

# FACTORS WHICH PREDICT THE EFFECTIVENESS OF DIFFERENT TREATMENTS OF MILD DEPRESSION OR DYSPHORIA

Carmen Rodríguez-Naranjo and Antonio Godoy

*University of Málaga*

---

*Factors which predict the effectiveness of different treatments of mild depression or dysphoria. Research on depression indicates different predictive factors for the development of depressive behaviour. In spite of this, cognitive-behavioural treatment is being applied to the general population of depressive subjects. In this study, two groups were formed from a sample of 236 mild depressive or dysphoric adolescents: the "cognitive dysphoric" group, composed of subjects with depressive attributional style, and the "behavioural dysphoric" group, made up of subjects with deficient social behaviour. We used these two groups to compare the effectiveness of applying a treatment matched with the type of dysphoria and a non-matched treatment. The ANOVA results indicate that the treatment matched with the type of dysphoria is more effective than the non-matched treatment.*

*Las investigaciones sobre la depresión señalan, factores predictores diferentes para el desarrollo de las conductas depresivas. A pesar de ello, el tratamiento cognitivo-conductual se aplica indistintamente a la población general de sujetos depresivos. En este estudio, se forman dos grupos a partir de una muestra de 236 adolescentes con depresión leve o disforia: el grupo "disfórico cognitivo" constituido por sujetos con un estilo atribucional depresivo, y el grupo "disfórico conductual" formado por sujetos con deficiencias en la conducta social. Utilizamos, estos dos grupos para comparar la eficacia de aplicar un tratamiento emparejado y uno no emparejado con el tipo de disforia. Los resultados del ANOVA indican que el tratamiento emparejado con el tipo de disforia es más efectivo que el tratamiento no emparejado.*

Neither researchers nor clinicians agree on the meaning of the term "depression" (Brewin, 1985), and it is used to refer to a wide variety of deficiencies. As with any other psychological disorder, there is a need for a precise distinction between the different types of depression. The factors on which we can most usefully base this differentiation are the symptoms or reactions associated with depression, their evolution and their treatment (Feinberg, 1992; Garber, Miller and Seaman, 1979). Etiological factors may also be very useful for the clinical prediction of the onset and, where it occurs, the worsening of depressive reactions.

The principal models that have been constructed to explain depression can be grouped in two blocks according to the role they assign to a series of factors in the development and persistence of the disorder: those that emphasise factors of cognitive vulnerability, and those that focus on the behavioural deficiencies involved in depression. Below, we present the main findings of each

approach, with the aim of clarifying the possibility that there exist different types of depression.

## *Findings of the cognitive models*

In the first place are the cognitive models of Ellis and Beck, the authors whose starting point was the clinical observation of depressive symptomatology. The approach of Ellis (1962, 1987; Ellis and Grieger, 1977) has become practically obsolete in research on depressive disorders, possibly because no reliable and valid measures of its cognitive constructs have been developed (Kendall and Korgeski, 1979; Smith, 1989). Moreover, research on its therapeutic assumptions is virtually non-existent. Beck's model (1967; Beck, Rush, Shaw and Emery, 1979), on the other hand, offers the approach that has been most influential, offering as it does a series of theoretical principles of great heuristic value, which continue to inspire numerous studies on cognitive factors in depressive disorders. Furthermore, it is on this approach that the most important current form of treating depression is based.

Most research based on the revised theory of learned helplessness (see Buceta and Polaino-Lorente, 1982), and the more recent theory of hopelessness (Abramson,

---

The original Spanish version of this paper has been previously published in *Psicothema*, 1997, Vol. 9 No 1, 105-117

.....  
*Correspondence concerning this article should be addressed to Carmen Rodríguez-Naranjo, Facultad de Psicología, Universidad de Málaga. Campus de Teatinos, s/n. 29071 Málaga. Spain.*

Metalsky and Alloy, 1989; Alloy, Abramson, Metalsky and Hartlage, 1988), indicates that there is an important relationship between negative attributions and depression. The findings from Seligman's (1975) reformulated learned helplessness approach already tended to confirm that the style of causal attribution, in interaction with stressful life events, is a factor of cognitive vulnerability for the development of depression (Alloy *et al.*, 1988; Alloy, Lipman and Abramson, 1992).

Nevertheless, in many other studies attributional style is not found to be related to depressive responses (Barnett and Gotlib, 1988; Brewin, 1985; Lewinsohn, Steinmetz, Larson and Franklin, 1981), even when a stressful element is present. The contradictory results in this field can perhaps partly be explained from the position of Alloy *et al.* (1992). These authors maintain that a depressive attributional style may contribute to the development of depressive symptoms and may increase the probability of depression, but that it is not a necessary condition for the generation of depressive reactions. Thus, further factors, cognitive or other, may also predispose subjects to experience depressive reactions.

