

**WHY DO PEOPLE THINK THEY ARE DEPRESSED?:
THE REASONS FOR DEPRESSION QUESTIONNAIRE**

MICHAEL E. ADDIS

Clark University

PAULA TRUAX

NEIL S. JACOBSON

University of Washington

The reasons for depression questionnaire (RFD) was constructed to measure the explanations people give for being depressed. In the first study presented, items were generated and administered to a large undergraduate sample to evaluate internal consistency and derive a preliminary factor structure. Principal components analyses yielded 8 internally consistent subscales including characterological, achievement, interpersonal conflict, intimacy, existential, childhood, physical, and relationship oriented reasons for depression. In the second study, the RFD was administered to a clinically depressed sample along with additional measures of functioning in specific areas. Specific RFD scales were generally associated with measures of functioning in corresponding domains. For example, people who attributed their depression to a lack of intimacy or relationship problems, reported higher degrees of marital distress. Characterological

reasons were associated with the tendency to offer global and stable reasons for other problems. The results are discussed with regard to the potential use of the RFD in case conceptualization and psychotherapy research.

Causal explanations for depression range from complex biological theories to common psychological metaphors. Some clients may say they are depressed because of a chemical imbalance while others refer to low self-esteem or a difficult childhood. Given a wide array of professional and lay theories, it is not surprising that many clients enter treatment with pre-existing attributions for feeling depressed. It is also possible that these various explanations can impact the process and outcome of treatment.

There are a number of ways in which a client's stated reasons for depression can impact treatment. First, offering explanations for the cause of a problem is one way to begin to take control of a client's experience (Frank, 1971). Whether client and therapist agree or disagree on what the problem is and what causes it can influence how engaged both will be in the treatment process. Second, different explanations for problems suggest different approaches to treatment. Clients who endorse childhood reasons for depression may be more likely to try and focus on family of origin issues in psychotherapy. Depending on the therapist's inclination, this may or may not be a fruitful treatment approach. Finally, clients often have personal meanings associated with alternative explanations for their problems. For example, the idea that depression is caused by negative

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Correspondence regarding this article should be addressed to Michael Addis, Ph.D., Department of Psychology, Clark University, 950 Main St., Worcester, MA 01610-1477. maddis@vax.clarku.edu.

thinking may lead to feelings of relief or shame depending on a client's history with similar ideas. We have observed that people who report growing up in abusive and emotionally invalidating environments (see Linehan, 1993) tend to resist a cognitive conceptualization of depression. They resist the rationale because it places blame on them for having "screwed up thinking." Similarly, couples with a depressed wife who see her depression as unrelated to the marriage are likely to resist a marital therapy rationale (Addis & Jacobson, 1991; Dobson, Jacobson, & Victor, 1988).

A number of empirical studies point to the role of reasons for depression in treatment outcome. Fennel and Teasdale (1987) found that clients who responded positively to a pamphlet explaining a cognitive model of depression changed more quickly and had better long term outcomes in a cognitive treatment for depression (Beck, Rush, Shaw, & Emery, 1979). Another study found that clients scoring high on a pre-treatment measure of learned resourcefulness did better in cognitive therapy than those low on this dimension (Simons, Lustman, Wetzel, & Murphy, 1985). Learned resourcefulness is a construct thought to reflect the degree to which a person believes he/she can control and change internal processes; a premise central to cognitive therapy (Beck et al., 1979). Simons et al. concluded that ". . . congruence between the patient's and the therapist's conceptualization of the problems and how they are best approached may be a powerful facilitator of treatment response . . ." (1985, p. 86).

Thus, there is evidence to suggest that clients' reasons for depression can be an important determinant of treatment success. Yet, to date little effort has been put forth to develop a tool for systematically assessing this variable. Instruments have been designed to measure the attributional styles of depressed individuals (Peterson & Villanova, 1988), reasons for staying alive (Linehan, Goodstein, Lars Nielsen, & Chiles, 1983), and attributions about the causes of a specific self-selected problem (Norcross, Prochaska, & Hambrecht, 1985). None of these measures assess the types of reasons clients offer for depression per se. Kuyken, Brewin, Power, and Furnham (1992) compared causal beliefs about depression in depressed patients, clinical psychologists, and lay persons using a structured interview. However, no validity data for the interview were presented. In addition, Kuyken et al. measured people's beliefs about the causes of depression in

general, not a client's reasons for his/her own depression.

