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ABSTRACT

Delayed treatment following a waiting list period often occurs in both clinical practice and psychotherapy outcome research. While studies often compare the improvements made over a treatment and a comparable waiting list, studies seldom consider the relative efficacies of immediate and delayed treatment. In this study, 40 mildly depressed clients received individual cognitive-behavioral therapy either immediately or following a 6-week waiting period. Cognitive-behavioral therapy of depression was provided in a 6-week format by graduate student therapists. Subjects were assessed at the beginning of either the 6-week treatment or waiting period and again following treatment using the Beck Depression Inventory (BDI), the D30 Depression Scale, the Brief Symptom Inventory (BSI), and the State-Trait Anxiety Inventory (both the A-State and A-Trait forms). A multivariate repeated measures analysis of variance was conducted and revealed a significant time by treatment condition interaction. Subjects who received immediate therapy improved significantly more than did subjects who received delayed treatment as measured by scores on the BDI, BSI, and A-State, and nearly significantly more on the A-Trait. Implications for the effectiveness of brief therapy following a waiting list period are discussed. (Author/NB)

The Effectiveness of Immediate versus Delayed Cognitive-Behavioral Treatment of Depression

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Running Head: IMMEDIATE VERSUS DELAYED THERAPY

Abstract

Forty mildly depressed clients received individual cognitive-behavioral therapy either immediately or following a six-week waiting period. Cognitive-behavioral therapy of depression was provided in a six-week format by graduate student therapists. Subjects were assessed at the beginning of either the six-week treatment or waiting peri and again following treatment using the Beck Depression Inventory, the D30 Depression Scale, the Brief Symptom Inventory, and the State-Trait Anxiety Inventory (both the A-State and A-Trait forms). A multivariate repeated measures analysis of variance was conducted and revealed a significant time by treatment condition interaction. Subjects who received immediate therapy improved significantly more than subjects who received delayed treatment on the BDI, BSI, and A-State, and nearly significantly more on the A-Trait. Implications for the effectiveness of brief therapy following a waiting list period are discussed.

The Effectiveness of Immediate versus Delayed Cognitive-Behavioral Treatment of Depression

Delayed treatment following a waiting list period often occurs in both clinical practice and psychotherapy outcome research. Studies that employ waiting list controls compare the improvements made over a treatment and a comparable waiting period. Less often, however, do these studies consider the relative efficacies of immediate and delayed treatment.

Gordon and Cartwright (1954) reported that Rogerian therapy was more successful when delivered immediately than following a 60-day waiting period. Roth, Rhudick, Shaskan, Slobin, Wilkinson, and Young (1964), after a six-month evaluation of clients seen in a V. A. Hospital clinic, found that therapy delayed one month was less successful than immediate therapy. Uhlenhuth and Duncan (1968) found that the length of time between intake evaluation and the beginning of a six-week program with a medical student therapist was negatively correlated with therapeutic outcome, and was one of the single best predictors of negative outcome.

Several factors contribute to a need for continued investigation of the relative efficacies of immediate and delayed therapy. First, contemporary psychotherapy may differ from that offered in the studies by Gordon and Cartwright (1954), Roth et al. (1964), and Uhlenhuth and Duncan (1968), and so the results of these studies may not generalize to contemporary therapeutic practice. For example, while much therapy today is short-term and

directive, clients in the Gordon and Cartwright (1954) study averaged 33 sessions in nondirective therapy.

In addition, several recent studies have suggested, counter to the studies cited above, that immediate therapy may be no more effective than delayed therapy. Ely, Guerney, and Stover (1973) and Mehlman, Baucom, and Anderson (1983) found that delayed marital therapy was as effective as immediate marital therapy. Sifneos, Apfel, Bassuk, Fishman, and Gill (1980) reported that immediate short-term (9 to 20 sessions) dynamic psychotherapy was about as effective as such therapy following a delay of from two to five months. Sifneos et al. also reported the results of a pilot study which agreed that immediate and delayed therapy were about equally effective. Zeiss, Lewinsohn, and Munoz (1979) investigated short-term interpersonal, activity, and cognitive therapy of depression, and found that these treatments were equally effective when delivered immediately or following a one-month delay.

