INSCOE, LAURA T. The Effect of Ego Assessment Training for School Counselors on the Outcome of Cognitive Behavioral Counseling for Female Adolescents Diagnosed as Clinically Depressed. (Under the direction of Professor S. B. Baker).

The purpose of the present study was to examine the relevance of ego development training for school counselors who integrated the knowledge acquired from the training into their treatment plans for female adolescent clients diagnosed as being clinically depressed. The participants were five female middle school counselors who volunteered to participate in the study and their five female middle school student clients diagnosed as clinically depressed who agreed, with the permission of their parents/guardians, to have the data associated with their treatments analyzed. The counselors were employed in several middle schools within a large metropolitan county school system in a southeastern state. The investigator selected the participating school counselors from a pool of volunteers based on their motivation to participate and level of counseling competence. The counselors ranged in age from 30 to 50 years, and all were White. The ages of the student clients covered a range of 11 to 14 years with two being White, two African Americans, and one Central American.

An intensive single-subject quantitative design replicated five times was employed in the present study. Following the selection process, the investigator conducted a formal standardized three-session training program for the five counselors. The training included learning how to integrate the results of the Beck Depression Inventory (BDI) and the Sentence Completion Test (SCT) into treatment plans for counseling clinically depressed clients that addressed symptoms of depression and ego development levels of the clients based on Loevinger’s theory. Each of the five counselors passed a knowledge test.
developed by the investigator at the close of the training and rated the training program high on a measure of confidence in the training itself.

Thereafter, the five counselors worked independently in dyads, each matched with one clinically depressed client for five counseling sessions lasting approximately 40 to 45 minutes. The investigator served as a mentor/coach to the counselors and monitored their adherence to the treatment plans. During the first counseling sessions, each of the five school counselors administered the BDI and SCT instruments. Thereafter, the BDI was used as a posttest measure of change in depressive symptoms over time, and the SCT data were used to determine if there were issues in the development of the adolescent clients that caused arrested ego development and integrated that information into a variety of cognitive-behavioral counseling strategies chosen to address the clients’ presenting symptoms. Each of the clients tracked their symptoms of depression in journals and on weekly self-monitoring forms, providing continuous behavior observation data over the duration of the treatments and the study.

Across the five replications, pre-to-posttest BDI data indicated decreases in symptoms of depression for all the clients; behavioral observation data indicated decreases in depressive thoughts and occurrences of presented symptoms; and the school counselors submitted favorable reports about the usefulness of the ego development training in their treatment planning and counseling techniques.

Internal validity for the findings was enhanced by the components of the research design that included a standardized training program for the counselors; supervision of the experimental process by the investigator; repeated observations that were planned before the beginning of the data collection; assessment of clearly defined cognitive, behavioral,
and affective process and outcome variables, and comparisons across the five replications of the design. Generalization may seem to be restricted to middle school-aged female clients treated by middle-aged female White counselors in large southeastern metropolitan school districts. On the other hand, external validity was enhanced by the five replications of the intensive single-subject design.
The Effect of Ego Assessment Training for School Counselors on the Outcome of Cognitive Behavioral Counseling for Female Adolescents Diagnosed as Clinically Depressed

by
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A dissertation submitted to the Graduate Faculty of North Carolina State University in partial fulfillment of the requirements for the Degree of Doctor of Philosophy

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DEDICATION

This work of art is dedicated to middle school counselors. God bless you for being willing
to work with students who are living through the years that no adult would ever want
to relive. Hopefully this work can serve as a tool to make your life easier at
school as you have so little time to devote to students who are
suffering from depression.
BIOGRAPHY

A native of the Triangle area, I grew up just south of Raleigh in Garner, North Carolina. I followed in my father’s footsteps and completed my undergraduate studies at North Carolina State University. I earned a Masters in Education with a specialization in school counseling from Campbell University and have been a School Counselor for the last nine years. I began my career in a high school and quickly transitioned into middle school, where the majority of my years of service have been spent.
ACKNOWLEDGEMENTS

I have to say that my life has been somewhat a fairy tale. I was reared by the most loving and supportive parents in the world. Education is something that both of them hold dear, since that is one thing that can never be taken away from a person. They encouraged me to continue my education after high school, then college, then my masters program. Without their support both financially and emotionally, I would not have had this opportunity. Mom and daddy, thank you for being my cheerleaders and biggest fans!

Dr. Stan Baker, what can I say?! I have put you through an awful lot these last six years. You have been a wonderful mentor. You have taught me to be a better writer, and have forced me to keep my chin up when I have wanted to pout. Thank you for letting me come into your office (mostly without appointments) to tell you stories, get suggestions, and vent. You are an inspiration and I appreciate your sticking by me and believing in me.

Dr. Rhonda Sutton, you are so special to me! I loved learning teaching and counseling strategies from you when I was your TA. You have always made me feel like I am capable of doing whatever I want in this field. I truly appreciate your sincerity and genuineness and it has been a pleasure getting to know you professionally and personally.

Thanks to Dr. Ed Gerler, Dr. Sylvia Nassar-McMillan, and Dr. Janice Hall for serving on my committee. I appreciate your time and input. It has been a pleasure to work with all of you and be in the company of such scholars and leaders in our field.

I have made many awesome friends in this program. Whether in class, or out on the town, I have loved spending time and laughing with you. You have made this school experience more bearable and lightened the load for me.
About half way through this doctoral process, I met my Prince Charming. Danny, thank you for being my rock as I have completed this process. Your loving and caring nature have helped me more than you know. I am proud to be your wife and hope that you feel as loved as I do.
TABLE OF CONTENTS

LIST OF TABLES ........................................................................................................ viii

LIST OF FIGURES .................................................................................................... ix

1 Introduction ........................................................................................................... 1
   Purpose ............................................................................................................... 1
   Background ..................................................................................................... 1
   Research Questions ....................................................................................... 3

2 Literature and Theory Review .............................................................................. 4
   Introduction ..................................................................................................... 4
   Depression and Adolescents ......................................................................... 4
   Cognitive-Behavioral Therapy ...................................................................... 6
   Ego Development .......................................................................................... 8
   Loevinger’s Theory of Ego Development .................................................. 9
   Erikson’s Theory of Psychosocial Development ....................................... 11
   Moral Development ...................................................................................... 14
   Related Literature ......................................................................................... 15
   Implications ................................................................................................. 16

3 Method .................................................................................................................. 17
   Participants .................................................................................................... 17
   Instrumentation ............................................................................................. 18
   Training Program .......................................................................................... 18
   Attitude Towards Treatment Scale ............................................................ 18
   Achievement Test ......................................................................................... 18
   Beck Depression Inventory .......................................................................... 19
   Sentence Completion Test .......................................................................... 19
   Behavioral Observations .............................................................................. 20
   Data Collection and Analysis ...................................................................... 20

4 Results ................................................................................................................. 23
   Summary Data ............................................................................................... 24
   Behavioral Observations .............................................................................. 32

5 Discussion .............................................................................................................. 39
   Summary ......................................................................................................... 39
   Discussion Topics ........................................................................................... 41
   Counselor Observations .............................................................................. 41
   Considerations ............................................................................................... 42
   Cognitive-behavioral Interventions ............................................................. 43
   Limitations ...................................................................................................... 44
References........................................................................................................45

Appendices........................................................................................................51
  Appendix A- NCSU Informed Consent Forms for Research ..............52
  Appendix B- Training Session Lesson Plans.................................56
  Appendix C- Attitude Towards Treatment Scale..........................62
  Appendix D- Achievement Test .....................................................64
  Appendix E- Weekly Symptom Record .........................................65
LIST OF TABLES

Table 1  Beck Depression Inventory (BDI) Feelings Categories ..............25
Table 2  Comparison Weekly Symptom Log ............................................35
LIST OF FIGURES

Figure 1  Comparison of total scores on BDI ............................................26
Figure 2  Summary of BDI findings for Student 1 .................................27
Figure 3  Summary of BDI findings for Student 2 .................................28
Figure 4  Summary of BDI findings for Student 3 .................................29
Figure 5  Summary of BDI findings for Student 4 .................................31
Figure 6  Summary of BDI findings for Student 5 .................................32
CHAPTER 1

Purpose

The purpose of this study was to examine the relevance of ego development in the lives of adolescents who have depression. School counselors were trained to use a clinical assessment technique that is derived from ego development theory and cognitive behavioral therapy. The assessment technique was applied in individual school counseling sessions in order to determine if the knowledge of ego development levels would be beneficial for school counselors when determining strategies for treating depression.

Background

Depression in children could be described as an epidemic in the United States today. It is a public health concern that affects 3% to 8% of adolescents (Kovacs, 1996). Because of deficient parenting, genetic defects, and traumatic events, children are suffering more now from depression than ever before. Keenan and Hipwell (2005) discovered that girls between the ages of ten and fifteen were diagnosed with depression twice as often as boys at that same age range. This may be explained by higher levels of stress resulting from the high priority of academic success and personal relationships, known as episodic stress (Shih, et. al, 2006). They found that girls are more reactive to stressors compared to boys. Furthermore, Eberhart, Shih, Hammen, and Brennan (2006) found that girls had more negative self-perceptions than boys and that their interpersonal skills acted as suppressors, which could either protect them from depressive occurrences or make girls more vulnerable to depressive episodes. Both sexes are vulnerable to depression; however, there is a much higher rate of diagnoses in adolescent girls. Depressive symptoms include, but are not limited to sadness, feelings of failure and discouragement, guilt, disappointment, suicidal thoughts, crying, loss
of interest in activities and people, trouble making decisions, difficulty eating and/or sleeping, and increased worry (Beck, et al, 1961).

In the field of counseling, depression in youth is often treated through the use of cognitive-behavioral therapy (CBT). CBT is a technique that counselors can use with various clients to address behavioral and cognitive or affective issues, which may result in change. Kahn and Kehle (1990) used cognitive restructuring, social skills, self-modeling, relaxation techniques, and role play as they looked at appropriate interventions for middle school aged students. They found that these strategies and techniques were effective in helping to raise self-esteem.

