The Reasons for Depression Questionnaire (RFD): UK Standardization for clinical and non-clinical populations

Richard Thwaites1*, Dave Dagnan1, Dale Huey2 and Michael E. Addis3

1North Cumbria Mental Health and Learning Disabilities NHS Trust, UK
2North Tyneside Primary Care Trust and University of Newcastle, UK
3Department of Psychology, Clark University, Massachusetts, USA

Recent research into reason giving for depression has illustrated the importance of client beliefs about the cause of their depression. Reasons given have been found to be associated with level of depression, perceived credibility of treatments and therapy outcome. It has been suggested that giving reasons for depression is a form of rule-governed behaviour and as such can cause the depression to be harder to treat (i.e. the reasons become functionally true for the individual).

This study investigates the reliability and validity of the Reasons for Depression Questionnaire (RFD; Addis, Truax, & Jacobson, 1995), a 48-item self-report measure developed to measure explanations for the causes of depression. The study provides preliminary normative data for both clinical (n = 123) and non-clinical (n = 105) UK samples. The data indicate high reliability for all subscales including a further subscale (biological) added since the measure was initially developed. Certain subscales correlate significantly with level of depression and specific aspects of self-esteem. This supports the validity of the measure and suggests that it is measuring a distinct concept rather than significantly overlapping with individuals' general beliefs about themselves.

Therapists from varying therapeutic traditions have suggested that the beliefs of clients about their problems play an important role in the therapeutic process. Addis, Truax,
and Jacobson (1995) have suggested that client beliefs about the cause of their depression can impact on treatment in several ways. First, the process of agreeing a shared explanation of depression can influence both the therapeutic alliance (Worthington & Atkinson, 1996) and the outcome of therapy (Tracey, 1988). Secondly, differing explanations for problems may suggest different treatment approaches. For example, clients who emphasize the role of childhood events may be less interested in working within a symptom-focused framework than individuals who allocate particular importance to recent events. The Reasons for Depression Questionnaire (RFD) has been constructed to measure the explanations provided by individuals for being depressed (Addis et al., 1995). The literature would suggest that clients’ reasons for depression are relevant to therapists for a number of reasons. This study briefly summarizes the reason-giving literature to date and provides the first normative data for non-clinical and clinical samples within the United Kingdom.

**Reason giving for depression**

Recent research has suggested that both individuals’ reactions to treatment rationales (insight-oriented vs. action-oriented) and the perceived credibility of the treatments are associated with reason giving for depression (Addis & Carpenter, 1999). Furthermore, the reasons endorsed for depression have also been found to be associated with therapy outcomes (Addis & Jacobson, 1996). Relationship-oriented reasons for depression were associated with negative process and outcome in cognitive therapy, whereas existential reasons for depression predicted better outcomes for individuals in cognitive therapy and worse outcomes in behavioural therapy.

Hayes, Strosahl, and Wilson (1999) have suggested that reason giving is encouraged by society and, as adults, we have been conditioned to generate reasons and explanations for overt behaviours. A relationship between reason giving and depression has been posited in that reasons offered to account for behaviour can begin to control the same behaviour (Addis & Jacobson, 1996). Hayes (2002) has suggested that reason giving for depression is a form of rule-governed behaviour and as such is relatively inflexible, thus causing the depression to be more difficult to treat. Using cognitive terminology, it could be explained that reasons become internalized and believed by individuals in a way that causes them to become ‘functionally true’.

Despite the important role accorded to such causal beliefs, there have been few empirical attempts to formally measure these beliefs. Much of the research in this area has been based on attributional theory (e.g. Wall & Hayes, 2000) rather than specific causal reasons for depression. Addis et al. (1995) have, however, developed a self-report measure to empirically investigate the reasons endorsed by clients for their current depression. Initially, 93 reasons for depression were generated by two experienced therapists/researchers based on those commonly presented by clients and also reflecting a variety of theoretical perspectives on the aetiology of depression. Via principal components analysis, eight factors were identified and 48 items were retained.
These are endorsed on a 4-point Likert scale depending on the individuals' view of their importance in causing their current episode of depression. The original eight factor-analytically derived subscales identified specific reasons for depression (existential, characterological, interpersonal conflict, intimacy, achievement, childhood, relationship, physical) in addition to a total score. As previously discussed, scores on this measure have been found to be associated with level of depression, responses to treatment rationales (Addis & Carpenter, 1999), the therapeutic process (e.g. homework compliance, perceived helpfulness of treatment) and therapeutic outcome (Addis & Jacobson, 1996).

