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A Self-Control Therapy Group for Depressed Women

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Depression is the most widespread psychiatric disorder existing today, not only among patients involved in therapy but also among nonpatient populations randomly drawn from the community.

The present chapter presents an approach to group therapy for one subset of this large population—depressed women. Since depression has been found to occur in women at twice the rate it occurs in men (Weissman & Klerman, 1977), women represent a high-risk group for depression. This chapter begins with a discussion of diagnostic criteria and prevalence rates for depression, along with a brief review of possible etiological factors specific to depression

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in women. The remainder of the chapter focuses on a description of two havioral treatment groups for depressed women: their rationale, implen tation, results, and implications for future treatment. By outlining both methods and the critical issues related to the delivery of therapeutic serv for depressed women, we can further enhance the efficacy of group treatn for this population.

Diagnosis of Depression and Prevalence Rates

Diagnostic Criteria

Depression can be considered a mood, a series of symptoms, or a syndro The third edition of the American Psychiatric Association's *Diagnostic Statistical Manual of Mental Disorders (DSM-III)* (American Psychiatric sociation, 1980) provides three criteria for identifying a major depressive sode: (1) a dysphoric mood or loss of interest and pleasure is present relatively persistent; (2) at least four of the following eight symptoms are pre nearly every day for at least two weeks: poor appetite or weight loss, insom or increased sleep, psychomotor agitation or retardation, loss of interes usual activities, loss of energy or fatigue, feelings of worthlessness, diminis concentration, and suicidal ideation; and (3) there is no evidence of ma psychosis, organic mental disorder, or normal bereavement.

One of the problems in research on depression is that many of the diagno criteria, including the dysphoric mood, are difficult to assess directly; thus diagnosis of depression is made primarily on the basis of self-report. To ov come this problem, researchers have developed self-report symptom sc that define and clarify specific behaviors, affects, and cognitions related depressive episodes. Inventories commonly used for assessing depression clude the Minnesota Multiphasic Personality Inventory (MMPI) Depress (D) Scale (Dahlstrom et al., 1972), the Beck Depression Inventory (Bec Beamesdorfer, 1974), and the Lewinsohn Pleasant Events Schedule (Lew sohn & Shaw, 1969).

The MMPI D-Scale, traditionally used to assess depression, consists of s eral dozen true/false items such as "No one seems to understand me." Beck Depression Inventory provides 27 groups of statements from which patient is asked to select the one statement in each group that best descri the way he or she felt during the preceding week. The Lewinsohn Pleas Events Schedule provides a list of 49 activities; patients are asked to indic how often they engaged in each activity during the preceding 30 days. Patie are also asked to state the perceived "enjoyability" (reinforcement potent of each activity on a 1-to-3-point scale.

Prevalence Rates

In epidemiological research, the point prevalence rate is defined as the proportion of the population exhibiting the specific disorder at a particular point in time. Boyd and Weissman (in press) have reported point prevalence rates, based on symptom scales, for depression ranging from 9 percent to 22 percent of the general population. When analyzed in terms of sex, point prevalence rates for men range from 6 percent to 19 percent; for women they range from 11 percent to 34 percent. These findings support an earlier finding that women may experience depression twice as often as men (Weissman & Klerman, 1977).

The 2 to 1 sex ratio of depressed women to depressed men is found in different regions of the United States as well as in other Western countries. As with depression in general, this ratio seems to occur in both patient and nonpatient groups selected randomly from community surveys of the general population. Exceptions to this sex ratio are provided by studies of populations in developing countries and studies that focus on manic depression, where the sex ratio is fairly well balanced (Weissman & Klerman, 1977).

Research on Women and Depression

Several theories have been advanced to account for the sex difference in depression rates. First, it has been postulated that biological factors might account for the sex difference. In the most complete review to date, Weissman and Klerman (1977) summarize the evidence for possible genetic transmission of susceptibility to depression and for female endocrine physiological processes in depression. The evidence they cite concerning the relationship between depression and genetic factors is inconsistent: good evidence supports a genetic factor in depression, but studies on cross-linkage are conflicting. There exists very good evidence that depression increases during the postpartum period. The evidence for premenstrual tension and for depression as the result of oral contraceptives is inconsistent. Finally, there is very good evidence that menopause does not result in higher rates of depression. Thus further research is needed to clarify the influence of biological factors in depression.

