frequencies in the behavior category, and lower than expected frequencies in the affective category. Students had higher than expected frequencies in the cognitive category, and lower than expected frequencies in the behavior category (see Table 4).

Table 3. Observed and Expected Frequencies with X^2 Values for Self-Help Preferences Based on Gender.

	Self-Help Categories				
Gender	Affective	Behavior	Cognitive	Eclectic	X^2 Totals
Females					
Obs.	103	84	59	60	
Exp.	88	83.2	72.8	61.8	
X^2	2.5	.01	2.6	.05	5.19
Males					
Obs.	41	52	60	41	
Exp.	56	52	46	40	
X^2	3.97	.01	4.12	.08	8.18
X^2 Total					13.37

a. df = 3

*p<.05

Table 4. Observed and Expected Frequencies with X^2 Values for Self-Help Preferences Based on Occupational Levels.

Occupational Levels	Self-Help Categories				
	Affective	Behavior	Cognitive	Eclectic	X^2 Totals
Professional & Managerial					
Obs.	24	42	18	23	
Exp.	30	29	26	22	
X^2	1.50	5.71	2.20	.09	9.5
Semi-Prof. & Small Business					
Obs.	14	8	11	9	
Exp.	12	11	10	9	
X^2	.29	1.01	0.1	.02	1.44
Skilled					
Obs.	40	24	17	18	
Exp.	28	27	24	20	
X^2	4.64	.31	1.84	0.2	6.39
Semi-skilled					
Obs.	8	22	16	9	
Exp.	16	15	13	11	
X^2	3.85	3.26	.64	.39	8.55
Student					
Obs.	58	40	57	42	
Exp.	57	53	47	40	
X^2	.02	3.45	2.17	.12	5.77
X^{2a} Total					31.66*

a. df = 12

*$p < .05$

Summary

The results of the data analysis were reported in this chapter. Significant differences were found in self-help preferences for the affective, behavior, cognitive, and eclectic category. Gender and occupational level were found to have an effect on self-help preferences. Age was not found to have an effect on self-help preferences.

CHAPTER V

SUMMARY, CONCLUSIONS, AND SUGGESTIONS FOR FURTHER RESEARCH

Summary

The purpose of this study was to examine the distribution of people choosing affective, behavior, cognitive, and eclectic approaches as their preferred self-help approach for alleviating depression. Five hundred volunteers were used for this study. A phenomenological interview was conducted by trained interviewers. The participants chose their preferred self-help approach for depression following an interview and a comprehensive analysis of their responses.

The research hypothesis selected for this study was that approximately equal numbers of people would choose the affective, behavior, cognitive, and eclectic self-help approaches. The hypothesis was rejected. The main finding of this study was that significant differences existed among the numbers of people choosing the affective, behavior, cognitive, and eclectic self-help approaches for relieving depression. Additional findings included the significant effect of gender and occupational level on self-help

preferences. Age was not found to have an effect on self-help preference for alleviating depression.

Conclusions

While there were preferences expressed by various groups, each category had enough representation to support the recommendation that counselors and psychotherapists should be skilled in utilizing affective, behavior, and cognitive treatment methods. The slight preference for the affective category may lend some support for using a person-centered approach in combination with other counseling approaches. It would seem that many people find relief from depression by talking to someone, more specifically, to a trusted relative or friend. Active listening, genuine interest in the individual, and a supportive atmosphere are important ingredients for any successful counseling relationship. As Shaw (1977) stated, discussing one's difficulties with interested persons seems to have a powerful treatment effect.

One reason for the overall preference for the affective category may have been that more females than males were interviewed. Three hundred and six females were interviewed as opposed to 194 males. Females chose the affective category more frequently than the behavior, cognitive, or eclectic categories. Females also chose the affective

category two and one half times more frequently than males. Other groups that preferred the affective category (i.e., those in the semi-professional and small business owner group and those in the semi-skilled group) had more females in their groups. These findings parallel the view that females tend to acknowledge and express their feelings more openly than males with the problem of depression (Sargent, 1985). A person-centered approach for females suffering from mild depression can be supported by the findings of this researcher.