Previous research has suggested that reasons given for depression are associated with functioning in related domains (Addis et al., 1995). For the measure to be of clinical use, it would require that while it correlates with aspects of functioning and self-view, it is also a distinct, specific measure of reason giving and does not overlap with generic beliefs about the self. For this reason, this study intends to investigate the relationship between reason giving and a measure of self-esteem to determine construct validity (Battle, 1992).

Although the RFD¹ has been used in a number of studies in the United States, this study attempted to investigate the validity of this scale for a UK sample and provide preliminary normative data for both clinical and non-clinical UK samples. Given the cultural differences between the United States and the United Kingdom, it is possible that different reasons could be given that would lead to different factor structures within the questionnaire. For example, it could be hypothesized that individuals in different social, cultural or political contexts might differ in the extent to which they emphasize certain factors. Furthermore, it could be hypothesized that certain cultures may emphasize reason giving itself to a greater extent. An additional aim of this study was to provide data on a further subscale (biological) added by the latter author since the original measure was developed. This subscale is comprised of four reasons relating to physiological reasons for depression (‘I have a chemical imbalance’, ‘It’s a biological illness’, ‘My nervous system is just wired this way’ and ‘It’s basically caused by genetics’).

**Method**

**Participants**

*Non-clinical*

Data were collected from 105 adults (84 female, 21 male) attending three further education (FE) centres and from staff in a social services family centre (all of which were in northern England). They ranged in age from 17 to 63 years old ($M = 32.54$ yrs, $SD = 11.92$ yrs).

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¹ The Reasons for Depression Questionnaire is available from Michael Addis Ph.D., Department of Psychology, Clark University, 950 Main St, Worcester, MA, USA (e-mail: maddis@clarku.edu).
Mixed clinical

Data were collected from 123 adults (67 female, 56 male) attending two NHS centres. Centre 1 was a psychology department in a small city in northern England, which covered both the city and the surrounding rural area. Centre 2 was a specialist centre for cognitive therapy based within a large urban area in northern England. The total patient sample ranged in age from 17 to 67 years old ($M = 38.26$ yrs, $SD = 11.11$ yrs).

Table 1 details the distribution of BDI scores within the mixed clinical and non-clinical groups. Although the BDI is not a diagnostic measure, for further information the scores have been divided into the standard BDI categories. The scores of 36.46% of the non-clinical sample would be consistent with mild–severe depression compared to a corresponding figure of 82.19% for the clinical sample. Although the level of depression appears slightly higher than expected for a non-clinical group, this is still at a considerably lower level than the clinical sample and there is no reason to suspect that this presents any major problems to the data analysis.

<table>
<thead>
<tr>
<th>Scores</th>
<th>Range of depression</th>
<th>Non-clinical $(n = 96)$</th>
<th>Clinical $(n = 73)$</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–9</td>
<td>Normal</td>
<td>61</td>
<td>13</td>
</tr>
<tr>
<td>10–18</td>
<td>Mild–moderate</td>
<td>29</td>
<td>18</td>
</tr>
<tr>
<td>19–29</td>
<td>Moderate–severe</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>30–63</td>
<td>Severe</td>
<td>1</td>
<td>20</td>
</tr>
</tbody>
</table>

Measures

Reasons for Depression Questionnaire (RFD; Addis et al., 1995)

The RFD is a 48-item self-report measure that asks respondents to rate the degree to which they believe various reasons have caused their depression. All items are rated on a 5-point Likert scale. As in previously published studies utilizing the RFD in clinical and non-clinical populations (Addis & Carpenter, 1999; Addis & Jacobson, 1996; Fitzgerald & Richardson, 2002), the instructions were as follows:

This questionnaire presents you with a number of reasons why you might be depressed. Each reason is given as a statement in the form of, ‘I am depressed because . . . ’ followed by a specific reason. For each statement, consider whether or not this particular reason causes you to be depressed. If you are not currently depressed, think of a time in the past when you were depressed and answer the questionnaire according to what the reasons were at that time.

