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Adult Outpatients With Major Depressive Disorder Forming Positive Responses During Challenging Events

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This is to certify that the doctoral dissertation by

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2013

Abstract

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MS, Walden University, 2007

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Dissertation Submitted in Partial Fulfillment

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Abstract

Previous empirical research demonstrated that major depressive disorder (MDD) had a profound impact on adults. What remained unaddressed in the research was the ability of those with MDD to form positive responses during challenging life events. The purpose of this exploratory quantitative study was to examine the cognitive ability of MDD patients to form positive responses on a standardized psychological assessment. This study, guided by Beck's cognitive theory of depression, was designed to determine whether depressed individuals were prone to negativity and had decreased ability to form positive responses to challenging situations. A 2x2 ANOVA was used to analyze 116 participants who voluntarily completed the Changes in Outlook Questionnaire **(**CiOQ). Results indicated that the group diagnosed with MDD scored significantly lower than a control group on the positive response scale of the CiOQ and that men diagnosed with MDD scored significantly lower than women diagnosed with MDD on the positive response scale of the CiOQ. This research has positive social change implications in that practitioners may use the findings in developing more effective treatments to help those with MDD to learn to form positive responses in the midst of challenging life events. Practitioners may also develop their ability to recognize when men with MDD are depressed by using the CiOQ to obtain written responses from individuals who do not verbalize depression. This research may also be useful for future research and application within the field.

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Dedication

This doctoral dissertation is dedicated to every person who has endured major depressive disorder, struggled to stay in life, never found answers, and somehow kept going. You deserve all that is good. Please don't stop searching. Keep going. Read this dissertation. It is dedicated to *you*.

In particular, this entire journey is dedicated to my Aunt and Godmother, Madeline Girgenti James. I promised I would never quit, Aunt Mag. I meant it. I love you. I will love you for *eternity*.

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I grew up quickly, and I knew that life threw curveballs. The goal was always the same: Hit it and go for the Home Run every time. There is nothing else worthwhile. Then, there is dissertation.

Even the most independent, responsible, reliable, dependable, loyal, hardworking, disciplined, and determined of individuals will *not* be able to hit the curveballs that dissertation inevitably throws their way. Life may throw curveballs, and you may hit them well into the ballpark all by yourself.

You will do *no such thing* in dissertation. Try as you might, try as you will, you will get *nowhere* until you realize that the very things you depended on, relied on, trusted in, and demanded of yourself are *precisely how you will strike out* with dissertation.

Here is the bottom line: *The only way around the bases in dissertation is to accept you cannot do it alone, and you will need every single player rooting for you to bring you "Home."*

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Chapter 1: Introduction to the Study

Introduction

Major depressive disorder (MDD) was traditionally treated with pharmacology; approaches to MDD have been updated in response to developments in theoretical and psychological frameworks of treatment (National Institute of Mental Health [NIMH], 2011). The professional literature has shown that those diagnosed with MDD can be resistant to traditional treatment methods and are increasingly prone to relapse (NIMH, 2011). For example, in one year, a total of 6.7% of the population in the United States was diagnosed with MDD, with 30.4% of those cases labeled as severe (NIMH, 2011). Hart, Craighead, and Craighead (2001) reported that 50% of those who recovered from MDD were at significant risk for recurrence of the disorder within 3 years of the initial diagnosis. Hart et al. further stated that "the cascading effect of recurrent depression makes clear the need for effective methods to prevent relapse and recurrence of MDD" (p. 633).

Research has also shown that female participants tended to be more prone to MDD in the midst of stressful life events (SLEs) when compared to male participants (Harkness et al., 2010; Stroud, Davila, Hammen, & Vrshek-Schallhorn, 2011). This study was intended to show that those coping with MDD may require more specific individual and group psychological interventions to circumvent their cognitive impairments, which could interfere with their ability to form positive responses, in order to maintain optimum mental health.

Background

The NIMH (2011) reported that MDD is one of the most debilitating disorders nationwide. The American Psychiatric Association (APA; 2000) defined MDD as the most severe of the three types of depressive disorders, with the other two depressive disorders being dysthymic disorder and depressive disorder not otherwise specified. The APA reported that 15% of persons diagnosed with MDD would eventually complete a suicide attempt, and individuals over 55 years of age who committed suicide were 4 times higher when compared to younger individuals (APA, 2000). The NIMH (2011) reported that persons between the ages of 30 to 44 were 120% more likely to be diagnosed with MDD, with the effects of MDD being as debilitating as those of major medical illnesses. Rothermund and Brandstater (2003) administered an 8-year longitudinal study that examined depression in an elderly population and found that complex symptoms of MDD appeared to increase with age. Their study showed a correlation between late onset of severe depression with perceptions of moving toward death rather than aging, which included loss of control, decreased openness to life experiences, and loss of coping resources (Rothermund & Brandstater, 2003).

The NIMH (2011) reported that 6.7% of individuals who lived in the United States had experienced depression for a 12-month period and that individuals aged 18 through 29 were 70% more likely than those of other age groups to experience depression. The report also showed that women were 70% more likely than men to be diagnosed with depressive disorder (NIMH, 2011). Harkness et al (2010) investigated stressful life events in men and women to determine if these events were correlated with an increased predisposition for depression in women. Results from the study indicated

that women were significantly more likely to have an occurrence of MDD between the ages of 18 and 29 (Harkness et al., 2010). Results also indicated that women were more likely to report the occurrence of a severe life event (SLE) prior to the onset of MDD (Harkness et al., 2010). Additional research conducted by Stroud et al. (2011) focused on severe life events (SLEs) and lower severity events (LLEs). Stroud et al. found correlations with the onset of depression in 155 adult female participants identified as culturally varied, middle class, and age 19 to 29. The study noted whether the participants' life events were interpersonal, involved relationship loss, or involved death (Stroud et al., 2011). Results from the study indicated a decrease in the tendency for SLEs with recurrence of major depressive episodes; however, relationship loss SLEs and LLEs significantly correlated with first onset and prior onset of depression (Stroud et al., 2011).

The DSM-IV-TR Criteria for Diagnosis of MDD

Depressive disorders were one of the three types of mood disorders identified in the DSM-IV-TR (APA, 2000). The symptoms differed in duration and severity and were defined in three categories: MDD, dysthymic disorder, and depressive disorder not otherwise specified (APA, 2000). MDD was the most severe form of depression and was diagnosed when patients demonstrated at least five of the following: (a) daily depression or sadness, (b) the inability to experience happiness or joy in activities, (c) a total of at least 5% weight gain or weight loss, (d) insomnia or hypersomnia, (e) psychomotor agitation or slow psychomotor activity, (f) excessive fatigue and lack of energy on a daily basis, (g) low self-esteem and self-worth with thoughts to the extent of being delusional in nature, (h) consistent indecisiveness, and (i) thoughts of death, dying, or thoughts of

committing suicide with or without plans of action (APA, 2000, p. 356). Additional criteria for MDD included (a) marked impairment in social, academic or occupational areas of life; (b) symptoms not due to a mixed episode of mood disorder, substance abuse, substance dependence, or a medical condition; (c) symptoms not due to losing a loved one unless they last for at least 2 months with marked focus on preoccupation with death, dying, or suicide; decreased sense of self-worth; and marked change in psychomotor activity (APA, 2000, p. 356). Some individuals diagnosed with MDD also evidenced psychotic features due to the severity of the depression (APA, 2000, p. 370). When this occured, the practitioner needed to specify "Major Depression With Psychotic Features" (APA, 2000, p. 370). Thus, the cognitive components of MDD can be overwhelming in their perplexity and severity, and these aspects of MDD require therapeutic intervention.

Basic Symptoms of Major Depressive Disorder

According to the research conducted by Stroud et al. (2011), patients with MDD experience feelings of hopelessness, helplessness, and avolition, as well as thoughts of death, dying, or suicide. The individual who is diagnosed with MDD believes that he or she will not be able to recover or feel better because this is part of the symptomology of depression (Corey, 2009). The person with MDD may be prone to feeling that many aspects of life will only become worse, and the person may continue to experience negative thoughts and ruminations that create a downward spiral in his or her moods, thoughts, feelings, overall perceptions, and responses to life events (Corey, 2009). The negativity in the thoughts of those with MDD is not deliberate; rather, it indicates a clinical level of impairment.

Research conducted by deRoon-Cassini, Mancini, Rusch, and Bonnano (2010) showed that patients who were diagnosed with MDD experienced a combination of emotional, psychological, and physical symptoms and life stressors. Gonzalez, Reynolds, and Skewes (2011) reported that individuals who were diagnosed with substance abuse, chronic pain, physical illness, and anxiety disorders were prone to being diagnosed with MDD (de-Roon-Cassini et al., 2010; NIMH, 2011). Tate et al. (2008) also reported that there was a tendency for those with comorbid depression and substance abuse disorders to have experienced complications without receiving adequate treatment and to have experienced increased severity of depressive symptoms and potentially harmful side effects from difficulties with medication management.

Statement of the Problem

According to the NIMH (2011), the efforts of mental health professionals who treat individuals with MDD have yielded limited success with regard to reducing symptoms, recurrence, or relapse. Current research has shown that individuals diagnosed with MDD continued to follow treatment plans that were not efficacious for severe or long-term depression (NIMH, 2011). As a result, those diagnosed with MDD might have been set up more for failure than for recovery when they attempted to perform traditional therapeutic tasks that they were unable to perform due to being incapacitated (Doumas, Smolders, Brunfault, Bouckaert, & Krampe, 2011).

Some of the most debilitating symptoms for individuals diagnosed with MDD include negative changes in thought content and thought processes (Beck, 1976; Doumas et al., 2011; Segal, Williams, & Teasdale, 2003). According to Craighead, Sheets, Craighead, and Madsen (2011), the term *negative changes in cognition* refers to

decreased thought content, lack of ability to focus and concentrate, difficulty with comprehension, and lack of timely response to information. In the most severe cases, patients with MDD experience psychotic thought processes that include auditory hallucinations, paranoia, delusional thought content, incoherence, aphasia, and psychotic regression to the point where the individual is unable to adapt or cope with reality (NIMH, 2011). In the process of forming a diagnostic plan, mental health practitioners have been required to specify if patients with MDD evidence psychotic features (APA, 2000). The severity of cognitive symptoms is a distinguishing factor in diagnosing MDD, as it indicates the severity of impairment (Riso et al., 2003).

In this study, I expected to show that individuals who were diagnosed with MDD evidenced significantly lower scores on the positive response scale of the Changes in Outlook Questionnaire (CiOQ) than those without any clinical mental disorder, which would indicate that there was impairment in their cognitive ability. In addition, I investigated whether female participants diagnosed with MDD evidenced lower scores on the positive response scales of the CiOQ when compared to male participants diagnosed with MDD, as previous studies indicated that females were more prone to being diagnosed with MDD than men during change or stressful life events (Harkness et al., 2010). Due to a lack of demographic variation in the geographic location where the research was conducted, the variables were limited to gender (Leu, Wang, & Koo, 2011).

Nature of the Study

This exploratory, quantitative study was guided by research questions and hypotheses, which are presented in the next section. The research question was derived from a thorough review of the existing professional literature.

Research Questions and Hypotheses

Research Question 1: Will there be a difference in positive responses when those diagnosed with MDD are compared to participants without a diagnosis of MDD?

H_{o1} :Participants diagnosed with MDD will not report significantly lower scores for positive responses as measured by the CiOQ when compared to participants without a diagnosis of MDD.

Ha_1 :Participants diagnosed with MDD will report significantly lower scores for positive responses as measured by the CiOQ when compared to participants without a diagnosis of MDD.

Research Question 2: Will there be a gender difference in the number of positive responses in those who are diagnosed with MDD?

Ho_2 :Female participants diagnosed with MDD will not report significantly lower scores for positive responses as measured by the CiOQ when compared with male participants diagnosed with MDD.

Ha_2 :Female participants diagnosed with MDD will report significantly lower scores for positive responses as measured by the CiOQ when compared with male participants diagnosed with MDD.

Purpose of the Study

The purpose of this quantitative exploratory study was to determine if individuals who were diagnosed with MDD evidenced significantly lower scores on the positive response scale of the CiOQ when compared to others who were not diagnosed with any clinical mental disorder.

The results provide empirical data to assist mental health practitioners in identifying the level of cognitive impairment and emotional limitations experienced by those with MDD during the initial phase of an evaluation. This study may prompt mental health practitioners to work collaboratively to add treatment goals that address the needs of those diagnosed with MDD more specifically. Currently, individuals who have been diagnosed with MDD in intensive outpatient programs receive treatment plans similar to those given to patients diagnosed with other disorders, despite the severity of their cognitive impairment (NIMH, 2011). For example, patients with MDD may be referred to an outpatient program that provides individual and group therapy for patients with anxiety disorders or other mental health disorders (Leahy, Holland, & McGinn, 2012). If the needs of those with MDD exceed the needs of others with different disorders, as indicated by the American Psychiatric Association (2000), then it is possible that these needs are not being met. This study has positive social change implications in promoting more positive outcomes and less recurrence of symptoms in this misunderstood population.

