An Experimental Study on Psychotherapy for Women with Major Depression

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An experimental study was conducted to test the effectiveness of clients-centered therapy (CCT) for the treatment of major depression. 30 women aged 15 to 55 reported with the main symptoms of major depression were randomly assigned to two groups; 15 treatment group and 15 waiting list as control group. The treatment group undergone four individual hourly therapy sessions within a period between 8 to 12 weeks. A one way ANOVA using the pre and post BDI assessment indicated significant effect of CCT ($F = 8.71$, $p < .01$, ES = .24) Follow up assessment was also conducted to observe the extent of therapy-client interaction effects. Qualitative data and subjective opinion of the subjects were also presented to support the results.

Keywords: psychotherapy for women, major depression, experimental study

Depression is defined as a state of deep sadness or bitterness normally experienced by an individual following a stressful event or grief. However, if it deepens and persists over a period of longer than two weeks affecting the person's behavior and daily functioning it may be a symptom of a depressive illness (Smith, 1990). Symptoms of depressive illness are categorized into four domains, namely, (1) affective symptoms, such as sadness, emptiness, , low motivation and loss of interest in enjoyable activities (2) cognitive symptoms mainly negative thoughts about oneself such as incompetence, unworthiness, hopelessness, helplessness and guilt, (3) observable behavior including social withdrawal and (4) psychomotor changes such as a slowing down in walking and speech, loss of appetite, excessive or lack of sleep (DSM IV; American Psychiatric Association, 1994).

Major depression is the leading cause of disability in United States for those aged 15 to 44 years affecting approximately 14.8 millions American adults accounting to about 6.7% of the population aged 18 and above (NIMH, 2006). Further estimates suggested that by 2010, depression will be the second most costly illness worldwide (Young, Weinberger & Beck in Barlow, 2001).

A review by Kaelber, Moul, and Farmer (1995) showed considerable variations in the rate of lifetime major depression in community based studies from 1983 to 1994 with 3.3% in Seoul, 3.5% in rural Korea, 4.6% in Puerto Rico, 8.6% in Canada, 8.8% in Germany, and 9.7% in rural Taiwan.

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Although prevalence study varies between countries, statistics on depression over time in different western and=

non-western countries indicated a consistent 2:1 ratio between women and men respectively (Weissman & Klerman, 1977; Weissman et al., 1991; Kessler et al., 1993, 1994; Bebbington et al., 1998; Murphy et al., 2000).

Varma and Azhar (1995) suggested depression (13.2%) as the most common psychiatric symptom observed by mental health practitioners in primary heath care facilities in Malaysia, while a psychiatric morbidity survey of Malaysians aged 16 years and above, using General Health Questionnaires (GHQ-12), reported 10.7% with emotional disorders (Ministry of Health, 1997). Azhar (2001) addressed the difficulty in detecting depressive disorders in the majority of patients since they tend to report physical symptoms only while others prefer to seek help in other ways such as through faith healers (bomoh). No research on CCT for the treatment of depression has been reported in Malaysia.

Client Centered Therapy (CCT) for depression was first documented by Snyder (1945) followed by other documentation of cases and researches in psychiatric setting (Raskin, 1996) and a major experimental study by Truax & Carkhuff and Kodman (1965). However, there was a marked change in interest on CCT after the Wisconsin Project (Rogers, Gendlin, Kiesler & Truax, 1967). Greenberg (1994) observed a decrease in literatures on CCT in mental health setting in the United States after 1970's while a number of clinical studies on CCT were conducted, for example, by Bohme et al. (1998) and Teusch et al. (2001) in Germany and Belgium as cited by Page et al. (2002). A few recent literatures on CCT were available in other European countries (e.g., Warner, 2000; Tudor & Merry, 2002; Sommerbeck, 2002, 2003).