Several environmental factors have been postulated to account for the high rates of depression among women. First, women's roles may be more restricted than men's and allow less financial, social, or occupational gratification. Second, women may be socialized to be unassertive, dependent, and passive; these qualities lead to depression rather than action during stressful situations. Third, as the media increasingly present exceptional women who have "made it" in high-level careers, many women may feel depressed with their own inability

to meet these rising expectations. Finally, women may be taught to be hel and to experience a lack of control over their environment, so that the ception of no relationship between their efforts and any significant re would lead to depression.

Much recent research has focused on specific factors relating to wom roles that could account for high depression rates. The following factors some of the research conclusions discussed in a recent review by Rothb (1983).

Social/interpersonal deficiencies are a major risk factor for depression. Wo who lack a social network of family and friends or who are not involved i intimate relationship are more depressed than women who have meanin interpersonal relationships (Brown et al., 1975; Pearlin & Johnson, 1977). Wo are more likely than men to report depression in response to rejectio distance in a relationship and after experiencing a loss of self-esteem (Par 1980).

Marriage serves a protective role for men but not for women. Married m are less depressed than never-married men, whereas married women are n depressed than those who were never married (Gove, 1972; Radloff, 19 Not only are married women more depressed than married men, but depre married women also have more marital problems (Bullock et al., 1972). Ho wives experience more marital friction and are less satisfied with their w than employed married women (Gove, 1972; Brown & Harris, 1978). Howe employed married women carry a dual load of work when they combine ho work with their jobs (Radloff, 1975).

Separated and divorced women constitute the largest category of depre individuals (Hirschfeld & Cross, 1982). A study of marital disruption (Bri & Smith, 1973) indicates that depressed divorced men and women consti different samples. Women are likely to become depressed in a disrupted m riage, often as the result of specific events contributing to the marital fric Few demographic variables distinguish depressed women from their non pressed counterparts, suggesting that it is the events leading to divorce result also in depression. Depressed divorced men, on the other hand, h histories of precipitating interpersonal and sexual factors that are not pre among nondepressed divorced men. This suggests that, among men, the capacitating symptoms of depression may result in divorce.

Women constitute the majority of *single parents*, with accompanying fin cial problems, loneliness, and difficulties in maintaining meaningful social c tacts. Ilgenfritz (1961) identified fear of loneliness, loss of self-esteem, pract problems of living, and specific concerns for children as the major stres facing single mothers. Divorced mothers experience little respect and nega social attitudes. In fact, single mothers often are blamed for a variety of so problems, such as the need for welfare (Brandwein et al., 1974).

The presence of young children in the home is a major factor contributing to depression among women (Shapiro et al., 1979). Additionally, depressed women have difficulty with child rearing. They have less involvement in their children's lives, experience difficulty communicating with their children, show a loss of affection for them, and report considerable friction between themselves and their children (Weissman et al., 1972). The effect of the mother's depression on children, notably adolescents, is negative (Weissman et al., 1971). Conversely, women become less depressed when grown children leave home (Radloff, 1980).

Employment has generally beneficial effects for women (Hall & Gordon, 1973). A study focusing on employed women and housewives in treatment for depression (Mostow & Newberry, 1975) found that employed women displayed significantly more depressed symptoms before treatment but recovered faster than housewives. Housewives were more impaired in social adjustment, had more economic problems, and displayed more boredom after treatment. One may argue that women in the labor market occupy jobs with lower salaries and status, and fewer opportunities for upward mobility, than men.

There has been little research on women in *nontraditional roles*, such as professional or executive women. Welner et al. (1979) investigated psychiatric illness among women physicians and Ph.D.s in the community. Their results indicated that 51 percent of women physicians and 32 percent of women Ph.D.s had primary affective disorders. Their study found little evidence of other forms of psychiatric illness. The women physicians were not only significantly more depressed than the Ph.D. sample, but they were also more severely depressed and had had more depressive episodes. Sixty-seven percent of depressed women M.D.s and 70 percent of depressed women Ph.D.s reported prejudice against them in their training or employment; the figures for nondepressed M.D.s and Ph.D.s were 50 percent and 48 percent, respectively. Thus prejudice was reported significantly more often by depressed women. Similarly, Pitts et al. (1979) examined American Medical Association records of deaths of physicians. They found the suicide rate for women M.D.s to be 6.56 percent higher than that of male M.D.s and four times higher than the suicide rate for white American females of the same age. Although additional research is warranted to corroborate these findings, it appears that professional women are at significantly more risk for depression and suicide than other women.