#### ***Clinical investigation on deficiencies of social behaviour in depressive subjects***

In the behavioural model of depression it is postulated that the decrease in the proportion of positive reinforcement contingent on behaviour plays a fundamental role as a triggering stimulus for depressive behaviours (Lewinsohn, Youngren and Grosscup, 1979). In accordance with this assumption, general difficulties as regards social skills for obtaining the available social reinforcement have been associated with depression (Lewinsohn, Mischel, Chaplin and Barton, 1980), as have deficiencies in assertive behaviour (Raich, Carregal, Hernández and Sánchez, 1987; Sánchez v Lewinsohn, 1980). This approach has given rise to the therapeutic proposal presented in the book *Control your depression* (Lewinsohn, Muñoz, Youngren and Zeiss, 1986).

Although this perspective on depression is less developed than the cognitive approach, there is a wealth of material on the social behaviour of depressive people (Coyne, 1976; Lewinsohn, 1975; Lewinsohn *et al.*, 1979; Rosenblatt and Greenberg, 1991; Sanz and Graña,

1991). It has even been found that measures of social skills predict subsequent depression (Wierzbicki, 1984). Other studies show that depressive subjects tend to be more sensitive to aversive social contingencies than control groups of normal and psychiatric subjects (Lewinsohn and Amenson, 1978; Lewinsohn, Lobitz and Wilson, 1973; Lewinsohn *et al.*, 1980). This means that these subjects perceive the consequences of negative social interaction (for example, being criticised or disagreed with) in a more aversive way than normal and psychiatric subjects.

According to Lewinsohn and his co-workers, once the subject fails to emit an adaptive pattern of social behaviour, a decrease is generated in the reinforcement contingent on this behaviour which, in the event of being perpetuated, may intensify the depressive state, giving rise to a vicious circle that is difficult to break. In this sense, in the interactive model of depression it is proposed that depressive behaviours generate negative reactions in others, which serve as negative feedback for maintaining the depressive state (Coyne, 1976). Coyne has shown that problematic social behaviour of depressive subjects (or with predisposition to depression) generates rejection by the social environment. However, the rejection is subtle: the depressive person (probably through his/her passive complaints) elicits feelings of guilt in others who, consequently, instead of responding in an openly hostile manner, offer non-genuine verbal support (Rosenblatt and Greenberg, 1991). The depressive person realises that he/she is not truly accepted, and consequently tries to control others' behaviour, generating more symptoms and expressing more affliction. The inconsistent and partial reinforcement generated by these behaviours makes them difficult to extinguish. Thus, reinforcement is very probably taking place, but in order to increase non-adaptive patterns of behaviour. Nevertheless, contradictory results with this approach have also been found in studies that do not find the phenomenon of negative feedback in depressive subjects (King and Heller, 1984; MacNeil, Arkowitz and Pritchard, 1987).

#### ***Implications of the exposed models for the treatment of depression***

The models described are those that have generated most research on depressive reactions, being mainly

focused on the study of the factors that facilitate or favour this type of reaction. It may occur, and the results reviewed are consistent with this, that different subjects present equally depressive behaviour controlled by different factors (Staats and Heiby, 1985). While the phenomenological nature of the depressive disorder may be similar (distorted thoughts, feelings of inferiority, low level of activity), both the distal environmental factors responsible for the onset of these reactions and, in turn, the proximal factors responsible for their taking root and continuing (for example, negative attributional style or deficiencies in social skills) may be different, and thus require the distinction of different types of depression. These types may predict the response to different types of treatment. It is on this basis that we can interpret the findings indicating that different treatments may be dealing with different levels, or dimensions, of the disorder (Maldonado, 1984; Polaino, Barcelo and Maldonado, 1991).

The classification of depressive behaviours should be made precisely on the basis of the factors that predict the effectiveness of therapy. In sum, we feel it necessary to resolve the existing contradictions between the theoretical-methodological assumptions of clinical psychology (determining the treatment according to the particular characteristics of each disorder) and its practice (the increasingly widespread design and use of multi-component programmes).

Within this conceptual framework, the study presented here is aimed at testing whether the results of treating mild depression or dysphoria depend on whether or not the treatment is matched with the type of depression suffered by the subject. The results are considered on the basis of effects on depression measures and on anxiety level of subjects. Since we postulate that the differential effectiveness of treatments depends on their modifying the variables that lead to the development of depressive episodes, we consider it advisable to test our hypothesis on subjects with mild depression or dysphoria, in whom it is less probable that there is a conjunction of factors which, in continuous interaction, require a more complex type of treatment. We leave, therefore, for future research the study of those variables on which we should take action to avoid the intensification of depressive behaviours and relapses.

## METHOD

### *Subjects*

The total sample of participants in this study was made up of 236 adolescents in secondary/further education, 97 of whom were male and 139 female. Mean age was 15 years 5 months, the age range being 14-23 years.

