Illinois State University
ISU ReD: Research and eData

Theses and Dissertations

6-26-2018

Experiential Similarity Of Depression And Interpersonal Empathy

Sarah E. Caputo
Illinois State University, secaput@ilstu.edu

Follow this and additional works at: https://ir.library.illinoisstate.edu/etd

🟡 Part of the Psychology Commons

Recommended Citation

EXPERIENTIAL SIMILARITY OF DEPRESSION AND INTERPERSONAL EMPATHY

SARAH E. CAPUTO

56 Pages

The ability to build and maintain supportive, social relationships has been linked to both physical and psychological well-being (e.g., Baumeister & Leary, 1995; Kawachi & Berkman, 2001). Yet, social struggles are a commonly observed symptom among individuals with Major Depressive Disorder (MDD), particularly with regards to interpersonal empathy. Perceptions of interpersonal similarity can influence empathic engagement with others (e.g., Batson et al., 1996; Hodges, Kiel, Kramer, Veach, & Villanueva, 2010); often, interpersonal similarity will lead to greater empathic engagement. The present study asked participants to listen to audio clips of a fictitious therapy client discussing either depression or non-depression-related financial distress and then to indicate the degree to which they felt and expressed empathy for this client via written response letters. I hypothesized that participants with depression would report greater *feelings* of empathy than non-depressed participants and that depressed participants who specifically listened to the audio clip of a depressed peer would *express* greater empathy for their peer than depressed participants who listened to the audio clip related to financial distress and non-depressed participants in either recording condition. Although these hypotheses were not supported, a discussion of possible implications for this research is offered.

KEYWORDS: emotion; depression; similarity; empathy

EXPERIENTIAL SIMILARITY OF DEPRESSION AND INTERPERSONAL EMPATHY

SARAH E. CAPUTO

A Thesis Submitted in Partial
Fulfillment of the Requirements
for the Degree of

MASTER OF SCIENCE

Department of Psychology

ILLINOIS STATE UNIVERSITY

2018

EXPERIENTIAL SIMILARITY OF DEPRESSION AND INTERPERSONAL EMPATHY

SARAH E. CAPUTO

COMMITTEE MEMBERS:

Jeffrey Kahn, Chair

Corinne Zimmerman

ACKNOWLEDGMENTS

CONTENTS

TABLES

FIGURES

CHAPTER I: INTRODUCTION

The ability to build and maintain supportive, social relationships has been linked to both physical and psychological well-being (e.g., Baumeister & Leary, 1995; Kawachi & Berkman, 2001). Social integration, social networks, and readily available social support can provide myriad health benefits including decreased risk of cardiovascular issues (Brummett et al., 2001), lower rates of depressive symptoms (e.g., Vanderhorst & McLaren, 2005), and even lower risk of early mortality (House, Landis, & Umberson, 1988). Given the established connection between social success and well-being, this raises possible implications for those who struggle to remain part of a healthy social network.

Social struggles are a pervasive challenge among those with Major Depressive Disorder (MDD). As discussed by Nezlek, Hampton, and Shean (2000), depressed individuals tend not to enjoy and experience the same degree of intimacy in their social relationships as non-depressed individuals. Thus, those who struggle with depression often appear to be more isolated and socially withdrawn than their non-depressed counterparts. This particular challenge is rendered even more insidious because of the circular nature of this relation: those who are depressed tend to struggle with maintaining social relationships, and the resultant social isolation tends to fuel depressive symptoms (e.g., Vanderhorst & McLaren, 2005).

A foundational component of successful social interaction and social relationships is the ability to engage in empathic responses to the mental states of another (Cliffordson, 2002). In short, the ability to understand another person's cognitive and affective experience may open the door for compassion, caring, and willingness to engage in pro-social behaviors (Decety, 2010;

Eisenberg & Eggum, 2009). As such, it has further been shown that a breakdown in empathy may itself lead to social strain (Bailey, Henry, & Von Hippel, 2008).