Ego development plays a part in many facets of one’s life. It determines the ways in which people see the world. Loevinger (1979) stated that the ego has a heavy influence on a person’s drive for self-consistency and meaning. She goes on to say that ego development impacts personal relationships and self-perception. Loevinger describes ego development as a series of changes in impulse control, interpersonal relations, and conscious preoccupations. Loevinger, as well as other theorists, developed stages associated with milestone developments and changes in one’s frame of reference.

Addressing depression in adolescence is essential to school counselors. With the rising amount of students, especially girls, who are diagnosed with depression, school counselors need to have a brief, effective way of working with these students. Cognitive-behavioral counseling is a widely used strategy, but it may be helpful to have more information to assist with this healing process.
Research Questions

Based on current research, it appears that children who are depressed may have deficits in their ego development. Hauser and Safyer (1994) found that anger and sadness could be attributed to lower levels of ego development, while affection, enthusiasm, and anxiety are associated with higher levels of ego development. Treatment programs for these children tend to focus on improving physical and emotional symptoms that they are experiencing (Evans, Velsor, & Schumacher, 2002). Cognitive-behavioral therapy is one well-researched and widely practiced means of treating depression. However, it may be beneficial to also look at ego development when assessing the needs of children who are depressed. Evans, Velsor, and Schumacher (2002) state that depression is one of the “most overlooked and under-treated psychological disorders of adolescence” (p. 211). Depression affects many areas including emotional, behavioral, and cognitive states. Erikson (1950) states that there is a transition in adolescence, which becomes a crisis, also known as exploration. In this exploration stage, Erikson believes that there are swings in mood, ups and downs in ego strength, and physical complaints.

In the present study, school counselors were trained to assess ego development accurately in order to enhance their use of cognitive-behavioral techniques when counseling clinically depressed female adolescents. The specific research questions were as follows: (a) Is the treatment effective in reducing depressive symptoms as measured by self-report depression inventory scores and (b) Is the treatment effective in reducing client-specific symptoms of depression of female adolescent clients?
CHAPTER 2

This chapter examines cognitive-behavioral therapy (CBT) techniques and interventions that have been used to treat children who are depressed. This section also examines Erikson’s theory and Loevinger’s theory and her Sentence Completion Test and its usefulness in helping to predict ego development in adolescents. Depression in children will be a guideline for this review.

*Depression and Adolescents*

Evans, Velsor, and Schumacher (2002) state that depression is one of the “most overlooked and under-treated psychological disorders of adolescence” (p. 215). Depression affects many areas, including emotional, behavioral, and cognitive states. It can cause changes in sleep, appetite, and one’s overall health. Reynolds (1984) mentions sadness, low self-esteem, listlessness, loss of concentration, and pessimism as indicators of adolescent depression. Depression may cause distortions in the processing of information, and evaluation of oneself. It can cause an adolescent to be extremely critical of him/herself, which could lead to feelings of worthlessness and ultimately self-defeat (Evans, Velsor, & Schumaker, 2002). Shih, Eberhart, Hammen, and Brennan (2006) mention two types of stress that youth may encounter. They are episodic stress and chronic stress. Episodic stress appears to be related to interpersonal factors and how one handles situations. Chronic stress relates more to academics and close friendships. Females tend to be more reactive to these stressors, which increases their likelihood to become depressed.

There are interventions that can help children who are depressed. Outward support from family and home is pertinent to children bouncing back from depression (Downing, 1988). Home and school can work together to encourage the adolescents who have
symptoms of depression by supporting positive social interactions and play (Welton & Vakil, 2001). Being aware of physical signs of depression, such as sleeping too much, loss of appetite, and decline in grades, is important at home and school. Welton and Vakil (2001) also suggest communication and collaboration between persons in the two environments. Adolescents who feel depressed may truly be depressed, and peer groups may notice depressive symptoms in others. Lefkowitz and Tesiny (1985) concluded that self-ratings and “peer nominations” among children correlated with depressive variables.

Assessment of Depression

Accurate assessment of depression in adolescents is essential. Crowley (1994) discusses the dependability of the Children’s Depression Inventory (CDI). Her findings suggest that while the Children’s Depression Inventory is fairly generalizable, the scores lack dependability, and multiple tests and testing sessions may produce better results. Research on the CDI by Craighead, Smucker, Wilcoxon, and Ilardi (1998) shows that the factor structures within the Children’s Depression Inventory do, in fact, support the predictability of depression. However, Craighead (1995) believes that the total CDI score is a better predictor than the factor scores.

Another assessment tool for depression in children that appears to have relatively high reliability is the Children’s Depression Scale (CDS) (Lang & Tisher, 1978). The CDS was developed for adolescents who are between the ages of nine and 16. When compared to the CDI, the CDS has seemingly better levels of internal consistency (Patton & Burnett, 1993). Patton and Burnett add that the scores between the two scales positively correlate, and the scores reflect a difference between normal and depressed adolescents.
Beck’s Depression Inventory (BDI) has been highly researched and utilized with clients who are depressed. The BDI is a self-administered 21 item self-report scale measuring supposed manifestations of depression. The BDI takes approximately 10 minutes to complete, although clients require a fifth – sixth grade reading age to adequately understand the questions (Groth-Marnat, 1990). Internal consistency for the BDI ranges from .73 to .92 with a mean of .86. (Beck, Steer, & Garbin, 1988). The BDI has a split-half reliability coefficient of .93. The content of the BDI was obtained by consensus from clinicians regarding symptoms of depressed patients (Beck et al., 1961). The revised BDI items are consistent with six of the nine DSM-111 categories for the diagnosis of depression (Groth-Marnat, 1990). The BDI will be a primary assessment tool used in the present research study due to its internal consistency, reliability, and ease of administration and scoring.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) has been used to treat depression in children. Evans et al. (2002) note that depression causes a feeling of self-defeat. Events that may have once produced positive thoughts and feelings may now appear to occur because of a lack of one’s control, and negative events may happen because of something one has done, which may be internalized as catastrophic. The future and world may seem hopeless. In response to these feelings, cognitive-behavioral therapy is used to change the outlook and thought processes in order to change behaviors and responses to negative events. “The major premise of the CBT approach is that a person’s affect and behavior are determined by the way she or he interprets the world…the interventions are designed to help adolescents
identify and correct distorted, irrational beliefs and develop…effective behaviors” (Evans et al., 2002, p. 214).

Strategies and specific methods of CBT vary. Kahn and Kehle (1990) chose to utilize relaxation and self-modeling treatments. In relaxation treatment, they presented the relationship between stressful situations and depression. The researchers educated the participants on relaxation techniques and procedures. Homework was given to the clients to complete so that the learned relaxation techniques could be transferred to places other than therapy.

The self-modeling treatment approach provided videotapes for the clients to review and model, based on the appropriate responses and behaviors that were seen on the tape. Kahn and Kehle (1990) reported that only desired target behaviors were recorded on the tapes and that the positive verbalization led to gains in the treatment of depression.

Problem solving is another cognitive-behavioral approach used in treating depression. Evans et al. (2002) used this technique in their research that resulted in improved interpersonal skills, as well as feelings of more self-control. Communication skills were strengthened, in addition to better interpretation of verbal and nonverbal cues. In this method of cognitive-behavioral therapy, there is a series of steps that children are taught to go through. They first identify the problem. Next, they identify the aim, which is also known as the goal. The next step is generating alternate solutions to the problem, followed by thinking of outcomes for each solution. Next, the child chooses what he or she feels is the best solution. Afterwards, he or she can think about and process how it worked. These children learn how to reflect on what they have learned and reinforce positive outcomes and re-evaluate negative outcomes without blaming themselves for the negative outcomes.
Bollenbach (1982) encourages the use of Velten’s Elation Mood Induction and the recording of positive incidents. Through the use of cognitive-behavioral mood therapy and the writing of happy events, she found that when clients who are depressed focus on positive things for long periods of time and negative things for a very limited amount of time, they learn that positive thoughts, or cognitions, affect mood.

_Ego Development_

Loevinger (1983) defines ego as instinctual and unconscious drives that strive to develop. Freud and Adler helped to develop this definition in much earlier years. In addition, Loevinger believes that there is a continuum of development that links personality and behaviors based on experiences. James (1980) believes that social identity begins to form in the preteen years. This may help to explain why ego development is important in adolescent years. Hauser and Safyer’s (1994) findings support that identity and ego development have a profound impact on adolescents’ emotions. They discovered that negative emotions, such as sadness and anger are associated with low ego levels, and happiness, affection, and enthusiasm are associated with higher levels of ego development. Reynolds (1984) defines depression as a significant affective disorder in children and adolescents. Since affect has to do with the way in which people show feelings and display the effects of emotional issues, it appears that ego may play a role in dealing with depressive matters. In working with adolescents who suffer from depression, counselors may need to address ego development in conjunction with the use of cognitive-behavioral therapy. Addressing this may give counselors a better idea of where a client is and if there are lapses in ego development.


Loevinger's Concept of Ego Development

Jane Loevinger (1979b) developed milestones of ego development. Although the stages do not have chronological ages associated with them, progression through the stages is expected. The first true stage is known as the Impulsive Stage. In this stage, people are illogical. They are limited emotionally and need concrete illustrations versus abstract concepts. They tend to be negative and may be hostile.

The second stage is the Self-Protective Stage. In this stage, there is a desire to protect oneself. The person may blame others since there is a fear of being caught. Control is important in this stage.

The third stage is the Conformist Stage. A person in this stage does not want to break any rules. Feelings of guilt and shame begin in this stage. There is need to belong to a group. Looks become more important to the person.

The next stage, Conscientious-Conformist Stage, is when a person sets goals. A desire to help and fit into a group is important. The person learns to adjust when faced with problems.

The fifth stage is the Conscientious Stage. There is self-criticism and self-evaluation in this stage. A person may feel guilty for consequences and becomes responsible. There is a concern for communication and expression of feelings. A person may begin to feel self-respect.