Theoretical Framework of Cognitive Behavior Therapy and Cognitive Therapy

Cognitive behavior therapy (CBT) is an area of psychotherapy that uses a combination of cognitive and behavioral principles for a short-term treatment approach with patients (Corey, 2009). One of the theories noted within the framework of CBT is Beck's (1963) cognitive therapy (CT; Corey, 2009). Beck (1963) developed CT to work with patients diagnosed with clinical depression, and it is still being used for the treatment of depression (Dozois et al., 2009). Beck (1963) observed that individuals with depression evidenced a negative bias when viewing life events that predisposed them to

cognitive distortions and further increased the likelihood of even more negativity (Beck, 1963). The intention of CT was to promote insight and self-awareness and to assist the patient in changing his or her negative thinking patterns and beliefs (Dozois et al., 2009). Some cognitive therapists believe that if depressed individuals can change their perceptions and irrational beliefs about life situations, they can form more proactive behaviors and prevent the recurrence of depressive thinking (Beck et al., 1963; Dozois et al., 2009).

Definitions of Terms

The following terms are defined as they are used in this study:

Augmentation: Antipsychotic medication combined with antidepressant medication prescribed for individuals diagnosed with MDD who have prolonged resistance to antidepressant medication alone (Klein et al., 2011).

Challenging life event: Any event that challenges the individual to adapt to a situation.

Changes in Outlook Questionnaire (CiOQ): A standardized psychological screening assessment that measures for positive and negative response rates in the midst of challenging or traumatic life events (Joseph, Williams, & Yule, 2003).

Comorbidity: Described when an individual meets the criteria for two or more mental health disorders at the same time (APA, 2000).

Depressive disorders: A group of three disorders identified in the DSM-IV-TR by the criteria for individuals experiencing subclinical to clinical levels of depression, including major depressive disorder, dysthymic disorder, and depressive disorder not otherwise specified (APA, 2000).

Major depressive disorder (MDD): MDD is the most severe of the three forms of depressive disorders (APA, 2000).

Monoamine oxidase inhibitors (MAOIs): Antidepressant medications used for the treatment of MDD and other depressive disorders (Cipriani, Geddes, Furukawa, & Barbui, 2007).

Pharmacotherapy: History and description of medications used for the treatment of depressive disorders (Beck et al., 1979).

Positive response rate: The total of 11 positive items on the CiOQ, which are self-reported (Joseph, Williams, & Yule, 2003).

Poverty of thought content: When an individual expresses an inability to think or express the subject matter or the content of his or her thoughts (APA, 2000).

Selective serotonin reuptake inhibitors (SSRIs): A class of medications used for the treatment of MDD and depressive disorders (Cipriani et al., 2007).

Tricyclic antidepressants (TCAs): Medications used for the treatment of depressive disorders (Cipriani et al., 2007).

Assumptions, Limitations, and Scope

Assumptions

The following assumptions were made in this study:

1. It was assumed that all participants placed into the MDD group met the criteria for MDD as indicated by the DSM-IV-TR (APA, 2000).
2. It was assumed that all participants were able to read, write, and communicate in English as their primary language or be culturally literate with English as a second language.

3. It was assumed that participants answered all of the questions in the CiOQ to the best of their ability.
4. It was assumed that all participants willingly agreed to participate in the study by having provided their informed consent.
5. It was assumed that the purposive sampling of convenience of participants was representative of the target population of referrals to the counseling center being used for this study, but generalizing the results of the study beyond the sample should be done with caution.
6. It is assumed that the findings would have a wider applicability among patients with MDD with demographics similar to those who participated at the counseling center for this study.

Limitations

The following limitations were recognized in this study:

1. The data obtained in this study were limited by participants' cultural, ethnic, and socioeconomic status; therefore, generalizing the results to other cultures, cities, and states should be done with caution.
2. The participants were individuals who had access to transportation to the study site. The study was therefore limited in the ability to represent individuals who were unable to secure transportation to participate in the study. Therefore, the results should be used with caution.
3. This study included individuals between the ages of 18 and 49; therefore, generalizing the results to a population of individuals under the age of 18 or over the age of 49 should be done with caution. Participants under the age of

18 were not considered to be adults, and participants over the age of 49 were considered more susceptible to health or hormonal changes that could have increased the chances of confounding variability in the groups of participants.

4. Interviewers might not have asked or participants might not have accurately disclosed how participants identified their race/ethnicity, so the number of participants from a particular group might not have been accurately recorded.
5. Thoughts, attitudes, beliefs, and perceptions of the participants and the evaluators were limited to those measured by the diagnostic instruments used. Data might be limited by the biases of the interviewers, who might or might not have been culturally sensitive.
6. Data were based on participants' self-reports on the CiOQ. The limits of self-report included the negative stigma that could come with reporting unfavorable patterns or behaviors, which may have caused some participants to respond in ways they felt made them more socially acceptable (Beck, Steer, & Brown, 1996). This might have included complete or partial denial of behaviors and characteristics that were deemed undesirable by society.
7. It was unclear what impact the sample size would have on this study due to the limited number of participants at one mental health location. Therefore, generalizing the findings should be done with caution.
8. Definitions of terms were limited to those provided by the instruments used in the study. Therefore, generalizing terms to other uses should be done with caution. Any developmental disorders, learning disabilities, substance abuse, or mood disorders other than MDD were ruled out during the intake

assessment conducted by the attending psychiatrist on site, as they were considered to be potential cofounders.

Scope

The scope of this study included a literature review, two research questions, hypotheses, variables, and a theoretical framework. The goal for this study was based on a gap in the current professional literature in reference to whether individuals diagnosed with MDD are as capable of forming positive responses as individuals without a clinical mental disorder are. There was also a need to identify whether women diagnosed with MDD evidenced lower scores on positive response scales of the CiOQ when compared to men diagnosed with MDD, as previous studies indicated that women had a greater tendency to be diagnosed with MDD when they perceived and experienced challenging or stressful life events (Harkness et al., 2010). The variable of positive response rates on the CiOQ was chosen for this study because those with MDD might not have been able to form positive responses due to the severity of their cognitive impairment (APA, 2000; Beck, 1976; Craighead et al., 2011; Doumas et al., 2011; Segal, Williams, & Teasdale, 2003). A thorough review of the literature showed that there was no previous empirical research that used a standardized psychological assessment to measure positive response rates in those diagnosed with MDD. The goal of this study was to highlight a potential cognitive difference in persons with MDD that makes traditional therapeutic treatments ineffective for this target population and instead contributes to relapse and recurrence. Identifying persons with MDD as a potentially misunderstood population might help in the effort to adapt more specific treatment methods to this target population and to reduce episodes of recurrence and relapse.

Significance of the Study

The significance of this study resides in its potential to draw attention to the treatment of depression and to prompt practitioners to recognize the need for more specific interventions for the treatment of those suffering with MDD, which has been noted as one of the most severely troubling of all of the psychiatric disorders (Leahy, Holland, & McGinn, 2012). It has been reported that MDD is the leading cause of disability in the United States among individuals between the ages of 15 and 44 years (Leahy et al., 2012). It is of utmost importance for mental health practitioners to realize that up to 61% of those with MDD have never pursued treatment for the disorder (Leahy et al., 2012). Those affected by MDD may be concurrently impaired in their ability to work and often demonstrate low efficiency, lack of focus, and difficulty with organization at the workplace (Leahy et al., 2012). In addition, MDD has been correlated with a 35% decrease in lifetime income (Leahy et al., 2012). Therefore, MDD not only affects the individual on an emotional level, but also has a downward spiraling effect that touches many aspects of the individual's life experiences, which further complicate his or her life and only reinforce the tendency for an increase in depressive symptoms (Leahy et al., 2012).

Social Change Implications

This study has implications for social change in that it shows that the level of cognitive impairment in those with MDD results in them being significantly less capable of forming positive responses and therefore unable to accept the benefits of traditional therapeutic treatments. Psychologists may be challenged by this research to develop more efficacious psychotherapeutic interventions for patients diagnosed with MDD, as the

current research literature indicates that individuals with MDD are among the most disabled in the United States (Leahy, Holland, & McGinn, 2012). A lack of cognitive ability to form positive responses in the midst of challenging life events may make those with MDD most susceptible to resistance to treatment or to relapse. Perhaps future psychological interventions could be developed to help patients with MDD learn how to form positive responses in the midst of challenging life events in order to increase their chances for recovery.

This research has the potential to support positive social change not only on the individual level, but also on the group level, as families of those with MDD may also be involved in their treatment. In addition, the results of this study could have impacts on group, institutional, and organizational systems. Learning how to form positive responses in the midst of challenging life events could be taught in workplaces, groups, volunteer facilities, communities, and organizations that strive to bring positive transformation to society as whole.

This study could be regarded as applicable not only to those diagnosed with MDD, but also to those who strive for overall improvement in coping, development, and positive transformation on the individual, group, organizational, and societal levels. The results of this study could prompt social change within the field of psychology. Mental health practitioners may gain further insight into specific cognitive limitations that contribute to the relapse and recurrence rates of those diagnosed with MDD (NIMH, 2011). Results from this study could prompt mental health practitioners to strive to develop new psychotherapeutic interventions that specifically focus on helping those with

MDD to develop the cognitive ability to form positive responses in the midst of challenging life events.

Summary and Transition

According to the current professional literature, the efforts maintained by psychiatrists and psychologists to offer effective treatment methods for MDD have yielded limited success (NIMH, 2011). Research has indicated that individuals diagnosed with MDD continue to be provided with treatment plans that are ineffective for severe or long-term depression (Riso et al., 2003). As a result, those diagnosed with MDD may be set up for failure more than for recovery when treating professionals encourage them to attempt to perform therapeutic tasks in a similar manner to those who do not suffer the same incapacitating symptoms. This treatment pattern does not reflect awareness that patients with MDD have a higher level of cognitive impairment, which creates a barrier to the performance of routine tasks. Without information on individual cognitive ability, ineffective treatment may reinforce a patient's ideas of inability and incapacity, refueling depressive and negative symptoms and creating further feelings of failure (Riso et al., 2003).

There was a gap in the empirical data from previous studies that measured the cognitive level of impairment for those diagnosed with MDD, particularly in their ability to form positive responses on a standardized psychological assessment. Results of my study show that participants diagnosed with MDD had significantly lower positive response rates when compared with participants without any clinical mental disorder. This may mean that those diagnosed with MDD were not receiving appropriate

psychotherapeutic interventions given the severity of their condition and were thus an underserved population.

The results of this study may prompt mental health practitioners to work specifically on helping these patients form the necessary positive responses to life events and stressors that would promote optimal and possibly long-term mental health. Improvement in these individuals' ability to form positive responses might, in turn, create an overall increase in their ability to interact with their caretakers, family, friends, and colleagues, and might help them to accept that they are being supported. Therefore, my study has the potential to create positive social change at the individual, family, group, institutional, organizational, and global levels.

This study integrated the theoretical framework of cognitive therapy (CT) for depression and the treatment of depression, as developed by Beck, Rush, Shaw, and Emery (1979). The literature review in Chapter 2 provides a thorough analysis of the theory of CT, which shows the reader how the negative thoughts of a person with depression deepen and expand into negative assumptions and conclusions about the self, life experiences, and the future (Beck et al., 1979). Chapter 2 also shows how the CT developed by Beck helps patients identify the negativity that pervades their thinking and confront those thoughts in order to replace negative assumptions and beliefs with more realistic and rational thoughts (Beck et al., 1979). This study incorporated Beck's theory of cognitive therapy in collaboration with a standardized tool that measures the cognitive ability of those diagnosed with MDD to form positive responses in the midst of challenging life events.

Chapter 2 presents a thorough review of the literature regarding the criteria for MDD, the development of cognitive therapy (CT), the terms used in CT, the history of pharmacotherapy, and the research methods used in past studies. Evidence of insufficient recovery rates, the severity of recurrence despite psychotherapy and medication monitoring, and the severity of cognitive impairment is integrated to justify the need for the study.

In Chapter 3, I discuss the research methodology for this study, including the research design, setting and sample, instrumentation, data collection and data analysis procedures, and measures taken to protect the participants' rights. Chapter 3 addresses the study's implications for positive social change and ethical considerations related to the use of the data.

Chapter 4 presents the research findings of this experimental study. This chapter includes the methods that were used in the study, a description of the sample, the results for each research variable, an overview of the procedures used, and a summary of the results obtained. The results of the study are indicated in tabular and textual form.

Chapter 5 provides a brief overview of the study, an interpretation of the results, implications for positive social change, and recommendations for action and further research.

Chapter 2: Literature Review

The purpose of this study was to determine whether individuals with MDD were capable of forming positive responses on the CiOQ or were incapable of doing so due to significant cognitive impairment that could have interfered with current available treatment methods. This chapter includes an overall review of the literature related to the study. It provides an overview of the current professional research on MDD and the limitations experienced by those diagnosed with the disorder. The chapter contains a synopsis of the key words used in the literature search and the database sources used to collect the current professional literature. Next, there is a review of the history and available treatments for MDD. This is followed by a review of the theoretical perspective taken in this study. A review of the literature with an emphasis on cognitive deficiencies in those diagnosed with MDD is included. Following is a review of the literature on MDD and a review of contemporary research trends and methods used in previous studies on the combination of CT and medication to treat MDD. Next is a review of research trends and methods used in previous studies on MDD, including the greater tendency of women to report stressful life events when diagnosed with MDD. Finally, a summary of the chapter is provided.