Males tended to choose more cognitive approaches than affective, behavior, or eclectic. The slight preference expressed by males for the cognitive category parallels the belief that males use a more analytical and logical approach for solving their problems (Sargent, 1985).

Most people chose from the affective, behavior, and cognitive categories. The fewest number of choices occurred in the eclectic category. Those who chose from the eclectic category could probably benefit from a more thorough analysis in an effort to determine if a single preferred approach would be superior to a combination of methods, or perhaps many individuals do benefit more from a combination of approaches such as the cognitive-behavioral approach.

Groups choosing the behavior category most often (i.e., professionals and managerial, and those in the skilled group) had about equal numbers of males and

females. Gender had no effect on self-help preference for these groups. Professionals and and those on the managerial level are generally product-and task-oriented individuals and appear to solve the problem of depression in much the same way as they solve work-related problems.

While students showed a higher than expected number in the cognitive category, there were actually more students who chose the affective category (see Table 4). A review of choices by students indicated a fairly even distribution in each category. Perhaps these findings reflected the wide diversity of personality types found within student populations on a university campus.

As suggested in the problem-solving literature, individuals do appear to have a preferred problem-solving or self-help approach. Self-assessment helps to identify preferred self-help approaches. Participants in this study were able to identify their preferred self-help approach for alleviating depression through a comprehensive interview process. Tailoring treatment to the self-help preferences of individuals who are mildly depressed may contribute to a more rapid termination of depression, allowing for much less incapacitation and continued functioning in important life roles (Lewinsohn & Clarke, 1984). The eventual goal is to cooperatively select treatment procedures for depressed individuals, based on pretreatment data that include self-help preferences.

Even though no hypotheses were generated for other data, the following data are included for reader interest. The results of the study were found to support Rippere's (1976) study. She found that individuals with no formal training can identify depression and what to do about it. Although a description of depression was included in the interview instructions, less than 1% of the participants interviewed and audiotaped for this study requested a description of depression. In our culture "feeling depressed" is a typical event, one of the familiar problems that socialization prepares people for encountering (Rippere, 1976). Additional information supporting the idea of socially learned concepts included the subjects' abilities to respond with only a moments' pause for reflection. Rippere (1980) stated that this readiness to respond to a question that they had probably not been asked before suggests that the issue was one which had concerned them in their reflections upon their own experience.

The findings of this study were also consistent with the findings of Rippere's (1977a) study. A great diversity of methods utilized for the alleviation of depression were listed (see Figure 1). Rippere stated that people have socially learned repertoires of contingency plans; a set of "recipes" for what to do in case the problem of depression should arise. The most frequently mentioned method in the Rippere (1977) study ($\underline{N}$ = 50) was "see people or a friend."

Method	% of people listing method	f
Talk to family/friends	74	372
Exercise	72	362
Listen to music	49	248
Shop	48	240
Household chores	47	236
Eat	41	206
Read	40	204
Hobbies	38	192
Sleep	35	176
Walk	33	164
Watch TV	32	162
Drug/Alcohol Use	32	162
Play (with children, pets)	30	151
Drive	26	132
Religious activities	20	100
Go to movie	19	98
Cry	16	82
Personal grooming	12	60
Outdoor excursions (hunting, fishing, hiking)	12	58
Sex	10	48
Think	9	47
Work at job	9	44
Accomplish something	8	40
Be alone	8	38
Vacation	8	28
Self-talk	6	28
Analyze problem/set goals	5	26
Dance	5	25
Physical aggression	4	22
Help others	4	20
Goof off	4	20
Study	4	18
Nothing	3	14
Meditate	2	12
Complain	2	10
Verbal Aggression	2	9
"Wallow" in it	2	9
Laugh	2	9
		3,872

Figure 1. Frequency Count of Methods Used.

The most frequently mentioned method in the present study was talk to family or friends. A comparison of other methods listed in the Rippere study with other methods listed in this study can be seen in Figure 2. Probably the most striking feature of the data pools are their heterogeneity. Methods may be solo or social, may represent close adherence to one's normal routine or various ways of breaking from it. Methods may involve great financial expense or no expense at all and may be directly related to solving the problem or to put the problems "on hold." The great diversity of items leave considerable scope for people to pick and choose methods that are likely to be appropriate to and applicable in their own particular circumstances (Rippere, 1977).