Finally, increased concern with the scientific evaluation of psychotherapy has led to widespread use of the waiting list control group in psychotherapy outcome studies (Gottman & Markman, 1978). Because waiting lists are already used in many clinics, they form a "natural" control group. Also, because clients on a waiting list are assured of receiving future treatment, they may show greater compliance than alternative control groups in completing pre- and post-assessments (Gottman & Markman, 1978).

The purpose of the present study was to examine the relative efficacies of immediate and delayed cognitive-behavioral treatment of mild depression. This treatment was structured, short-term, and equal in duration to the waiting period.

Method

Subjects

Subjects were recruited through advertisements placed in the local media. These advertisments stated that subjects were sought for a research program for the treatment of mild depression. The advertisements briefly summarized the inclusion and exclusion criteria which are described below.

Forty subjects were screened from about 60 respondents to the advertisements. Respondents were screened through a three-stage procedure. When individuals first telephoned the investigator to inquire about the project, they were given a brief description of the treatment program and a summary of the exclusion criteria listed below. Individuals who expressed continued interest in the treatment program and who denied meeting any of the exclusion criteria were scheduled for the second stage of the screening procedure. This consisted of a structured interview that was designed to assess the individual's prior psychiatric history and current symptoms. In the third screening stage, subjects were administered a questionnaire that assessed pre-treatment levels of depression and other symptomatology. Subjects in this study partially overlapped those in a previous study of the relative

efficacies of individual and group cognitive therapy of mild depression (Wierzbicki & Bartlett, 1986).

Respondents were considered for inclusion in the program if they: (a) were at least 18 years of age; (b) reported persistent symptoms of depression; and (c) scored between 12 and 35 on the Beck Depression Inventory (BDI; Beck, 1967). Most of the subjects met the DSM-III criteria for the diagnoses of Dysthymic Disorder or Atypical Affective Disorder (Dysthymic Disorder symptoms which were present for less than two years).

Respondents were excluded from further participation in the study if they met any of the following criteria: (a) currently in psychotherapy, or previously in therapy for more than four weeks; (b) currently taking any psychotropic medication, or previously having taken any for longer than three weeks; (c) previous history of suicide attempts, or expressed current suicidal ideation; (d) presence of another psychiatric disorder in addition to depression, or a history of previous psychiatric problems.

These exclusion criteria served two purposes. First, they ensured that subjects were depressed and not experiencing some other psychiatric problem. Second, they ensured that subjects were not severely depressed nor potentially dangerous to themselves. Individuals who met any of the exclusion criteria were referred to a community treatment center.

Twenty subjects received immediate therapy, and twenty

subjects received delayed therapy. Subjects were not randomly assigned to treatment conditions. Subjects were assigned to immediate treatment until immediate openings were filled; subsequently, subjects were assigned to delayed treatment unless an opening arose for immediate treatment. Following the waiting period, all delayed therapy subjects received individual cognitive-behavioral treatment of depression.

Therapists were nine graduate students enrolled in an M.A. program in Psychology. Therapists each met with four or five clients. All subjects were randomly assigned to therapists. Therapists were blind to the nature of the exact hypotheses of the study.

Therapy was based on Beck's cognitive treatment of depression (Beck, Rush, Shaw, & Emery, 1979). In order to ensure that all clients in both formats received the same treatment, a cognitive therapy program designed by Emery (1982) was employed. This treatment program provides cognitive as well as behavioral methods for managing depression. The program contains audio tapes and manuals for the instruction of both clients and therapists, and forms for structured homework assignments. Emery's program was tailored so that all therapeutic tasks could be presented in six therapy sessions. This structure was then followed in both therapy formats. Individual sessions lasted 60 minutes and were scheduled once a week for six weeks.