In our society, it is more acceptable for women than men to *express depression*. Hammen and Peters (1978) used both male and female college students to rate male and female confederates who played a standardized depressed or nondepressed role over the telephone. Results showed that depressed persons of the opposite sex were most strongly rejected. Female raters made little distinction between depressed males and females on role impairment. Male

raters, however, considered the depressed females more impaired. Rate came significantly more depressed following an interaction with depr actors.

What are the effects of long-term interactions with depressed indivic Kreitman et al. (1970) and Nelson et al. (1970) investigated the effects of term interactions on women who were living with neurotic husbands. male outpatients and their wives were interviewed and compared wi control couples (Kreitman et al., 1970). Patients' wives were five times likely to be incapacitated than control wives in household roles, social a ties, health, and child rearing activities.

Finally, there is some evidence that men make better use of *coping stra* in the face of stressful life events (Pearlin & Schooler, 1978). Thus wome not only at higher risk for depression but they seem to receive less prepa to cope with disruptive life events.

Rothblum (1983) concludes: "Basically, the woman who hopes for mar a family, and a providing husband who will be the sole wage-earner is matically increasing her chances of depression. On the other hand, the w who enters graduate or medical school to pursue an advanced degree t tionally reserved for men is not immune from stress and depression" as a r of the prejudice and sexism in these professions. Thus rates of depressio suicide among professional women are extremely high. It is evident depression among women is significantly affected by women's sex rol relation to work, the marital relationship, and motherhood. In general, t tional sex-role stereotypes about women place them at greater risk for de sion.

Starting the Depression Groups

The Rationale

In 1977 staff members of the outpatient psychological clinic at the Grad School of Applied and Professional Psychology at Rutgers University in Brunswick, New Jersey, established a depression treatment program that sisted initially of two short-term therapy groups for depressed women b on behavioral techniques. This initiative seemed indicated for the follo reasons:

1. Since depression is a high-frequency clinical diagnosis and women depressed at about twice the prevalence rates of men, group thera a more cost-effective method of treating comparatively large num of women than individual therapy.
2. It is evident from the preceding sections that the environment pla

major role in precipitating depression. A group setting allows individual members to share their experiences related to risk factors for depression, such as marital and interpersonal difficulties, childcare, housework, and employment-related stressors. Clients can also self-disclose more readily if they realize that others share their problems.

3. The group setting enables women to recognize that their emotions and experiences are not unique or unusual, thus validating these experiences. Clients who attribute the causes of their depression to their husbands, their bosses, or to themselves will instead realize commonalities with other patients.
4. Support and advice from group members provide more broad-based and varied feedback than that from one therapist. Furthermore, group members may also provide more practical advice concerning details of coping with domestic and job-related problems than the therapist, who may have less in common with the clients' lifestyles.
5. Since depression often results in lack of energy to engage in activities and thus in social isolation, the group serves a social function by increasing client social involvement and activities.
6. Finally, women have limited financial resources and can afford the relatively low cost of group therapy more readily than the cost of individual therapy.

The staff of the depression treatment program had several goals in forming the group-therapy project:

1. To provide a program for women who were clinically depressed and who wished to enter treatment for depression.
2. To offer a short-term (six week) treatment program that focused on active intervention strategies and that required daily activities to change the concomitants of depression.
3. To investigate the outcome of treatment over a three-month follow-up period after the last treatment session, during which the clients practiced intervention strategies on their own.

The remainder of the chapter will focus on these components of the group-therapy program.

Group Members

To publicize the depression treatment program, advertisements were placed in three local newspapers describing the program and soliciting applications for group membership. A total of 69 applicants telephoned to express their interest. They were given more information about the treatment program and

told the fee. They were also told that they would be required to com series of assessment procedures in order to be accepted into the progr

Forty-two applicants attended the pretesting session. Of these, 20 v fit the acceptance criteria, which included: (1) not receiving other psycl apy at the time; (2) scoring at or above the level of clinical depressio 70) on the MMPI D-Scale; and (3) not scoring above the depression sc any other clinical scale of the MMPI.

These 20 women were accepted into the program and organized in groups of 10 each. However, two women in each group failed to atte initial group meetings. Thus each of the treatment groups started with women. One woman dropped out of each group during the course treatment program: one after two sessions for unspecified personal reaso the other after all six sessions because of disagreement with the philoso the group. There was no attrition during the maintenance phase of group. The results of the program were tabulated for the 14 wome completed it.