Cognitive Behavior Therapy (CBT) is the most frequently cited approach in psychiatric setting, with few studies on Interpersonal Therapy (IPT) (Prochaska & Norcross, 2003). In Malaysia, few studies on psychotherapy for depressive illness were reported and the focus was on religious psychotherapy (Azhar & Varma, 1995; Razali, Hasnah, Aminah & Subramaniam, 1998), while no clinical study on CCT has been reported. Therefore this experimental study on the effectiveness of CCT for women with major depression may provide additional knowledge on an alternative approach to psychotherapy for women with depressive disorder.

Method

A pre-post experimental design study was conducted for 30 women aged 18 to 55 years, who had symptoms of major depression. Participants were randomly assigned into two equal sized groups with 15 in the treatment group and 15 in the waiting list (control group). A 21 item Beck Depression Inventory (Malay version, α =.86) was used for pre- post and follow-up assessment of participants. Participants in the treatment group were given four individual CCT sessions within eight weeks while

participants in the control group were given a briefing on depression before the waiting period. Several measures were taken to control interaction between treatment group and control group and the effect of therapist-client interactions on the participants' assessment of depression. Quantitative analyses were computed to assess the effectiveness of CCT for the treatment group as compared to the control group. In addition, qualitative data as on the effects of the therapy as reported by the participants were also presented.

Client- Centered Therapy Sessions

The therapy consisted of four individual sessions within a period of eight weeks. Each individual session took about 45 to 60 minutes. The sessions comprised client-centered therapy based on the non-directive approach and providing the therapeutic conditions as discussed in Rogers' "six necessary and sufficient conditions" (Rogers, 1957). The therapist acted with unconditional acceptance, congruence and empathy. The therapist's main role was to provide a non-threatening atmosphere by being fully present or being with the client while the client was freely expressing her "here and now" experiences. The phenomenal concept of being with the person's experiences instead of analyzing the causes of the client's behavior is considered as a therapeutic process helping the client to feel better about her *self*. These conditions were observable through the verbal and non-verbal responses of the therapist. Examples of observable behavior of the therapist were as follows:

1. The therapist provided continuous attention during the sessions without interruption while the clients were pausing or expressing intense emotions commonly manifested during the sessions such as depression, guilt, anger, bitterness, hatred, fear, regret, and hopelessness.

2. After the clients had fully expressed their emotions, the therapist may respond by either non-verbal or verbal acceptance of ideas, beliefs and emotions expressed by the clients with the intention of showing respect towards the clients' experiences.

3. The therapist did not try to change the clients' negative emotions by comforting them or providing any additional information with the intention of changing their present negative thinking or feeling towards a certain issue or person.

4. The therapist did not make any effort to facilitate or guide the clients towards a certain direction or towards solving the problems. However, the therapist did not stop the clients towards progressing in understanding and analyzing the problems or deciding on a certain problem-solving action.

5. The therapist avoided asking questions to seek further information or to encourage self-exploration. Asking questions might divert the clients' flow of thought to the therapist's interest or concern. Allowing the free flow of thought is considered an important component of the therapeutic condition of unconditional acceptance.

6. The therapist did not try to diagnose the symptoms or analyze the causes of the clients' depression because it might imply that the therapist is trying to find out what was wrong with the clients.

7. The therapist fully respected clients' "here and now" concerns and did not try to control the clients' conversation even though similar concerns and emotions were narrated and expressed repeatedly during the same session or during the following sessions.

8. The therapist had no intention or agenda to facilitate the problem-solving process or change the clients' negative behavior. The therapist refrained herself from giving any advice or suggestion to help the clients. When clients asked the therapist's opinion for a solution, the therapist responded accordingly based on her genuine opinion in context of the particular situation. Some of the possible answers were: "Honestly, I'm not sure what's the best solution", "I need to understand the situation more", or "One alternative solution might be ……, but I'm not sure whether it work for you".