The next stage of ego development according to Loevinger is the Individualistic Stage. All of the above attributes have been achieved by the time one moves to this stage. In addition, the person has respect for people as individuals. Being independent is essential, as dependency is considered a problem.
In the Autonomous Stage, a person builds on the above stages and is able to cope with conflicting needs. Toleration is important, as well as respecting autonomy. There is self-fulfillment and one can identify in a social context. A person in this stage is objective in thinking and can convey feelings appropriately.

The last stage is Integrated. In this stage, a person can resolve inner conflicts. Individuality is cherished and a person’s “whole” identity is established.

Loevinger (1983) developed the Sentence Completion Test (SCT). It is an effective and useful way of assessing ego development. In a study performed by Redmore and Loevinger (1979), researchers found a correlation between ego level and intelligence. Since children who suffer from depression are likely to have a decline in grades, looking into the ego level of these children may be helpful in treatment planning. It is a good tool for counselors to use in a therapy setting with clients to assist in the recognition of what stage the client is in developmentally. The test is based on Loevinger’s theory and milestones of ego development. A person’s level of ego development is based upon the responses given to the test. There are several forms of the SCT, including but not limited to: Women, Men, Girls, and Boys. The appropriate test should be administered based on the chronological age of the client. The clinician simply reads Loevinger’s beginning of a sentence, and the client responds, making the sentence complete. The clinician then compares the responses to a score sheet provided with the SCT and determines if the responses are stage appropriate.

Responses will vary. Some responses may be elaborate and include great detail, while others are brief and unemotional. This test appears to be extremely subjective and responses may be given different scores, based on who the clinician is and what the
expectations are. Although interaction differs between genders, Levit (1993) found that male and female adolescents transition similarly through Loevinger’s theory and stages. Based on the different forms of the SCT, a clinician would score it similarly among all clients. It is not scored differently based upon gender or age, rather it is scored based on stage only.

Psychometric studies of the WUSCT have yielded high levels of interrater reliability, high levels of internal consistency, and high test-retest reliability. Perfect interrater agreement per item is typically about 85% and interrater agreement within one stage is often close to 95%. Cronbach alpha values are often reported to be .90 or higher, and test-retest correlations are often about .80. Preliminary evidence also suggests that test-retest reliability, internal consistency, and interrater agreement is high when protocols are administered to clinical populations (Westenberg, Hauser, & Cohn, 2004).

Evidence for the construct validity of the WUSCT is provided by several lines of research, which have been reviewed by Loevinger (1979a, 1998), Hauser (1976), and Manners and Durkin (2001). The SCT-Y was only recently developed and cross-validated and thus lacks a similarly large research base. Evidence for the construct validity of the SCT-Y is accumulating (Westenberg, Hauser, & Cohn, 2004).

Erikson’s Theory of Psychosocial Development

Erik Erikson was a part of the rise of Ego Psychology in the 1930s. There was a common belief that the ego is formed at birth and is influenced mostly by the outside world. He believed in an epigenetic principle, which states that in development, there is an inevitable revealing of personalities in eight stages (Erikson, 1950, 1974). There are psychosocial tasks in each stage. There are two terms associated with each stage, such as
Trust versus Mistrust, which leads one to believe that there must be a balance between the two conditions in order to survive and prosper.

The first stage in Erikson’s theory is Trust versus Mistrust. This stage is from birth to one year old. The mother is significant in this stage and the baby needs to get and give in return and form hope and faith. If this does not occur, the baby may form withdrawal tendencies. In stage two, Autonomy versus Shame and doubt is when a child is two and three years old. Parents are important in this stage and the child is learning to hold on and let go. If this happens correctly, the child will have determination, and if not may be impulsive. Erikson’s third stage is Initiative versus Guilt. This stage spans three to six years old. Family is important to the person and he/she learns to play. A sense of purpose and courage are formed in this stage. A maladaptation that could occur here would be ruthlessness. In state four, age seven to twelve, the psychosocial crisis is Industry versus Inferiority. Neighborhood and school are important to the person. There is a need to complete and make things together. This forms competence. If not, an inferiority complex may set in. Stage five is Ego-Identity versus Role-Confusion. This is the stage that most adolescents are in. It occurs from age twelve to eighteen. Peer groups are of most importance. One seeks to be himself and share himself. Adolescents form fidelity and loyalty here. The possible maladaptive tendency at this stage is having too much ego and believing that no one else is right. The next stage is Intimacy versus Isolation. Partners and friends are most significant in the stage. Most people go through this stage in their twenties. It is when people learn to love and find oneself in another. If a person has maladaptive ego in this stage, he/she may become promiscuous or exclude himself/herself from others. The seventh stage is Generativity versus Self-Absorption. Twenty to fifty-year-olds are in this stage. Household
and co-workers are important to a person in the stage. A person will learn to care and take care of others. If not, overextension, or not allowing time for rest, may occur. The last of Erikson’s stages is Integrity versus Despair. Most older adults are in this stage. Gaining wisdom and approaching old age without fear is considered healthy in this stage. Those who do not gain wisdom and fear death, face despair.

Erikson is commonly compared to Freud in his thought processes and stages. He is criticized for his theory applying mostly to males, however because of Erikson’s clear-cut stages and descriptions, as well as expected progression through the stages, it can be applied to all individuals (Hamachek, 1988). Erikson (1950, 1974) says that the stages in his theory build upon each other. He believes that humans face a crisis at each stage and it is up to the ego at the stage to resolve the crisis and allow development to continue. He believes that if the ego does not manage a crisis well, there are maladaptive behaviors and thoughts that may occur, which may impede future developments. If a crisis is managed well by the ego, however, there is a psychosocial strength that travels with the person through the other remaining stages. Depression may come as a result of a maladaptation, which is hurtful to the ego.

Portes (1995) examined the ego strength and transitions of adolescents. Erikson (1959) states that adolescent exploration creates an identity crisis. He says that during this stage, adolescents experience reduced ego strength, which results in mood swings, impulsivity, and physical complaints. Portes (1995) sought out to see if in fact, Erikson’s theory holds true when adolescents were given a Minnesota Multiphasic Personality Inventory (MMPI) and the Ego-Identity Interview. Portes suggested that if Erikson’s theory was true, adolescents who scored high on these tests, would also have the physical and
psychosocial symptoms that Erikson described. This study concluded that in fact, there is a correlation between reduced ego strength and this adolescent crisis. Erikson’s theory is supported through this finding. Portes (1995) states “the decline in ego strength implies a reduced capacity for coping with problems and stress”. Portes goes on to say that at this age, adolescents who explore more options and are more thoughtful when it comes to decision-making would have more of a tendency to become confused and stressed. They may worry and feel like adults do not understand them. These thoughts could lead to them feeling bad physically or having feelings of depression.

Although Erikson’s theory was introduced some time ago, it is still applicable. Counselors can strengthen the ego so that a person can face everyday problems and handle them effectively. Since the stages are classified by a name, as well as a chronological age, they are easy to identify. Counselors can focus on the areas that are weak and help the person become healthier psychosocially. Ego identity development in the areas of occupational choice, religion, and political ideology was studied by Waterman and Goldman (1976) and the findings are “clearly consistent” with Erikson's theory of psychosocial development during adolescence. The sample included a multicultural group of participants, which implies that Erikson’s theory may be culturally sensitive, as well.

Moral Development and Ego Development

Moral development is defined by Giesbrecht (2000) as motivation, the process of learning how to deal with inner conflict, and knowing right from wrong. James (1980) discovered that social development begins in preteen years and ego may have an impact on social development. In addition to social development and its relation to ego, moral
development should be considered, as well. Gfellner (1986) compared Rest’s Defining Issues Test to Loevinger’s Sentence Completion Test with 517 adolescents between ages twelve and twenty-one. The findings indicate that there is a strong relationship between moral and ego development during adolescence. D’Andrea and Daniels (1992) established that psychological development and developmental assessment are essential in counseling. These authors encourage the use of ego development in counseling settings.

Related Literature

Hauser and Safyer (1994) investigated connections between ego development and emotional communication. They looked at 73 adolescents, half of which were patients in a psychiatric hospital. Their findings indicate that affection, enthusiasm, and anxiety are associated with higher levels of ego development. In contrast, they also found that anger and sadness could be attributed to lower levels of ego development. Their findings did not differ based on population or location (i.e., in or out of hospital).

Research by Bakken and Romig (1989) indicates that family cohesion and adaptability of adolescents greatly affect ego development. They studied 180 early high school students and saw that the most important factor in ego development was family structure. Students who had upper levels of ego development when compared to their peers tended to have strong family ties and felt comfortable in different environments.

In a different type of study, Cole and Jordan (1995) studied the recall of self-referring adjectives. Their findings were that children who were depressed recalled the negative information that caused them to display more depressive symptoms. These investigators found that depressive symptoms increased in the eighth grade.
Implications

There does seem to be some type of relationship between unhealthy ego development and depression. Though the two may not be indications of each other, there may be a correlation between them. However, the severity of depression or any other psychopathology is not related to ego development (Waugh & McCauley, 1981). Severity of abnormal psychological issues is an independent factor when studying ego development.

Of all of the above research and reviews of studies regarding ego development and depression, Hauser and Safyer’s (1994) work seems to be the best evidence that ego development should be assessed and addressed in counseling children who suffer from depression. Knowing that sadness and anger tend to show a lower level of ego development and enthusiasm and affection show a higher level, it is apparent that healthy, normal ego development is important and may assist in treating depression.