The current studies describe the development and psychometric evaluation of the Reasons for Depression Questionnaire (RFD). In the first study, items were generated and administered to a large undergraduate sample to determine an initial factor structure, evaluate the measure's internal consistency, and examine its relationship to current depressed mood. We hypothesized that RFD scores would be positively correlated with depressed mood since people tend to offer reasons for problems when they are emotionally distressed (e.g., Zettle & Hayes, 1986). In the second study, the same items were administered to a depressed sample to evaluate the measure's internal consistency in a clinical sample, and to address some preliminary validity questions.

Study 1 Method

Item Generation and Questionnaire Format

The two senior authors generated a pool of reasons for depression based on seven years clinical experience conducting diagnostic interviews with depressed people. In generating items, we strove to find a balance between items which reflected the types of reasons that clients commonly give, and those that represented a range of theoretical perspectives on the etiology or maintenance of depression. Redundant items were omitted resulting in 93 total reasons for depression. Each reason was reworded into the first person and formatted as a statement ("I am depressed because . . .") to be rated on a 4-point scale (1 = definitely not a reason, 2 = probably not a reason, 3 = might be a reason, 4 = definitely a reason). 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. If you don't think you've ever been depressed, think back to a time when you were extremely sad and it lasted more than just a little while.

Participants and Measures

602 undergraduate students (353 females, 249 males, mean age = 20) completed the RFD in exchange for course credit. A subset of this sample ($n = 184$) also completed the Beck Depres-

sion Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), a widely used self-report measure of current depression. These 184 participants were drawn from the same pool as the rest of the participants and displayed a mean BDI score of 9.10 indicating that this was not, on average, a clinically depressed sample. The BDI is also widely used as a measure of depressed mood in analogue studies of clinical depression (e.g., Lyubomirsky & Nolen-Hoeksema, 1993; Nolen-Hoeksema & Morrow, 1993). Thus, in the current study we were able to evaluate the relationship between reasons for depression and depressed mood in a college sample.

Procedure

Participants completed the questionnaires during class time or in small groups of 5 to 15. We informed participants that the purpose of the research was to evaluate the types of reasons people give for being depressed, and that this information might be helpful in enhancing the effectiveness of treatments for depression. Participants were informed that completion of the questionnaires was voluntary and that they could discontinue participation at any time. After this brief oral presentation, participants read a 1-page written description of the study which explained the potential benefits of the research, as well as the small likelihood of adverse effects resulting from participation. Subjects then completed the questionnaires. Confidentiality was assured by identifying questionnaires with a code number and participants' names were in no way connected with the data.

Results

Our intent was to develop a multi-dimensional measure of reasons for depression. The first step was to select items which contributed to the underlying factor structure of the RFD. All 93-items were subjected to a principal components analysis which yielded 20 factors with eigen values greater than 1 accounting for 63.6% of the variance. Given that the last 9 factors accounted for only 12.5% of the variance, we considered an 11 factor solution to be a liberal estimate of the potential number of factors. We then conducted a second principal components analysis with a specified 11 factor solution and rotated the matrix to a varimax solution. These 11 factors accounted for 57.8% of the variance in the original 93-items. Three of the factors were indicated by 5 or fewer items

with cross loadings greater than .3 on two or more factors. The remaining 8 factors were indicated by items which were conceptually related and had few cross loadings. Thus, it seemed that an 8 factor solution best represented the structure of the RFD.

The 8 factors with internal consistency coefficients and percentage of variance accounted for are presented in Table 1. Items were retained if they loaded at least .4 on a single factor and no greater than .3 on any other factor.¹ Forty-four items met these criteria. Items factored into characterological, achievement, interpersonal conflict, intimacy, existential, childhood, physical, and relationship oriented reasons for depression. The individual factors demonstrated good internal consistency and the alpha coefficient for the entire scale was .94. Items loading on each factor were then summed to create subscale scores. The number of items per subscale ranged from 10 (characterological) to 3 (significant other) with a mean of 5. Table 2 shows the number of items, means, and standard deviations for each subscale.²

We predicted that RFD subscales would be positively correlated with current depressed mood since people who are distressed should be more likely to offer reasons for their problems. All correlations between RFD subscales and BDI scores were significant ($p < .01$) and ranged from .14 to .49. Thus, there was a moderate association between current dysphoria and the tendency to endorse reasons for feeling depressed.

We were also interested in whether the 8 RFD subscales themselves clustered together into a higher-order structure. The intercorrelation matrix revealed a moderate degree of association between the subscales (average $r = .39$, $p < .01$) which suggested a possible higher-order multiple or single factor structure for the RFD. The

¹ Two items were retained despite violating these criteria. One item ("I am depressed because I haven't done anything important in my life") loaded .53 on the existential factor and .30 on the achievement factor. This item was retained on the existential factor because of its conceptual consistency with other items on the factor. Another item ("I am depressed because I'm not active enough") loaded .52 on the physical factor and .33 on the Existential factor. This item was retained on the physical factor.