9. The therapist provided information or references only when requested by the client.

10. The therapist responded only occasionally, after clients completed their narration or expression, with empathetic understanding responses (EUR). EUR are responses reflecting the facts, opinions and emotions expressed by the clients verbally to check the therapist's understanding of the clients' situation or to indicate the therapist's unconditional acceptance and empathetic understanding of the clients' expressed experience. The therapist avoided interpreting the client's message, giving evaluation or personal opinion. Examples of EUR during the therapy were:

    "You mentioned that you worked so hard to avoid the divorce, and when it happened you felt really sad."

    "Well…earlier on….thought that your mother didn't care for you but after what has happened you realized that she really loves you."

    "It's like you can't stand his behavior anymore… you wished that he wasn't in the house; in fact you said you were happier when he wasn't around."

    "You regret for not crying in the presence of her dead body…"

    "You feel it was your fault she became this way…. And as long as she does not recover you feel depressed and guilty."

    "Feel like you want to hide somewhere and not face the problems."

    "You love him so much; you'd rather die than lose him."

"Sounds like you regret marrying him…. You feel that you have wasted over 20 years being with him."

"You feel it's stressful… You can't stand his abusive language and strange sexual behavior."

"OK, its fine with me. If you don't want to talk about your past, then we don't talk about it. You can choose to talk about whatever topic you like."

"You try to forget the incidence, but the obscene image is still disturbing you."

"It feels that you are never good enough no matter how hard you work."

"It's not that you don't know. You know it isn't logical to behave this way…. You try hard to control it but the fluster is still there…. You worried that something is wrong with you."

"The phobia is still there and it comes when you are about to sleep."

"After what has happened, you feel that you are such a bad person… a useless one…you feel that you have hurt your mother."

"Feel so small compared to your friends…. you don't measure up to them… have no energy to become one like them. Sometimes you are so scared and feel as though you were dying… something like that?"

Results

Socio- Demographic Characteristics of Participants

A total of 30 women who met the criteria of major depression were selected to participate in the experimental study. Their names were obtained from the list of applicants who responded to the advertisement in a Malay language daily newspaper on the availability of psychotherapy for depression. The 30 participants were randomly assigned into two groups, 15 in the treatment group and 15 in the waiting list group (treated as the control group). The treatment group was assessed before and after the treatment period with a follow-up, while the waiting list group was assessed before and after the waiting period of two months. No follow-up was done for the waiting list group and the reason has been discussed in the research method chapter. The socio-demographic characteristics of participants are shown in Table 1.

The mean age of the treatment group was 36.80 (SD=12.51) and the control group 39.53 (SD = 13.02). There was no significant difference in age between the two groups (t (28) = .59, p= .56). The

Levene's test for equality of variance was non-significant (F= .15, p= .67) indicating similar variances in both groups.

Table 1
Socio-Demographic Characteristics of Participants (N = 30)

Socio-demographic factors	Frequencies (percentage)		Test of significant difference	
	Treatment group	Control group	p	
Mean age	36.80 (SD = 12.51)	39.53 (SD = 13.02)	t= .59	n.s
Marital status				
Single	5 (33.3%)	6 (40.0%)		
Married	9 (60.0%)	7 (46.7%)	χ^2 = .67	n.s
Divorced	1 (6.7%)	2 (13.3%)		
Employment status				
Unemployed	8 (53.3%)	9 (60.0%)		
Employed	7 (46.7%)	6 (40.0%)	χ^2 = .14	n.s
Education level				
Secondary	8 (53.3%)	7 (46.7%)		
College	4 (26.7%)	3 (20.0%)	χ^2 = .71	n.s
University	3 (20.0%)	5 (33.3%)		

The distribution of participants by marital status in the treatment group was 33.3% single, 60.0% married and 6.7% divorced, while in the control group 40.0% single, 46.7% married and 13.3% divorced. The Pearson χ^2 (2, N = 30) = .67, p = .71 did not show significant difference in distribution between the two groups.