Maag (1988) found that school counselors possess the most knowledge regarding characteristics of depression. Furthermore, school counselors should use cognitive-behavioral counseling techniques with students who are depressed. Self-esteem building, cognitive restructuring, improving social skills, relaxation, and improving coping skills are all ways that counselors may help depressed students (Forrest, 1983). Based on past research and literature, it appears that ego development could be incorporated into brief counseling sessions at school. This may help school counselors to better treat symptoms of depression, as well as gain valuable information on an adolescent’s background and ego.
CHAPTER 3

METHOD

Participants

In this research study, there were two different types of participants. Five school counselors were invited to participate. They are all counselors at the middle school level and agreed to be trained to work with adolescents at their respective schools who had been diagnosed with depression. These seasoned counselors were selected based on their desire to participate, as well as their high skill level in counseling. They were interviewed by the investigator in order to determine if their clients fit the criteria, as well as their willingness to participate in the research. The counselors were located at various middle schools across Wake County, North Carolina and had a diverse group of students that they worked with. All five were middle aged (30 to 50 years old) White women who had at least five years of experience as a school counselor.

The second group of participants were the middle school students who had been diagnosed with depression and were seeing a school counselor regularly for brief counseling. They ranged in age between 11 and 14. Two were White, two were African American, and one was Central American. They had symptoms such as withdrawal, grades dropping, behavioral issues, anger, crying, and other typical depressive symptoms. To avoid a gender confound, all of the students were female. They were not taking medication for depression. All participants and their parents/guardians completed their respective informed consent forms (see Appendix A).
Instrumentation

Training Program

The researcher presented a training program to the school counselors. This program entailed three meetings to ensure that they felt comfortable and were competent when it came to utilizing the tool for depression. A copy of lesson plans for the training program is located in Appendix B. The trainer mentored each trainee through the entire program and was readily available should the counselors have had questions during the process. The researcher utilized measures to determine whether or not the counselors understood the process.

Attitude Towards Treatment Scale. The first measure used was the Attitude Towards Treatment Scale (ATT). This scale showed how the counselors rated the training and gave the researcher an idea of if they felt the training was worthwhile. The ATT (Baker, n.d) is in Likert format. The scale asked the participants to rate training from 1 (not at all confident), to 7 (very confident). Topics covered in the ATT range from confidence in the training program to comparisons with other programs. There are fourteen questions on the ATT. The answers that the participants gave were extremely helpful to the researcher’s knowledge of whether or not the training was effective from the eyes of the counselors. (See Appendix C)

Achievement Test. The second measure was an achievement test. This test was composed of multiple choice and true/false questions. It ensured that the counselors were competent and understood the information they had been given. The researcher saw that the questions match the goals of the study. The items were developed based on the expectations of the training to ensure that the counselors were competent in the areas covered in training. The test items were reviewed and revised by expert judges. (See Appendix D)
Training Application Measures

**Beck Depression Inventory.** The Beck Depression Inventory (BDI) was used to determine where the student was as it relates to depression. This test has been highly researched and utilized with clients who are depressed. The BDI is a self-administered 21 item self-report scale measuring supposed manifestations of depression. The BDI takes approximately 10 minutes to complete, although clients require a fifth – sixth grade reading age to adequately understand the questions (Groth-Marnat, 1990). Internal consistency for the BDI ranges from .73 to .92 with a mean of .86. (Beck, Steer, & Garbin, 1988). The BDI has a split-half reliability coefficient of .93. The content of the BDI was obtained by consensus from clinicians regarding symptoms of depressed patients (Beck et al., 1961). The revised BDI items are consistent with six of the nine DSM-111 categories for the diagnosis of depression (Groth-Marnat, 1990).

**Sentence Completion Test.** The Sentence Completion Test (SCT) (Hy & Loevinger, 1996) is a measure of ego status that was used by the counselors as a tool diagnose where the student’s ego level was. Psychometric studies of the WUSCT have yielded high levels of interrater reliability, high levels of internal consistency, and high test-retest reliability. Perfect interrater agreement per item is typically about 85% and interrater agreement within one stage is often close to 95%. Cronbach alpha values are often reported to be .90 or higher, and test-retest correlations are often about .80. Preliminary evidence also suggests that test-retest reliability, internal consistency, and interrater agreement is high when protocols are administered to clinical populations (Westenberg, Hauser, & Cohn, 2004). This form of the test was used in this study since all of the participants were female.
Behavioral observations. There were behavioral observations, as well. The counselors documented behaviors they observed and recorded them over time. In this N of 1 study, it was predicted that there may be symptom reduction over time. The counselors were able to form a baseline by noting the score on the BDI and asking probing questions regarding their client’s responses to the BDI. They could then track the symptoms of depression that the student was showing. The students recorded the symptoms they had on a daily basis in a journal. They also had a self-monitoring form to keep as a weekly record of symptoms. This form can be found in Appendix E. The BDI was re-administered toward the end of the sessions. The counselor was able to compare the two scores of the BDI and incorporate their behavioral observations into a summary before the counseling sessions ended. In addition, the student’s journal was a useful tool in noting behaviors and changes.

Procedure

Data Collection and Analysis

The research design was an intensive single-subject quantitative design replicated five times. The counselors collected data from the clients throughout their sessions. They took note of the impact of ego development incorporation in therapy. The researcher collected data in the training program in several ways. First, they administered and scored the BDI. This test has a number associated with each response. The counselor simply added the numbers of all of the responses and gets a total score. If the score was between 1 and 10, the ups and downs were considered to be normal (this outcome was not expected since the students had already been diagnosed with depression). If the total score was between 11 and 16, there were mild mood disturbances. Scores between 17 and 20 led to the level of
borderline clinical depression. Scores between 21 and 30 showed that the client is moderately depressed. The student may have been severely depressed if scores ranged from 31 to 40. Scores above 40 pointed to a level of extreme depression. After the counselor scored the BDI, they had a better understanding of the client’s symptoms and feelings. This information was used in sessions. The BDI was administered for the first time during the first session. The BDI was administered for a second time during the fifth session. The counselor devised a comparison chart to note where the client was at the beginning of the process compared to where she was toward the end. Results of the two administrations of the BDI were shared with the clients, noting especially positive changes in scores in specific areas. These results could have been reported in a bar graph, pie chart, or other method of noting comparison and change. The researcher collected this information at the end of the project to include in the results section.

The SCT was the second instrument used by the counselors. They administered the Women’s form of the SCT. This test was completed by the client during the second therapy session. With the help of the trainer to ensure uniformity, the counselors scored the SCT after that session and assessed where the client was on an ego development level. This information was useful to the counselors in the third, fourth, and fifth counseling sessions. The counselors were able to ask questions and have discussions regarding answers to the SCT. Particular attention was paid to those questions that the clients scored extremely low or extremely high on. This may have indicated gaps in ego development and gave the counselor insight into the client’s development.
The clients tracked their symptoms of depression in a journal, as well as on a weekly self-monitoring form. A table was created to depict each client’s progress after the intervention was completed.

The scores of the ATT and achievement test, as well as questions and concerns of each counselor were documented. In the training segment of the study, the researcher looked at the raw scores of the achievement test and assessed them. There was a set score of 90% above level 5 for the counselor to meet in the ATT, and a set score of 80% or better on the Achievement Test. Not meeting these score requirements would have disqualified the counselor from participation. Success of the counselors was monitored over time and recorded.

Success of this program was measured by the feelings of the counselors. There was a meeting following the sessions with each counselor to discuss the findings. The purpose of this study, along with the goals was reviewed. The researcher’s hope was that the incorporation of an ego development measure, in this case the SCT, was a useful tool in assessing and addressing ego development as it pertains to adolescent depression.
CHAPTER 4

RESULTS

The present study, data were collected from ten participants, five counselors and five female student clients. The data were analyzed as five single case experiments based on the results of the counseling process. Since the counselors were fully trained and cleared by the researcher prior to the formal counseling sessions being implemented, the results come mainly in the form of reports from the five student clients as N of 1 single case studies, that is one design replicated five times. The study took place over a period of six weeks with one counseling session each week. The proposed research questions for this research study were as follows: Is counseling treatment based on the training of school counselors to assess ego development accurately and employ cognitive-behavioral counseling effective in (a) reducing depressive symptoms as measured by depression inventory scores and (b) reducing client-specific symptoms of depression of female adolescents who have been diagnosed as clinically depressed.

All parts of the research questions were addressed and will be reported in the results. The research hypothesis for each single case was that training school counselors to work with female clients who were clinically depressed would be effective in reducing depressive symptoms as measured by depression inventory scores and that specific client symptoms would also be reduced. The null hypothesis was that there would be no change in symptoms, or that the students would exhibit depressive symptoms.
Counseling Treatment Effective on Symptom Reduction

The counseling treatment based on ego development training appeared to be an effective means of reducing depressive symptoms in students. All five student participants appeared to have a reduction in the amount of depressive symptoms based on the results of the BDI. The thorough training and screening of the counselors helped to ensure that all students involved would receive the same treatment and had potential to gain positive results. Being able to administer the BDI and have the results for the next session gave counselors insight and needed information. Knowledge about the SCT and the ability to score and have assistance scoring it ensured non-biased results and immediate feedback. Counselors stated that being able to compare the results of the BDI and SCT and looking at possible gaps in ego development based on the students’ scores and answers on those assessments greatly improved their counseling experience and provided direction in the sessions. All counselors felt more competent in the areas of depression and symptoms thereof and ego development. They felt more able to address specific issues involving depression since they were provided a guideline for each session.

Summary Data

In inspecting the BDI results, all students decreased in score related to symptoms of depression. This outcome coincided with the goals of the study. The BDI asks the clients to rank their feelings in each of the following categories: Sadness, pessimism, sense of failure, dissatisfaction, guilt, expectations of punishment, self-dislike, self-accusations, suicidal ideas, crying, irritability, social withdrawal, indecisiveness, body image change, work retardation, insomnia, fatigue, anorexia, weight loss, and somatic preoccupation. Wording from the BDI is used in the score interpretations. The higher the ranking, the more intense
the feelings the student has in that particular area. Table 1 provides the respective symptoms that are represented on the BDI. A comparison of total scores on the BDI among all of the participants is shown on Figure 1.