² Due to space limitations, certain results are not presented in tables. Tables of individual items and factors loadings, subscale intercorrelation matrices, and higher-order factor loading matrices are available from the first author.

TABLE 1. RFD Factors

Factor	% Variance	Alpha Coefficient
Characterological	28.2	.86
Achievement	5.8	.85
Interpersonal Conflict	4.5	.85
Intimacy	3.5	.79
Existential	3.0	.78
Childhood	2.6	.84
Physical	2.2	.79
Relationship	2.1	.82

8 subscales were subjected to a principal axis factor analysis with varimax rotation.³ This analysis yielded two higher-order factors accounting for 47.4% of the variance. One factor indicated by the existential, achievement, characterological, and physical subscales appeared to reflect individual or autonomous oriented reasons for depression. The other factor, indicated by the interpersonal conflict, relationship, intimacy, and childhood subscales reflected interpersonally oriented explanations for depression. There was, however, substantial overlap between these two factors. Four of the 8 subscales loaded .3 or greater on both higher-order factors and the correlation between the autonomous and interpersonal factors was .62 ($p < .001$). Thus, although there was a relatively clear conceptual distinction between the tendencies to offer autonomous or interpersonally oriented reasons, these higher-order factors were not statistically independent.

Discussion

The goal of the first study was to examine the preliminary factor structure and internal consistency of the RFD in a large undergraduate sample. Items were generated, administered to a large student sample, and factor analyzed into subscales. The subscales demonstrated good internal consistency and were moderately correlated with depressed mood. The results suggest that individuals who are not clinically depressed reliably endorse diverse explanations for depression. At the same time, alternative explanations for de-

pression tend to be moderately correlated. It may be that some individuals are more discriminating in the reasons they offer while others show a more general "reason-giving" tendency across a range of explanations. While preliminary evaluation on a large undergraduate sample enhanced our confidence in the RFD, administration to a clinical sample was necessary to begin to evaluate the utility of the RFD as a clinical and research instrument.

Study 2 Method

Participants

133 individuals (101 females, 32 males, mean age = 37.8) seeking participation in a depression treatment study (Jacobson, Dobson, Truax, Adis, Koerner, Gorther, Gollan, & Prince, in press) completed the RFD. To be included in the sample participants had to meet the following criteria: (1) a score of 20 or higher on the Beck Depression Inventory (BDI; Beck et al., 1961), (2) a score of 14 or higher on the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960), and (3) each subject had to receive a diagnosis of current major depression as determined by the Structured Clinical Interview for the DSM-III-R (SCID; Spitzer, Williams, Gibbon, & First, 1989). SCID interviews were conducted by clinical psychology graduate students trained by one of the original authors and supervised by a psychiatrist specializing in psychiatric diagnosis.

Measures

Participants completed the RFD and the BDI as part of a larger pre-treatment assessment battery. In addition, they completed three measures to assess areas of functioning corresponding to specific RFD scales.

Expanded Attributional Style Questionnaire (EASQ; Peterson & Villanova, 1988): The EASQ measures the tendency to attribute causes to events in a characteristically depressive way. Respondents provide explanations for specific events and then rate their explanations on the dimensions of globalness, stability, and internality. Only the global and stable subscales were used for the current study. These scales have demonstrated high internal consistency and have been shown to be correlated with current depressed mood (Peterson & Villanova, 1988).

Social Adjustment Scale (SAS; Weissman & Bothwell, 1976). The SAS is a widely used self-

³ Principal axis as opposed to principal components was chosen in order to capitalize only on variance unique to the 8 subscales in evaluating a possible higher-order structure.

TABLE 2. Descriptive Statistics for RFD Subscales in an Undergraduate and a Clinically Depressed Sample

	# of Items	Sample				
		Undergraduate		Clinically Depressed		
		Mean	SD	Mean	SD	Alpha
Characterological	10	15.9	5.8	23.7	5.8	.81
Achievement	6	14.5	4.8	19.2	3.6	.78
Interpersonal Conflict	6	9.8	3.9	11.8	4.1	.82
Intimacy	5	10.4	3.9	12.1	3.4	.69
Existential	5	8.7	3.3	13.3	3.5	.73
Childhood	5	7.8	3.4	12.4	4.1	.86
Physical	4	7.1	2.8	9.7	2.0	.82
Relationship	3	4.3	2.2	5.3	2.7	.85

report measure of social functioning in the areas of work outside the home, housework, social/leisure activity, extended family, marital relationships, parental functioning, and the family unit. For the current study, we were particularly interested in the areas of work and social/leisure activity.