Individuals who have never been depressed are asked to ‘think back to a time when [they] were extremely sad and it lasted more than just a little while’, then indicate their reasons for this experience. Although these instructions allowed individuals who did
not consider that they had previously been depressed to complete the questionnaire, in practice the majority of the non-clinical sample (76.9%) indicated that they had previously experienced depression and could therefore complete the questionnaire with respect to this experience.

Eight subscales have been derived via factor analysis (characterological, existential, interpersonal conflict, intimacy, achievement, relationship, physical, and childhood reasons). Subscale scores are derived by totalling the individual subscale items and dividing by the number of subscale items (mean number of items per scale = 5.5, range = 3–10). The characterological subscale reflects a stable sense of the person as a depressed individual (e.g. ‘I am depressed because this is the way I’ve always been’, ‘That’s just the type of person I am’), whereas the existential items reflect a stable disillusionment with life (e.g. ‘I don’t know who I am or what I stand for’, ‘I’m stuck where I am in life, nothing ever changes’). The achievement subscale includes items such as ‘I can’t accomplish what I want to’ and ‘I’m not living up to my personal standards’. The interpersonal conflict subscale relates to problems in interpersonal relationships (e.g. ‘Other people criticize me’, ‘People don’t give me the respect I deserve’), whereas the intimacy subscale emphasizes a lack of intimacy (e.g. ‘I don’t feel loved’, ‘There is no one to share my innermost thoughts and feelings with’). The relationship subscale concerns the specific relationship with spouse or partner (e.g. ‘My spouse/partner treats me poorly’, ‘My spouse/partner doesn’t understand me’). The childhood subscale concerns reasons given regarding childhood events (e.g. ‘I haven’t worked through things that happened to me as a child’, ‘My family treated me poorly as a child’). Finally, the physical subscale reflects physical (rather than biological) reasons for depression (e.g. ‘I’m not active enough’, ‘I don’t take care of myself physically’).

Subsequent to the published studies involving the RFD, the latter author (MA) has added a further four biological items. This study provides preliminary data on their internal consistency and relationship to the other scales.

**Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961)**
The BDI is a 21-item self-report questionnaire that assesses severity of depression. This measure is widely used, highly correlated with other measures of depression such as the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1967), and has excellent psychometric properties (Beck, Steer, & Garbin, 1988).

**Culture-Free Self-esteem Inventory (CFSEI-2; Battle, 1992)**
The CFSEI-2 is a 40-item (forced-choice: yes/no) self-report measure that measures self-esteem levels in adults. In addition to the total score, there are also three subscales (general, social and personal) and a lie scale.

**Procedure**
The majority of individuals completed these measures as part of a study investigating social comparison (ranking) and depression. Only the non-clinical sample completed
the CFSEI-2. Of the clinical sample, 50 were from a separate study and did not complete the BDI. Therefore, the analysis involving level of depression utilized only the 73 individuals from the main study. For the non-clinical sample, nine participants had to be excluded from the depressions analyses due to invalid completion of the BDI, leaving 96 in the non-clinical sample.

**Non-clinical**
Non-clinical participants were recruited from three FE colleges and a social services centre within the local region. A brief rationale for the study was provided by the first author. It was explained that a non-patient sample was required for a research project investigating social comparison and depression.

**Clinical**
During their first appointment, the study was introduced to patients by their therapist. They were provided with an information sheet and consent forms inviting them to take part in a study investigating depression and social comparison. If they agreed, they were given the pack of questionnaires to complete at home before returning them to their therapist or to the departmental secretaries.

**Data analysis**
All data was analysed using SPSS v.11. In order to reduce the risk of Type I error, for all statistical tests utilized, the significance levels shown are those calculated for the number of tests performed in that particular group of tests.