Empathic deficits have also been shown to be a common symptom of depression (e.g., O'Connor, Berry, Weiss, & Gilbert, 2002; O'Connor, Berry, Lewis, Mulherin, & Crisostomo 2007). Although depression is commonly characterized by such empathic deficits, O'Connor and colleagues (2007) are careful to explain that it is not necessarily the case that depressed individuals do not feel empathy for others – in fact, it may be quite the opposite. O'Connor et al. (2007) clarify that depressed individuals actually feel *highly* empathetic for others; however, because of the increased levels of personal (empathic) distress that result from empathic engagement, these individuals often become overwhelmed and begin to avoid these kinds of interactions. Thus, although it may *behaviorally* appear that depressed individuals do not feel an appropriate level of empathy due to this observed social withdrawal, this external behavior may be grounded in hindering levels of internal empathic experiences.

Interactions with those who we perceive as similar-to ourselves have been shown to influence our feelings of empathy for other people (e.g., Batson et al., 1996; Hodges, Kiel, Kramer, Veach, & Villanueva, 2010). In short, we tend to feel and express greater levels of empathy for "people like us." As it currently stands, there is little research on how individuals with depression may relate to each other; rather, most research in the area of empathy and similarity has occurred specifically within therapeutic (i.e., therapist-client) contexts or in the context of how depressed individuals relate to others more generally (who may or may not understand what it is like to be depressed).

In what follows, I outline the socially relevant characteristics of MDD, how empathy may lie at the heart of successful social interaction, and the relations between empathy, interpersonal

similarity, and MDD. The present study explored whether providing a social context of understanding of depressive experiences would allow depressed individuals the opportunity to appropriately express feelings of empathy for another person. In doing so, I aimed to better understand the social implication of MDD that may allow for further progress in the alleviation of depressive symptoms.

Defining Depression

Major Depressive Disorder (MDD) can be characterized by a prolonged, depressed mood, marked decrease in pleasure from previously enjoyed activities, difficulties with sleep and concentration, and a number of other "sluggishness-inducing" symptoms that greatly impair daily functioning (American Psychiatric Association, 2013). When in the midst of a depressive episode, an individual may find him- or herself experiencing feelings of helplessness or worthlessness, a desire to socially withdraw, and, in severe cases, self-injurious or suicidal ideation. Colloquially referred to as the "common cold" of mental disorders, in 2015, it was estimated that nearly 7% of the U.S. adult population (approx. 16.1 million people) had experienced a major depressive episode within the past year (National Survey on Drug Use and Health, 2015).

Of particular import to the present study are the commonly observed social deficits in those who suffer from depressive symptoms. Depressed individuals tend not to fully engage in socially appropriate behaviors (e.g., smiling, eye contact, head nodding) and rate themselves as having poor social skills (see Segrin, 2000 for a more complete review). They are less likely to self-disclose their emotional experiences (e.g., Kahn & Garrison, 2009) and are less likely to seek out and to receive appropriate social support (e.g., Rimé, Finkenauer, Luminet, Zech, &

Philippot, 1998; Williams & Galliher, 2006) than non-depressed individuals. As a result, depressed individuals often withdraw from many of their social relationships.

Previous research has suggested that such social withdrawal may, in part, be linked to deficits in empathy – a cornerstone of social interaction – among those with depression (e.g., O'Connor et al., 2007). If a person struggles to appropriately process and empathically respond to others' displays of emotion (particularly emotional distress), this could indeed negatively impact one's social success. Gaining a better understanding of the development and associated symptoms of MDD within the realm of social interaction may bring about widespread alleviation to those currently suffering from this common disorder.

Empathy and Depression

Although current research has yet to reach a consensus on the exact constituents of empathy, it is widely accepted that empathy appears to involve both affective and cognitive components (i.e., emotional responses to the cognitive and/or affective states of another person and actually understanding the mental states of another, respectively). In short, to engage in an empathic interaction is to take on the emotional (or cognitive) states of another, thus understanding another person's experience through "vicarious merging" with another's feelings (Escalas & Sterns, 2003). Feelings of sympathy, in contrast, involve understanding another's feelings via *the listener's own perspective* rather than through the perspective of another person. To illustrate this difference, imagine a situation in which Person A expresses feelings of sadness to Person B; upon engaging with Person A, Person B may demonstrate feelings of *sympathy* by imagining what Person A may be perceiving and experiencing and deducing an appropriate response, whereas feelings of *empathy* may be demonstrated by Person B's involuntary urge to cry along with Person A in response to Person A's experience. The present study sought to

4

understand these latter feelings of empathy as they may arise in individuals who share similar experiences of depression.