### *Materials and procedure Assessment instruments*

(a) *Depression*. To evaluate the depressive state, we used the *Centre for the Epidemiological Study of Depression Scale* (CES-D) constructed by Radloff (1977), which includes the following factors: (1) Somatic disorders, (2) Depressed affect, (3) Positive affect, and (4) Interpersonal problems. Subjects are requested to indicate the frequency with which they experienced each symptom during the previous week. Responses are assessed on a 4-point scale that ranges from "rarely or not at all (less than once a day)": 0, to "most or all of the time (5-7 days)": 3. This scale of 20 items has been used successfully to assess depressive symptoms in adolescents (Compass, Ey and Grant, 1993; Gotlib, Lewinsohn and Seeley, 1995). Its alpha coefficients range from .84 to .90, and its four-factor structure has been sufficiently endorsed (Joseph and Lewis, 1995). The total scores have a range of 0 to 60 points, with 17 or more being taken to indicate "possible" depression, and 23 or more "probable" depression. However, some authors recommend reducing the cut-off scores in order to decrease the frequency of false negatives (Myers and Weissman, 1980). Thus, in order to select dysphoric subjects, we used the mean in depression of the sample under study (Mean: 14.10 points; S.D.: 8.39).

We also used *Beck's Depression Inventory* (BDI), designed by Beck *et al.* (1979) to assess the seriousness of the depressive symptoms and their response to treatment, specifically, its Spanish adaptation, composed of 19 items (Conde, Esteban and Useros, 1976).

(b) *Attributional style*. Attributional style was assessed by means of the Attributional Style Questionnaire (ASQ) of Seligman, Abramson, Semmel and Von Baeyer (1979) and Peterson, Semmel, Von Baeyer, Abramson, Metalsky and Seligman (1982). We used the version of Vázquez, Avia, Alonso and Fernández (1989), in which to the original dimensions (internal-external, stable-unstable and global-specific) they add

the dimensions controllable-uncontrollable and personal-universal. These attributional dimensions were assessed only for negative events, since these correlate more strongly with depressive affect than positive events (Raps, Peterson, Reinhard, Abramson and Seligman, 1982; Seligman *et al.*, 1979; Sweeney, Anderson and Bailey, 1986). To adapt the situations of the scale to our population of adolescents we carried out a pilot study on 198 adolescent students, with similar characteristics to the sampled subjects, who were asked to write down all those events that had given them bad feelings over the last two years. We found the following events to be those most frequently mentioned, and consequently it was these that made up the final scale:

1. You spend some time worrying about school marks.
2. You fail a subject.
3. Your father punishes you and scolds you for something that has happened.
4. You have some problem at home (such as an argument with a member of your family).
5. You have to repeat a school year.
6. You have an accident.
7. You have an argument with a friend.
8. You have a disappointment in love.
9. You have a problem with a teacher.
10. You lose someone's friendship.
11. Your pet dies.

The final score of the scale is obtained by including only the responses about those events that subjects consider important for themselves, operationalised in a score of 5 points on a scale that ranges from "no importance" (1 point) to "very important" (7 points).

(c) *Social skills*. To assess this variable we used the College Self-Expression Scale (CSES; Galassi, Deleo, Galassi and Bastien, 1974), in its Spanish adaptation by Caballo and Carrobes (1987). This scale was chosen as it concentrated specifically on subjects' self-assertion. It assesses three types of behaviour: positive expression, negative expression and negative consideration of oneself. The people-stimuli to which the scale refers are: strangers, figures of authority, family and relatives, and peers of both sexes.

(d) *Anxiety*. The *Stimulus-Response Inventory of Anxiousness* (S-R) of Endler, Hunt and Rosenstein (1962) and Endler and Okada (1975) consists of 11 potentially anxiety-inducing situations (involving inter-

personal threat, physical harm and ambiguous or novel situations), and 14 questions asking about the anxiety reactions of the subject faced with each of the situations presented. Specifically, three modalities of answer were considered: (1) fear, hindrance and avoidance; (2) optimism, joy and approach; and (3) autonomic reactions.

(e) *Questionnaire for the assessment of various disorders according to the criteria of the DSM III-R*. A questionnaire was developed from the DSM III-R (APA, 1987) for the assessment of anxiety disorder, severe depression, obsessive-compulsive reactions and addiction (current or previous) to drugs or alcohol.

#### ***Procedure used for the selection of subjects to be involved in the treatment conditions***

The subjects to be employed were chosen in the following way. A first selection was made on the basis of those who obtained scores of 14 points or more on the CES-D. From this group we selected those who fulfilled the criteria for the formation of the two groups *cognitive dysphoric* and *behavioural dysphoric*. In the case of the *cognitive dysphoric* group, these criteria were the following: (a) showing a negative style of causal explanation (scores higher than 0.25 standard deviations above the mean of the sample in the ASQ); and (b) absence of deficiencies in social skills (scores lower than 0.25 standard deviations below the mean of the sample in the CSES). Following the same criteria, the behavioural dysphoric group was made up of subjects who presented: (a) an intact attributional style, and (b) deficiencies in social skills. A previous study (Rodríguez-Naranjo and Godoy, 1996) lent support to the formation of these two groups on the basis of, among others, the following results: (a) Attributional style (ASQ) and social skills (CSES) demonstrated significant and independent predictive power for the scores in mild depression or dysphoria. (b) Other variables classically associated with depression, such as self-esteem, negative life events and anxiety were not found to associate significantly with the scores in dysphoria. (c) Dysphoric subjects that did not present deficiencies in either causal attributions or in social skills did not attain the criterion of mild depression in the BDI, and those who presented deficiencies in the two variables were the ones that scored highly on this depression scale. (d) The most interesting finding in this study was that subjects who pre-

sented deficiencies in causal attribution style, but not in social skills (*cognitive dysphoric* group), reported having experienced a significantly greater number of important negative life events than those subjects with deficiencies in social skills, but with an intact attributional style (*behavioural dysphoric* group). This latter group presented the same scarcity of negative life events as the non-dysphoric subjects. These findings, obtained in two independent samples of dysphoric adolescents, allowed us to differentiate two types of dysphoria, in line with the suggestions of Alloy *et al.* (1988).