Dyadic Adjustment Scale (DAS; Spanier, 1976). The DAS is a widely used self-report measure of marital functioning. Higher scores on this measure reflect greater degrees of marital satisfaction and functioning.

Results

RFD subscale scores were computed by summing items according to the factor loadings in study 1. As expected, the reliability of these subscales was somewhat lower than in the non-depressed sample (alpha range: .69 to .86, mean = .80) but still high enough to justify summing items into subscale scores. As in study 1, we were also interested in the possible presence of a higher-order factor structure underlying the individual subscales. Examination of the subscale intercorrelation matrix revealed a substantial number of moderate size correlations. Principle axis factor analysis of the subscales yielded 3 factors accounting for 44.6% of the variance. As in study 1, the RFD subscales factored into autonomous (characterological, existential, physical, achievement) and interpersonal (interpersonal conflict, intimacy) higher-order factors with the interpersonal conflict scale loading roughly equally on both factors. The correlation between the autonomous and interpersonal factors was .42 ($p < .01$). The relationship and childhood scales

indicated a third factor. However, the stability of this factor was questionable given that the relationship scale loaded only .38, while also loading .21 on the individual factor and .25 on the interpersonal factor. Thus, in a clinically depressed sample, RFD subscales appeared to factor broadly into interpersonal vs. autonomous reasons for depression. However, as in study 1, there was also substantial overlap in the tendency to offer reasons for depression in both domains.

Validity

It is an empirical question whether people offer reasons for depression which are consistent with their actual functioning in corresponding areas. For example, do people who attribute depression to interpersonal conflict also report worse interpersonal functioning? We assumed that people are at least reasonably good at describing the variables effecting their mood. We therefore predicted significant relationships between specific RFD subscales and self-reports of functioning in corresponding domains.

As in study 1, we expected RFD scales to be positively associated with severity of current depression as measured by the BDI. In the interpersonal domain, we predicted that relationship oriented reasons would be associated with decreased marital satisfaction as measured by the DAS. We predicted that interpersonal conflict reasons would be associated with decreased work and social/leisure functioning on the SAS since people who attribute depression to conflict with others should be functioning less well in these domains. We predicted that intimacy reasons for depression would be associated with decreased social/leisure

functioning and less marital satisfaction since both of these areas involve feelings of closeness with others. We did not predict a relationship between intimacy reasons and work functioning since not all people meet their intimacy needs at work.

We were also interested in the relationship between certain reasons for depression and the tendency to make similar attributions in other areas of life. We predicted positive associations between characterological and existential reasons and scores on the global and stable scales of the EASQ. Many of the items on the characterological subscale (e.g., "I am depressed because this is the way I've always been" or "That's just the type of person I am") reflect a stable and ingrained sense of the self as a depressed person. Rather than an isolated illness, these items describe depression as both a global and stable aspect of one's character. Similarly, the existential subscale includes items that reflect a global and stable disillusionment with life in general (e.g., "I am depressed because I don't know what I stand for"). We hypothesized that the tendency to offer characterological and existential reasons for depression would be associated with the tendency to make global and stable attributions for other problems as well.

Table 3 shows the correlations between RFD subscales and current depression, global and stable attributions, work and social/leisure functioning, and marital functioning. Contrary to our prediction, only three of the RFD scales were positively correlated with current depression. As we predicted, characterological and existential

reasons were associated with both global and stable attributions on the EASQ. Interestingly, intimacy and physical reasons were also significantly correlated with global and stable attributions. Interpersonal conflict was positively correlated with stable but not global attributions.

As predicted, people who endorsed interpersonal conflict reasons were significantly more likely to report decreased work and social/leisure functioning. Individuals who endorsed intimacy related reasons for depression also reported worse social/leisure functioning. The tendency to endorse either intimacy or relationship oriented reasons was associated with decreased marital satisfaction. Although we did not predict the relationships, childhood and physical reasons for depression were also associated with decreased marital satisfaction.