To date, empathic interactions have primarily been investigated within the therapist-client relationship (e.g., Elliot, Watson, Bohart, & Greenburg, 2011). Although empathy may indeed influence the success of these specific relationships, the majority of empathic responses occur outside of this context as a foundational component of daily life. It has been shown that successful social relationships depend, in part, on one's ability to appropriately engage in responses of other-oriented empathic concern (Cliffordson, 2002). For example, a person's ability to demonstrate feelings of empathy may lead to greater feelings of compassion and caring (Decety, 2010), which in turn may be related to greater levels of motivation for pro-social behaviors (Eisenberg & Eggum, 2009).

It is important to note a distinction between *internal feelings* of empathy and *behavioral demonstration* of empathy. Current literature in emotion research differentiates between the internal experience of emotion (i.e., emotional reaction) and the observable behaviors (i.e., emotional response) that one may produce as a result of his or her emotional reaction and regulation style (e.g., Gross, 2002; Gross & John, 2003). In short, the manner in which an individual responds to an internal emotional experience can be modulated by this individual's ability to regulate his or her experience (Carthy, Horesh, Apter, & Gross, 2010). As an illustration of this discrepancy, Carthy et al. (2010) examined the emotional responses of anxious and non-anxious children (as assessed by medical professionals) when faced with emotionally-provoking scenarios (e.g., "Your mother was supposed to return home from work but she is late. What are you first thoughts? How would you calm yourself down in this situation?"). It was found that anxious children with diminished emotional-regulation skills reacted more negatively

(e.g., resorted to avoidance behavior) and more intensely (e.g., felt a lesser sense of emotional control) than anxious children with appropriate regulation skills and non-anxious children. In other words, when presented with similar events, these children responded differently depending upon their reactions to and abilities to regulate their emotional responses within emotionally provoking situations. This provides support for the notion that one's internal, emotional reactions may not necessarily "match" the observable response.

In relation to MDD, previous research has suggested a similar discrepancy between internal feelings and external behavior. When processing an empathic response, individuals with MDD may *appear* to be less empathetic in their expression of emotion, but this may not necessarily reflect internal deficits in empathy. As discussed by O'Connor et al. (2002), individuals with depression are actually highly attuned to the distress of others and thus experience a high degree of empathic arousal. However, because such responses also tend to lead to a greater amount of empathic distress, the behavioral consequence is an appearance of depleted empathy, as observed through the social withdrawal that may be used to prevent further distress.

Such difficulties in translating internal experience to external behavior were further explored in a discussion by O'Connor et al. (2007). O'Connor and colleagues posit that individuals with depression struggle to maintain an appropriate degree of separation between their own feelings and the feelings of others. It is not that case that depressed individuals have a dysfunctional system of empathy but that they often misattribute the cause of another's emotional distress to their own actions. As a result, they may lack the ability to effectively and appropriately respond to others due to their being "stuck" in a cycle of self-blame and fear of negative social evaluation (Flory, Räikkönen, Matthews, & Owens, 2000). Although these

individuals do indeed desire to maintain their social relationships, this harmful pattern often leads them to withdraw from others in order to lessen their (perceived) social impact and to attenuate their own feelings of empathic distress. Further, as O'Connor et al. (2007) discuss, depression is known to be "contagious": friends, family, and caretakers may also fall victim to becoming overly self-focused, feeling that they are themselves responsible for these individuals' pain, thus perpetuating the cycle of depression.

Similarity and Empathy

Perceptions of interpersonal similarity can be influenced by a variety of factors including personality traits, personal values, and even the mere coincidence of having the same birthdate as another person (Miller, Downs, & Prentice, 1998). Of recent interest is the notion that perceived similarity is itself an indicator of social closeness (Liviatan, Yaacov, & Liberman, 2008). It is a well-known and robust finding in social-psychology research that when attempting to form or integrate into an "in-group," people tend to gravitate towards those who are perceived as similar-to themselves (e.g., Brewer, 1979; Wright, Giammarino, & Parad, 1986). Further, perceptions of similarity (and in effect, social closeness) can affect behaviors related to group conformity and normativity (e.g., Hohmana, Gaffney, & Hogg, 2017), intra-group altruism and inter-group tension (e.g., Halevy, Bornstein, & Lilach, 2008), and, of particular import for the present study, feelings of empathy for others (e.g., Batson et al., 1996; Davis, 1994; Papp, Kouros, & Cummings, 2010).