The distribution of participants by employment status in the treatment group was 53.3% unemployed and 46.7% employed, while in the control group 60.0% unemployed and 40.0% employed. The Pearson χ^2 (1, N = 30) = .14, p = .71 did not show significant difference in distribution between the two groups

The distribution of participants by education level in the treatment group was 53.3% secondary, 26.7% college and 20.0% university while in the control group 46.7% secondary, 20.0% college and 33.3% university. The Pearson χ^2 (2, N = 30) = .71, p = .70 did not show significant difference in distribution between the two groups.

All the tests of significant difference show non-significant results indicating similarity in the socio-demographic characteristics of participants such as age, marital status, employment status and education level between the two groups. The random assignment method used to select the participants was able to control the differences in socio-demographic factors between groups, therefore reducing the error due to the effect of uncontrolled variable differences between the two groups.

Pre – Post Assessment of Depression

In order to evaluate the effect of the treatment, t-tests were computed to examine significant differences between the treatment group and the control group. Three types of measures were used in the analysis namely pre-assessment (BDI score before the treatment period), post-assessment (BDI score after the treatment period) and BDI differences (BDI before treatment minus BDI after treatment). The result of the analysis is as shown in Table 2.

Table 2
Analysis of Significant Difference between Treatment Group and Control Group

BDI Score	Treatment Group		Control Group		Difference between means	
	M	SD	M	SD	t	p
1.Pre-assessment	25.53	11.17	18.40	11.22	1.77	ns
2. Post-assessment	13.93	9.56	15.93	11.21	.52	ns
3. BDI diff ((1-2)	11.60	8.75	2.47	8.19	2.95	.00

The mean pre-assessment BDI score for the treatment group was 25.53 (SD = 11.17) and for the control group 18.40 (SD = 11.22). The test of significant difference t (28) = 1.74, p = .09 did not indicate significant difference in pre-assessment BDI score between the treatment group and the control group. The Levene's test for equality of variance in the two groups was non-significant (F = .00, p = .98) indicating equal variance between the two groups. The result of the tests did not show significant differences in means and variances between the two groups indicating similarity in the rate of depression measured before treatment in both groups.

The mean post-assessment BDI score for the treatment group was 13.93 (SD = 9.56) and for the control group was 15.93 (SD = 11.21). The test of significant difference t (28) =.52, p = .60 did not indicate significant difference in post-assessment BDI score between the treatment group and the control group. The Levene's test for equality of variance in the two groups was non-significant (F = .76, p =. 39) indicating equal variance between the two groups. The result of the tests did not show significant differences in means and variances between the two groups indicating similarity in the rate of depression measured after the treatment period in both groups.

The mean BDI difference score for the treatment group was 11.60 (SD = 8.75) and for the control group was 2.47 (SD = 8.19). The test of significant difference t (28) = .2.95, p = .00 indicated significant difference in BDI difference score between the treatment group and the control group.

Using the post-assessment BDI score as a dependent variable, a one-way analysis of covariance (ANCOVA) was conducted with group as independent variable included in two levels: the treatment group and the control group, and pre-assessment BDI as covariate. A preliminary analysis evaluating the homogeneity-of-slopes assumptions indicated that the relationship between the covariate and the dependent variable did not differ significantly as a function of the independent variable, $F(1, 26) = .44$, $MSE = 59.48$, $p = .51$, partial $\eta^2 = .02$.

The result of the ANCOVA shown in Table 3, was significant, $F(1, 27) = 5.08$, $MSE = 58.24$, $p < .05$, resulting in a change effect ($\eta^2 = .16$) indicating that 16 % of the variance in post-treatment BDI could be explained by the treatment variable after holding constant pre-treatment BDI score. The result supported the hypothesis that there is a significant reduction in the rate of depression in the treatment group, after controlling as constant the pre -treatment assessment.