**Results**

**Reliability**
With respect to internal consistency of the RFD subscales, very similar results were found within the UK samples compared to the US samples. Table 2 presents Cronbach’s alpha for each subscale separately for the clinical and non-clinical samples. This table also presents 95% confidence intervals for each alpha (Feldt, Woodruff, & Salih, 1987) and alphas for the scale as reported by Addis et al. (1995). All subscales (including the added biological subscale) were found to have high Cronbach’s alpha coefficients (ranging between .73 and .94)—although the 95% confidence interval suggests some caution for some scales, as the lowest confidence intervals are relatively weak.

**Descriptive statistics**
As Table 3 illustrates, using independent samples t tests, significant differences were found between the clinical and non-clinical groups for five of the nine subscales. It may be of note that all three interpersonal subscales were included in the four subscales for Richard Thwaites et al.
which no significant difference was found. This pattern of findings is consistent with the higher order factor structure for the RFD identified by Addis et al. (1995), which clusters specific subscales into autonomous and interpersonal dimensions.

**Additional biological subscale**

Within the non-clinical sample, the biological subscale was found to correlate highly with the majority of the original subscales (see Table 4). However, within the clinical

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**Table 2. Internal consistency coefficients for RFD subscales**

<table>
<thead>
<tr>
<th>No. of items</th>
<th>Characterological</th>
<th>Achievement</th>
<th>Interpersonal conflict</th>
<th>Intimacy</th>
<th>Existential</th>
<th>Childhood</th>
<th>Physical</th>
<th>Relationship</th>
<th>Biological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample</td>
<td>Non-clinical (n = 105)</td>
<td>Clinical (n = 123)</td>
<td>Addis et al. (1995)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.82 (.65 –.93)</td>
<td>.88 (.77 –.95)</td>
<td>.86</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.83 (.62 –.96)</td>
<td>.80 (.55 –.95)</td>
<td>.85</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.89 (.75 –.97)</td>
<td>.86 (.69 –.97)</td>
<td>.85</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.73 (.35 –.95)</td>
<td>.76 (.43 –.96)</td>
<td>.79</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.73 (.35 –.95)</td>
<td>.79 (.50 –.96)</td>
<td>.78</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.88 (.71 –.98)</td>
<td>.90 (.76 –.98)</td>
<td>.84</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.73 (.29 –.97)</td>
<td>.79 (.44 –.97)</td>
<td>.79</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.94 (.81 –.99)</td>
<td>.83 (.48 –.91)</td>
<td>.82</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.76 (.36 –.97)</td>
<td>.80 (.47 –.97)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: aCronbach’s alpha (95% confidence intervals); bCronbach’s alpha.

**Table 3. Descriptive statistics for RFD subscales in a clinical and non-clinical sample**

<table>
<thead>
<tr>
<th>Sample</th>
<th>Non-clinical (n = 105)</th>
<th>Clinical (n = 123)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
</tbody>
</table>
| Characterological | 1.78                  | 0.55               | 1.00 –3.80 | 2.21              | 0.71               | 1.00 –3.80 | 5.13*
| Achievement   | 2.36                  | 0.72               | 1.00 –4.00 | 2.80              | 0.71               | 1.00 –4.00 | 4.65*
| Interpersonal conflict | 1.83                 | 0.76               | 1.00 –4.00 | 2.01              | 0.77               | 1.00 –3.83 | 1.73
| Intimacy      | 2.25                  | 0.74               | 1.00 –3.80 | 2.44              | 0.75               | 0.80 –4.00 | 1.93
| Existential   | 1.91                  | 0.63               | 1.00 –3.40 | 2.44              | 0.77               | 1.00 –4.00 | 5.60*
| Childhood     | 1.93                  | 0.89               | 1.00 –4.00 | 2.18              | 0.97               | 1.00 –4.00 | 2.02
| Physical      | 1.77                  | 0.65               | 1.00 –3.75 | 2.25              | 0.81               | 1.00 –4.00 | 4.82*
| Relationship  | 1.93                  | 1.12               | 1.00 –4.00 | 1.68              | 0.84               | 1.00 –4.00 | 1.92
| Biological    | 1.58                  | 0.65               | 1.00 –3.23 | 1.95              | 0.79               | 1.00 –3.75 | 3.86*

*p < .006.
sample a very different pattern was found. Only three subscales were found to correlate
with the additional subscale of which the highest was the characterological subscale
\((r = 59, p < .01)\).