In the current study, then, we follow the same criteria for the formation of the groups *cognitive dysphoric* and *behavioural dysphoric*. Of all the subjects of the sample assigned to one group or the other, we discarded those who, according to the criteria of the DSM-III R, suffered from any of the following disorders: anxiety disorder, severe depression, obsessive-compulsive reactions and addiction (current or previous) to drugs or alcohol. Also discarded were subjects that had received psychological or psychiatric treatment at some point in their lives, and those who had suffered serious physical disorders. Lastly, we excluded those subjects that the BDI indicated were considering suicide and those that were unwilling to participate in the treatment.

**Design used to constitute the treatment conditions**

The final sample, used for comparing the effectiveness of matched and non-matched treatments with the two types of mild depression or dysphoria described above, was made up of 30 subjects (9 males and 21 females) ranging in age from 14 to 23 years (mean age: 15.50; S.D. = 1.74). Subjects were randomly assigned to one of the two following conditions: (a) matched treatment condition (*cognitive dysphoric* group treated with cognitive therapy and *behavioural dysphoric* group treated with behavioural therapy) (n = 14); and (b) non-matched treatment condition (*cognitive dysphoric* group treated with behavioural therapy and *behavioural dysphoric*

group treated with cognitive therapy) (n = 16) (Table 1). The respective analyses were carried out on the subjects who responded to the scales completely: 30 subjects for the scale CES-D; 29 subjects for the scale BDI (matched treatment: 14; non-matched treatment: 15); and 19 subjects on the scale S-R (matched treatment: 9; non-matched treatment: 10).

**Procedure carried out for the application of the cognitive and behavioural therapies**

For the application of the treatments, two groups of cognitive therapy were formed, and another two of behavioural therapy, each consisting of 7 or 8 subjects, mixed with regard to type of dysphoria, cognitive or behavioural. Both those subjects undergoing cognitive therapy and those undergoing behavioural therapy had weekly meetings with two therapists over a period of eight weeks. The therapists were blind with respect to the experimental conditions.

*Cognitive therapy.* The modification of the depressive style of causal explanation has received very little attention from the clinical perspective, such attention being limited, in terms of treatment for depression, to the reattribution strategies suggested by Beck in his therapeutic procedure. This procedure has, however, been carried out in the experimental literature on achievement motivation (Försterling, 1980; Seligman, 1981).

In applying attributional retraining to those subjects with mild depression, our basic objective was that they learn to formulate adaptive causal explanations for negative events. To this end, we proceeded with the following phases: (1) Subjects were provided with a cognitive explanation of emotional distress (Evans and Hollon, 1988). (2) The target situations of the treatment were determined (e.g., arguments with family and friends, disappointments in love, failing or having to repeat school subjects or years, etc.). We reviewed the causal explanations most frequently formulated by subjects about negative situations and analysed them on the basis of the attributional dimensions: internality, uncontrollability, stability and globality. (3) We analysed the evidence for maintaining these causal interpretations about the target situations. Possible alternative interpretations were suggested and discussed with subjects. The process included the elements: (a) moving from internal causal explanations to external ones; (b) moving from internal

Table 1 Assignment of subjects to the treatment conditions "matched and non-matched with type of dysphoria"		
	Cognitive dysphoric group	Behavioural dysphoric group
Cognitive therapy group	7 subjects (matched treatment condition)	9 subjects (non-matched treatment condition)
Behavioural therapy group	7 subjects (non-matched treatment condition)	7 subjects (matched treatment condition)

and uncontrollable explanations with internal foundations (e.g., “I’m to blame for having failed”) to internal and controllable ones (“I failed because I didn’t study enough”); (c) moving from stable explanations to unstable ones; and (d) moving from global explanations to specific ones. In cases where the attributed internal cause is considered pertinent, the objective is for subjects to perceive this cause in terms of another, more adaptive dimension (for example, “they argued because I argued with them”, moving from the global pole, “I always argue with everybody”, to the specific pole, “on that occasion I argued with them”). (4) We analysed and discussed the negative conclusions derived from the non-adaptive causal explanations, mainly those related to self-blame and self-criticism (Beck *et al.*, 1979). With respect to point (d) above, we analysed how global explanations tend to lead to negative general conclusions (for example, “my failures are due to my general lack of ability, so I’ll probably fail in everything I do” to “I think I’m a failure”). (5) Lastly, we analysed the positive consequences of formulating alternative interpretations (external, controllable, unstable and/or specific) for negative events. Following the previous example, if failures are something specific that have a series of specific causes (what these causes may be are determined with the active cooperation of the subjects), the subject will not expect to fail in other activities. This is an interactive process in which, following the example, we move again to point (4), asking subjects to formulate examples of other negative conclusions that can be drawn from failing an exam or getting bad marks, analysing the implicit attributional dimensions, generating alternatives and reassessing the previous conclusions.