Literature Search

The following databases were searched: (a) PsychINFO, (b) SocINDEX with full text, (c) PsycARTICLES, and (d) Academic Search Premier. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, *Text Revision* (DSM-IV-TR) and the website for the National Institute of Mental Health were also used for this literature review. The following key search terms were used: *major depressive*

disorder, cognition, cognitive-therapy (CT), The Changes in Outlook Questionnaire (CiOQ), The Structured Clinical Interview for DSM Disorders (SCID-II), pharmacotherapy, monoamine oxidase inhibitors (MAOIs), tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), and *augmentation pharmacotherapy*. The scope of the literature search was limited to articles and scholarly literature published in the last 10 years. An exception was made with reference to material related to the history and the theoretical foundation of cognitive therapy (CT) for depressive disorder. Several hundred articles were reviewed regarding depression, MDD, cognition in those diagnosed with MDD, pharmacotherapy for the treatment of depression, recurrence of MDD, and the resistance of MDD to psychotherapy and medical treatment. Articles not directly related to the topic of study were excluded. There was a need for additional research concerning what was missing in the treatment of those with MDD that impacted their ability to improve.

Professional Standards

Mental health practitioners have made moderate progress in the development of treatment for mental health disorders, and researchers in the fields of psychiatry and neurology have contributed to the development of pharmacotherapy to treat numerous psychiatric ailments (Seo, MacPherson, & Young, 2010). Psychologists have developed new insights and theories of psychotherapy for patients in need of counseling (Corey, 2009). According to Hersen, Turner, and Beidel (2007), mental health practitioners have observed that those diagnosed with MDD evidence a better chance of recovery with a decreased chance of recurrence if they receive early intervention through pharmacotherapy and psychotherapy. The purpose of this study was to determine whether

individuals with MDD evidenced significant cognitive impairment that interfered with available treatment methods and prevented their ability to recover from symptoms of MDD.

Purpose of the DSM-IV-TR for Identifying Disorders

The DSM-IV-TR (APA, 2000) is based on the medical model of mental illness and is the most widely used diagnostic tool for clinical mental illness, personality, and developmental disorders (Remley & Herlihy, 2010). According to Remley and Herlihy (2010), the main purpose of the DSM-IV-TR is to provide a systematic description of mental health disorders using universal language and criteria. The DSM-IV-TR assists the practitioner in forming optimal treatment plans, given the nature and severity of the pathology observed in each patient, including medical disorders that may need the attention of a physician (Remley & Herlihy, 2010). The DSM-IV-TR also provides an appendix that helps to ensure that cultural competence is maintained during the diagnostic process.

Some mental health practitioners who identify with the wellness model believe it is negative to focus on psychopathology (Remley & Herlihy, 2010). In practice, psychologists and psychiatrists form a multiaxial diagnosis for treatment purposes and consider medical disorders, comorbid disorders, and differential diagnoses to be important aspects of diagnoses used in patient treatment (Comer, 2007). Some individuals might be less likely to pursue treatment if the practitioner does not use the DSM-IV-TR, as a formal diagnosis is required for patient expenses to be covered with health insurance carriers (APA, 2000; Comer, 2007). According to Herlihy, Watson, and Patureau-Hatchett (2008), some mental health practitioners are troubled by the practice of

labeling patients with psychopathology for the sake of health insurance coverage and payments.

Research suggests that it is important for mental health practitioners to be mindful of the risks involved in applying labels to patients, as patients may be prone to identifying with diagnostic labels (APA, 2000). This is especially true for individuals who suffered with MDD because, by definition, they are prone to heightened feelings of hopelessness, helplessness, excessive rumination, and negativity (APA, 2000).

This study explores whether the symptoms of MDD create an inability for individuals to form positive responses in the midst of challenging and stressful life situations. Highlighting this possibility may uncover a need for practitioners to guide these patients to identify MDD as the disorder that affects them, rather than a disorder that defines them.

The DSM-IV-TR Criteria for Diagnosis of Major Depressive Disorder

Depressive disorders are one of the three types of mood disorders identified in the DSM-IV-TR (APA, 2000). The symptoms differ in duration and severity and are defined in three categories: MDD, dysthymic disorder, and depressive disorder not otherwise specified (APA, 2000). MDD is the most severe form of depression and is diagnosed when patients demonstrate at least five of the following: (a) daily depression or sadness, (b) the inability to experience happiness or joy in activities, (c) a total of at least 5% weight gain or weight loss, (d) insomnia or hypersomnia, (e) psychomotor agitation or slow psychomotor activity, (f) excessive fatigue and lack of energy on a daily basis, (g) low self-esteem and self-worth with thoughts to the extent of being delusional in nature, (h) consistent indecisiveness, and (i) thoughts of death, dying, or thoughts of committing

suicide with or without plans of action (APA, 2000, p. 356). Additional criteria for MDD include (a) marked impairment in social, academic, or occupational areas of life; (b) symptoms not due to a mixed episode of mood disorder, substance abuse, substance dependence, or a medical condition; (c) symptoms not due to losing a loved one, unless they last for at least 2 months with marked focus on preoccupation in thoughts toward death, dying, or suicide; decreased sense of self-worth; and marked change in psychomotor activity (APA, 2000, p. 356). Some individuals diagnosed with MDD also evidence psychotic features due to the severity of the depression (APA, 2000, p. 370). When this occurs, the practitioner has to specify "Major Depression With Psychotic Features" (APA, 2000, p. 370). Thus, the cognitive components of MDD can be overwhelming in their perplexity and severity, and these aspects of MDD require therapeutic intervention.

The History of Pharmacotherapy Treatment for MDD

A brief review of the development of pharmacotherapy for the treatment of depression was provided by Seo, MacPherson, and Young (2010). The development of pharmacotherapy for the treatment of depression was based on the notion that depression was primarily due to a neurochemical imbalance (Seo et al., 2010). Seo et al. noted that monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressant medications (TCAs) were the first principal types of medication to treat depression. Their study also showed that bothersome and potentially dangerous side effects occurred with MAOIs and TCAs and overwhelmed patients as much as the depression itself (Seo et al., 2010). Their research eventually revealed that selective serotonin reuptake inhibitors (SSRIs) were

effective for the treatment of depression and had far fewer side effects than the MAOIs and the TCAs (Seo et al., 2010).

In current practices it was noted that psychiatrists and physicians use SSRI medications as the first choice for the treatment of depressive disorders, but patients with long-term, severe depression continued to show resistance to treatment despite the overall benefits of the SSRIs (Delgado & Ehert, 2011). Many of the medications used for augmentation had more negative and potentially harmful side effects, which became problematic for patients with more severe forms of depression (Seo et al., 2010). However, Delgado and Ehert (2011) proposed that certain atypical antipsychotic medications were efficacious for treatment in collaboration with SSRIs and did not pose as high of a risk of negative and severe side effects in some patients. Research suggested that those who were diagnosed with MDD may have had imbalances in dopamine and serotonin, and antipsychotic medications, which included aripripazole and quetiapine balanced the feedback mechanisms of these neurotransmitters within the brain (Delgado & Ehert, 2011).

Despite the ongoing development of pharmacotherapy within the medical and psychiatric arenas, the research showed there were still large numbers of individuals on a global level that were resistant to pharmaceutical treatments. My study intended to show the possibility that those who suffered with MDD needed more individual or specific psychological interventions to learn how to circumvent their cognitive impairments, which contributed to their inability to form positive responses.

Combining Psychotherapy and Pharmacotherapy for MDD

Current research focused on the practice of combining psychotherapy and medication monitoring for the effective treatment of depression. Manber, Kraemer, Arnow, Trivedi, Rush, Thase, and Keller (2008) conducted studies over a three-month period, which utilized individuals diagnosed with MDD who were in acute remission in three treatment groups: antidepressant medication, psychotherapy, and a combination of antidepressant medication and psychotherapy. Observations were made to account for predictors of remission during acute phases of MDD (Manber et al., 2008). The participants in the study included adults, ages 18 to 75 years with a mean of 43.5 years. A total of 65.4% of the participants were female and all participants were evaluated and diagnosed according to criteria of the Structured Clinical Interview for DSM disorders (SCID) (First, Spitzer, Gibbon, & Williams, 1994). Participants were placed into one of three groups: (1) those who met criteria for Major Depressive Episode (MDE) for two years without prior diagnosis of Dysthymic disorder, (2) those who met criteria for MDE after meeting criteria for dysthymic disorder, and (3) those who had recurrent MDE throughout two-years with incomplete resolution between episodes for two-years of time (Manber et al., 2008). Participants were prescribed nefazadone at 200 milligrams daily for week one and were titrated upward by 100 milligrams each week until participants were taking at least 300 milligrams or a maximum of 600 milligrams of nefazadone daily. Participants placed into the psychotherapy group received a combination of behavioral, cognitive, psychodynamic, and interpersonal psychotherapies twice a week; week one through week four; then one time each week; weeks 5 through weeks 12. Participants who still needed therapy twice weekly throughout the duration of the study continued to

receive therapy biweekly (Manber et al., 2008). Results from the study showed that 28.9% of the participants who received a combination of pharmacotherapy and psychotherapy went into remission, in comparison to 14.1% of those who received psychotherapy or medication monitoring alone (Manber et al., 2008). The available data did not lend to the understanding of why the occurrence and the recurrence rates for MDD continued to rise but indicated that further studies are necessary.

A Brief Review of Cognitive Behavior Therapy

Cognitive behavior therapy (CBT) combined behavioral approaches while having recognized how cognition affected the behavior of the individual (Corey, 2009). There were various theories of CBT, but all of the cognitive behavioral methods of psychotherapy were geared toward short-term treatment (Corey, 2009). In addition, all forms for CBT maintained the importance of having a team approach between the client and the therapist, and that the client was an active participant in his or her own psycho-educational learning process (Corey, 2009). Furthermore, all forms of CBT maintained the premise that changing cognitions would result in a change in behavior, and that short-term treatment which focused on targeting problems was most beneficial for the client (Corey, 2009). However, Beck's cognitive therapy (CT) was specifically developed during his observations of clinically depressed patients (Corey, 2009).

Beck's Cognitive Model for the Treatment of Depression

For the purpose of this study, the cognitive model for the treatment of depression as proposed by Beck, Rush, Shaw, and Emery (1979) was utilized to articulate the specific aspects of how individuals who suffered with depression became prone to negativity toward the self, experiences, and the future. The cognitive model also

proposed predisposing factors to depression, as early life experiences formed the foundation for developing negative schemas, which were then activated by similar experiences later on in life that made them prone to negativity (Beck et al., 1979). For the purpose of this study, the cognitive model for depression best explained why patients diagnosed with MDD became significantly less capable of forming positive responses on a standardized psychological assessment when compared to those with other forms of clinical mental illness, and when compared to those without clinical mental disorders. Beck's cognitive model for the treatment of depression (1979) most precisely and concisely described what made the individual with depression prone to relapse and recurrence.

Cognitive Theory of Depression

According to Beck, Rush, Shaw, and Emery (1979) there were three aspects to the cognitive model of depression: the cognitive triad, schemas, and cognitive errors. The cognitive triad had three major cognitive patterns: The person's negative view of the self, the tendency to interpret experiences negatively, and an overall depressive view of the future (Beck et al., 1979). Activation of these negative cognitive patterns led the person to behave as if his or her negative thoughts were actual reality. For example, if a person believed he would never do anything right, he tended to view all of his attempts as failures, even though this was not actually true. Thus, the person believed his entire future was doomed to failure and acted as if it were already the reality. As a result, this person likely experienced additional symptoms of depression, simply from being convinced that his thoughts were equivalent to what was real, and attracted negative consequences by his behavior (Beck et al., 1979).

The cognitive model maintained that avolition, escapism, and the tendency to avoid life situations were motivational symptoms and were a result of the negative cognitions (Beck, Rush, Shaw, & Emery, 1979). Suicidal thoughts were viewed as one of the extreme examples of escapism for the patient (Beck et al.). The cognitive model also explained that the negative cognitions led to physical symptoms of depression and an overall tendency to become slow, lethargic, and prone to feeling physically compromised (Beck et al., 1979).

The structural organization of depression or schemas explained why people maintained painful or self-defeating attitudes about themselves or aspects of their life, despite objective evidence to the contrary (Beck, Rush, Shaw, & Emery, 1979). The cognitive model (1979) proposed that when one was confronted with a life situation, a schema related to that particular situation became activated within the person. The schema was the basis of how data formed into cognitions and constituted the basis for screening out, discriminating, and recognizing the information in the situation that was confronting the patient (Beck et al., 1979). Types of schemas would determine how the individual structured different experiences and how the person used schemas to relate to life situations when depressed.

Errors in cognition were the third component in the cognitive model of depression. Incorrect thinking resulted in the person consistently having maintained his thoughts were true, despite consistent evidence to the contrary (Beck et al., 1979). Therefore, a person with errors in cognition could have had a team of practitioners who articulated facts and showed data that contradicted the person's beliefs, and the patient still maintained that his thoughts were true.

Observing Beck's Cognitive Theory for the Purposes of This Study

It was important to acknowledge that the current professional literature showed researchers tended to incorporate variations in cognitive behavioral therapy as they studied MDD (Corey, 2009). However, this study proposed to explore MDD from the cognitive theory of depression proposed by Beck, Rush, Shaw, and Emery (1979). It was my opinion that having isolated Beck's important theoretical perspective of depression will have produced a distinct perspective in the study the positive response rates of persons with MDD. It was also important to note that there were practitioners who still utilized and investigated the CT in current day research (Dozois, Bieling, Patelis-Siotis, Hoar, Chudzik, McCabe, & Westra, 2009). Therefore, for the purposes of this study, CT was operationally defined and followed by the original model of treatment for depression (Beck et al.).