Another interesting observation of this study was the task/defense oriented classification of the methods listed. It was assumed that defense oriented methods would reflect avoidance of the problems. Review of the audiotaped interviews refuted this assumption. It became increasingly clear that defense oriented methods were more than attempts to avoid dealing with the problem of depression. It was found that many of these methods were being used for a "time-out" period; a time for rejuvenation, to prepare oneself for dealing with the problem of depression. Rippere (1977a) warned against professionals misconstruing what clients say or do. What may be a perfectly valid way

Method	% of people listing method in Rippere's study (1977b)	% of people listing method method in present study
Talk to family/friends	36	74
Exercise	18	72
Listen to music	22	49
Shop	14	48
Household chores	10	47
Eat	14	41
Read	16	40
Hobbies	--	38
Sleep	20	35
Walk	32	33
Watch TV	16	32
Drug/Alcohol Use	14	32
Play (with children, pets)	6	30
Drive	10	26
Religious activities	6	20
Go to movie	16	19
Cry	--	16
Personal grooming	8	12
Outdoor excursions (hunting, fishing, hiking)	6	12
Sex	4	10
Think	4	9
Work at job	8	9
Accomplish something	12	8
Be alone	10	8
Vacation	--	8
Self-talk	6	8
Analyze problem/set goals	6	6
Dance	--	5
Physical aggression	6	5
Help others	6	4
Goof off	6	4
Study	--	4
Nothing	4	4
Meditate	8	2
Complain	8	2
Verbal Aggression	6	2
"Wallow" in it	8	2
Laugh	4	2

Figure 2. Comparison of Percentages of Methods Listed in Rippere's (1977b) Study and the Present Study.

of dealing with depression for a client may be promptly invalidated by a professional as symptomatic, defensive, or otherwise pathological. Such a reaction could be antitherapeutic to individuals who may already be struggling with their beliefs about themselves and their abilities to cope.

In summary, many self-help activities listed in the present study were listed in Rippere's (1980) study of activities that made depression worse. One person's pleasure may, indeed, be another person's pain.

> If the intending therapist enquires what the problems are that the patient would like help with, what he or she has been doing about them and has found helpful and unhelpful, and what kind of help he or she thinks would be most useful, the therapist will obtain information about the patient and the work to be done and at the same time will convey information to the patient about himself. At the very least, the therapist's enquiry conveys acknowledgement of and respect for the patient's views and judgment. Because it presupposes the patient's ability to take initiative and responsibility for himself, the enquiry suggests that the stance the therapist proposes to adopt is that of a collaborator, putting his resources at the other's disposal rather than foisting abstract 'therapy' upon him whether he likes it or not. The overall implication of such an enquiry is a message of confidence in the patient's ability to define and attempt to solve his own problems. (Rippere, 1980)

Suggestions for Further Research

Suggestions for further research include the development of an inventory that would expedite the

survey/interview process. This would also make it possible to gather information about self-help preferences for other problem areas such as: anger, fear, and anxiety. Interviews conducted with individuals responding to a variety of problems could be compared to determine if the same self-help approach is preferred for different problems or if different self-help approaches are preferred for different problems. Correlational studies could also be done with personality inventories, such as the Myers-Briggs Type Indicator, to see if their personality classifications correlate with self-help preferences.

More research is needed to determine if the self-help preferences expressed by individuals are the most appropriate approach for the counselor to use. Once the self-help preference is determined by the client and counselor, the counselor would then utilize this approach with the client. The results of such an approach could be compared with the results of counseling based on random treatment assignment to determine if client selection of treatment, based on increased self-awareness, is more effective.

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APPENDICES

APPENDIX A

Survey Form

When you are depressed, what are your methods for improving the situation?