Table 1

*Beck Depression Inventory (BDI) Feelings Categories.*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Sadness</td>
</tr>
<tr>
<td>B</td>
<td>Pessimism</td>
</tr>
<tr>
<td>C</td>
<td>Sense of failure</td>
</tr>
<tr>
<td>D</td>
<td>Dissatisfaction</td>
</tr>
<tr>
<td>E</td>
<td>Guilt</td>
</tr>
<tr>
<td>F</td>
<td>Expectation of punishment</td>
</tr>
<tr>
<td>G</td>
<td>Self-dislike</td>
</tr>
<tr>
<td>H</td>
<td>Self-accusations</td>
</tr>
<tr>
<td>I</td>
<td>Suicidal ideas</td>
</tr>
<tr>
<td>J</td>
<td>Crying</td>
</tr>
<tr>
<td>K</td>
<td>Irritability</td>
</tr>
<tr>
<td>L</td>
<td>Social withdrawal</td>
</tr>
<tr>
<td>M</td>
<td>Indecisiveness</td>
</tr>
<tr>
<td>N</td>
<td>Body image change</td>
</tr>
<tr>
<td>O</td>
<td>Work retardation</td>
</tr>
<tr>
<td>P</td>
<td>Insomnia</td>
</tr>
<tr>
<td>Q</td>
<td>Fatigability</td>
</tr>
<tr>
<td>R</td>
<td>Anorexia</td>
</tr>
<tr>
<td>S</td>
<td>Weight loss</td>
</tr>
<tr>
<td>T</td>
<td>Somatic preoccupation</td>
</tr>
</tbody>
</table>
Student 1 (White) Counselor 1 (White)

Student 1 showed an improvement in reducing most of her symptoms of depression based on her BDI scores. The first time she took the BDI, she acknowledged that she did not like herself. She blamed herself for her faults and had thoughts of hurting herself but would not carry them out. She was less interested in others than she used to be. She got tired more easily than she used to (this was the highest or most intense feeling), but had no eating or weight issues. Her total pretreatment score was a 17, which is in the mild range of depression according to Beck. When she re-took the BDI at the end of the counseling sessions, her score came down, which indicated a reduction in depressive thoughts and symptoms. She came down in the areas of self-dislike, self-accusations, suicidal ideas, social withdrawal, and fatigability. She actually had an increase in the area of pessimism. Her total score the second time was a 13, within the minimal range of depression. Student 1’s BDI test results are compared on Figure 2.
Figure 2. Summary of BDI data findings for Student 1 (Counselor1).

Student 2 (Central American) Counselor 2 (White)

Student 2’s scores on the BDI indicate that she showed an improvement in reducing all of her symptoms of depression. The first time she took the BDI, she ranked herself very high in the areas of sadness, pessimism, and expectation of punishment. These were the categories that she scored the highest or most intense feelings. She was so sad or unhappy that she could not stand it. She felt that her future was hopeless and that things in her life could not improve. As she looked back on her life, she saw a lot of failures. She was bored and felt badly about herself most of the time. She wanted to be punished and blamed herself for her faults. She acknowledged that she cried more at the time she took the test than usual. She was less interested in other people than she used to be. She felt annoyed all the time and put off making decisions. She had lost more than 5 pounds at that time. Her total pretreatment score was a 21, in the moderate range of depression according to the BDI. When she re-took the BDI at the end of the counseling sessions, her score came down to
zero, which indicates a complete and drastic reduction in depressive thoughts and symptoms.

Student 2’s BDI test results are compared on Figure 3. Please see Table 1 for names of subscales that are represented by the letters in Figure 3.

![Figure 3. Summary of BDI findings for Student 2 (Counselor 2).](image)

**Student 3 (African American) Counselor 3 (White)**

Student 3’s scores on the BDI were more intense overall than the others. She showed an improvement in reducing some of her symptoms of depression, however, there were a few that actually went up the second time she took the BDI. The first time she took the BDI, she was so sad or unhappy that she could not stand it. She blamed herself for everything bad that happened. She felt that she was ugly or repulsive-looking and had no appetite at all at the time. These areas were her highest score and most intense feelings. She also did not feel that she had anything to look forward to and felt that she had failed more than the average person. She felt bored and guilty about things most of the time. She did not feel like she was being punished, but did blame herself for things that happened. She had thoughts of harming
herself but would not carry them out. She felt irritated all of the time and was less interested in people than usual. She claimed that she had to push herself really hard to get things done and she tired easily. She had lost more than five pounds and was so concerned with how she felt that it was hard to think about anything else. Her total pretreatment score was a 31, which is in the severe category of depression according to the BDI. When she re-took the BDI at the end of the counseling sessions, her score came down, which indicates a reduction in depressive thoughts and symptoms. She came down in the areas of sadness, self-dislike, self-accusations, suicidal ideas, irritability, body image change, work retardation, and anorexia. She actually had an increase in the areas of sense of failure, expectations of punishment, indecisiveness, insomnia, fatigue, weight loss and somatic preoccupation. Even with the increase of feelings in these categories, her total score the second time was a 27, in the moderate range of depression. Student 3’s BDI test results are compared on Figure 4.

![BDI Feelings Categories](image)

**Figure 4.** Summary of BDI data findings for Student 3 (Counselor 3).
Student 4 (White) Counselor 4 (White)

Inspection of Student 4’s scores on the BDI showed that she was able to maintain or reduce all of her depressive symptoms except for two, which were insomnia and irritability. The first time she took the BDI, she said that she was blue or sad all the time and could not snap out of it. She felt that she had nothing to look forward to and that she had accomplished very little that was worthwhile or means anything. She felt bored most of the time. She said that she felt like she was bad a good part of the time. She had a feeling that something bad could happen to her and expressed that she did not like herself. She blamed herself for her faults and cried more than she used to. Her most intense feelings were in the areas of self-accusations, indecisiveness, body image change (she felt ugly or repulsive-looking), fatigue, and somatic preoccupation, which indicated that she was completely absorbed in her feelings. Her total pretreatment score was a 34, which puts her in the severe category of depression. When she re-took the BDI at the end of the counseling sessions, her score came down, which indicates a reduction in depressive thoughts and symptoms. She came down in the areas of sadness, pessimism, sense of failure, dissatisfaction, crying, social withdrawal, indecisiveness, fatigue, and somatic preoccupation. Her total score the second time was a 22, well within the moderate range of depression. Student 4’s BDI test results are compared on Figure 5.
In looking at Student 5 scores on the BDI, she showed an improvement in reducing most of her symptoms of depression. The first time she took the BDI, she acknowledged that she was blue or sad all the time and could not snap out of it. She felt that she had nothing to look forward to and that she had accomplished very little that was worthwhile or means anything. She felt bored most of the time. She said that she felt like she was bad or worthless (this was the highest or most intense feeling along with work retardation). She had a feeling that something bad could happen to her and expressed that she did not like herself. She blamed herself for her faults and cried more than she used to. She had thoughts of harming herself, but would not carry them out. She got annoyed more easily than she used to and was less interested in other people than she used to be. She had great difficulty in making decisions and felt unattractive. She could not do any work at all. She got tired easily, but had no eating or weight issues. She thought a lot about how she felt and found it hard to think of anything else. Her total pretreatment score was a 29, which is on the low end of the severe depression category according to the BDI. When she re-took the BDI at the end
of the counseling sessions, her score came down, which indicates a reduction in depressive thoughts and symptoms. She came down in the areas of sadness, pessimism, sense of failure, guilt, self-accusations, suicidal ideas, social withdrawal, indecisiveness, body image, work retardation, and somatic preoccupation. Her total score the second time was a 14, in the minimal to mild range of depression. Student 5’s BDI test results are compared on Figure 6.

![Figure 6. Summary of BDI data findings for Student 5 (Counselor 5).](image)

**Behavioral Observations**

Counselors observed their students’ behaviors over the course of the study. They set goals and monitored behavioral progress throughout. Students kept a journal of their feelings and how they handled situations. The thoughts and emotions they logged into their journals were points of discussion during therapy sessions.

**Student 1 (Counselor 1)**

Student 1 (Counselor 1) set a goal of being able to make decisions more quickly and worked on strategies to increase her energy level so that she would not tire so easily. The
counselor observed that under pressure, the student became so frazzled that she could not make decisions. She was a conscientious student who felt the effects of stress physically. The counselor observed that when the student wrote about incidents that occurred that made her have depressive symptoms, she was exhausted the next day. Teachers also notified the counselor when the student appeared to be so tired that she had a hard time paying attention in class. Since the student typically was concerned about making good grades, it was obvious when she was not feeling her best. The counselor noted that the student loved to write and wanted to continue to journal and track her feelings during the weeks following the end of this study. Student 1 was able to lower her symptoms of fatigue and indecisiveness on the BDI scale (see Figure 2). The counselor observed a change in her and attributed it to the strategies they worked out in counseling sessions. For example, when the student noted an event that triggered depressive symptoms on her weekly symptom record, the counselor would encourage her to write about it and go to bed earlier. Her hope was that this would help her to be less tired the next day. Another strategy they implemented was in regards to decision making. The student was to allow herself thirty seconds to make a decision at first, then she reduced it to twenty seconds, then ten seconds. The counselor observed that this was really difficult for the student, but the more she practiced, the better and faster she got. The counselor felt that this helped to eliminate some stress and that depressive symptom was reduced in the end.

*Student 2 (Counselor 2)*

The counselor of student 2 described her as “weepy” at the beginning of the study. She observed crying and feelings of extreme sadness. When they talked, student 2 would say that she did not ever have anything to look forward to. Her weekly symptom logs indicated
that she cried often in class, yet she knew that it drew negative attention toward her. The counselor mentioned that the student did not appear to be totally comfortable at first and that she took a long time to warm up. Her depressive symptoms and sadness were very pronounced and obvious. The counselor cited her journal on two occasions where the student had written that she felt like she was being punished. The counselor discovered that the student’s father was incarcerated while she was administering the Sentence Completion Test. Her behavior in class was not good. When she was not upset, the counselor said that teachers complained about poor behavior. The goals that they set for counseling were to improve her class behavior and improve her grades. The counselor felt that improving grades would lift her spirits and assist with diminishing the feeling of being punished. Through learning relaxation techniques, this student was able to show improvement. Her teachers noticed that her behavior was improved. Through the counseling process, she became more open and comfortable and would write notes in her journal about good scores on tests. The counselor noted that the Sentence Completion Test was a great tool in getting the student to talk and disclose information. She felt that it moved the sessions along and helped them to focus on specific concerns and goals, which led to great improvements.