Operational Terms

The cognitive model of depression proposed by Beck, Rush, Shaw, and Emery (1979) described six operational terms that provided psychologists with a framework to address the skills and language needed to work with the MDD population. They included:

1. *Arbitrary inference*: The tendency for a person to have formed conclusions despite evidence that these conclusions were incorrect.
2. *Selective abstraction*: Occured when a person took a detail out of context and formed their belief of an entire experience on that perception, while being unable to have seen the most important parts of the experience.

3. *Overgeneralization*: Referred to the tendency for a person to take one incident and to have formed an overall conclusion toward related and unrelated circumstances.
4. *Magnification and minimization:* Occurred when the person made errors in assessing an event to the extent where such errors were considered to be unrealistic.
5. *Personalization:* Referred to the tendency for the patient to make external events about himself even when there was no basis for such perception.
6. *Dichotomous thinking*: The tendency to have categorized experiences in one of two extremes, such as wonderful or horrible (Beck, 1976, p. 345).

Cognitive Therapy for the Treatment of Depression

According to Beck, Rush, Shaw, and Emery (1979) cognitive therapy (CT) was founded by the theoretical notion that the behavior of an individual was primarily shaped by his cognitions, which were formed from schemas developed during previous experiences. The goal of cognitive therapy was to help the client work on changing distorted beliefs about the self, life situations, and the future, by having identified the schemas that underlie the distorted beliefs (Beck et al., 1979). The client eventually learned to correct his own thinking by evaluating his thoughts and correcting them to function in a more adaptive manner. The patient learned how to monitor negative thoughts. The patient learned how to see the connection between thoughts, emotions, and behaviors. The patient learned how to determine whether there was actual evidence to either support or dismiss the negative thought, and then would form a thought, which was

based on reality. This would help the patient to alter the negative schemas that underlied the automatic, negative cognitions (Beck et al., 1979).

Cognitive Therapy With the Depressed Patient

According to Beck, Rush, Shaw, and Emery (1979) the first interview with the patient usually occurred in the therapist's office or over the telephone, and was conducted in a relaxed manner, while having maintained the professional boundaries and roles of the client-practitioner relationship. The practitioner might have utilized the initial interview to gain specific information about the client's past mental health history, current life stressors, psychological challenges, attitude about psychotherapy, and motivation to pursue and engage in CT for treatment (Beck et al., 1979). Once the therapist gained this information, he would discuss the underlying principles for CT, the process of treatment, and provide the client with the booklet called Coping with Depression (Beck et al., 1979). The patient was then asked to identify any areas of the booklet that needed further explanation which could be considered as a first homework assignment. Sometimes in the first interview, the practitioner conducted a thorough mental status examination to determine diagnosis, or whether the patient evidenced suicidality or psychotic features, then labeled the chief complaint as a target symptom (Beck et al., 1979). The therapeutic goal of the initial interview was to provide the client with some relief for the severity of his symptoms, to have developed rapport, and to have established a sense of confidence for the therapeutic intervention of CT for future sessions (Beck et al., 1979). During the following sessions, the case history was obtained to include personal data, and prior assessments; then plans were developed for each CT session and homework was assigned for the client (Beck, Rush, Shaw, & Emery, 1979). The homework assignments were

specific and instructed the patient to keep a record of how he was actually functioning; to have identified problems he viewed as contributing factors to the depression; to have developed or continued a schedule which included pleasurable activities; and to have made notes of periods of sadness, anxiety, apathy or depressed feelings so that the underlying cognitions or schemas were identified and worked through during CT sessions (Beck et al., 1979). There were approximately 20 CT sessions with the patient and psychological assessments were completed throughout the duration of treatment in order to have determined how he was functioning. Once the 20th session was completed, the CT practitioner usually had the patient return for a one-month, two-month, and 6-month follow up session to assess his level of functioning (Beck et al., 1979).

Evaluations of the structure of the self-schema in the original CT were investigated by Dozois and Dobson (2001) when they had participants complete a computerized task in which they rated self-referential adjectives on the basis of their own self-description. These participants were retested 6 months later, and data indicated negative cognitive organization still remained stable across time in individuals who did not meet criteria for MDD (Dozois & Dobson). Further studies showed that negative content remained well organized in both individuals who did meet criteria for MDD, and for those who did not fully meet criteria for MDD (Dozois & Frewen, 2006). These findings suggested that cognitive vulnerability could have been a factor consistent with Beck's theories, and raised the question of whether CT could have changed cognitive organization (Dozois, Bieling, Patelis-Sioitis, Hoar, Chudzik, McCabe, & Westra, 2009). It was noted that three aspects of evidence proposed that CT did contribute to altering cogntive structures: (1) prophylactic effects of CT, (2) priming studies which indicated

cognitive differences between patients treated with CT versus those treated with pharmacotherapy, and (3) neruobiological data on the differenital neural responses to CT and antidepressant medication (Dozois et al.).

Beck, Rush, Shaw, and Emery (1979) noted that the mental health practitioner

Prerequisites to Conduct Cognitive Therapy for Depression

had to meet certain qualifications to have correctly utilized cognitive therapy with patients. The practitioner had to have a thorough knowledge of depression as a clinical presentation of cognitive, motivational, behavioral, and physical symptoms, and had to recognize the strong tendency for recurrence and for suicidal thinking (Beck et al., 1979). According to Beck et al., mental health practitioners needed to demonstrate excellent skills in the following: psychotherapeutic intervention with a combination of technical skills, a sympathetic nature, comprehension of the cognitive model of depression, integration of the theoretical framework of cognitive therapy, participation in formal training conducting CT with clients under supervision, and continued training in CT with supervision after concluding formal CT training classes. In addition, the practitioner needed to be adept in evaluating for suicidal thoughts, and was required to have the ability to form immediate action to maintain safety for the patient and for others, and must have been able to form recommendations for treatment within a secure or hospitalized setting (Beck et al., 1979).

The Combination of CT With Pharmacotherapy

Beck, Rush, Shaw, and Emery (1979) documented that antidepressant medication could have a considerable benefit for those who suffered from severe depression; however, the degree of the therapeutic response, the overall appropriateness in having

used the medication, and the safety of the patient had to be considered when medication was prescribed for the treatment of depressive disorders. Medication monitoring might have contributed to the reduction of depressive symptoms, but medications alone were not associated with complete remission of symptoms on an ongoing, long-term basis (Beck et al., 1979).

Despite CT and combination of CT with pharmacotherapy being reported as efficacious for the treatment of depression, the relapse and recurrence rates of MDD continued to propose there was a gap in the research literature (NIMH, 2011). A total of 6.7% of the population in the United States was diagnosed with MDD with 30.4% of those cases labeled as severe (NIMH). This current study sought to explore what contributed to the ineffective treatments on a long-term basis with regard to the nature, duration, severity, and persistence of MDD. This study intended to add to the gap in the professional literature by having provided empirical data to highlight the possibility that indicators of cognitive impairments in those diagnosed with MDD, such as a decreased ability to form positive responses, needed to be recognized and addressed in more specific treatment methods.

Cognitive Deficiencies Observed in Patients Diagnosed With MDD

Riso et al. (2003) conducted an exploration of four cognitive approaches to chronic depression that included dysfunctional attitudes, early maladaptive schemas, attributional style, and the ruminative response style (Riso et al.). The four cognitive approaches were examined with the following groups; outpatient participants who met criteria for chronic dysthymic disorder, outpatient participants with nonchronic MDD, and participants without any history of psychiatric illness (Riso et al.). Results from this

study indicated that participants with MDD and participants with dysthymic disorder evidenced a significantly higher level of dysfunctional thinking, including early maladaptive schemas, dysfunctional attitudes, dysfunctional attributional styles, and ruminative response styles, when compared with the group of participants who were never psychiatrically ill (Riso et al., 2003). These results indicated the underlying cognitive mechanisms of psychopathology were present in both chronic dysthymic disorder and non-chronic MDD. Participants with chronic dysthymic depression showed more rigid, internalized, core beliefs such as an inability to set goals and exert self-control which led to decreased autonomy, increased hypervigilence, and poor response to treatment (Riso et al., 2003). Petersen et al. (2007) also observed the pattern of more rigidly held beliefs and hypervigilence in people with recurrent and chronic depression. They noted the those with chronic depression made internal, global attributions to negative instances, and demonstrated external, unstable causation for positive experiences (Petersen et al., 2007).

Riso et al. (2003) reported the findings in their study supported the additive model of depression, which said the cognitive factors underlying the predisposition to MDD and dysthymic disorder varied more in degree rather than in type. A limitation in their study was the lack of specificity with regard to cognitive factors that contributed to MDD. This limitation added credibility to the need for additional studies, as cognitive impairments appeared to be a contributing factor in resistance to treatment for those with MDD. My study intended to expand on this issue as an empirical contribution to the current professional literature.

Riso et al. (2003) and Petersen et al. (2007) explored how particular cognitive symptoms predisposed individuals toward chronic depression. In contrast, Ruchshow et al. (2008) explored neurocognitive functioning to determine if there were cognitive deficits in patients diagnosed with MDD. Ruchshow et al. (2008) studied electroencephalogram (EEG) recordings of 14 right handed, German, participants diagnosed with MDD, and 14 right-handed, German, participants in a control group without MDD. The EEG readings were taken while these participants performed tasks with 144 experimental sentences and 48 filler sentences. The 144 experimental sentences were divided into three types; completely correct, syntactic mismatch, and semantic mismatch. Results indicated the participants diagnosed with MDD had longer reaction times when compared to the healthy participants in the control group. In addition, impairment in syntactic processing was noted in participants diagnosed with MDD when compared to the healthy control group of participants in the study (Ruchshow et al., 2008). Future studies were needed to identify the nature and the severity of impairment in syntactic processing. The results of the study supported Beck's (1979) cognitive model of depression as it showed that cognitive impairment is a significant component in individuals diagnosed with MDD. The results of the Ruchshow et al. (2008) study contradicted the notion proposed by Riso et al. (2003) that cognitive symptoms varied in degree rather than type for those with MDD.

It was important for the community of mental health practitioners to recognize that varied degrees of cognitive dysfunction could become entirely different manifestations of mental illness when going from chronic dysfunction into clinical impairment. Current research revealed that gender was also a predisposing factor to

MDD (Harkness, Nazazin, Monroe, Slavich, Gotlib, & Bagby, 2010). My study proposed to be the first to use a standardized measurement to assess these gender factors. It is this identified gap in information that highlighted the need for additional studies to include empirical data that added to the current body of professional literature.

Empirical Support for Gender Differences in MDD

Harkness, Nazazin, Monroe, Slavich, Gotlib, and Bagby (2010) noted that one of the most pervasive findings was that a higher prevalence of MDD was noted in females versus males. The gender difference was noted to occur in early adolescence and reached a rate of two-to-one by mid-adolescence (Harkness et al.). This two-to-one rate was reported to occur until, at the very least, the end of middle life (Kessler, 2003). The NIMH (2011) reported that women are 70% more likely than men to experience depression during their lifetime, and that by the year 2008, a total of 8.1% of females were depressed in the United States when compared to a total of 4.6% of males. The American Psychiatric Association [APA] (2000) reported that women were of significantly greater risk for developing major depressive episodes at some point in their lives according to studies conducted in the United States and in Europe. Correlations occurred with the onset of puberty and several days before menses, and depressive episodes occurred twice as frequently in females than males [APA].

Empirical Support for Differences in Stressful Life Events and MDD

Psychologists researched the role of life stress and how it contributed to the development and the ongoing persistence of depression in individuals (Brown & Rossellini, 2011). One of the consistent findings was that stressful life events occur before major depressive episodes (Brown & Rossellini). This finding led many

researchers to focus on the causal effect on stress at the onset of depression in individuals vulnerable to the disorder (Brown & Rossellini). However, there were studies which investigated concurrent stressful life events during time periods of depression, and results indicated compromised outcome for depressed participants during follow-up periods of treatment (Brown & Rossellini). There was also evidence that ongoing, chronic, stressors may be the most predictive of depression severity, rather than acute, severe stressors (Brown & Rossellini). However, Brown and Rossellini (2011) also noted it was possible that different types or occurrences of stress led to different types of depression. For example: There were a number of studies that found acute stressors were associated with first episodes of depression rather than with recurrent depression (Brown & Rossellini). To the contrary, chronic, ongoing stress was generally more associated with chronic depression (Brown & Rossellini). Stroud, Davila, Hammen, and Vrshek-Schallhorn (2011) showed that two theoretical models were proposed to explain the connection between stress and depression in first onset and recurrent episodes of depression: (1) stress autonomy (SA) and (2) stress sensitization (SS). The model of SA suggested episodes of depression occurred autonomously of stress with repeated episodes, while the model of SS suggested that events of lower severity triggered depressive episodes with successive recurrences (Brown & Rossellini). Stroud et al. proposed that from the SS perspective, severe life events (SLEs) compared to lower life events (LLEs) were less likely to induce episodes of depression over the duration of time, because individuals became sensitized to stress. Stroud et al. further proposed that, due to this sensitivity to higher levels of stress, the individual was actually more likely to have been triggered by

lower level events of stress than acute, severe stressors, which was similar to what Brown and Rossellini (2011) found in ongoing stressors associated with chronic depression.