Of the clients who participated in the treatment program, the majori percent) were 40 or over; 21 percent were in their thirties; and anoth percent were in their twenties. Fifty percent of the clients were marrie percent divorced or separated, and the remainder were either single (14 cent) or widowed (7 percent). The majority of the women (78 percent) employed in secretarial/assistant positions, two were housewives, and on unemployed.

Before entering treatment, clients were asked about the nature of depression. Durations of the current depressive episodes ranged from month to "all my life." In general, durations were divided into three categ less than one year (21 percent), one to five years (29 percent), and over years (46 percent). Thus most clients reported long-standing depressed mo

There was a large range of perceived precipitating events for the depres Three clients (21 percent) listed the breakup of their marriage, five (37 per did not know a specific event, and the rest (42 percent) listed such even factors as job stress, being overweight, and death of a significant other.

Most clients (86 percent) reported past episodes of depression preceding current episode. However, fewer than half (36 percent) reported prev therapy for depression.

Conducting the Therapy Groups

The Therapists

Two female therapists led all sessions of the depression treatment progra Both were advanced graduate students in clinical psychology and had exp ence in group therapy and in self-control behavior therapy.

The general aims of the treatment program were to provide (1) a structured, cumulative method of intervening in the depressed mood and behaviors; (2) a supportive environment; and (3) skills for coping independently after the termination of treatment. The guidelines for the treatment program were taken from Rehm's (1977) *Self-Control Therapy Manual*, which had been used for the self-control of depression (Fuchs & Rehm, 1977).

Structured Intervention

The first session began with an introduction to the treatment program. Information sheets were distributed that stressed self-help based on strategies developed by Rehm, such as the following:

> Depression can be looked at in various ways. Traditionally therapists have attempted to deal with depressed feelings by uncovering personality variables which, they believed, lay behind the symptoms of depression. More recently psychologists have been focusing directly on the actual here-and-now functioning of the person, believing that if current behavior changes in a meaningful way then the person's feelings will improve accordingly. In this program our goal will be to help you to change your own pattern of activity, in order to feel better (Rehm, 1977).

The goal of the treatment program was described on the information sheets as follows:

> To control your own behavior effectively, you will be teaching yourself to do three things:
>
> 1. Monitor behavior—checking to see which activities have been performed.
> 2. Evaluate behavior—comparing each activity against standards you have set for yourself.
> 3. Rewarding behavior which has met the standards you set for yourself.
>
> As we hope you will soon see for yourself, these three things are a means of increasing your rate of satisfying activity, which in turn influences your positive feelings (Rehm, 1977).

Thus clients were informed that mood was the function of one's own behavior and that they could gain greater control by learning skills that would help them work toward goals of their own choice.

The first and second treatment sessions focused on *self-monitoring*. Clients were instructed that depressed individuals selectively attend to negative events and to immediate rather than delayed outcomes of behavior. Thus a woman might focus on the one criticism that her boss made that day rather than the eight compliments that preceded it. Similarly, this woman might dwell on the

rejecting nature of the criticism instead of receiving it as feedback to porate into her next project. Clients were trained to orient toward pc activities as target behaviors—that is, to work toward participating in activities that commonly result in pleasurable outcomes, though not neces immediately. Clients were urged to seek out opportunities to particip these activities, and continually to discover potential pleasurable ever their environment. Most of the first two sessions was allotted to group bers' suggestions and discussion of self-monitoring.

The third and fourth sessions continued discussion of self-monitoring focused now on *self-evaluation*. Depressed individuals tend to set overly criteria for their behavior and to attribute failure to the wrong sources. a woman who spent 15 years at home raising a child might be devasta she does not immediately succeed in obtaining an interesting, highly den ing job. She is setting her immediate goal too high, even though it is a plau one for her in the future. The group sessions focused on attainable Clients were instructed to develop lists of subgoals, realistic componer larger goals. A client who wanted to lose 50 pounds included a detailed exe and caloric-intake program that called for three hours of exercise a week eating no more than 1,000 calories a day. A divorced woman planned to en in two social events a week and to invite a close friend to go shopping o movie whenever she felt lonely. Clients were instructed to evaluate their formances in these subgoals rather than to overgeneralize by focusing o long-range goals.