*Student 3 (Counselor 3)*

Student 3 and her counselor set goals at the beginning of their sessions to improve her body image and self-esteem. The counselor felt that because of depression, the student was unable to see her good qualities. She commented that she had no appetite and that she felt ugly. The counselor encouraged journal writing to document feelings. On the SCT, the counselor noticed that student 3 was extremely hard on herself. She had to continually assure her that there was no wrong answer. The counselor felt that there were some self-esteem
issues. She incorporated strategies into their sessions to help with her confidence. One
cognitive-behavioral technique that she used involved the laws of attraction. She based this
on the premise that if the student was positive, positive events and people would attract to
her. The counselor modeled the behaviors and reactions that she wanted to see from the
student. Behaviorally, the student began eating more and felt better about herself. She kept a
weekly symptom log (see Table 1.2) and the counselor saw that her depressive thoughts went
down. The counselor observed her hanging around a new group of friends. She was
encouraged by this since this new group appeared to be a good influence on her and made her
feel good about herself. By the end of the last session, there was no mention of going
without food or feeling fat and ugly. This was a far cry from where she was when they
began.

Table 2

*Comparison Weekly Symptom Log for Student 3 (Counselor3) for Weeks 1 and 4*

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Symptom</th>
<th>Event that triggered it</th>
<th>Rating (1-5)</th>
<th>Week 4</th>
<th>Symptom</th>
<th>Event that triggered it</th>
<th>Rating (1-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sad</td>
<td>J called me a name</td>
<td>3</td>
<td>Mad</td>
<td>A talked about my mom</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bad about myself</td>
<td>Heard someone say ugly</td>
<td>5</td>
<td>Sad</td>
<td>Got a zero</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sad</td>
<td>Bad grade</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not working</td>
<td>Bad grade</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mad</td>
<td>Trouble for talking</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

35
Student 4 (Counselor 4)

The counselor for student 4 remarked that she learned a lot from observation. She watched her student complete the BDI and SCT early in the counseling process and noted that she had a very difficult time making decisions. She became concerned about her emotional stability and wanted to make an effort to build her up and give her coping skills. She was lacking in self-esteem and viewed herself as ugly. Student 4 was critical of herself and felt that she was a doormat to others. She claimed to be a victim of bullying, and her counselor observed some things she did which made her a target for bullies. She drew negative attention to herself and vocalized her negative feelings about herself to others. Her counselor wanted to have a positive impact on her. She decided to use relaxation training and assertiveness training in sessions. She noticed that there were several responses on the SCT that indicated that she was an outcast, or loner. In assertiveness training, the counselor gave her tips and strategies for standing up for herself appropriately. She taught her to use “I-statements” when she was telling people how she felt about issues that came up. She assigned homework and the student was to write responses in her journal of how she felt in certain situations as reported by the counselor in her case notes. Slowly, the counselor observed an increase in positive interactions with other peers. She made more appropriate comments and did not try to draw negative attention to herself as much. The counselor observed that along with an improvement in social interactions, she also became more confident in making decisions. The counselor had her make “un-important” decisions in counseling sessions such as “where do you want me to sit” or “what color pen do you want to write with”, which improved the amount of time it took her to make decisions. The
counselor observed that her time in making decisions increased an average of fifty percent by the end of the sessions. This was noted in the counselor’s case notes.

_Student 5 (Counselor 5)_

The counselor for student 5 was concerned about her at first because she found out that a sibling had been removed from the home recently. The mother was defensive and wanted to assure that there was no intent by the school to have her daughter taken, as well. The student noted on her SCT that she had been abused in the past. The counselor felt that she had to be very gentle with her so that she trusted her. She found that trust was an issue and so was self-concept. Student 5 displayed feelings of guilt. She felt that many things that happened to her were her own fault. The counselor observed that simply allowing the student a chance to talk and be heard made her feel better. Student 5’s counselor observed that at first, the student had a hard time doing school work and appeared to be unmotivated. She decided to incorporate study skills training into some of their sessions. She thought that experiencing what it felt like to make good grades may provide her with a boost to her self-esteem, as well as improving her motivation in class. The counselor observed some mood swings. Some sessions, she was chatty and happy, and other times she was subdued and withdrawn. The counselor used the SCT to help with leading the conversations and getting more information out of her and found it to be helpful. She noticed gaps in her ego development in certain areas which led her to believe that she had repressed some painful memories. The student did not write much in her journal because she said that she preferred to talk. The counselor observed her in class and said that she avoided work at times and thought it may be because she did not understand. She worked with her on asking questions in class. A referral to Student Support Team followed their last session. The counselor felt
that there were some learning issues that needed to be addressed. Overall, she felt that student 5 came a long way and had a reduction in observable depressive symptoms. The reduction in depressive symptoms was observed by the counselor and reported in the case notes.

Anecdotal Data

At the end of the training, counselors gave feedback, suggestions, and input. The comments were positive and promising. The overall feeling was that this study was a good use of their time. They felt supported and appreciated having a way to assess students’ ego level and depressive symptoms without spending an immense amount of time. During treatment, they kept their own notes and reflections.
CHAPTER 5
DISCUSSION

Summary

The purpose of the present study was to examine the relevance of ego development training for school counselors who integrated the knowledge acquired from the training into their treatment plans for female adolescent clients diagnosed as being clinically depressed. The participants were five female middle school counselors who volunteered to participate in the study and their five female middle school student clients diagnosed as clinically depressed who agreed, with the permission of their parents/guardians, to have the data associated with their treatments analyzed. The counselors were employed in several middle schools within a large metropolitan county school system in a southeastern state. The investigator selected the participating school counselors from a pool of volunteers based on their motivation to participate and level of counseling competence. The counselors ranged in age from 30 to 50 years, and all were White. The ages of the student clients covered a range of 11 to 14 years with two being White, two African Americans, and one Central American.

An intensive single-subject quantitative design replicated five times was employed in the present study. Following the selection process, the investigator conducted a formal standardized three-session training program for the five counselors. The training included learning how to integrate the results of the Beck Depression Inventory (BDI) and the Sentence Completion Test (SCT) into treatment plans for counseling clinically depressed clients that addressed symptoms of depression and ego development levels of the clients based on Loevinger’s theory. Each of the five counselors passed a knowledge test developed
by the investigator at the close of the training and rated the training program high on a measure of confidence in the training itself.

Thereafter, the five counselors worked independently in dyads, each matched with one clinically depressed client for five counseling sessions lasting approximately 40 to 45 minutes. The investigator served as a mentor/coach to the counselors and monitored their adherence to the treatment plans. During the first counseling sessions, each of the five school counselors administered the BDI and SCT instruments. Thereafter, the BDI was used as a posttest measure of change in depressive symptoms over time, and the SCT data were used to determine if there were issues in the development of the adolescent clients that caused arrested ego development and integrated that information into a variety of cognitive-behavioral counseling strategies chosen to address the clients’ presenting symptoms. Each of the clients tracked their symptoms of depression in journals and on weekly self-monitoring forms, providing continuous behavior observation data over the duration of the treatments and the study.

Across the five replications, pre-to-posttest BDI data indicated decreases in symptoms of depression for all the clients; behavioral observation data indicated decreases in depressive thoughts and occurrences of presented symptoms; and the school counselors submitted favorable reports about the usefulness of the ego development training in their treatment planning and counseling techniques.

Internal validity for the findings was enhanced by the components of the research design that included a standardized training program for the counselors; supervision of the experimental process by the investigator; repeated observations that were planned before the beginning of the data collection; assessment of clearly defined cognitive, behavioral, and
affective process and outcome variables, and comparisons across the five replications of the design. Generalization may seem to be restricted to middle school-aged female clients treated by middle-aged female White counselors in large southeastern metropolitan school districts. On the other hand, external validity was enhanced by the five replications of the intensive single-subject design.

Discussion Topics

Since ego development helps to determine the way in which people view the world, it appeared that taking a look at Loevinger’s and Erikson’s theories of ego development may shed some light on depression and treatment. It was hypothesized that the incorporation of ego development theory along with cognitive-behavioral therapy would produce a reduction in depressive symptoms. Counselors were able to administer the Beck Depression Inventory to get baseline scores of depression at the beginning of their sessions. They also administered the Sentence Completion Test to assess ego level. The counselor participants gave oral feedback at the end of the process in the form of an interview.

Counselor Observations

The counselors reported that they enjoyed the training and were able to learn everything they needed to know about the format, structure, and purpose of the study. They all scored highly (90 percent or above) on the achievement test they took after training. The counselors commended the way in which training was organized and implemented and felt supported throughout training and the sessions.

All of the counselor participants liked using the SCT to gain information about their students’ backgrounds and ego development. They each said that it gave them insight into their client’s past and they were able to try to fill in any gaps if they noticed that there was a
missing piece. They also found that it provided them with a theory/evidence based tool to assist in developing a treatment plan. At the end of the sessions, they re-administered the BDI and all five student participants showed a reduction in symptoms of depression. These results are promising, especially since the assessments they used were well-researched and fairly high in validity and reliability. The counselors appreciated having a tool to assist in counseling sessions that was not time consuming since school counselors are limited on the time they have to spend with individual students. Working with the BDI and SCT helped the counselors to recall things they learned in their respective programs and may have forgotten. The counselors commented on the fact that the BDI and SCT gave them specific things to talk about and address. It eliminated any guesswork and allowed them to delve into the issues behind their students’ depression. Both instruments are excellent diagnostic and treatment tools.