Discussion

In the second study, we administered the RFD to a clinically depressed sample to evaluate internal consistency and gather preliminary validity data. The RFD demonstrated internally consistent scale scores in a clinically depressed sample. Higher-order factor analyses revealed an individual and an interpersonal factor, consistent with the notion that depression can be characterized by either an interpersonal or an achievement oriented focus (Beck, 1983; Blatt & Maroudas, 1992). However, given the moderate to high degree of correlation between these higher-order factors in both an undergraduate and a depressed sample, the present results suggest that most people tend to give multi-dimensional explanations for de-

TABLE 3. Correlations between RFD Subscales and Measures of Depressed Mood, Attributional Style, Social Functioning, and Marital Satisfaction

RFD Subscale	BDI	EASQ-Global	EASQ-Stable	SAS-Work	SAS-Leisure	DAS
Characterological	.01	.22*	.17*	-.05	-.06	.06
Achievement	.19*	.14	.04	-.08	.00	-.13
Conflict	.20*	.19	.26**	-.19*	-.31**	.00
Intimacy	.26**	.28**	.34**	-.08	-.45**	-.43**
Existential	.11	.20*	.19*	-.12	-.11	-.03
Childhood	.06	.17	.12	.00	-.20*	-.26*
Physical	.11	.22*	.21*	-.21*	-.11	-.20*
Relationship	.10	.00	.04	-.02	-.04	-.65**

Note. * $p < .05$, ** $p < .01$.

BDI = Beck Depression Inventory, EASQ = Expanded Attributional Style Questionnaire, SAS = Social Adjustment Scale, DAS = Dyadic Adjustment Scale.

pression and do not fit neatly into a single category. This is also evidenced by the consistent intercorrelation among the RFD subscales in both samples.

The relatively consistent intercorrelations among the RFD subscales also suggests a general tendency in some individuals to offer reasons across a variety of domains. Such a tendency is consistent with recent studies on rumination which suggest that individuals who spend more time focusing on why they feel depressed experience longer episodes of depression (Nolen-Hoeksema & Morrow, 1993) and are less likely to see the value of engaging in pleasant or distracting activities (Lyubomirsky & Nolen-Hoeksema, 1993). As a general measure of reason-giving the RFD may therefore be helpful in examining differential response to more active behavioral or problem-solving approaches to treating depression.

Despite the intercorrelations among RFD subscales, we did find evidence of concurrent and discriminant validity for specific scales. First, only three of the subscales were moderately correlated with current depression. Although we expected some overlap between the RFD and depression, we did not want to create a redundant measure of depression. Thus, the results are encouraging because they suggest that giving reasons for depression is not synonymous with being depressed and can be considered as an independent process. This may be even more the case in a clinically depressed as opposed to a non-depressed population. The explanations a person offers for depression may become more independent of his/her mood the longer depression persists.

We also found evidence of concurrent validity. People who scored highly on interpersonal conflict reasons also tended to endorse poorer work and social/leisure functioning. Similarly, intimacy and relationship oriented reasons for depression were associated with decreased marital functioning. These results suggest that depressed people can provide explanations for their depression which are consistent with reports of functioning in corresponding domains. This is important clinically because therapists often rely on clients' explanations of problems in formulating a case conceptualization and treatment plan.

There are limitations to the current studies which prevent definitive conclusions about the validity and clinical utility of the RFD. Because of the small number of subjects relative to the

number of RFD items it was not practical to derive a separate factor structure in the clinically depressed sample. Consequently, the combination of items into subscale scores in the depressed sample was based on the factor structure of the undergraduate sample. It is, therefore, possible that the subscales in study 2 do not adequately represent the categories of reasons depressed people naturally give. While we cannot rule out this possibility it is unlikely given that the original reasons were created based on experience with depressed populations. The internal consistency of the scales in the depressed sample and the concurrent validity data also argue for the utility of the current factor structure. Nonetheless, future research should aim towards confirmatory factor analysis on a large depressed sample.

The current studies did not evaluate the relationships between reasons for depression and psychotherapy process or outcome. Such data would provide evidence for the ultimate clinical utility of the RFD. Accordingly, we are currently working on a study evaluating the relationship between RFD subscales and client reaction to cognitive-behavioral treatment rationales in the context of a controlled clinical trial.

There are a number of other important clinical questions which could be studied with the RFD. Do different RFD subscales predict client-treatment match? For example, do clients who endorse interpersonal conflict or intimacy reasons for depression improve more in Interpersonal Therapy? (Klerman, Weissman, Rounsaville, & Chevron, 1979). At a process level, different reasons may also predict willingness to learn new coping skills (Burns & Nolen-Hoeksema, 1991), perceived helpfulness of various interventions (Gaston, Marmar, Gallagher, & Thompson, 1989), and response to specific treatment rationales (Fennell & Teasdale, 1987). All of these predictions assume that therapist interpretations, interventions, and metaphors will create more of an impact when they are consistent with a client's pre-existing explanations for depression.

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