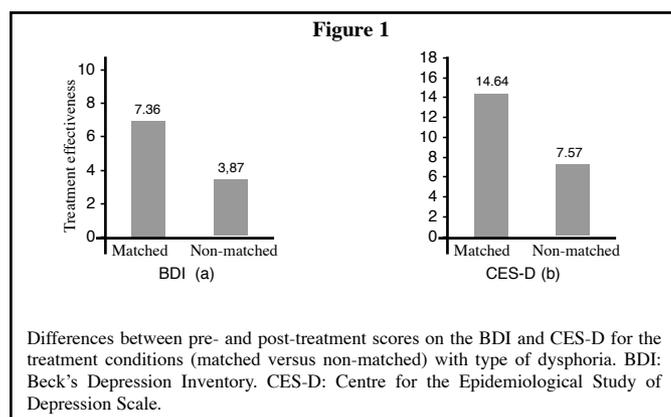
*Behavioural therapy.* This consisted in carrying out training in coping skills for social interaction situations,

giving particular importance to training in social skills. Specifically, the techniques used were those deriving from the work of Lewinsohn, Biglan and Zeiss (1976) for training in social skills, which have been shown to be effective for the treatment of depressive reactions (Antonuccio, Ward & Tearnan, 1989; Reed, 1994). The procedure consists of the following elements: (1) The social skills basis is explained as the cause of the emotional distress. (2) The target behaviour is determined. (3) The target behaviour is modelled and practised. (4) Feedback and reinforcement from the group is implemented after the realisation of the target behaviour. These steps are carried out for the training of the following behaviours: giving and receiving affection and praise, making and rejecting requests, dealing with criticism, initiating and maintaining conversations, and dealing with intimate relationships. Also included were skills of assertive acceptance and expression of positive feelings for increasing the social support received by subjects (Henderson, 1974).

Both procedures being directed towards the treatment of subjects with mild depression, the treatment programme has a marked didactic character; consequently, it is carried out without the inclusion of “homework” tasks.

## RESULTS

To assess the differential effectiveness of matched and non-matched treatments for the specific type of mild depression or dysphoria presented by subjects, we carried out an ANOVA for each depression measure (BDI and CES-D) separately. The ANOVA was used in a mixed design of two factors with repeated measures in one of them. One factor was treatment condition (matched *versus* non-matched) and the second was constituted by the treatment phase (pre- *versus* post-treatment). Thus, in the case of differences in effectiveness occurring between the matched and non-matched treatments, these would be produced by the interaction of the two factors. The results obtained show that the interaction is very close to statistical significance in the case of the BDI ( $F(1,27) = 3.81, p = .06$ ), and statistically significant for the scores on the CES-D ( $F(1,28) = 4.09, (p \leq .05)$ ). Figure 1 shows the differences between pre- and post-treatment scores for the BDI and CES-D, in the two treatment conditions.



Lastly, we carried out the same type of analysis to determine whether treatment condition (matched *versus* non-matched) affected subjects' anxiety. The results show a decrease in anxiety after the matched treatment, whilst the non-matched treatment was seen to produce a slight increase in these reactions. However, these differences were not statistically significant ( $F(1,17) = 2.69$ ,  $p = .12$ ).

## DISCUSSION

The results of this study allow us to draw a series of conclusions. Firstly, subjects with dysphoria or mild depression appear to improve differentially according to whether they undergo treatment that is matched or non-matched with the type of mild depression from which they suffer. As expected, the dysphoria of those subjects to whom the treatment matched with the dysphoric state was applied decreased significantly more than that of those subjects to whom the non-matched treatment was applied, at least as it is measured by the CES-D.

These results are concordant with the latest predictions of the reformulated model of learned helplessness in that the style of causal attribution is a predominant factor for a depression type (Abramson *et al.*, 1989), in our study mild depression or dysphoria, referred to as cognitive. The results obtained also support previous findings about the role played by social skills for predicting depressive reactions (Lewinsohn, 1975). The differential effectiveness for decreasing dysphoria of attributional training, on the one hand, and of social skills training, on the other, according to the presence or absence of deficiencies in these factors, supports our distinguishing of two types of mild depression or dysphoria (Rodríguez-Naranjo and Godoy, 1996).

Following García Hurtado, Fernández-Ballesteros, Montero and Heiby (1995), and in terms of the paradigmatic behavioural theory (Heiby and Staats, 1990; Staats and Heiby, 1985), the deficiencies in social skills of dysphoric subjects may be constituted in the sensory-motor repertoire and the negative attributional style in the linguistic-cognitive repertoire, which respectively trigger two different types of dysphoria, which in turn respond differentially to therapy. We also feel that this approach might be complemented by the distinction between proximal and distal causes of depression, made by Alloy *et al.* (1988), since this

approach allows a better understanding of the development of depressive reactions. Thus, the interaction of negative life events with depressive attributional style (distal causes) permits us to predict the probable appearance of a specific type of mild depression or dysphoria, which we call *cognitive dysphoria*, and to differentiate it from another type generated by deficiencies in social skills, which we call *behavioural dysphoria* (Rodríguez-Naranjo and Godoy, 1996). Other types of proximal causes, such as expectations of lack of control over one's own depressive reactions, may prolong or exacerbate depressive reactions. Teasdale (1985) refers to this as *depression about depression*, and emphasises the important repercussions of this factor for therapy. In this case we would not be speaking, then, about factors that lead to dysphoria, but rather about factors that contribute to depressive behaviours being maintained, or even aggravated.