Considerations of Beck Depression Inventory Results

There were similarities across the board in the results of the BDI. All of the student participants decreased their total scores on the BDI the second time they took it. The one area that all students initially ranked as a concern was self-accusations. They all decreased in that area, which can be interpreted as they were less likely to blame themselves for things at the end of treatment than they might have been originally. There was one student (student 3) who actually had several depressive symptoms that increased. At the end of treatment, she scored higher on failure, punishment, indecisiveness, insomnia, fatigue, and somatic preoccupation. There could be several reasons for this increase such as counselor effect, the complexity of her background, or the timing of the test. It is possible that a different counselor with each student would have had an effect on the results. However, it appears
that even minor changes would stand up to scrutiny because of the overall results. Some results were more dramatic than others based on the counselors’ observation of the changes. 

Considerations of Behavioral Observations

The counselors in this study reported that they noticed a reduction in depressive behaviors and symptoms. They worked individually with their student to set goals and reach them. In one particular case (student 2), the counselor unveiled that the student’s father was in prison. She knew that there were trust issues with men based on the SCT. The student’s behavior was poor in class and she knew that this had to be addressed. She observed the student crying on several occasions. By creating a safe place to talk, the student opened up to her and was willing to work on strategies to assist in making school a happier place for her. Another counselor realized that her student had been abused in the past. She had trust issues as well. Making her feel comfortable was top priority. She observed the student being moody, yet talkative. She also observed frustration with school work, which led to a referral.

It is possible that other counselors could have interpreted these behaviors in different ways. However, with the pairing of the behaviors and the depressive symptoms, it appears that the counselors observations were valid.

Cognitive-behavioral Interventions

There were several cognitive-behavioral techniques that were chosen by the counselors to use in this study. Relaxation training, assertiveness training, modeling, role plays, and journaling were all utilized in the sessions. Based on the results and comments from the counselors, they appeared to be helpful. The techniques gave the counselors some freedom to be creative and cater the sessions to the individual student they were working with. It was important for them to have this flexibility so that each student’s needs could be
met. Relaxation training was appropriate and useful for one student, but may not have been for the others.

Limitations and Recommendations for Future Research

All of the participants in this study were females. The reasoning behind this was to ensure that there was no gender confounds to bias the results. More research should be performed regarding ego development and CBT with males to see if they have similar results. This study could be replicated with males and male/female combinations.

Both assessments appear to be multiculturally sound. This study involved participants who were White, African American, and Central American. Since the results indicated lesser depressive symptoms in all cases, it appears that the methods used in this study are useful among all races.

The results look as though they are generalizable since there were different counselors in each case and similar results. Because of the positive feedback from counselor participants, it appears that the training and length of the study were appropriate and effective.
References


Crowley, S. (1994). The children’s depression inventory: A comparison of
generalizability and classical test theory analyses. Educational and Psychological
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Implementing developmental eclecticism. Journal of Humanistic Education and
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School Guidance and Counseling, 22 (3), 231-240.

difference in vulnerability to adolescent depression. Journal of Abnormal Child Psychology,
34 (4), 493-506.

for school counselors. Professional School Counseling, 5, 211-220.
School Counselor, 30 (4), 269-279.
Gfellner, B. M. (1986). Ego development and moral development in relation to age and


Westenberg, P. M., Hauser, S. T., & Cohn, L. D. (2004). Sentence completion measurement of psychosocial maturity. In M. Hersen (Ed.), *Comprehensive*
Title of Study: The Effect of Ego Assessment Training for School Counselors on the Outcome of Cognitive Behavioral Counseling for Female Adolescents Diagnosed as Clinically Depressed

Principal Investigator: Laura A. Taylor  
Faculty Sponsor (if applicable): Dr. Stanley Baker

We are asking your student to participate in a research study. The purpose of this study is learn more about different methods of school counseling, and how they may help adolescents. We want to examine the effect of ego development theory on counseling. Your student will take a Depression Inventory Test at the beginning of the study as well as at the end. This will help her counselor to note changes in depressive symptoms. She will also be administered a Sentence Completion Test to assess ego level. This will help the counselor to see where your student is on an ego level to know how to best work with her.

INFORMATION
If you agree for your student to participate in this study, her school counselor will undergo training to learn how to use a new counseling technique. This new technique will be used in counseling sessions with her. In order to learn how well the new technique works, the researcher will observe some of her sessions, and ask her to keep a journal about her depression as well as to take some surveys. Your student will be asked to attend six counseling sessions for one hour each session for six weeks.

RISKS/BENEFITS
There should be no risks to your child from this study. We are trying out this therapy with your student and her counselor, because we have some reasons to believe it may help teenagers to feel better. If this technique works for your student, she may begin to feel better. However, this is an evaluation of the technique, and we do not yet know if this technique will improve outcomes for teenagers with depression. That is the purpose of this study.

CONFIDENTIALITY
The information in the study records will be kept strictly confidential. Information from the study will be stored securely in a locked drawer in Ms. Taylor’s office at Wakefield Middle School. Confidentiality rules will be followed regarding student journals kept during this study. Students will be able to keep journals at the end of the study. No reference will be made in oral or written reports which could link your student to the study.

CONTACT
If you have questions at any time about the study or the procedures, you may contact the researcher, Ms. Laura Taylor at Wakefield Middle School, 2300 Wakefield Pines Drive, Raleigh, NC 27614 or at 919-562-3515. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. David Kaber, Chair of the NCSU IRB for the Use of Human Subjects in Research Committee, Box 7514, NCSU Campus (919/515-3086) or Mr. Matthew Ronning, Assistant Vice Chancellor, Research Administration, Box 7514, NCSU Campus (919/513-2148)

PARTICIPATION
Your participation in this study is voluntary; you may decide to not participate without penalty. If you decide to participate, you can change your mind at any time and drop out. If you choose not to participate or drop out, you can still receive counseling.
CONSENT
“I have read and understand the above information. I have received a copy of this form. I agree to participate in this study with the understanding that I may withdraw at any time.”

Subject's signature ________________________________  Date ________________

Investigator's signature ___________________________  Date ________________
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Subject's signature ___________________________________________ Date __________

Investigator’s signature _________________________________________ Date __________

54
We are asking you to participate in a research study. The purpose of this study is learn more about different methods of school counseling, and how they may help adolescents.

INFORMATION
If you agree to participate in this study, you will undergo training to learn how to use a new counseling technique. This new technique will be used in counseling sessions. You will be asked to attend training for school counselors where you will learn how to assess ego development levels and incorporate that into therapy for female students who are depressed. You will need to work with the student for six weeks.

RISKS/BENEFITS
There should be no risks to you from this study. We are trying out this therapy with you because we have some reasons to believe it may help teenagers to feel better. If this technique works for your student, she may begin to feel better. However, this is an evaluation of the technique, and we do not yet know if this technique will improve outcomes for teenagers with depression. That is why we are doing the study!

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Subject's signature_______________________________________ Date _________________

Investigator's signature__________________________________ Date _________________
Appendix B

Session 1

<table>
<thead>
<tr>
<th>Subject:</th>
<th>Introduction</th>
<th>Depression Dialogue, Journal</th>
<th>Beck Depression Inventory</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Overview &amp; Purpose</th>
<th>Education Standards Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The client will be introduced to the counseling program and will understand what depression is and will develop goals for counseling.</td>
<td>Psychosocial, emotional areas</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Counselor Guide</th>
<th>Student Guide</th>
<th>Materials Needed</th>
<th>Other Resources (e.g. Web, books, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>Introduce yourself and the program. This program requires that the student be a female in middle school who has been diagnosed as being depressed.</td>
<td>Awareness that there will be a counseling session one time a week for at least six weeks.</td>
<td>Journal</td>
<td></td>
</tr>
<tr>
<td>Understanding of depression</td>
<td></td>
<td></td>
<td>Beck Depression Inventory</td>
<td></td>
</tr>
<tr>
<td>Goal setting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Information | | |
|-----------------|-----------------|---------------|------------------|----------------------------------------|
| Depression | What is depression? (Allow student a chance to answer.) What are your symptoms? What would like to see as an outcome of our meetings? | What does depression mean to the student? What are her symptoms? What outcomes does she want out of counseling? (Improve grades, do not cry at school, make more friends, etc.) | | |

| Verification | | |
|-----------------|-----------------|---------------|------------------|----------------------------------------|
| Paraphrase | Dialogue about the above. | | | |
| Active listening | | | | |

| Activity | | |
|-----------------|-----------------|---------------|------------------|----------------------------------------|
| Journal | Introduce the journal. The student should keep a journal during the six week period so that she can track feelings, symptoms, and experiences. | Student will receive the journal in this session. | Student will complete the Beck Depression Inventory (BDI). | |
| Beck Depression Inventory | | | | |

| Summary | | |
|-----------------|-----------------|---------------|------------------|----------------------------------------|
| | Allow an opportunity for questions and/or clarification. | | | |

| Additional Notes | Score the BDI sometime before the next session. | |
|------------------|----------------------------------------| |
## Session 2

### Subject: Getting into the Groove

### Summary

### Sentence Completion Test

#### Overview & Purpose

The client will understand her results from the BDI and will be introduced to the SCT.