The last two group sessions focused on *self-reinforcement* in addition to monitoring and self-evaluation. Depressed individuals frequently blame th selves for failures rather than feel good about their accomplishments. pattern of "punishment" lessens persistence and increases depression. Cl were instructed that "self-reward" or reinforcement makes efforts more p urable and increases motivation. Thus clients were instructed to self-admin rewards in the form of pleasurable activities. These rewards were give engaging in the difficult and time-consuming subgoals described in the vious sessions. Furthermore, rewards were to be administered *contingent* that is, only if the activity had been completed. Thus the weight-loss c decided to set aside one dollar for each completed hour of exercise and each day she ate within her 1,000-calorie limit. This money was then app to the purchase of a new wardrobe. A client who had difficulty asserting he to coworkers rewarded herself by telephoning a friend long-distance each she asserted herself at work. Self-reinforcement is particularly importan subgoals become routine and tedious.

Homework Assignments

It is evident from the description of the treatment program that homew assignments played a major role. Particularly in short-term group progra

in which direct client contact with therapists may not be extensive, it is important that clients engage in treatment-related activities between sessions. To illustrate the role of homework assignments, we will describe the assignments of a specific client. Ms. T was a 44-year-old secretary who recently had been divorced. She attributed her depression to the social isolation she felt as a newly single woman. She had relied extensively on her husband to initiate social activities during her marriage, and now she felt that she had no friends.

Homework assignments for the self-monitoring phase included:

1. Engage in positive activities.
2. Record positive activities in a Daily Activities Log provided by the therapists. Records should be made as soon as possible after a positive activity occurs. Daily logs should be kept at hand (e.g., in purse) and brought to group sessions.
3. Do not record failures or negative activities.
4. Monitor every positive activity/event, no matter how trivial (e.g., relaxing nap, warm shower, admiring beautiful scenery).
5. Record subsequent *mood* experienced during the positive activity on a scale from 0 (miserable) to 10 (euphoric).
6. Compute average number of activities per day and average daily mood rating each week. Graph these ratings (optional) on graphs provided by the therapists.

After the first session, Ms. T's daily activities log looked as follows:

Positive Activities	*Mood Rating*
Enjoyed brisk weather	8
Looking at attractive scenery	8
Thinking about something good/personal achievement	8

Clearly, this client was not engaging in much active behavior. After receiving feedback on this along with encouragement to engage in more pleasurable activities, she recorded in her next log:

Positive Activities	*Mood Rating*
Expressing myself to another person	10
Learning how to crochet	5
Working on my knitting	8
Caring for myself	8
Getting a good meal	10
Looking forward to a social event	10
Making time for myself	10

Homework assignments for the self-evaluation phase consisted of pursuing

subgoals, recording subgoals, and administering points according to their portance or usefulness. Specifically, directions included (Rehm, 1977):

1. Prompt clients to maximize points by doing the following:
   a. Do each positive activity more often.
   b. Do more different positive activities.
   c. Set more reasonable, achievable subgoals.
   d. Work at a few higher, more significant subgoals.
   e. Break down new or significant behaviors into components.
2. Even though stress is on significant or difficult activities, clients sh not neglect to accumulate points in easier ways. Suggest that t subgoals be arranged hierarchically according to difficulty or orde which they must be enacted.
3. Direct clients to continue monitoring and graphing as before, but to record each engagement in a subgoal/component behavior. They sh briefly describe what they did, note what it is a subgroup of, and their subsequent mood.
4. Encourage clients to deliberately engage in subgoal behaviors.

Since Ms. T was working on becoming more socially active, she chose subg relating to initiating friendships and participating in social and interpers activities. An entry in her log reads:

Positive Activities	*Mood Rating*	*Po*
Took care of myself	8	
Talked to someone on elevator	10	]
Made something for party on Thursday	10	
Went shopping	10	

Finally, in the last phase, self-reinforcement, clients "rewarded" themse by engaging in a pleasurable activity each time they accomplished one of t subgoals. Thus clients were asked to: (1) reward positive activities, (2) be erous with rewards initially, (3) reward activities contingently.

Supportive Environment

Throughout the treatment program, the therapists encouraged ideas discussion by the clients. Clients were supported in their efforts to ini activities and solutions for their own depression-related behavior and af Clients were also encouraged to assist others with example, feedback, support. The group became increasingly cohesive and the atmosphere was of camaraderie.