Following the sixth therapy session, subjects were given a

packet of materials to complete at home and return through the mail. This packet contained the post-treatment assessment questionnaires.

Materials

A questionnaire was administered during the initial screening of subjects to determine their pre-treatment level of functioning. This questionnaire was again administered to the delayed treatment group subjects following the six-week waiting period to assess improvement during that period. This questionnaire contained the following instruments: the BDI, the D30 (Dempsey, 1964), the revised State-Trait Anxiety Inventory (STAI; Spielberger, Vagg, Barker, Donham, & Westberry, 1980), and the Brief Symptom Inventory (BSI; Derogatis & Spencer, 1982).

The BDI was administered because it has been shown to have sufficient reliability and validity (Beck, 1967), has been reported to be sensitive to clinical changes in studies of the treatment of depression (e.g., Rehm & Kornblith, 1979), and is one of the most widely used measures of depression in both research and clinical practice (Rehm, 1981).

The D30 was administered as a second measure of depression. Its reliability and validity have been documented by Dempsey (1964). The D30 was derived from the MMPI Depression scale, and was developed for use within a normal population. The D30 was used in the present study because subjects were selected on the basis of experiencing only mild levels of depression.

Both the A-State and the A-Trait forms of the revised STAI were administered to assess levels of both current distress and trait anxiety, since anxiety has often been reported to be correlated with depression in both patient and nonpatient samples (e.g., Gotlib, 1984). The reliability and validity of the original STAI have been demonstrated by its developers (Spielberger, Gorsuch, & Lushene, 1970), and the items of the revised STAI have been reported to have psychometric properties superior to those of the original items (Spielberger et al., 1980).

The BSI is a self-report questionnaire which requires subjects to rate the degree to which each of 53 symptoms is present. Derogatis and Spencer (1982) provided reliability and validity data on the instrument, as well as scores for normal, outpatient, and hospitalized psychiatric populations. The BSI was included in this study to obtain a global index of symptom level or subjective distress. Though scores for various subscales can be obtained, only the Total score was used.

Results

Because some of the subjects in the delayed therapy condition had not been randomly assigned, a preliminary analysis was conducted to determine whether subjects in the immediate and delayed treatment conditions were equivalent on the five pre-measures. A multivariate analysis of variance determined that the two treatment groups did not differ significantly at the

beginning of the study, $F(5, 34) = 1.84$, n.s. Means and standard deviations of the two treatment groups on the five pre-measures are presented in Table 1.

Insert Table 1 about here

A repeated measures multivariate analysis of variance was conducted to determine whether subjects in the two treatment conditions improved to different degrees on the five outcome measures. This analysis indicated that there was a significant treatment by time interaction, $F(5,34) = 5.90$, $p<.01$. Univariate tests indicated that subjects in the immediate treatment condition improved significantly more than did subjects in the delayed treatment condition on the BDI, $F(1, 38) = 4.42$, $p<.01$, the BSI, $F(1,38) = 15.04$, $p<.01$, and the A-State, $F(1, 38) = 4.32$, $p<.05$, and nearly significantly more on the A-Trait, $F(1, 38) = 3.78$, $p<.06$. Means and standard deviations of subjects in the two treatment conditions on the five post-treatment measures are also presented in Table 1.

Discussion

This study found that immediate short-term cognitive-behavioral therapy of mild depression was more effective than such treatment following a delay equal in length to the treatment period. Greater improvements were produced by immediate treatment in depression, anxiety, and other symptoms of distress.

This finding is significant in that it is consistent with reports of the relative efficacies of immediate and delayed psychodynamic and client-centered therapies (Gordon & Cartwright, 1954; Roth et al., 1964; Uhlenhuth & Duncan, 1968), although it does contrast the results of one investigation of immediate and delayed short-term treatment of depression (Zeiss et al., 1979).