### Education Standards Addressed

- Psychosocial, emotional areas

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Counselor Guide</th>
<th>Student Guide</th>
<th>Materials Needed</th>
</tr>
</thead>
</table>
| Summarize last session | Follow up on items discussed last session. | Share journal from this past week. What feelings have you had? | - Journal
- Beck Depression Inventory results
- Sentence Completion Test |

<table>
<thead>
<tr>
<th>Information</th>
<th>Counselor Guide</th>
<th>Student Guide</th>
<th>Materials Needed</th>
</tr>
</thead>
</table>
| BDI Results       | Go over the results of the BDI. “Tell me about your family.” How do you feel about school?” What do you feel you are good at?” | Student should understand the results of the BDI. | - Journal
- Beck Depression Inventory results
- Sentence Completion Test |
| Discuss background | Introduce the SCT. “I want you to complete this short test. All you have to do is fill in the blanks. This will help me understand a little more about you and where you are coming from.” | Student should respond. Questions about the test or how to complete it? |

<table>
<thead>
<tr>
<th>Verification</th>
<th>Counselor Guide</th>
<th>Student Guide</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraphrase</td>
<td>Dialogue about the above.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active listening</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>Counselor Guide</th>
<th>Student Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCT</td>
<td>Administer the SCT.</td>
<td>Complete the SCT.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Summary</th>
<th>Counselor Guide</th>
<th>Student Guide</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage journaling during the upcoming week.</td>
<td>Allow an opportunity for questions and/or clarification.</td>
<td>Score the SCT sometime before the next session. Assess ego levels and possible gaps.</td>
<td></td>
</tr>
</tbody>
</table>

### Other Resources

- Journal
- Beck Depression Inventory results
- Sentence Completion Test

### Additional Notes

Score the SCT sometime before the next session. Assess ego levels and possible gaps.
## Session 3

### Subject:  
Meat of SCT

### Overview & Purpose

The client will understand that the results of the Sentence Completion Test made the counselor more aware of who she is.

### Education Standards Addressed

Psychosocial, emotional areas

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Counselor Guide</th>
<th>Student Guide</th>
<th>Materials Needed</th>
<th>Other Resources</th>
</tr>
</thead>
</table>
| **Summarize last session** | Follow up on items discussed last session. | Share journal from this past week. What feelings have you had? | Journal  
Sentence Completion Test results |  |
| **Information** | **Sentence Completion Test (SCT)** | Review the purpose of the SCT. Counselor does not need to go into detail about the results, but let the student know that she has a better understanding of who the student is (if you do). |  |  |
| **Verification** | **Paraphrase** | Dialogue about the above. |  |  |
| **Active listening** |  |  |  |  |
| **Activity** | **SCT** | Focus on the parts of the SCT that may not be developed. For example, if she has a low score for the answer for “school is ______”, talk about school and the reason she feels that way. |  |  |
| **Summary** |  | Assess her feelings during the discussion. Is she upset? Discuss feelings regarding subjects that come up. Allow an opportunity for questions and/or clarification. |  |  |

### Additional Notes

Continue to assess ego levels and possible gaps for discussion purposes.
## Session 4

### Subject: Nitty-gritty of SCT

#### Overview & Purpose

The client will understand that the results of the Sentence Completion Test made the counselor more aware of who she is.

#### Education Standards Addressed

Psychosocial, emotional areas

<table>
<thead>
<tr>
<th>Counselor Guide</th>
<th>Student Guide</th>
<th>Materials Needed</th>
<th>Other Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td>Follow up on items discussed last session.</td>
<td>Share journal from this past week. What feelings have you had?</td>
<td><strong>Journal</strong></td>
</tr>
<tr>
<td>Summarize last session</td>
<td></td>
<td></td>
<td><strong>Sentence Completion Test results</strong></td>
</tr>
<tr>
<td><strong>Information</strong></td>
<td>Look at the items from the SCT that she scored particularly high in and the ones that were lower on the scale.</td>
<td>The student will not know which ones are considered high or low.</td>
<td></td>
</tr>
<tr>
<td>Sentence Completion Test (SCT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Verification</strong></td>
<td>Dialogue about the above.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paraphrase</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Active listening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Activity</strong></td>
<td>Discussion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Summary</strong></td>
<td>Assess her feelings during the discussion. Is she upset?</td>
<td>Discuss feelings regarding subjects that come up.</td>
<td><strong>Additional Notes</strong></td>
</tr>
<tr>
<td></td>
<td>Encourage journaling during the upcoming week.</td>
<td>Allow an opportunity for questions and/or clarification.</td>
<td>Continue to assess ego levels and possible gaps for discussion purposes.</td>
</tr>
</tbody>
</table>
# Session 5

<table>
<thead>
<tr>
<th>Subject:</th>
<th>Transition</th>
<th>SCT</th>
<th>BDI</th>
</tr>
</thead>
</table>

## Overview & Purpose

The client will understand that the results of the Sentence Completion Test made the counselor more aware of whom she is. She will also take the BDI again.

## Education Standards Addressed

Psychosocial, emotional areas

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Counselor Guide</th>
<th>Student Guide</th>
</tr>
</thead>
</table>

**Summarize last session**

Follow up on items discussed last session.

Share journal from this past week. What feelings have you had?

**Look at the items from the SCT that she scored particularly high in and the ones that were lower on the scale.**

The student will not know which ones are considered high or low.

**Materials Needed**
- Journal
- Sentence Completion Test results
- Beck Depression Inventory

<table>
<thead>
<tr>
<th>Information</th>
<th>Counselor Guide</th>
<th>Student Guide</th>
</tr>
</thead>
</table>

**Sentence Completion Test (SCT)**

Look at the items from the SCT that she scored particularly high in and the ones that were lower on the scale.

**Materials Needed**
- Journal
- Sentence Completion Test results
- Beck Depression Inventory

<table>
<thead>
<tr>
<th>Verification</th>
<th>Counselor Guide</th>
<th>Student Guide</th>
</tr>
</thead>
</table>

**Paraphrase**

Dialogue about the above.

**Activity**

Discussion.

Administer the BDI again. This will allow you to compare the results from the last time and note any changes/improvements.

Complete the BDI.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Counselor Guide</th>
<th>Student Guide</th>
</tr>
</thead>
</table>

**SCT**

Administer the BDI again. This will allow you to compare the results from the last time and note any changes/improvements.

**BDI**

Discuss feelings regarding subjects that come up.

Allow an opportunity for questions and/or clarification.

**Summary**

Assess her feelings during the discussion. Is she upset?

Encourage journaling during the upcoming week.

Discuss feelings regarding subjects that come up.

Allow an opportunity for questions and/or clarification.

**Additional Notes**

Score the BDI before the next session. Prepare comparison chart to show where she was and where she is now. Note improvements.
## Session 6

### Subject: Finale

<table>
<thead>
<tr>
<th>Overview &amp; Purpose</th>
<th>Education Standards Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The client will be able to assess whether or not she met her counseling goals (set in Session 1).</td>
<td>Psychosocial, emotional areas</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Counselor Guide</th>
<th>Student Guide</th>
<th>Materials Needed</th>
<th>Other Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summarize last session</td>
<td>Follow up on items discussed last session.</td>
<td>Share journal from this past week. What feelings have you had?</td>
<td></td>
</tr>
<tr>
<td><strong>Information</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Discuss changes in BDIs from Test 1 to Test 2, if any.</td>
<td>The student may be able to tell you what they see that is different, based on the comparison chart.</td>
<td></td>
</tr>
<tr>
<td><strong>Verification</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paraphrase</td>
<td>Dialogue about the above.</td>
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<tr>
<td><strong>Activity</strong></td>
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</tr>
<tr>
<td>Reflection</td>
<td>“Have you seen a reduction in your symptoms of depression since we have been meeting?</td>
<td>“You told me in the beginning that you wanted to _____ (reduce crying, improve grades, etc.). Have you been able to do that?</td>
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<tr>
<td><strong>Summary</strong></td>
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<td></td>
<td>Assess her feelings during the discussion.</td>
<td>Discuss feelings regarding subjects that come up.</td>
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<td></td>
<td>Encourage further sessions as needed.</td>
<td>Allow an opportunity for questions and/or clarification.</td>
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**Additional Notes**

Leave the door open and remember to follow up!
Appendix C

Attitude Toward Treatment Scale (ATT)

Based on your experience with this training, please answer the following questions by circling the number on the scale which is closest to your feelings.

1. How confident are you that this program was successful in helping you?

1     2           3     4  5  6  7
Not at all                                      Somewhat                           Very
Confident                                      Confident                           Confident

2. How logical does this type of program seem to you?

1     2           3     4  5  6  7
Not at all                                      Somewhat                           Very
Logical                                        Logical                            Logical

3. Are you willing to undertake a similar program sometime in the future?

1     2           3     4  5  6  7
Not at all                                      Somewhat                           Very
Willing                                        Willing                            Willing

4. How beneficial do you think this program was for you?

1     2           3     4  5  6  7
Not at all                                      Somewhat                           Very
5. How does this program compare in effectiveness with just doing nothing?

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<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td></td>
<td>Much worse</td>
<td>Same</td>
<td>Much better</td>
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<td>Than nothing</td>
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<td>than nothing</td>
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6. How does this program compare in effectiveness with teaching yourself?

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<tbody>
<tr>
<td></td>
<td>Much better than</td>
<td>Same</td>
<td>Much worse than</td>
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<tr>
<td>Teaching self</td>
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<td>Teaching self</td>
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7. How useful were the described program techniques?

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<td>Not at all</td>
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Appendix D

Achievement Test for Counselors

True/False

1. This study is designed to address depression by incorporating ego development theory into counseling. 
   True    False

2. Students may set goals such as improving grades or reducing crying episodes. 
   True    False

3. To score Beck’s Depression Inventory, you simply add up the totals of the numbers by the chosen statements. 
   True    False

4. Loewinger’s first stage in her ego development theory is Conformist. 
   True    False

5. You should explain the rule of confidentiality as it relates to the journal. 
   True    False

Multiple Choice

6. Which of the following is not a goal of this study? 
   Symptom Reduction    Knowledge of ego level    Reaching the Integrated Stage

7. Why are you working with female students only? 
   This won’t work with boys    To reduce gender confound    Girls are more suicidal

8. To incorporate the SCT into counseling sessions, you may 
   Discuss items that are high or low    Tell them what they scored    Tell them what to work on

9. Which is not a likely ego development level where middle school students may be? 
   Self-Protective    Conformist    Autonomous

10. The purpose of having a comparison chart for the BDI is to 
    Identify ego level    Point out weaknesses    Show improvements in symptoms
# Appendix E

## Weekly Symptom Record

<table>
<thead>
<tr>
<th>Date</th>
<th>Symptom</th>
<th>Event that triggered it</th>
<th>Rating 1-5 How bad was it? (1- not so bad – 5- really bad)</th>
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