Analysis of Pre – Versus Post – Treatment and Follow-up in the Treatment Group

Further analyses were conducted to examine the differences in the rate of depression before treatment, after treatment and a follow-up assessment after four weeks without treatment. Table 4 shows the summary of pair wise t-test for the treatment group. The mean BDI scores before treatment, after treatment and after one month follow-up were (25.53, 13.93, and 9.80 consecutively) showing a decline in the rate of depression over time. The pair wise $t(14) = 5.14$, $p = .00$ between BDI before and after treatment, and pair wise $t(14) = 2.88$, $p = .01$ between BDI after treatment and follow-up showed significant decline after the therapy and during the following four weeks without therapy.

Table 3
ANCOVA of Main Effects on Treatment Group: Dependent Variable- Post- Assessment BDI

Source	df	F	p	Partial Eta Squared (η^2)
Covariate - pre-assessment BDI	1	25.20	.00	.48
Main effects - Group	1	5.08	.03	.16
Error	27	(58.24)		

In contrast to the control group pair wise $t(14) = 1.17$, $p = .26$ between BDI before and after treatment was non-significant.

The results further supported the hypotheses that first, there was a significant reduction in depression level after CCT in the treatment group when compared to the control group and second, there was a significant reduction in the rate of depression after CCT compared to that before psychotherapy. Further significant reduction in the rate of depression after one month follow-up implied the long-term effect of CCT, ruling out the possibility that the decline in the rate of depression could be solely due to the therapist-client's interaction effect.

Table 4

Mean Difference of Three Measures of BDI for the Treatment Group

	Mean	SD	t	P
BDI before treatment	25.53	11.17		
BDI after treatment	13.93	9.56		
BDI follow-up	9.80	10.53		
BDI before – BDI after			5.14	.00
BDI after – BDI follow-up			2.88	.01

Additional Analyses

In addition to the BDI measures, treatment group participants were asked to give subjective rating of their satisfaction towards life before and after treatment. The rating scores were between one and nine with 1 as "very dissatisfied" and nine as "very satisfied". A paired sample t-test analysis between life satisfaction scores before and after treatment in Table 5 shows a significant difference with $t(14) = 3.06$, $p = .00$ indicating a similar result to the earlier analysis of variance of BDI measures.

Table 5

Life Satisfaction Rating Before and After Treatment

	Mean	SD	t	p
Life satisfaction before treatment (1)	3.20	2.04		
Life satisfaction after treatment (2)	5.45	2.36		
Life satisfaction 1 – Life satisfaction 2			3.06	.00

Main Issues Explored during Therapy Sessions

The main issues categorized in Table 6 were based on the primary concerns of clients shared repeatedly during the therapy sessions. Those issues were: (1) relationship with significant others, (2) anxiety and distorted self-perception, (3) childhood traumatic experiences, and (4) terminal illness.

Table 6

Main Issues Reported by Clients

Main issues/ concerns	No of clients involved	%
Relationship with significant others	9	60.00
Anxiety and distorted self-perception	4	26.66
Childhood traumatic experiences	1	6.67
Terminal illness	1	6.67

The first issue related by clients was relationship with significant others, including husband (7 clients), mother (1 client) and lover (1 client). Most of the relationship problems with husband were due to husband's affair with another woman, which was perceived as traumatic for four clients who admitted having phobia following the experience. Another two clients had problems with husbands' abusive behavior resulting in similar symptoms of anxiety. One client expressed the problem of callousness on her husband's part and the burden of taking on the family's responsibility alone without her husband's help.

The second issue was related to anxiety symptoms admitted by clients themselves. Two of them were observed to experience distorted perception of self, while another two had negative perception of self but were able to perceive themselves rather accurately. The third issue was reported by one client who shared her post-traumatic childhood incest experiences. The fourth was related by another who had undergone treatment for cancer.

Participants' Evaluation of the Therapy

The effects of the therapy based on participants' subjective opinions were post-coded into (1) development of positive emotions, (2) progress or improvement in behavior, (3) ability to find specific solutions, (4) understanding and acceptance of the problem, and (5) no change. Table 7 shows the frequencies and percentages of responses related to the effects of the therapy as reported by the participants.