**Table 4. Correlations between new biological subscale and original subscales**

<table>
<thead>
<tr>
<th>Sample</th>
<th>Non-clinical ((n = 105))</th>
<th>Clinical ((n = 123))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characterological</td>
<td>.53*</td>
<td>.59*</td>
</tr>
<tr>
<td>Achievement</td>
<td>.23</td>
<td>.19</td>
</tr>
<tr>
<td>Interpersonal conflict</td>
<td>.40*</td>
<td>.09</td>
</tr>
<tr>
<td>Intimacy</td>
<td>.39*</td>
<td>.09</td>
</tr>
<tr>
<td>Existential</td>
<td>.39*</td>
<td>.28*</td>
</tr>
<tr>
<td>Childhood</td>
<td>.46*</td>
<td>.08</td>
</tr>
<tr>
<td>Physical</td>
<td>.41*</td>
<td>.25*</td>
</tr>
<tr>
<td>Relationship</td>
<td>.18</td>
<td>.15</td>
</tr>
</tbody>
</table>

*p < .006.

**RFD and demographic features**

Parametric independent \(t\) tests were performed investigating possible gender differences on RFD subscales. This was investigated for the combined sample and for the clinical and non-clinical groups. No significant gender differences were found on RFD subscale or total scores.

Age was not found to be a particular significant factor in RFD subscale scores. This was investigated for the combined sample and for the clinical and non-clinical groups. No significant correlations between age and RFD subscale or total scores were found.

**BDI and CFSEI-2 scores**

As Table 5 illustrates, for the non-clinical and combined samples there are high correlations between the level of depression and the various self-esteem indices. For the small numbers within the clinical sample, no significant correlations were found.

**RFD and level of depression**

As detailed in Table 6, for the non-clinical sample, only one subscale (achievement) was found to correlate significantly with the level of depression. For the clinical sample, the relationship between RFD subscales and level of depression were considerably higher in this study than in the original US sample (Addis et al., 1995). For subscales such as achievement, intimacy and existential, the correlations were found to be between .51 and .61, whereas the highest in the US clinical sample was .28. Possible reasons for these findings are discussed below.
There were few significant relationships between reasons endorsed for depression and self-esteem in the non-clinical sample. The personal scale of the CFSEI-2 did correlate significantly with three of the subscales indicating that lower levels of self-esteem were significantly associated with greater endorsement of characterological, achievement and existential reasons. However, further analysis revealed that none of these remained significant once depression had been partialled out (see Table 7).

**Discussion**

The aim of this study was the collection of UK data for the RFD scale (a measure of reason giving for depression). The data collected within this study have provided preliminary evidence of high reliability for all subscales for both clinical and non-clinical samples.
Significant differences were found between the clinical and non-clinical samples for several of the subscales. As mentioned, there were no significant differences on interpersonal subscales between patients and non-patients. It is currently unclear why there is common agreement on the importance of interpersonal reasons for depression but not those based around autonomy and physical/biological causes. Hayes et al. (1999) would perhaps explain that these reasons are more societally validated and encouraged from an early age. For example, one can imagine that interpersonal reasons such as ‘I don’t feel loved’ or ‘No one really cares about me’ may be more socially acceptable than characterological reasons such as ‘I’ve always been this way’.

While there were significant differences between the clinical and non-clinical samples, no significant effects were found to be exerted by demographic factors on RFD scores. It appears likely that neither age nor gender significantly effect individuals’ beliefs regarding the causes of their depression. This finding further supports the validity and sensitivity of the measure.