The vicious circle that appears to constitute clinical depression means that it is very difficult to make valid generalisations about clinical depressives from research carried out with students that present subclinical depression or dysphoria (Coyne, 1994; Fechner-Bates, Coyne and Schwenk, 1994). Without contradicting the above, this study was carried out on the assumption that the differential factors that predispose people to depression should be studied in subjects with low levels of depression, followed, ideally, by longitudinal studies. Consequently, the study of the effectiveness of treatment for mild depression ceases to be a mere analogy of clinical research and becomes a study carried out under real treatment conditions.

In conclusion, these results demonstrate the usefulness of distinguishing different types of depression, at least where mild depression or dysphoria is concerned. The fact that we have identified predictive, and possibly determinant, factors of two types of mild depression has helped us to clarify some of the factors on which the effectiveness of different treatment strategies depends. As early as the 1950s it was suggested that if the experimental method could be applied to the clarification of the basic causal factors underlying functional abnormalities, then, evidently, the same techniques (aimed at the experimental manipulation of these factors) could be applied to changing the abnormal behaviour (Yates, 1970).

Today, research has developed from the study of specific cases to levels of more generalisability when making predictions about change. Thus, studies that identify factors of vulnerability or risk for suffering from future disorders are more and more frequent. The next step in our work must therefore be to test whether treatments matched with a type of dysphoria are also more effective than non-matched treatments for preventing subjects demonstrating high-risk characteristics from developing depressive behaviour in the future, both in the school context and in that of institutions whose purpose is to promote health. This is an area in which great advances can, and should, be achieved in coming decades.

## REFERENCES

- Abramson, L. Y., Metalsky, G. and Alloy, L. B. (1989). Hopelessness depression: A theory-based subtype of depression. *Psychological Review*, 96, 358-372.
- Alloy, L. B., Abramson L. Y., Metalsky, G. I. and Hartlage, S. (1988). The hopelessness theory of depression: Attributional aspects. *British Journal of Clinical Psychology*, 27, 5-21.
- Alloy, L. B., Lipman, A. J. and Abramson, L. Y. (1992). Attributional style as a vulnerability factor for depression: Validation by past history of mood disorders. *Cognitive Therapy and Research*, 16, 391-407.
- American Psychiatric Association (APA) (1987). *Diagnostic and statistical manual of mental disorders: DSM III-R*. (3. ed. rev.). Washington, D. C.: APA. (Spanish version: Masson, Barcelona, 1988).
- Antonuccio, D. O., Ward, C. H. and Tearnan, B. H. (1989). The behavioral treatment of unipolar depression in adult outpatients. In M. Hersen, R. M. Eisler and P. M. Miller (Eds.). *Progress in Behavior Modification, Volume 24* (pp. 152-191). Newbury Park: Sage Publications.
- Barnett, P. A. and Gotlib, I. H. (1988). Psychosocial functioning and depression: Distinguishing among antecedents, concomitants and consequences. *Psychological Bulletin*, 104, 84-96.
- Beck, A. T. (1967). *Depression: Clinical, experimental and theoretical aspects*. New York: Harper & Row.
- Beck, A. T., Rush, A. J., Shaw, B. F. and Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press. (Spanish version: Descleè de Brouwer, Bilbao, 1983).
- Buceta, J. M. and Polaino-Lorente, A. (1982). *Reformulación del modelo de "Learned Helplessness" desde el punto de vista de la psicología atribucional* (Reformulation of the "learned helplessness" model from the perspective of attributional psychology). *Revista de Psicología General y Aplicada*, 37, 13-29.
- Brewin, C. R. (1985). Depression and causal attributions: What is their relation? *Psychological Bulletin*, 98, 297-309.
- Caballo, V. E. and Carrobbles, J. A. I. (1987). *Adaptación de la escala "The College Self-Expression Scale (CSES)"* (Adaptation of the CSES) of Galassi, Deleo, Galassi and Bastien (original version from 1974). In R. Fernández-Ballesteros and J. A. I. Carrobbles (Eds.), *Evaluación conductual*. Madrid: Pirámide.
- Compas, B. E., Ey, S. and Grant, K. E. (1993). Taxonomy, assessment and diagnosis of depression during adolescence. *Psychological Bulletin*, 114, 323-345.
- Conde, V., Esteban, T. and Useros, E. (1976). *Revisión crítica de la adaptación castellana del Cuestionario de Beck* (Critical review of the Spanish adaptation of Beck's questionnaire). *Revista de Psicología General y Aplicada*, XXXI (140), 469-497.
- Coyne, J. C. (1976a). Depression and the response of others. *Journal of Abnormal Psychology*, 85, 186-193.
- Coyne, J. D. (1976b). Toward an interactional description of depression. *Psychiatry*, 39, 28-40.
- Coyne, J. C. (1994). Self-reported distress: analog or ersatz depression? *Psychological Bulletin*, 116, 29-46.
- Endler, N. S., Hunt, J. and Rosenstein, A. J. (1962). An S-R Inventory of Anxiousness. *Psychological Monographs: General and Applied*, 536.
- Endler, N. S. and Okada, M. A. (1975). A multidimensional measure of trait anxiety: The S-R Inventory of general trait anxiousness. *Journal of Consulting and Clinical Psychology*, 43, 319-329.
- Ellis, A. (1962). *Reason and emotion in psychotherapy*. Secaucus, NJ: Lyle Stuart. (Spanish version: Descleè de Brouwer, Bilbao, 1980).
- Ellis, A. and Grieger, R. (1977). *Handbook of rational-*