Gender, Stressful Life Events, and MDD

Harkness, Nazazin, Monroe, Slavich, Gotlib, and Bagby (2010) proposed the idea that men and women had differing predispositions to MDD when they experienced stressful live events (SLEs). They conducted a study to determine if SLEs correlated with an increased predisposition for MDD in women, with all participants specifically meeting the criteria for MDD without any other clinical mental disorder (Harkness et al., 2010). Participants who had developmental disorders, any other clinical mental disorder, personality disorder, or medical conditions were excluded from their study. All participants were administered the 21-item Beck Depression Inventory-II (*BDI-II*) and the Life Events and Difficulties Scale (*LEDS-II*) (Beck & Steer, 1993; Bifulco et al.,1989). A total of four studies were conducted to examine for gender difference in MDD (Harkness et al.). Three of the four studies were conducted with adult participants and included a total of 76 women between ages 18 to 65 living in the state of Oregon; a total of 100 adult men and women between ages 18-58 living in San Francisco, California and a total of 147 between ages 18 to 65 years recruited from the Greater Toronto region of Canada (Harkness et al.). Results from those three studies indicated women were significantly more likely to have an occurrence of MDD between ages 18-29, and they were also significantly more likely to report the occurrence of an SLE prior to the onset of MDD (Harkness et al.). Harkness et al. (2010) proposed the increased reports of SLEs and the symptoms of MDD by females were due to an increased predisposition to

negatively react to what they defined as SLEs; but that additional studies were needed to explore stressors in the male population diagnosed with MDD.

Stroud, Davila, Hammen, and Vrshek-Schallhorn (2011) studied women's predisposition to experience depression. The research examined severe life events (SLEs) and lower severity events (LLEs), in order to observe correlations within the onset of depression in 155 young adult female participants defined as middle-class, and approximately age 18-29 years of age (Stroud et al.). The study included cultural variation between Caucasian, Latina, Chicana, and Asian-American participants in their study conducted in Los Angeles, California, and the participants were followed for a 5-year period of time (Stroud et al., 2011). The results identified whether life events were interpersonal, involved relationship loss, involved death, or a decreased tendency for SLEs with the recurrence of MDE. Relationship loss SLEs and LLEs were correlated with the first onset, and the prior onset of depressive disorder (Stroud et al., 2011). Despite the findings reported by Harkness et al. (2010) and Stroud et al. (2011) there was still a need for further investigation to more precisely determine why females were more prone to becoming depressed in the middle of stressful life events when compared to males.

Research Methods Used in Previous Studies

Mental health practitioners and researchers conducted hundreds of empirical studies focused primarily on psychotherapy and medication monitoring, to identify efficacious treatment of MDD. Some of the studies provided information on gender, as females appeared to be more prone to being diagnosed with MDD in early adulthood and upon reporting SLEs (Harkness et al., 2010). The study conducted by Stroud et al. (2011)

supported the previous findings and further identified that young females of various cultural backgrounds experienced relationship loss SLEs and LLEs that were correlated with the first onset and the prior onset of depressive disorder. However, the current research highlighted uncertainty as to why females were more prone to develop MDD than males, which supported the need for further studies.

Riso et al. (2003) discussed the limitations of research and used the example that if females were shown to be more prone to MDD because of how they think, experience, and react to SLEs and LLEs prior to the onset of MDD, than it was important to study if males think, experience, and react differently than females with regard to SLEs and LLEs. It was important to gather empirical data to identify if there was a specific type of cognitive impairment that affected both males and females who were diagnosed with MDD, such as the inability to form positive responses on a standardized psychological assessment. This current study intended to explore if males and females diagnosed with MDD evidenced similar scores or significantly different scores, on the positive response scale of the *CiOQ,* which provided the empirical data necessary to highlight that there were cognitive impairments effecting males and females diagnosed with MDD.

Summary

A thorough review of the current professional literature identified a gap in the research which indicated if there was a specific cognitive impairment in those diagnosed with MDD that prevented them from forming positive responses and ultimately impeded their treatment. This study was a first step toward closing the gap in the professional literature acknowledging variables that contributed to the ongoing occurrence, relapse, and recurrence of MDD, due to an individual's inability to form positive responses. This

study compared participants with MDD, to participants without any clinical mental disorder, in an attempt to learn if those with MDD had more significant cognitive barriers that interfered with their ability to benefit from the available treatment methods. This study was also a first step to observe whether females diagnosed with MDD were prone to score lower positive responses, when compared to males diagnosed with MDD. This study intended to show the possibility that those who suffered with MDD need more individual or specific interventions to learn how to circumvent their cognitive impairments, which contributed to their inability to form positive responses. This study had the potential to affect positive social change through an increased awareness that individuals diagnosed with MDD may be a globally underserved population, contributing to the rise in numbers who suffered relapse and recurrence.

Chapter 3 included a discussion of the research methods proposed for the study, and included research design, setting and sample, instrumentation, data collection and data analysis procedures, and measures taken to protect the participants' rights.

Chapter 3: Research Method

The purpose of this study was to explore whether participants diagnosed with MDD demonstrated lower scores for positive responses on the positive response scale of the CiOQ when compared to participants without any clinical mental disorder. In addition, the study was designed to determine whether women diagnosed with MDD evidenced lower scores on the CiOQ when compared to men diagnosed with MDD. However, the study was limited in that it was not possible to assess the impact of cultural differences, due to the limitations of the demographics of the location of the study.

Purpose of the Study

This chapter includes a description of the research design, the setting and sample, the instrumentation, data collection, and the procedures used for data analysis. This chapter also provides a description of the protection of participants' rights. The first section of this chapter includes the research design and the justification for this approach. Next, the sampling procedures and sample sizes are described. In the third section, the instrumentation is defined, and details about the data collection tools and data related to each variable are provided. This is followed by a description of data collection procedures. The fifth section addresses the quantitative analysis method chosen for this study, the tested hypotheses, and the analytical tools that were used. The final section of this chapter includes a summary of the effort maintained to protect the rights of the participants.

The purpose of this study was to explore whether participants diagnosed with MDD were more likely to evidence lower positive response rates on the CiOQ when compared to participants without any clinical mental disorder. In addition, I sought to

determine whether women diagnosed with MDD evidenced lower scores on the CiOQ when compared to men diagnosed with MDD.

Research Design and Approach

In this quantitative experiment, descriptive statistics were obtained. It was assumed that the values were normally distributed, and parametric statistical analysis was used. A between groups, 2x2 analysis of variance (ANOVA) included the two independent variables: diagnosis (MDD and no clinical mental disorder) and gender (male and female the CiOQ were significantly lower in participants diagnosed with MDD when compared to participants without any clinical mental disorder. This quantitative study also sought to determine if female participants diagnosed with MDD evidenced significantly lower scores on the positive response scale of the CiOQ when compared to male participants diagnosed with MDD. This exploratory quantitative design was appropriate because the independent variables were expected to provide the data needed to answer the research questions (Gravetter & Wallnau, 2010). Because the CiOQ measure was used in the data collection, the goal was to determine if there were mean differences between the two groups, which made this a quantitative statistical approach (Gravetter & Wallnau, 2010).

Setting and Sample

Participants

The research began at the counseling center in Michigan and concluded when the data collection was completed. The target population for this study was composed of participants who had been diagnosed with MDD and participants without any clinical mental health disorder. A sample size of 116 participants (30 male and 30 female

participants in the control group without MDD, and 30 female and 26 male participants in the group diagnosed with MDD) was collected to achieve a statistical power of 0.8 (a chance of a desired effect 80% of the time), given that the effect sizes were expected to be 1 or more (Gravetter & Wallnau, 2010). This was derived given the preferred standard, according to Joseph and Linley (2006), where the CiOQ was significantly different in people diagnosed with MDD. The purposive sampling method was chosen over random sampling to have selected participants for each group in the study, so that drawn conclusions on those populations would be based on their responses to the assessments in the study (Gravetter & Wallnau, 2010).

Procedure

First, I sought permission to perform the study from the director of the counseling center (see Appendix A). Then, I sought and obtained approval to conduct this study from the Walden IRB department and provided the approval number in the informed consent form (see Appendix B). Once approval to conduct the study was granted, I acquired the participants' signatures on the informed consent form (see Appendix B). Once the signatures were obtained, all participants were administered the CiOQ (Appendix D). The instrument did not require any personal information, but each completed assessment was coded with an M for male or F for female, as well as 1 for MDD or 2 for no clinical mental disorder. Personal information for each participant was not included for the purposes of maintaining confidentiality, protecting the participants' identities, and deidentifying the assessment instruments. The informed consent form, as determined by Walden University, apprised all participants of their right to withdraw their participation in the study at any time, for any reason without penalty.

Participants were first evaluated by the attending psychiatrist at the counseling center in Michigan and were expected to meet the following inclusion criteria: (a) they were between the ages of 18 and 49, (b) they were in overall good physical health, (c) they had been previously assessed at the counseling center, and (d) they were either male or female. Participants were excluded if the attending psychiatrist determined that they had a chronic or major medical illness or had a prior diagnosis of a developmental, personality, or comorbid clinical mental health disorder. The psychiatrist determined which patients met criteria to participate in one of the two groups being evaluated in this study: (a) those who met criteria for MDD according to the SCID-II and (b) those who did not meet any criteria for clinical mental disorders according to the SCID-II. Participants were men and women between the ages of 18 and 49 years who willingly provided informed consent as indicated by Walden University to participate in the study.

The CiOQ was used to collect data from the participants. In research settings, psychological assessments are often used to increase the reliability of the information gathered for a study (Joseph, Williams, & Yule, 1993). Written permission to use the CiOQ was provided by the assessment's publishers (Appendix C). The instrument is described in the following sections. The CiOQ was used to measure positive response scores on the positive response scales for all participants.

CiOQ

The CiOQ is a 26-item self-report assessment of positive and negative changes in responses, with a total of 11 items that measure for positive responses and 15 items that measure for negative responses (Joseph & Linley, 2006). The CiOQ was the first measure developed to assess positive and negative changes following adversity (Joseph, Williams,

& Yule, 1993). Joseph et al. reported satisfactory properties of internal consistency reliability for the positive and negative change scales on the CiOQ (.83 and .90, respectively), and the positive and negative change scales are uncorrelated (r = .12) (Joseph et al., 1993). For the purposes of this study, the 11 items of the positive response scale were used to measure the scores of positive responses for all participants in this study. The 11 items on the positive scale of the CiOQ were summed to give a total raw score of 11 to 66 (Joseph & Linley, 2006). Each item on the positive response scale was rated by a response on a Likert scale that ranged from 1 through 6, with 1 indicating *strongly disagree* and 6 indicating *strongly agree* (Joseph & Linley, 2006). A response of 4 indicated *agree a little* on the Likert scale and was necessary for the response to be considered positive (Joseph & Linley, 2006). For example, an item on the positive response scale might have asked the participant if it was possible for him or her to perceive his or her future in a positive way. This study only explored the positive responses of participants; therefore, the negative scale of the CiOQ was not used.

Joseph et al. (2005) examined the internal consistency, reliability, and convergent and discriminant validity of the CiOQ, and results indicated that the internal consistency and reliability of the positive and negative change scales were satisfactory. Linley et al. (2003) reported internal consistency reliabilities of .89 for the positive change scale and .84 for the negative change scale after examining 108 British participants who were exposed to the terrorist attacks of September 11, 2001. Joseph et al. (2005) examined for convergent and discriminant validity by comparing the CiOQ to four other scales developed to assess for positive changes. Results of partial correlations revealed that scores on the CiOQ were not correlated with scores on the Perceived Benefit Scales

(PBS); (r =.18) or the Post Traumatic Growth Inventory (PTGI); (r =.17), which evidenced the internal consistency reliability and convergent discriminant validity of the CiOQ (Joseph et al., 2003).

Data Collection

Before data collection began, an approved application was obtained from the Institutional Review Board at Walden University (IRB #12-18-12-0039716) which granted permission to access participants and collect data from the counseling center. Then, the director of the counseling center was contacted by phone and informed the study could commence.

The data were reported in aggregate form and used for research purposes only. All data obtained throughout the study were immediately placed into an envelope, and kept in a secured cabinet within the counseling center, under lock and key. Only the researcher and the Director of the counseling center had access to the key. When data collection was complete, the researcher conducted a statistical analysis.

Restatement of the Research Questions and Hypotheses

The following research questions were formulated to guide the study:

Research Question #1: Will there be a difference in positive responses when those diagnosed with MDD are compared to participants without a diagnosis of MDD?

H_{o1} :Participants diagnosed with MDD will not report significantly lower scores of positive responses as measured by the *CiOQ* when compared to participants without a diagnosis of MDD.

Ha_1 :Participants diagnosed with MDD will report significantly lower scores of positive responses as measured by the *CiOQ* when compared to participants without a diagnosis of MDD.

Research Question #2: Will there be a gender difference in the number of positive responses in those who are diagnosed with MDD?

Ho_2 :Female participants diagnosed with MDD will not report significantly lower scores of positive responses as measured by the *CiOQ* when compared with males diagnosed with MDD.