High correlations between the subscales and level of depression were found only within the clinical sample. For non-patients, only one subscale correlated with the level of depression. This is in direct contrast to the findings within the United States where all subscales were found to significantly correlate ($p < .01$) with the BDI scores. It is possible that this was a reflection of the educated undergraduate sample utilized within the US study. It could be hypothesized that a higher level of education would be associated with increased psychological mindedness, self-reflection and reason giving regarding emotional experiences. As discussed, the large majority of the non-clinical sample in this study indicated that they were completing the RFD with respect to a previous episode of depression. There was no prior expectation that RFD scores in non-patients should correlate with level of depression.

Table 7. Correlations between RFD subscales and measure of self-esteem (non-clinical sample, $n = 98$)

<table>
<thead>
<tr>
<th>CFSEI-2 subscales</th>
<th>General</th>
<th>Social</th>
<th>Personal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characterological</td>
<td>-.37*</td>
<td>-.20</td>
<td>-.27*</td>
<td>-.25</td>
</tr>
<tr>
<td>Achievement</td>
<td>-.18</td>
<td>-.15</td>
<td>-.30*</td>
<td>-.25</td>
</tr>
<tr>
<td>Interpersonal conflict</td>
<td>-.01</td>
<td>-.08</td>
<td>-.02</td>
<td>-.03</td>
</tr>
<tr>
<td>Intimacy</td>
<td>-.04</td>
<td>-.01</td>
<td>-.16</td>
<td>-.08</td>
</tr>
<tr>
<td>Existential</td>
<td>-.25</td>
<td>-.06</td>
<td>-.27</td>
<td>-.25</td>
</tr>
<tr>
<td>Childhood</td>
<td>-.10</td>
<td>.18</td>
<td>-.15</td>
<td>-.09</td>
</tr>
<tr>
<td>Physical</td>
<td>-.17</td>
<td>-.01</td>
<td>-.20</td>
<td>-.17</td>
</tr>
<tr>
<td>Relationship</td>
<td>.15</td>
<td>.17</td>
<td>.01</td>
<td>.13</td>
</tr>
<tr>
<td>Biological</td>
<td>-.11</td>
<td>-.04</td>
<td>-.07</td>
<td>-.11</td>
</tr>
</tbody>
</table>

*p < .001.

Significant differences were found between the clinical and non-clinical samples for several of the subscales. As mentioned, there were no significant differences on interpersonal subscales between patients and non-patients. It is currently unclear why there is common agreement on the importance of interpersonal reasons for depression but not those based around autonomy and physical/biological causes. Hayes et al. (1999) would perhaps explain that these reasons are more societally validated and encouraged from an early age. For example, one can imagine that interpersonal reasons such as ‘I don’t feel loved’ or ‘No one really cares about me’ may be more socially acceptable than characterological reasons such as ‘I’ve always been this way’.

While there were significant differences between the clinical and non-clinical samples, no significant effects were found to be exerted by demographic factors on RFD scores. It appears likely that neither age nor gender significantly effect individuals’ beliefs regarding the causes of their depression. This finding further supports the validity and sensitivity of the measure.
For the clinical sample, correlations between subscales and BDI were higher than in the US sample. The original authors suggested that they wanted to avoid high correlations between depression and all RFD scales to prevent the measure becoming ‘a redundant measure of depression’ (Addis et al., 1995, p. 482). Although the correlations were found to be higher within the current sample, they are not at a level where reasons offered for depression are synonymous with level of depression. A similar finding was found for self-esteem. Although some low correlations were found, self-esteem and reason giving for depression were not found to be highly associated. This is in contrast to the extremely high correlations between self-esteem and level of depression in the non-clinical and combined sample. This supports the divergent validity of the RFD and suggests that it is measuring a distinct concept rather than significantly overlapping with a general measure of self-concept.

In conclusion, this study has provided preliminary support for the usage of this measure within a UK population, although further data collection for the additional biological scale may be beneficial. Both individuals experiencing mental health problems and those that are not can be seen to offer diverse explanations for depression. The RFD has shown great potential in investigating patient views about their depression but also with respect to treatment matching.

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References


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