Methods	Ts	P	$	Tw	R	12 mo.	T/D	B,F,T

_____Age

_____Occupation

_____Gender

_____Race

_____Behavior

_____Feelings

_____Thinking

_____Eclectic

Ts - Time to get started

P - Number of people required

$ - Cost of activity

Tw - Time it takes to work

R - Rank order of effectiveness, with 1 being most effective

12 - Check if used in last 12 months

T/D - Task oriented/defense oriented

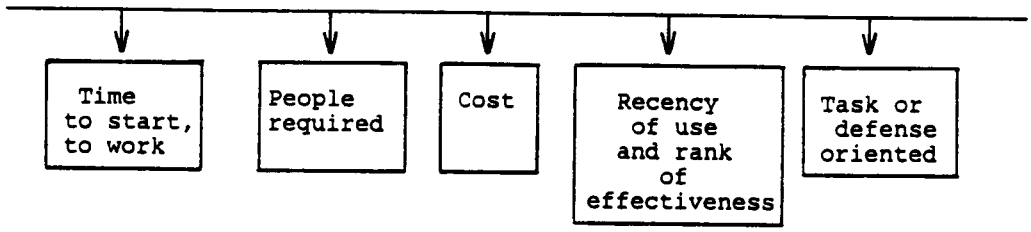
APPENDIX B

Flow Chart

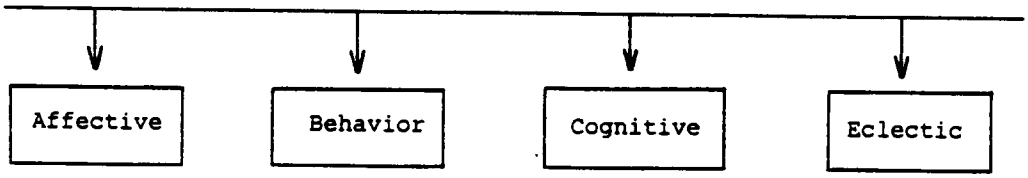
Subjects interviewed on self-help methods for relieving depressed feelings.

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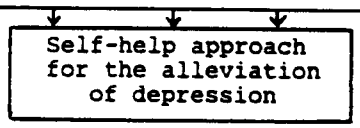
Subjects evaluate the effectiveness of each of their self-help methods for relieving depressed feelings according to the following criteria:



Subjects and interviewer analyze and clarify each self-help method as having one or more of the following counseling orientations:



Data collected for analysis will provide information on:



APPENDIX C

Occupational Levels

Professional and Managerial
Therapists
Engineers
Consultants
Scientists
Professors
Medical Specialists
Artists
Social Workers
Certified Public Accountants
Architects
Nurses
Pharmacists
Veterinarians
Editors
Teachers

Semi-Professional and Small Business
Welfare Workers
Salespersons
Accountants
Owners (small business)
Contractors
Foremen
Farm owners
Technicians
Reporters

Skilled
Barbers
Practical nurses
Policemen
Auctioneers
Buyers
Cashiers
Foremen
Salesclerks
Electricians
Mechanics
Technical assistants

Semi-skilled and unskilled
Drivers
General Houseworkers
Waiters
Firemen
Clerks (file, stock, etc.)
Typist/word processors
Delivery
Hospital Attendant
Laborers

APPENDIX D

Peer Review Form

Date _____
Interviewer's Name _____
Evaluated by _____

Did the interviewer follow the guidelines of the survey?
If no, please explain.

Do you agree with the final classification of the subject?
If no, please explain.

APPENDIX E

Interview instructions

The purpose of this survey is to determine the ways people rid themselves of depressed feelings. As interviewers you will guide the participants through the survey following the structured interview schedule provided on the following pages. You are to conduct 10 individual surveys, two of which are to be taped for review. Each interviewer will review one of the two taped sessions submitted by another interviewer to determine if the interview schedule was adhered to and if agreement exists regarding the subject's classifications. Each interview will take approximately 30 minutes to complete.

Begin each interview by explaining the purpose of the survey to the participants as written on the interview schedule. Following this explanation, instruct the participants to complete the information regarding gender, age, occupation, and race. You are now ready to guide the participant through the survey. It is possible for the participant to list up to 10 ways of alleviating depression, however, less than ten is acceptable. Following completion of each column on the survey, you and the participant will discuss each method, how it helped the participant to feel better and label each method as behavioral, thinking, or feeling. If a method is helpful in more than one way, help the participant to determine if one stands out as being more important than the other(s) and identify the most important way. Following the completion for this step, review all the responses with the participant and how each activity helps the participant to determine the predominant approach used by the participant. Report the predominant approach by placing a check mark in the appropriate place at the bottom of the page. If no predominant approach is ascertained, place a check mark on the blank next to "eclectic".