Ha_2 :Female participants diagnosed with MDD will report significantly lower scores of positive responses as measured by the *CiOQ* when compared with males diagnosed with MDD.

Data Analysis

A descriptive analysis was chosen to examine the hypothesis, and to credibly and effectively answer the research questions. A 2x2 ANOVA was used for this study, where each participant in the two independent variables fell into one of the two categories, (MDD diagnosis and no diagnosis of MDD) and one of the two categories for gender (male, female). The dependent variable was the scores on the positive response scale of the *CiOQ.* The 2x2 ANOVA was the appropriate statistical analysis to examine the data. The purpose was to examine if there was a significant difference between whether participants diagnosed with MDD would evidence statistically lower scores of positive response rates on the *CiOQ* when compared to participants without a diagnosis of MDD. In addition, the purpose of this study was to examine if there was a significant difference between female participants diagnosed with MDD*,* and statistically lower scores on the

CiOQ, when compared to males diagnosed with MDD. If the overall 2x2 ANOVA was significant then a post hoc test such as the Tukey HSD was used. The participants were determined by their completion of all of the materials and by meeting the criteria for inclusion in the study.

The SPSS Statistical package for Social Science (version 20.0.0) was used to analyze the frequencies of the scores in the data collected with the instruments described. The descriptive statistics included the means and standard deviations for all quantitative data. Bar graphs were used to compare scores on the *CiOQ* and describe significant mean differences among three or more categorical variables. In this study, a series of bar graphs were presented to summarize and display differences in scores on the *CiOQ* between female participants and male participants diagnosed with MDD (Gravetter & Wallnau, 2010).

Protection of Participants' Rights

All information obtained throughout this study was kept confidential by the researcher under lock and key. The study consisted of participants who were previously assessed and diagnosed at the counseling center. All sensitive data obtained throughout the study was under the control and protection of the researcher at all times. All research requiring computer software was transferred to an external flash drive. All data obtained throughout the study was coded in a format, with an M for male, F for female, 1 for MDD, and 2 for no diagnosis of MDD. Personal information for each participant was removed for the purpose of maintaining confidentiality, protect the participants' identities, and the assessment instruments was de-identified, immediately placed into an envelope, and kept in a secured cabinet within the counseling center, under lock and key.

Only the researcher and the Director of the counseling center had access to the key. When data collection was complete, the researcher conducted a statistical analysis. The researcher was aware of the importance of protecting the confidentiality for each participant and made every effort to satisfy this condition. This researcher was bound by professional and ethical standards to maintain strict confidentiality. An agreement with the counseling center was in place and included consequences if the researcher was to breach these standards in accordance with the professional code of ethics (see Appendix A). Collected data, stripped of any identifying pieces of information, was made available to qualifying professionals upon request to the researcher. When all of the data was collected, it was analyzed and kept in a secured cabinet under lock and key for a minimum of 5 years. If any participant was determined to be suicidal, he or she was immediately referred to the Director of the facility.

Summary

This chapter described the research design, setting and sample, instrumentation, data collection and data analysis procedures, and the participant's rights and protection of the data. The *CiOQ* was used to measure the number of positive responses in each of the three groups (variables) being compared in this study. A 2x2 ANOVA was used for this study, where each participant fell into one of the two categories of independent variables: 1) MDD and no diagnosis; 2) gender (male, female). The dependent variable was the scores on the positive response scale of the *CiOQ.* A 2x2 ANOVA, the method of choice for this study was explained and the results of this study were reported in a future chapter in narrative and tabular format. Conclusions were drawn based on the findings in this study. Recommendations were offered for practical application and future research.

Chapter 4 presents the research findings of the study. This chapter also includes the methods of the study, a description of the sample, the results of each research variable, an overview of the procedures, and a summary of the results. The results of the study were indicated in tabular and textual form. Chapter 5 provided a brief overview of the study, an interpretation of the study's results, implications for social change, and recommendations for action and further research.

Chapter 4: Results

This chapter describes the time frame for data collection as well as the actual recruitment and response rates. Chapter 4 also presents any departures in data collection from the plan presented in Chapter 3. This chapter reports baseline descriptive and demographic characteristics of the sample. Additionally, Chapter 4 describes how representative the sample was of the population of interest or how proportional it was to the larger population (external validity). The results are reported with appropriate tables and figures for illustration.

The purpose of this quantitative exploratory study was to determine if individuals who were diagnosed with MDD evidenced significantly lower scores on the positive response scale of the CiOQ when compared to others who were not diagnosed with MDD, and to determine if women who were diagnosed with MDD scored lower on the positive response scale of the CiOQ when compared with men who were diagnosed with MDD.

Assumptions and Analysis

To address Hypotheses 1 and 2, a two-way analysis of variance (ANOVA) was conducted on CiOQ scores by gender (male vs. female) and group (control vs. treatment). Significant interaction effects between gender and group were analyzed with independent sample *t* tests to determine where significant differences were among gender level and group level. The main effect of gender on CiOQ scores was analyzed by an independent *t* test to determine where differences were among participants in the treatment group and the control group. Prior to the analysis, the assumptions—normality and equality of variance—were assessed. Normality on CiOQ scores was assessed with a Kolmogorov-

Smirnov (KS) test; the result was not significant, $z(116) = 0.75$, $p = .636$, indicating that the assumption was met. Equality of variance was assessed with a Levene's test; the result was not significant, $F(3, 112) = 2.22$, $p = .090$, indicating that the assumption was met.

Research Question 1

Would there be a difference in positive responses when those who were diagnosed with MDD were compared to participants without a diagnosis of MDD?

$H_0$1: Participants who were diagnosed with MDD would not report significantly lower scores for positive responses as measured by the CiOQ when they were compared to participants without a diagnosis of MDD.

Ha1: Participants who were diagnosed with MDD would report significantly lower scores for positive responses as measured by the CiOQ when they were compared to participants without a diagnosis of MDD.

Research Question 2

Would there be a gender difference in the number of positive responses in those who were diagnosed with MDD?

$H_0$2: Female participants who were diagnosed with MDD would not report significantly lower scores of positive responses as measured by the CiOQ when they were compared with males who were diagnosed with MDD.

Ha2: Female participants who were diagnosed with MDD would report significantly lower scores of positive responses as measured by the CiOQ when compared with males who were diagnosed with MDD.

Data Collection

One hundred and sixteen participants took part in the survey over a 4-month period. Participants were assessed by the attending psychiatrist at the counseling center in Michigan and voluntarily completed the CiOQ for this study. Sixty (51.7%) participants were female, and 56 (48%) were male. Similarly, 60 (51.7%) participants were in the group without MDD, and 56 (48%) were in the group diagnosed with MDD. There were equal numbers of participants in the female group without MDD, the female group diagnosed with MDD, and the male group without MDD (30, 26%). There were slightly fewer MDD males relative to the other three groups (26, 22%). Frequencies and percentages for participants' demographics are presented in Table 1.

Table 1

Frequencies and Percentages for Participants' Demographics

Demographic	*N*	%
Group		
MDD	56	48
Without MDD	60	52
Gender		
Female	60	52
Male	56	48
Group and gender		
Females without MDD	30	26
MDD females	30	26
Males without MDD	30	26
MDD males	26	22

Note. Percentages may not total 100 due to rounding error.

CiOQ scores ranged from 0 to 66, with mean (*M*) = 38.31 and standard deviation (*SD*) = 15.26.

Data Analysis

A 2x2 ANOVA with statistical significance determined by p values < .05 was used for this study. Data were entered into SPSS version 20.0 for Windows. Descriptive statistics were conducted to describe the sample demographics and the research variables used in the analysis. Frequencies and percentages were calculated for gender and group. Means and standard deviations were calculated for CiOQ scores. Data were screened for univariate outliers. The presence of univariate outliers was tested by creating standardized residuals for the variables of interest and examining cases for values that fell above 3.29 and values that fell below -3.29 (Tabachnick & Fidell, 2012).

Results

The first null hypothesis (participants diagnosed with MDD would not report significantly lower scores for positive responses as measured by the CiOQ when compared to participants without MDD) was rejected. The main effect of group was statistically significant, $F(1, 112) = 15.82$, $p < .001$, partial $\eta^2 = .12$, suggesting differences on CiOQ scores by group. An independent samples t test was conducted, and the results showed that the control group had a significantly higher CiOQ mean score ($M = 42.93$) than the treatment group ($M = 33.36$). The effect size (partial η^2) of .12 indicates a small difference between CiOQ scores for those participants in the treatment group and those in the control group. Thus, participants diagnosed with MDD scored significantly lower on the positive scale of the CiOQ than the control group.

The second null hypothesis (female participants with MDD would not report significantly lower scores for positive responses as measured by the CiOQ when compared with males with MDD) was retained. The main effect of gender was

statistically significant, $F(1, 112) = 14.39$, $p < .001$, partial $\eta^2 = .11$. This suggests that there were differences in CiOQ scores by gender. An independent samples *t* test was conducted to examine where the significant differences resided. The results of the *t* test showed that females had a significantly higher CiOQ mean score ($M = 42.70$) than males ($M = 33.61$). The effect size (partial η^2) of .11 indicates a small difference between men's and women's CiOQ scores. Thus, males diagnosed with MDD scored significantly lower on the positive scale of the CiOQ than the females diagnosed with MDD, and the second hypothesis was retained.

The result of the interaction effect on CiOQ scores by gender and group was not statistically significant, $F(1, 112) = 3.72$, $p = .056$, partial $\eta^2 = .03$, suggesting that CiOQ scores are not significantly different by the interaction of gender and group.

The means and standard deviations on CiOQ scores by group and gender are presented in Table 2. The results of the two-way ANOVA are presented in Table 3. Figure 1 presents group-show scores by MDD versus non-MDD groups. Figure 2 presents group-show scores by gender (male versus female).

Table 2

Means and Standard Deviations on CiOQ Scores by Group and Gender

	MDD		No MDD	
Gender	*M*	*SD*	*M*	*SD*
Females	40.10	14.01	45.30	13.61
Males	25.58	15.65	40.57	11.22

Table 3

Two-Way ANOVA on CiOQ Scores by Gender and Group

Source	*SS*	*df*	*MS*	*F*	*Sig.*	*Partial* η^2
Group	2943.96	1	2943.96	15.82	.001	.12
Gender	2678.07	1	2678.07	14.37	.001	.11
Group * Gender	692.17	1	692.17	3.72	.056	.03
Error	20840.71	112	186.08	-	-	-

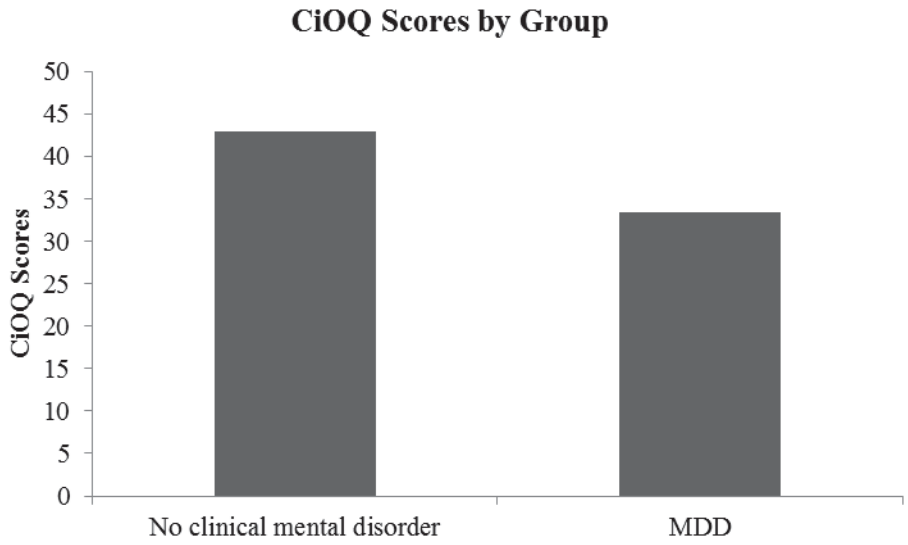

Figure 1. Bar chart of *CiOQ* scores by group.

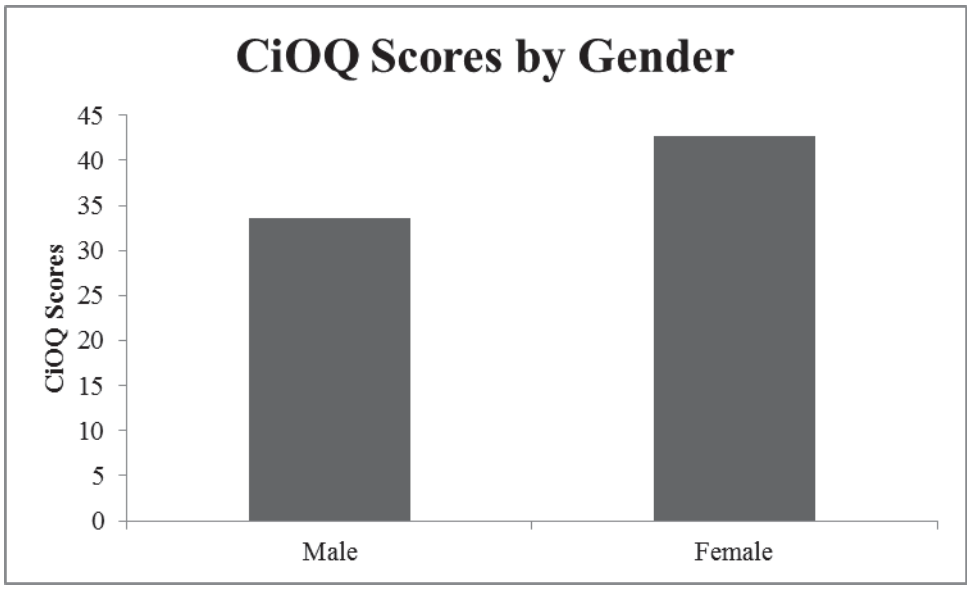

Figure 2. Bar chart of CiOQ scores by gender.