- emotive therapy*. New York: Springer. (Spanish version: Desclèe de Brouwer, Bilbao, 1981).
- Ellis, A. (1987). A sadly neglected cognitive element in depression. *Cognitive Therapy and Research* 11, 121-146.
- Evans, M D. and Hollon, S. D. (1988). Patterns of personal and causal inference: Implications for the Cognitive Therapy of Depression. In L. B. Alloy (Ed.). *Cognitive Processes in Depression (1<sup>st</sup>. Ed)*, (pp. 344-377). New York: Guilford Press.
- Fechner-Bates, S., Coyne, J. C. and Schwenk, T. L. (1994). The relationship of self-reported distress to depressive disorders and other psychopathology. *Journal of Consulting and Clinical Psychology*, 62, 550-559.
- Feinberg, M. (1992). Comment: Subtypes of depression and response to treatment. *Journal of Consulting and Clinical Psychology*, 60, 670-674.
- Försterling, F (1980). Attributional aspects of cognitive behavior modification: A theoretical approach and suggestions for techniques. *Cognitive Therapy And Research*, 4, 27-37.
- Galassi, J. P., Deleo, J., Galassi, M. D. and Bastien, S. (1974). The College Self-Expression Scale: A measure of assertiveness. *Behavior Therapy*, 5, 165- 171.
- Garber, J., Miller, W. R. and Seaman, S. F. (1979). Learned helplessness, stress and the depressive disorders. In R. A. Depue (Ed.), *The Psychobiology of the Depressive Disorders: Implications for the Effects of Stress*, (pp. 335-364). New York: Academic Press.
- García Hurtado, J., Fernández-Ballesteros, R., Montero, I. and Heiby, E. M. (1995). Multiple correlates of unipolar depression: contributions from the paradigmatic behavioral theory. *Psicothema*, 7, 41-50.
- Gotlib, I. H., Lewinsohn, P. M. and Seeley, J. R. (1995). Symptoms versus a diagnosis of depression: differences in psychosocial functioning. *Journal of Consulting and Clinical Psychology*, 63, 90-100.
- Heiby, E. M. and Staats, A. W. (1990). Depression and its classification. In G. Eifert and I. Evans (Eds.), *Paradigmatic Behavioral Therapy*, New York: Springer.
- Henderson, S. (1974) Care-eliciting behavior in man. *Journal of Nervous and Mental Disease*, 159, 172-181.
- Joseph, S. and Lewis, C. A. (1995). Factor analysis of the Center for Epidemiological Studies-Depression scale. *Psychological Reports*, 76, 40-42.
- Kendall, P. D. and Korgeski, G. P. (1979). Assessment and cognitive behavioral intervention. *Cognitive Therapy and Research*, 3, 1-21.
- King, D. A. and Heller, K. (1984). Depression and the responses of others: A re-evaluation. *Journal of Abnormal Psychology*, 93, 477-480.
- Lewinsohn, P. M. (1975). The behavioral study and treatment of depression. In M. Hersen, R. M. Eisler and P. M. Miller (Eds.), *Progress in Behavior Modification*. Vol. I, New York: Academic Press.
- Lewinsohn, P. M. and Amenson, C. S. (1978). Some relations between pleasant and unpleasant mood-related events and depression. *Journal of Abnormal Psychology*, 87, 655-664.
- Lewinsohn, P. M., Lobitz, W. C. and Wilson, S. (1973). "Sensitivity" of depressed individuals to aversive stimuli. *Journal of Abnormal Psychology*, 81, 259-263.
- Lewinsohn, P. M., Mischel, W., Chaplin, W. and Barton, R. (1980). Social competence and depression The role of illusory self-perceptions? *Journal of Abnormal Psychology*, 89, 213-219.
- Lewinsohn, P. M., Muñoz, R., Youngren, M. A. and Zeiss, A. (1986). *Control your depression* (rev. ed.). Englewood Cliffs, NJ: Prentice Hall.
- Lewinsohn, P. M., Steinmetz, J. L., Larson, D. W. and Franklin, J. (1981). Depression-related cognitions. Antecedent or consequence? *Journal of Abnormal Psychology*, 90, 213-219.
- Lewinsohn, P M., Youngren, M. A. and Grosscup, S. J. (1979). Reinforcement and depression. In R. A. Depue (Ed.), *The Psychobiology of Depressive Disorders: Implications for the Effects of Stress*, New York: Academic Press.
- MacNeil, D. E., Arkowitz, H. S. and Pritchard, B. E. (1987). The response of others to face-to-face interaction with depressed patients. *Journal of Abnormal Psychology*, 96, 341-344.
- Maldonado, A. (1984). *Terapia de conducta y depresión: "Un análisis experimental de las interacciones entre tratamientos cognitivos y conductuales con tratamientos farmacológicos en sujetos depresivos"*