As a guideline for categorizing responses, use the following criteria.

Category Descriptions

Behavioral - active participation, deliberate behavior change directed toward alleviating depressed feelings, accomplishing something worthwhile, being productive (in other words, any task-oriented method as opposed to defensive-oriented or avoidance method such a taking drugs, excessive sleeping, eating, withdrawing, etc.) (Coleman & Glaros, 1983).

Thinking (Cognitive) - thinking strategies, e.g., self-thoughts, self-statements, thinking/analyzing problem, planning.

Feelings (Affective) - dealing directly with feelings, expression and/or exploration of feelings, e.g., talking to others about feelings, prayer, meditation.

Eclectic - any method that involves two or more of the above methods e.g., some may exercise (behavioral) and explore their feelings (affective) at the same time.

Interview training

To clarify the interview/survey procedure, I am now going to model the interview process, with you as the participant.

Interview Schedule

"I would like you to complete this survey for me. It will take approximately 30 minutes to finish. I am hoping to learn more about the methods people use to make themselves feel better when they are depresses." (Hand the survey form to the subject.) "I am going to ask you to write in your responses as I guide you through the survey. First, please fill in the information on the lower left hand side of the page: age, occupation, gender, and race." When completed, ask: "When you are depressed, what are your methods for improving the situation: After you have thought about the methods you use to alleviate your depression, list these in the column on the left." (Subject may list up to ten responses, but less than ten is acceptable if subject indicates he/she cannot come up with ten. If subject expresses confusion about the definition of depression, read the description on last page of interview schedule.)

When this task is completed, state the following: "The rest of the survey will help you evaluate what your methods do for you. Under the column heading "Ts", state how much time it takes for you to get started for each method you have listed.:

When completed, state:
"Under the column heading "P", write in how many people are needed for each method listed."

When completed, state:
"Under the $ (dollar sign) indicate, on the average, the cost of each method."

When completed, state:
"Under the "Tw" heading, write how much time each method takes to work."

When completed, state:
"Under heading "R" rank each response in the order of effectiveness; with 1 representing your most effective approach."

When completed, state:
"Under the heading "12", check each method that you have used in the last 12 months."

When completed, state:
"Under the "T/D" heading, write in T if method is task oriented or D if method is defense oriented. Task oriented is directed toward solving the problem. Defense oriented is directed toward temporary relief and putting problems on hold."

When completed, state:
"In the final column, we are going to indicate how each of these activities help you. Each response will be labeled behavioral, thinking, feeling, or some combination of these three categories. For example: when you jog or work out, do you get a feeling of accomplishment, which is behavioral, or does this help you rethink your problem situation, which is a thinking strategy, or does this help you deal with your feelings, which would be the feelings approach, or is the method a combination of any of the above; behavioral, thinking, feelings? If it is a combination of 2 or more of the above, does one stand out as being more important than the other(s), if so, which one?"

After participant's methods have been categorized as behavioral, affective, or cognitive, state:
"To help you evaluate a predominant approach you may be using in dealing with depression, let's review your methods, how each method helps you, and determine your predominant method for feeling better."

Description of Depression for Participants

Depression, for this interview, is defined as a "down" feeling which may involve feelings of sadness, tearfulness, fatigue, discouragement, dejection, self-depreciation, unworthiness, or sluggishness.

VITA

Sharon Brandon Campbell was born November 22, 1947 in Roane County, Tennessee. She attended public schools in Crossville, Tennessee where she graduated from Cumberland County High School in May, 1965. In 1969, she received a Bachelor of Science degree from George Peabody College for Teachers. In August, 1972 she received a Masters of Science degree from Tennessee Technological University. In 1982, she was admitted to the doctoral program in the Department of Educational and Counseling Psychology.

Her work experience includes employment in the Tennessee public school system as an elementary guidance counselor and special education teacher. During her doctoral program she was a graduate teaching assistant and coordinator for graduate teaching assistants. After graduation Ms. Campbell will seek licensure as a psychologist by the Tennessee Board of Healing Arts.