Summary

The scores of the CiOQ were significantly lower in participants who were diagnosed with MDD when compared to participants who were without any MDD diagnosis. In this quantitative study, I also sought to explore whether female participants who were diagnosed with MDD evidenced significantly lower scores on the positive response scale of the CiOQ when compared to male participants who were diagnosed with MDD. A total of 116 participants took part in the study. The participants included both men and women from two groups: individuals who had been diagnosed with MDD and a group without MDD. A two-way analysis of variance (ANOVA) was conducted on CiOQ scores by gender (male vs. female) and group (those without MDD vs. those diagnosed with MDD) to test both hypotheses. The results indicated that the first null hypothesis was rejected. Participants who had been diagnosed with MDD scored lower on the positive response scale of the CiOQ when compared with the group without MDD.

The second null hypothesis was retained, as it was found that men diagnosed with MDD scored lower than women diagnosed with MDD.

Chapter 5 provides a brief summary of the study and explains why and how the study was undertaken and performed. Limitations of the study are discussed. Social change implications are also presented. Recommendations for future action and further research are offered.

Chapter 5: Discussion, Conclusions, and Recommendations

This chapter contains a concise overview of the purpose and nature of the study, why the study was conducted, and key findings from the study. An interpretation of the findings is provided, and comparisons between findings in this study and previous research are reviewed. A review of the limitations of the study is provided, and recommendations for further research are mentioned. Chapter 5 provides the implications for positive social change and ends with the conclusion of this exploratory study.

Study Overview

The purpose of this study was to answer two research questions: (a) Were participants diagnosed with MDD cognitively unable to form positive responses on a positive response scale on a standardized psychological assessment when compared to a group of participants who were without MDD? (b) Were female participants diagnosed with MDD cognitively unable to form positive responses on a positive response scale on a standardized psychological assessment when compared to male participants who were diagnosed with MDD? My intention with this study was to take a first step in identifying whether mental health practitioners were overlooking a potentially important aspect of the ability of those with MDD to recover from their illness and be prevented from experiencing relapse: the cognitive ability to form positive responses in the midst of challenging life events. Prior to this study, there was no research that sought to investigate the cognitive capability of those diagnosed with MDD to form positive responses on standardized psychological assessments. There was a lack of empirical research despite the criteria of cognitive limitations for those diagnosed with MDD as indicated by the DSM-IV-TR (APA, 2000).

Summary of Results

A total of 116 participants took part in the study. The number of participants included both males and females in two groups: those who were diagnosed with MDD and a group without MDD. A two-way analysis of variance (ANOVA) was conducted on CiOQ scores by gender (male vs. female) and group (those without MDD vs. those diagnosed with MDD) to test both hypotheses. The results indicated that the first null hypothesis was rejected. Participants diagnosed with MDD scored lower on the positive response scale of the CiOQ when compared with the group without MDD. The second null hypothesis was retained. Results showed that males diagnosed with MDD scored significantly lower on the positive response scale of the CiOQ when compared with females diagnosed with MDD. In fact, males diagnosed with MDD scored lower on the positive scale of the CiOQ than any other group in the study.

Interpretation of Findings

This was the first study to investigate positive response rates in individuals diagnosed with MDD when compared with a group without a diagnosis of MDD and positive response rates in women diagnosed with MDD compared with men diagnosed with MDD that attempted to connect with Beck's (1979) cognitive model of depression. Throughout the duration of the study, I found that most of the findings supported Beck's (1979) cognitive model of depression, as participants who were diagnosed with MDD scored lower on the positive response scales on the CiOQ than participants in the group without MDD. However, there were also findings that differed from one of the two hypotheses proposed in the study: Male participants diagnosed with MDD scored significantly lower on the positive response scales of the CiOQ when compared with

female participants diagnosed with MDD. In fact, the men who were diagnosed with MDD scored significantly lower on the positive response scale on the CiOQ than any other group that was examined in the study.

Research Findings

The finding that men diagnosed with MDD scored lower on the positive response scales on the CiOQ than women diagnosed with MDD was compelling. The hypothesis formed for this present study was based on prior research indicating that women were more likely than men to report symptoms of MDD (American Psychiatric Association, 2000; Harkness et al., 2010; NIMH, 2011). However, what I noted was that none of the prior researchers ever sought to investigate how participants who were diagnosed with MDD would perform on cognitive tasks that demanded the ability to form positive responses on a standardized psychological assessment. My research showed that, contrary to prior research, when participants diagnosed with MDD were challenged with the task of forming positive responses in the midst of challenging life events, males who were diagnosed with MDD were significantly less able to form positive responses when compared with female participants who were diagnosed with MDD. This finding may have finally provided a window—a way to see how practitioners can identify when men are suffering symptoms of MDD even when they are not verbally reporting such symptoms by using the CiOQ as part of an intake assessment.

In my professional experience with male and female patients referred for mental health treatment, I have often observed that women are more verbally open about their feelings, emotions, and sense of vulnerability, whereas men are often less verbal and more restricted in their expression of feelings, emotions, and sense of vulnerability.

Interestingly, the findings provided in my research suggest that, when presented with a questionnaire that asked men and women to nonverbally report their feelings and to write their responses on a standardized psychological assessment, the men who were diagnosed with MDD provided responses that clearly showed that they were not as able to form positive responses on a standardized psychological assessment when compared with women who were diagnosed with MDD.

However, it is important to note that cultural differences may not have been accurately represented in this study, as this research was conducted in a small region of a state in the midwestern part of the United States. Due to the lack of variation in the demographics of the geographic location, the demographic variables were limited to gender (Leu, Wang, & Koo, 2011). Thus, I would recommend that more studies be conducted to observe more culturally diverse populations.

Theoretical Implications

Beck, Rush, Shaw, and Emery's (1979) cognitive model of depression was supported by the findings of this study. Within the cognitive model of depression, there are three major cognitive patterns: the person's negative view of the self, the tendency to interpret experiences negatively, and an overall depressive view of the future (Beck et al., 1979). These cognitive patterns create greater likelihood that the individual will become increasingly negative and depressed (Beck et al., 1979). It was expected that participants who were diagnosed with MDD would score lower on the positive response scale of the CiOQ when compared with participants without MDD. The results from the study indicated that the participants who were diagnosed with MDD were less able to form

positive responses on a standardized psychological assessment when compared with participants without MDD.

Limitations of the Theory

One of the limitations of Beck, Rush, Shaw, and Emery's (1979) CT is that it does not propose the notion or potential importance of depressed individuals having the cognitive capacity to form positive responses in the midst of challenging life events. Beck et al. challenged patients to replace dysfunctional thoughts with rational thoughts, but they did not focus on developing positive responses in the midst of thoughts or situations that challenged clinically depressed patients.

Implications for Social Change

Societal Benefits

According to the current professional literature, the efforts of psychiatrists and psychologists to offer effective treatment methods for MDD have yielded limited success (NIMH, 2011). Research indicated that individuals diagnosed with MDD were provided with ineffective treatment plans for severe or long-term depression (Riso et al., 2003). As a result, those diagnosed with MDD were set up for failure more than for recovery when treating professionals encouraged them to attempt to perform therapeutic tasks in a similar manner to others who did not share the same incapacitating symptoms. This treatment pattern did not take into account that patients with MDD had a higher level of cognitive impairment that created a barrier to the performance of routine tasks.

My study identified two important findings, bringing critical awareness to the mental health field and positive social change. The first important finding was that participants diagnosed with MDD scored lower on the positive response scale of the

CiOQ when compared with a group without MDD. This finding evidenced that those diagnosed with MDD needed more specified treatment plans that were geared to help them overcome their predisposition to negativity. Furthermore, psychologists, psychiatrists, and mental health practitioners could begin to develop specific forms of psychotherapy to help those diagnosed with MDD to develop insight into their predisposition to negativity. Mental health practitioners could further help those with MDD to replace negative cognitions with positive cognitions and to form long-term treatment plans for them to strengthen their ability to form positive responses in the midst of challenging life events.

The second important finding of this was contrary to what the second hypothesis proposed would be found in this study. Males who were diagnosed with MDD scored significantly lower on the positive response scale of the *CiOQ* when compared with females who were diagnosed with MDD, and to both, males and females in the group who were without MDD. This study brought forth critical information about the severity of a type of cognitive impairment in those who were diagnosed with MDD, particularly in males diagnosed with the disorder. This is a finding not seen in any other research. This finding would contribute to positive social transformation within the field of psychology, as practitioners might have a way to reach males who are suffering with MDD even when they do not report symptoms.

In the United States, men were often taught not to speak about emotion or any type of vulnerability. This might have prevented males from verbally reporting depression to their physicians and mental health practitioners. The use of the CiOQ as part of a brief intake assessment for male patients may provide crucial information about

depression when interviewing may not do so. This could bring about positive social transformation within the fields of psychology, psychiatry and the mental health field in general. The ability to administer the CiOQ to males upon intake assessment could create profound positive change for males who are suffering from MDD, their families, friends, colleagues, and for society at large. Practitioners could have a greater chance at detecting when males are severely depressed, and may further have the opportunity to teach depressed males how to replace negative cognitions with positive cognitions. Furthermore, males could have more of a chance to experience support from their mental health practitioners by experiencing the development of treatment plans that further assist them to follow through on replacing negative thoughts with positive thoughts. In addition, the treatment plans could teach patients with MDD to form proactive behaviors that support a healthier view and experience of life. In addition, these techniques and strategies could be taught to all individuals diagnosed with MDD.

Research Limitations

Despite the findings of this study and how they contribute to positive social transformation, this study was not without limitations. There was the possibility of participants answering questions in a way that would seem more appropriate or socially desirable to those viewing the answers (Paunonen & LeBel, 2012). There were limitations in the number of participants at the counseling center in Michigan. It would be beneficial to have more participants for studies like this one in the future. In addition, the counseling center was located in a small section of the Midwestern state of Michigan. There are various regional and cultural differences within the United States, let alone in other countries. Future researchers may want to broaden their horizons and conduct

further investigations of this type to see if the findings are similar, or if they differ in various parts of the United States and in other countries, as MDD is a disorder that affects people worldwide (NIMH, 2011). In addition, this study was limited to data obtained by a questionnaire that provided some insight into MDD, but now leaves practitioners with more questions. Additional research should investigate the implementation of psychotherapy that specifically teaches clients to form positive cognitions to replace negative cognitions over a period of time. Perhaps in the future, longitudinal studies can be conducted in order for mental health practitioners to see if such treatment plans are truly efficacious for those with MDD and other depressive disorders.

Recommendations for Future Research

This study, in and of itself, was a shift into positive social transformation, as it was the first of its kind. We, as mental health practitioners, need to further our investigation of the cognitive abilities of those diagnosed with MDD to form positive responses, rather than focusing entirely on the negativity of the disorder. As researchers, we need to search out of the box; beyond what is assumed and is already known. Researchers need to focus more specifically on how cognitive impairment in forming positive responses occurs in those diagnosed with MDD in different settings and environments; in different cultural backgrounds, and in different age groups. Mental health practitioners need to interview those who have recovered from MDD and note the differences and uniqueness that may help others with the disorder in the future. Research should focus on psychotherapy that is specifically developed to help those with MDD to form positive responses in the midst of challenging life events, such as Fredrickson's (2001) broaden-and-build theory and the positivity ratio, (2009) which instructs

practitioners and depressed clients how to work with building positive responses in the midst of experiencing negative thoughts and challenging life events. Furthermore, research should continue to investigate the efficacy of integrating antidepressant pharmacotherapy with psychotherapy in order to increase the chances for long-term recovery and to prevent relapse and recurrence of MDD.

Conclusion

MDD is a disorder of global proportions. It affects individuals, families, friends, employers and employees, communities, organizations and society at large. Unlike other forms of depression, MDD contains a specific component, which has gone overlooked for far too long: Cognitive impairment; specifically, the inability for those with MDD to form positive responses in the midst of traumatic and stressful life events. This was clearly evidenced by the results obtained in this study, which utilized a standardized assessment that specifically measured for the precise ability to form positive responses. In a world that is becoming more and more challenging, we as mental health practitioners have a responsibility to meet the needs of our clients. It is imperative that practitioners continue to learn how to conduct thorough assessment and to follow through with the necessary forms of psychotherapy that will most thoroughly help clients recover, adapt, and face their challenges in life. Furthermore, it is our responsibility as psychologists to help patients to form the adaptive coping strategies that not only help them to survive, but to learn how to thrive. This should always be the goal of every mental health practitioner, and we are now one step closer to more effectively helping those with MDD. This study showed an aspect of the disorder that was being overlooked, and further showed us how to possibly detect when depressed males might not be verbally reporting the severity of

their depressive symptoms. We need to take this information and apply it every time we sense that someone sitting on the other side of our desk may be depressed.