This finding is also significant in that it produced a result that some might regard as counterintuitive. Because time alone, or what has been termed "spontaneous remission," is often sufficient to produce improvement in clinical disorders (e.g., Bergin & Lambert, 1978), one might expect that time plus treatment would be more effective than treatment alone. However, in this study, treatment alone was found to be more effective than time followed by treatment.

That immediate treatment has been found to be more effective than delayed treatment for both traditional and now for cognitive-behavioral treatments suggests that the finding is robust and worthy of further investigation. Future studies should attempt both to replicate the result and to determine the reasons for the greater effectiveness of immediate therapy.

Several explanations have been proposed for the greater effectiveness of immediate over delayed treatment. Gordon and Cartwright (1954) suggested that waiting list clients may develop feelings of resentment toward the clinic, which may adversely affect their relationship with a therapist and their

cooperativeness in therapy. This suggestion might be tested by examining the effect of being placed on a waiting list on later indices of compliance, such as regular attendance of sessions, compliance with weekly homework assignments, or dropping out of treatment altogether.

Uhlenhuth and Duncan (1968) recognized that some clients remit "spontaneously" during the waiting period. Actually, these clients have either responded to informal therapeutic influences or have recovered from a time-limited disorder. If a client is still interested in receiving therapy following a waiting period, the client has not responded to such informal therapeutic influences or to time alone. Thus, clients who receive delayed treatment have been selected on the basis of being more resistant to therapeutic influences than other clients, and so they would not be expected to respond to later therapy as successfully as other clients. This explanation does not account for the observed difference in effectiveness between immediate and delayed treatment in the present study for two reasons. All subjects placed in the waiting list condition later participated in treatment, and so the subjects in the delayed treatment condition were not more severely disturbed than the subjects in the immediate treatment condition. Also, the results of this study cannot be accounted for by the possibility that the adjustment of delayed treatment subjects worsened over the course of the waiting period. Post hoc analyses determined that subjects in the delayed

treatment condition tended to improve over the waiting period, though nonsignificantly so, on outcome measures.

Lazare, Cohen, Jacobson, Williams, Mignone, and Zisook (1972) proposed a variant of a crisis model of clinical intervention to account for the greater effectiveness of immediate treatment. They suggested that, during a waiting period, a client may deal with the presenting problem in either a successful or a pathological manner. Clients who cope successfully no longer experience the presenting problem and so will refuse the delayed treatment. On the other hand, clients who deal with the problem in a pathological manner may become more resistant to later interventions.

This study suggested that short-term structured cognitive-behavioral treatment of mild depression was more effective when delivered immediately than when delivered following a delay equal in length to the treatment period. It is important to be aware that delayed treatment, common to both clinical settings and therapy outcome research, may be less effective than immediate treatment. Clinicians should be aware of the possible limitations of delayed therapy, and should make efforts both to minimize such delays and to investigate the phenomenon further. Further research should address the robustness of the finding, determine those treatments and delays which produce the phenomenon, and identify the mechanisms through which treatment delay interferes with therapeutic effectiveness.

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Table 1

Means and Standard Deviations of the Pre- and Post-Measures [a]

	Pre		Post	
Condition	M	SD	M	SD
Immediate				
BDI	18.30	5.74	7.65	5.42
D30	15.10	4.20	10.15	5.29
BSI	77.95	28.77	44.80	25.55
A-State	53.85	11.69	41.05	7.67
A-Trait	54.85	6.66	42.60	8.52
Delayed				
BDI	18.15	6.03	11.90	9.04
D30	17.10	3.77	11.00	3.64
BSI	72.25	28.14	62.50	33.23
A-State	48.50	10.81	45.00	9.81
A-Trait	51.10	9.10	44.30	8.76

[a] Pre-assessments were conducted at the time of admission to the study, before either the six-week immediate treatment or waiting period. Post-assessments were conducted following the treatment period, six weeks after the pre-assessment for the immediate treatment condition and 12 weeks after the pre-assessment for the delayed treatment group.