Cost of Treatment

The financial costs of psychotherapy are often prohibitive for women. To encourage attendance in the depression treatment program, clients were asked to deposit $50 at the first group session and then received a refund of $5 at the end of each session they attended (including the first). If clients came to all nine sessions (six weekly and three follow-up monthly sessions), the cost of the entire program was only $5, which was used to cover advertising and secretarial expenses. (Clients who wished to drop out of the program received a refund of their entire fee.) Thus treatment costs were used to motivate clients for therapy; in effect, clients were paid for coming with their own money. This method has been used successfully in the area of weight reduction by Collins et al. (1980).

Maintaining Treatment Effects

A major goal of therapy is to ensure maintenance of treatment effects. Thus we were concerned that clients continue therapy-related activities on their own after the termination of the six-week therapy period. To provide feedback for clients during this crucial posttherapy stage, three follow-up sessions were scheduled at one-month intervals after treatment was completed. During these "maintenance" sessions no new techniques were presented. Rather, clients were encouraged to discuss their progress and their improvement was assessed.

Results of the Depression Treatment Program

The assessment battery we administered to clients before treatment was readministered after the last treatment session and at each monthly maintenance session. We were also interested in measuring the degree to which clients had participated in the treatment-related activities.

Our data indicate that clients attended a mean number of 5 sessions out of a total of 6 and completed a mean of 3.36 homework logs out of a total of 5. Clients engaged in a mean of 3.75 pleasant activities daily and gave the accompanying mood an average rating of 6.62 out of a possible 10 (highest mood).

The same symptom-assessment scales given before treatment were administered after treatment and at the one-, two-, and three-month maintenance sessions. Because the full-scale MMPI takes several hours to complete, it was administered in its entirety only before treatment and during the last maintenance session. At all other maintenance sessions, only the MMPI D-Scale items were administered.

Significant assessment-period main effects were thus apparent for the global

MMPI D-Scale and for the cognitive scale (Beck Depression Inventor well as for other MMPI subscales, such as K, Psychopathic Deviance, Female, Paranoia, Psychasthenia, Mania, and Social Introversion. One nation for the improvement, in the direction of lessened psychopatholo the above MMPI scales during a depression-treatment program could b number of items that are considered part of the D-Scale at the same tim they are also part of other scales. Rush et al. (1977) studied the typical M profile of clients whom they had admitted to a depression-treatment pro They found clients to score at a T of 70 or above on F, Hypochondria, chopathic Deviance, Paranoia, Psychasthenia, Schizophrenia, and Soci troversion, as well as Depression. Another explanation could be the ten of depressed clients to answer items in the direction of pathology as a of their low self-esteem and self-devaluation, both frequent sympto depression. Improvement in self-esteem as a result of treatment wou likely to reverse this tendency, thus producing improvement on the clinical scales of the MMPI. Finally, it is also possible that these scales general improvement. It is not certain why the Lewinsohn Pleasant E Schedule did not show any improvement on depression, except that it to be only the more global measures mentioned earlier that indicate signi differences in the present program.

Conclusion and Recommendations

This chapter makes the following points concerning group therapy f pressed women:

1. Depression is twice as prevalent among women than among me cent research on women's roles indicates that marriage, divorc separation, the presence of young children in the home, the dual of housework and job, and employment in nontraditional jobs for w are all risk factors for depression. This consideration of these f should be incorporated into treatment programs.
2. There is a high attrition rate among both applicants for a depre treatment program and accepted clients. Future programs might admission criteria and offer increased motivational incentives tending group sessions. Furthermore, our data indicate that the m of clients did not seek treatment for past episodes of depression. might be directed at targeting such populations through the news or through general practitioners.
3. Clients both adhered to the group treatment program and impro depression symptoms. The program was cost-effective in that group-administered and short-term (six weeks). Homework assign

assured continued participation in treatment-related activities between sessions.

4. Clients maintained improvement at three months follow-up and reported continued adherence to treatment activities.

Feminists have claimed (e.g., Chesler, 1972) that sex-role biases of mental-health professionals contribute to women's emotional distress by readily allocating clinical diagnoses and treating women in the context of the "sick role." Mental health professionls, on the other hand, may argue that "consciousness raising" alone without regard to psychopathology could prove harmful as women are urged to become "liberated" without regard to their own readiness or emotional independence to assume new roles. The group-treatment format, we believe, can constitute an ideal compromise: a structured therapeutic model within a setting that exposes clients to other women in similar situations, with the potential for receiving feedback and providing mutual support.

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