Depression is a lonely and potentially dangerous condition for those who suffer from it. As psychologists, we have the ability and the privilege to work with these patients; to help them heal and to discover a whole new way of looking at their world, if only we will take the time and make the opportunity to help those with MDD to shift their cognitions to a better, brighter place for themselves, their loved ones, and for society. Let us strive toward this contribution for those suffering with MDD, for their family and friends, and for society.

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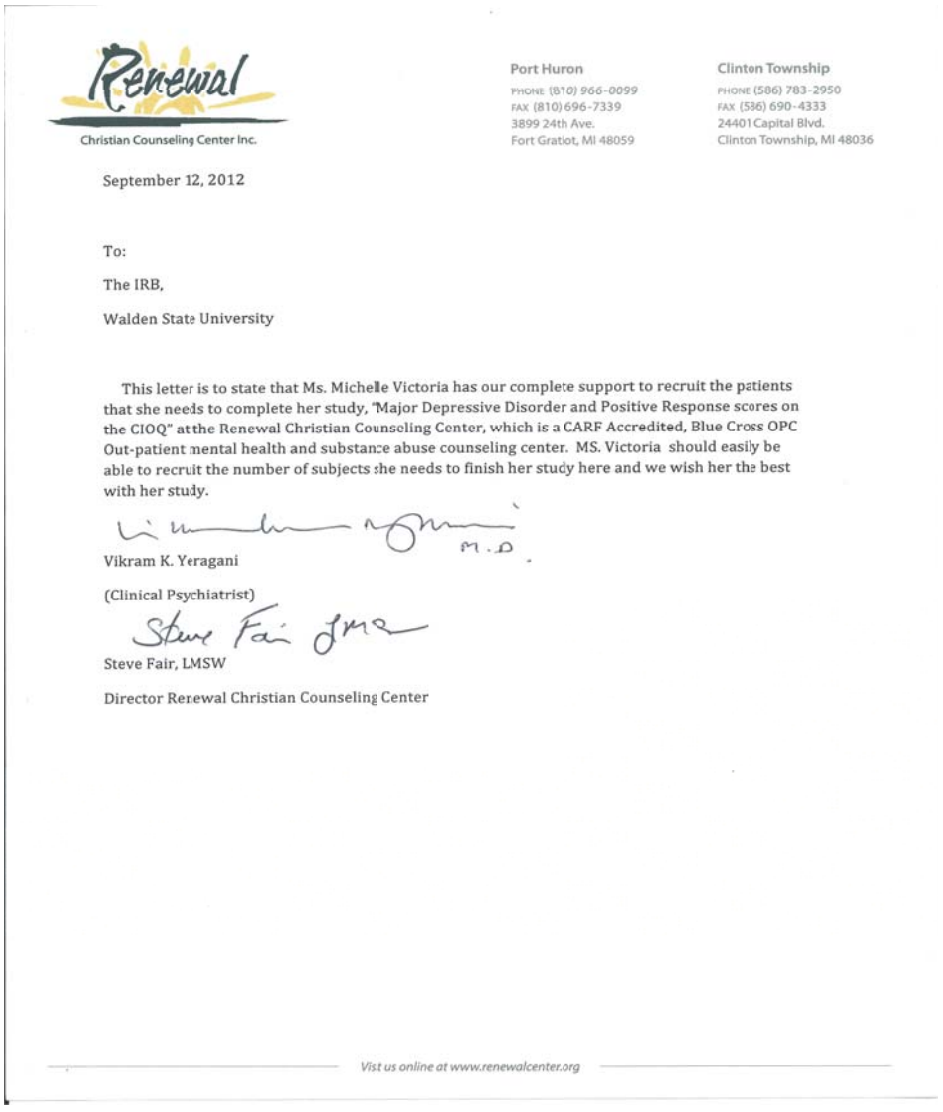
Appendix A: Letter of Cooperation From Counseling Center



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Christian Counseling Center Inc.

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24401 Capital Blvd.
Clinton Township, MI 48036

September 12, 2012

To:

The IRB,

Walden State University

This letter is to state that Ms. Michelle Victoria has our complete support to recruit the patients that she needs to complete her study, "Major Depressive Disorder and Positive Response scores on the CIOQ" atthe Renewal Christian Counseling Center, which is a CARF Accredited, Blue Cross OPC Out-patient mental health and substance abuse counseling center. MS. Victoria should easily be able to recruit the number of subjects she needs to finish her study here and we wish her the best with her study.

M.D

Vikram K. Yeragani

(Clinical Psychiatrist)

Steve Fair LMSW

Steve Fair, LMSW

Director Renewal Christian Counseling Center

Vist us online at www.renewalcenter.org

Appendix B: Informed Consent Form

Informed Consent

You are invited to participate in a dissertation research study investigating the impact of Major Depressive Disorder (MDD) and scores on positive scales of the Changes in Outlook Questionnaire, when compared to participants without any clinical mental disorder.

Please read this form and ask any questions you may have before acting on this invitation to be in the study (contact information is provided below)**.**
This study is being conducted by Michelle Victoria, a doctoral candidate with the School of Psychology, Clinical Psychology licensure track program at Walden University, Minneapolis, MN. Walden University's approval number for this study is **IRB #12-18-12-0039716, and it expires on December 17, 2013.**

Background Information (Importance and Reason for this Study):
The results of this study will help mental health professionals in assessing and treating persons with Major Depressive Disorder.

Purpose of the Study:
The purpose of this study is to determine the relationship between Major Depressive Disorder and scores on the positive response scale of the Changes in Outlook Questionnaire, when compared to participants who are not diagnosed with any clinical mental disorder.

Procedure:
Dr. Yeragani will prescreen the individuals to identify those with a diagnosis of MDD or those with no clinical diagnosis. If the individual is willing to participate; the researcher will present the Informed Consent Form, obtain the signature of the potential participant, and once obtained, the researcher will administer the CIOQ psychological assessment questionnaire. Each assessment will receive a code indicating a letter M or F to identify gender of the participant, and a number to indicate the MDD diagnosis or to indicate no diagnosis. No other identifying data will be entered anywhere on the rating scales. The CiOQ will not require a signature and will therefore be deidentified limiting any risk of violating the confidentiality of the participants.

Confidentiality:
Your participation is voluntary and all data will be kept confidential. Once you provide your signature to consent to participate in the study, no further personal identifying information will be collected. Your name is not required. All inventories will be kept confidential and results will be stored in a locked cabinet. No feedback will be given, and no follow-up action is required. The researcher will not use your information for any purposes outside of this research project. The researcher will not include your name or

anything else that could identify you in any reports of the study and therefore the collected data will be deidentified.

Participant requirements for this study:

1. Each participant must be an adult at least 18 years, and not older than 49 years of age.
2. Each participant must have already been pre-screened by Dr. Yeragani.
3. Each participant must be in overall good physical health.
4. The study will include both male and female participants.
5. Each participant must be fluent in English.
6. Each participant must provide consent to participate in the study.
7. If you consent to participate in the study, you will be required to complete the Changes in Outlook Questionnaire which will take about 15 minutes.

Participant's rights

Participation in this study is strictly voluntary. All participants have the right to withdraw their participation in the study at any time.

Risks and Benefits of Being in the Study:

There are minimal risks associated with participating in this study. This study does require self-assessment that may elicit negative self-emotions. Some questions might address sensitive topics and cause mild anxiety. You may stop participating in the study at any time by choosing not to answer any more questions and exiting from the study. You may skip any questions that you feel are too personal. If your participation results in emotional distress and requires support, the following emergency options are available in your community. If it is an emergency, please contact 911. Refusing or discontinuing participation involves no penalty. There will be no physical risks or compensation involved in participation.

Incomplete surveys will not be used in the data analysis. However, participation in the survey may provide information that will be beneficial to professionals by helping to improve their understanding of Major Depressive Disorder and how it impacts adults, which could lead to improved services for individuals and their families.

Compensation:

There will be no compensation provided for your participation in this study.

Contacts and Questions:

If you have questions, you may contact the researcher by phone or e-mail.
You may also contact the Faculty Advisor at
Walden University Research Participant Advocate at (The Research Participant Advocate is a Walden University representative to whom you may direct any further questions you may have about your rights as a research participant.) If you want to talk privately about your rights as a participant, you may also call the study supervisor who can discuss this with you. Walden University's approval number for this study is **IRB #12-18-12-0039716** ; it expires **December 17, 2013.** Please feel free to keep this form.

Statement of Consent:
I have read the above information. I have asked questions and received answers. I consent to participate in the study. The completion of the inventories implies my consent. I have read and understand the risks, benefits, and confidentiality guidelines of this research study. I affirm that I am an adult, age 18 years or older. I affirm that I am in good overall health.

I also consent to Dr. Vikram Yeragani's participation in the statistical analysis process of the study and I am aware that the information he will have access to, has been deidentified and confidentiality will be maintained.

Sincerely,
Michelle Victoria, Ph.D. candidate, Walden University

_ I wish to participate in this survey.

Your Signature Provides Your Consent

Appendix C: Permission to Use the Instrument

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Appendix D: Changes in Outlook Questionnaire

The Changes In Outlook Questionnaire

Directions: Please place an "x" within the parentheses that best describes how you feel.

	Strongly disagree	Disagree	Disagree a little	Agree	Agree a little	Strongly agree
1. I don't look forward to the future anymore	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
2. My life has no meaning anymore	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
3. I no longer feel able to cope with things	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
4. I don't take life for granted anymore	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
5. I value my relationships much more now	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
6. I feel more experienced about life now	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
7. I don't worry about death at all anymore	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
8. I live every day to the full now	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
9. I fear death very much now	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
10. I look on each day as a bonus	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
11. I feel as if something bad is just around the corner waiting to happen	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
12. I'm a more understanding and tolerant person now	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
13. I have a greater faith in human nature now	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
14. I no longer take people or things for granted	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
15. I desperately wish I could turn the clock back to before it happened	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
16. I sometimes think it's not worth being a good person	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
17. I have very little trust in other people now	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
18. I feel very much as if I'm in limbo	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

	Strongly disagree	Disagree	Disagree a little	Agree	Agree a little	Strongly agree
19. I have very little trust in myself now	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
20. I feel harder towards other people	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
21. I am less tolerant of others now	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
22. I am much less able to communicate with other people	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
23. I value other people more now	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
24. I am more determined to succeed in life now	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
25. Nothing makes me happy anymore	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
26. I feel as if I'm dead from the neck downwards.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Curriculum Vitae

MICHELLE RENEE VICTORIA

EDUCATION

2007 M.S., General Psychology
Graduate Student
Walden University, Minneapolis, Minnesota

2005 M.A.T.S., (Master of Arts in Transpersonal Studies)
Graduate Student
Institute of Transpersonal Psychology, Palo Alto, California

1995 BA, Psychology; Minor in Spanish
Head of Academic Affairs for Undergraduate Students
Psychology Tutor: Physiological Psychology, Social Psychology, Abnormal Psychology and Psychology of Learning.
Georgian Court College, Lakewood, New Jersey.

EMPLOYMENT EXPERIENCE

8/08-5/10 Clinical Evaluator, Psychiatric and Addiction Services of Southern New Jersey, Mt. Laurel, NJ. – Clinical Psychology Practicum and Clinical Psychology Intern. Performed intake assessments for court ordered evaluations. Presented cases to the psychiatrist and Medical Director. Provided verbal and written reports to caseworkers from the Division of Youth and Family Services upon request. Developed templates for clinicians to use for recording information and for presenting client cases to psychiatrists and to the Medical Director. Developed templates for court ordered clinical and forensic psychiatric evaluations.

8/08-2/10 Psychology Intern, FCI Fort Dix Correctional Facility, Fort Dix, New Jersey. Performed private counseling for inmates. Developed curriculum and performed Anger Management group therapy for male prison inmates. Performed cognitive assessment for prison inmates referred by Education Services of FCI Fort Dix.

1/03-6/10 Transpersonal Counselor: Integrated Mental Health Professionals. Conducted sixty-minute and ninety-minute transpersonal counseling sessions with clients. Worked with psychiatrists and clinical psychotherapists to develop treatment plan and to review client history. Helped clients form immediate and long-term goals for recovery and

personal growth. Informed clinicians of acute mental status changes and need for immediate clinical intervention.

09/97 – 02/98 Case Manager. Child Protective Services, Augusta County, Virginia. Investigated reports of child abuse and child neglect. Attended court hearings at the Augusta County Family Courthouse.Wrote reports for each case. Removed children from abusive, neglectful or dangerous homes with the Augusta County Police. Brought children to foster placement homes upon court order . Performed "on-call" duty through weekends as assigned for emergencies.

06/95 – 07/97 Mental Health Technician. Kennedy Memorial Hospital, West Pavilion, Adult Psychiatric Unit. Cherry Hill, New Jersey. Provided individual and group counseling for patients. Recorded and provided reports for patients admitted to unit. Reported acute mental status changes in patients to psychiatrists and charge nurses on the unit.

09/93 – 03/95 Georgian Court College, Lakewood, New Jersey. Psychology Tutor for undergraduate students in Physiological Psychology, Social Psychology, Abnormal Psychology, and Psychology of Learning.

PROFESSIONAL ORGANIZATIONS

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