- (Behavioural therapy and depression: "An experimental analysis of the interactions between cognitive and behavioural treatments with pharmacological treatment in depressed subjects"). *Revista de Psicología General y Aplicada*, 39, 517-535.
- Myers, J. K. and Weissman, M. M. (1980). Use of a self-report symptom scale to detect depression in a community sample. *American Journal of Psychiatry*, 137, 1081-1084.
- Peterson, C., Semmell, A., Von Baeyer, C. Abramson, L. Y. Metalsky, G. I. and Seligman, M. E. P. (1982). The Attributional Style Questionnaire. *Cognitive Therapy and Research*, 6, 287-299.
- Polaino, A., Barcelo, M. and Maldonado, C. L. (1991). *Versatilidad atribucional y tratamiento farmacológico de la depresión* (Attributional versatility and pharmacological treatment of depression). *Revista de Psiquiatría de la Facultad de Medicina de Barcelona*, 18, 173-184.
- Radloff, L. S. (1977). The CES-D scale: a self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385-401.
- Raich, R. M., Carregal, M. D., Hernández, L. and Sánchez, M. L. (1987). *Estudio sobre creencias irracionales, asertividad y depresión en estudiantes universitarios* (Study on irrational beliefs, assertiveness and depression in university students). *Revista de Psiquiatría y Psicología Médica*, 18, 97-106.
- Raps, C. S., Peterson, C., Reinhard, K. E., Abramson, L. Y. and Seligman, M. E. P. (1982). Attributional style among depressed patients. *Journal of Abnormal Psychology*, 91, 102-108.
- Reed, M. K. (1994). Social skills training to reduce depression in adolescents. *Adolescence*, 29, 293-302.
- Rodríguez-Naranjo and Godoy (1996). Attributional style and social skills deficits as predictors of dysphoric states and response to treatment. Manuscript submitted for publication.
- Rosenblatt, A. and Greenberg, J. (1991). Examining the world of the depressed: Do depressed people prefer others who are depressed? *Journal of Personality and Social Psychology*, 60(4), 620-629.
- Sánchez, V. and Lewinsohn, P. M. (1980). Assertive behavior and depression. *Journal of Consulting and Clinical Psychology*, 48(1), 119-120.
- Sanz, J. and Graña, J. L. (1991). *Factores psicosociales y síntomas depresivos: El caso de la auto-observación* (Psychosocial factors and depressive symptoms: The case of self-observation). *Psicothema*, 3, 381-399.
- Seligman, M. E. P. (1975). *Helplessness: On depression, development, and death*. San Francisco: W. H. Freeman.
- Seligman, M. E. P. (1981). A learned helplessness point of view. In L. P. Rehm (Ed.), *Behavior Therapy for Depression. Present Status and Future Directions*. New York: Academic Press.
- Seligman, M. E. P. Abramson, L. Y. . Semmell, A. and Von Baeyer, C. (1979). Depressive attributional style. *Journal of Abnormal Psychology*, 88, 242-247.
- Smith, T. W. (1989). Assessment in rational emotive therapy: Empirical access to the ABCD model. In M. E. Bernard and R. DiGiuseppe (Eds.), *Inside Rational-Emotive Therapy. A Critical Analysis*. New York: Academic Press.
- Staats, A. W. and Heiby, E. M. (1985). Paradigmatic behaviorism's theory of depression: Unified, explanatory and heuristic. In S. Reiss and R. R. Bootzin (Eds.), *Theory Issues in Behavior Therapy*. Orlando, FL: Academic Press.
- Sweeney, P. D., Anderson, K. and Bailey, S. (1986). Attributional style in depression: a meta-analytic review. *Journal of Personality and Social Psychology*, 50, 974-991.
- Teasdale, S.D. (1985). Psychological treatments for depression. How do they work? *Behaviour Research and Therapy*, 23(2), 157-165.
- Vázquez, C., Avia, M. D., Alonso, B. and Fernández, E. (1989). A test of the diathesis-stress model of depression Attributional style as a predictor of dysphoric reactions after an academic failure. Communication presented to the 1st European Congress of Psychology, Amsterdam.
- Yates, A. (1970). *Behavior Therapy*. New York: Wiley. (Spanish version: Trillas, México, 1980).
- Wierzbicki, M. (1984). Social Skills Deficits and Subsequent Depressed Mood in Students. *Personality and Social Psychology Bulletin*, 10(4), 605-610.