Subjective opinions were obtained from the final therapy session and from an open- ended "*What is your evaluation regarding those therapy sessions you have attended?"* asked after clients completed the final therapy sessions. Examples of positive emotions reported by the participants were; *feeling good, less stressful, feel more peace with myself, feel relieved, no more restless and sadness, and feel less angry*. Progress or improvement in behavior reported by the participants include improved appetite, improved relationship with husband, more confident to make decision, more motivated to get better, and better appreciation of family members. Some of the specific decisions made by the participants were; arranging for a transfer, a new approach in communicating with husband, moving

abroad for better income, involved in charity work, and arranging for a holiday with children. Examples of understanding and acceptance of the problem were "*not to expect husband to change" "understood the root of my excessive worry" "accept the fact that I am not able to change the situation"* and **"***learn to live with the present situation.*

Table 7

Subjective Opinions on the Effects of the Therapy

Category of responses	Frequency of responses	%
Develop positive emotions	7	29.2
Show progress or improvement in behavior	6	25.0
Able to find specific solutions	6	25.0
Understanding and acceptance of the problem	4	16.7
No change	1	4.1

After completing the therapy sessions, participants were asked whether they need to continue with the therapy sessions. The summary of their responses are shown in Table 8.

Table 8

Subjective Opinion on the Need to Continue the Therapy

	Frequency	Percentage
No need	2	13.3
Weekly/biweekly	1	6.7
Monthly	3	20.0
When necessary	9	60.0

Most of the treatment group (86.7%) agreed to continue the therapy sessions when necessary, monthly, weekly/biweekly implying their satisfaction with the outcome of the therapy sessions or due to their feeling of vulnerability of possible relapse of the depressive behavior. Only two (13.3%) were not willing to continue the sessions, one was due to transfer to other places and another was due to no positive outcome of the session.

Discussion

Since the unfavorable results of the Wisconsin Project, CCT was concluded as inappropriate for mental illness (Rogers et al., 1967; Sommerbeck, 2002). On the contrary, review of several experimental studies on CCT showed positive outcomes (Greenberg, Elliot, & Lietaer, 1994). The

positive result of this study supported past studies on the efficacy of CCT as an alternative to CBT and IPT for the treatment of depression.

The three necessary therapeutic conditions, namely, congruence, unconditional positive regards and empathy provided without any directed intervention during the therapy resulted in significant positive outcome. Beck's hypothetical statement that the therapist's qualities as "*necessary but not sufficient"* (Beck, Rush, Shaw, & Emery, 1979) to produce positive outcome was not observed in most of the participants in this experimental study. The results showed otherwise indicating that the therapist's qualities is able to produce positive outcome.

Limitation of the study

The study was conducted within a period of three months; therefore it was not able to observe the complete recovery process which normally begins after eight weeks, and the possible recurrence that may happen over a longer period than three months as reported by Kennedy, Abbot, and Paykel (2003). Only one experienced therapist was involved in the therapy; therefore other personal qualities of the therapist which might influence the outcome were not observed in this experiment.

Conclusion

The overall findings indicated the positive effect of CCT as compared to the control group accounting for 16% effect change after four therapy sessions over eight weeks. A follow-up after four weeks in the treatment group indicated further significant decline in the depression measures. However, since this is the first experimental study on the application of CCT for psychiatric illness in Malaysia, further study involving more therapists with similar level of experience conducted over a longer period of time is needed to further test the hypothesis relating to the effectiveness of CCT for depressive illness.

Most of the participants in the treatment group expressed their depression in relation to relationship issues with significant others (mainly spouses). Depression in relation to anxiety and distorted perception of self were observed among the treated group. Further studies on understanding the association between relationship problems, depression and anxiety in women is needed to provide better understanding of women with depression.

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