Previous research has taken a variety of approaches in attempts to establish a link between feelings of empathy and interpersonal similarity, but mixed results have yet to provide clear evidence in support of such a link. In addition, this area of research has primarily developed within the context of a therapist-client relationship despite the fact that most empathic

interactions and social comparisons for similarity occur beyond the confines of this specific relationship. Some researchers have examined empathic responses between clients and patients with similar demographic characteristics (e.g., age, sex, gender). For example, in examining women within two age groups (25-35 years and 60-70 years) as they interacted with female counselors ranging in age from 26-66 years, Robiner and Storandt (1983) found no difference between the client groups in perceptions of counselor facilitation (e.g., empathy, genuineness, regard for client) and therapeutic satisfaction. In other words, similarity of age did not appear to play a significant role in client's perceptions of therapeutic empathy and evaluations of therapeutic success in these relationships. However, other measures of demographic similarities may tell a different story. For example, Grantham (1973) found that Black university students significantly preferred the therapeutic outcomes of a session with Black counselors than with White counselors. In this case, similarity of race indeed brought forth a greater sense of therapeutic satisfaction in Black students, who rated Black counselors more highly on similar facilitative abilities as those described above.

These latter results of racial similarity and perceived therapeutic satisfaction raise the question of the unique impact that certain personal characteristics may have on empathic responding: is a characteristic such as race a simple piece of demographic information or is it something more? It is imaginable that this particular part of a person's identity is less about the mere similarity of a personal characteristic and more about the similarity of *experiences* that two people in a particular group may share. Although these studies of age and race have provided a starting point, more recent research has delved further into exploring empathy as it arises via experiential similarity.

It is this dimension of experiential similarity that has brought about a second line of research that expands beyond externally observable measures of demographic similarity (e.g., age, race), exploring interpersonal empathy as it arises via perceptions of similar *experiences*. This line of research has attempted to understand the implications of not only stating, "I'm like that, too" but offering, "I've *been there*, too". For example, Hodges and colleagues (2010) demonstrated that women's similarity of motherhood experiences influenced empathic responses between these women. In their study, Hodges et al. (2010) asked participants who were either new mothers, currently pregnant, or who were neither pregnant nor experienced in raising children to respond to the experiences of new mothers. Participants in each motherhood category (deemed "perceivers") were asked to watch video recordings of new mothers speaking about their own motherhood experiences. After viewing the recording, perceivers responded to measures of empathic concern and wrote response letters to the mothers in the recordings. Perceivers who themselves were new mothers (i.e., most closely aligned in experiences to the new mothers in the video recordings) expressed greater empathic concern for the women in the video recordings than women who were either currently pregnant or who had never experienced pregnancy or motherhood.

In a more clinically relevant context, Barnett, Tetreault, and Masbad (1987) found that female victims of sexual assault felt both more similar-to and empathetic towards an actress who described herself as a victim of sexual assault than did participants who were not victims of sexual assault. In this study, victims and non-victims of sexual assault were asked to watch 5-6 min videotapes of a peer's initial session with a therapist. In these videotapes, an actress discussed either her assault experience or another unrelated problem (e.g., death of a brother or an alcohol-dependent father) with an off-screen (acting) therapist. Barnett et al. found that even

9

when controlling for dispositional empathy, participants who were themselves sexual-assault victims indeed identified more closely with and felt greater empathy towards the actress in the assault condition than did control participants. Further, there were no group differences in these measures within the non-assault condition, suggesting that the increase in empathy within the assault condition was indeed influenced by the unique experience of having been sexually assaulted. Taken together, Hodges et al. (2010) and Barnett et al. (1987) demonstrate that *experiential* similarity – regardless of the emotional nature of that experience – can indeed lead to greater feelings of empathy for those who share the experience.

Generally speaking, people tend to seek interpersonal connection with others whom they view as similar-to themselves, even if such similarity comprises the experience of a negative event. As Rimé et al. (1998) discuss, the social sharing of negative experiences can allow for (a) clarification of an emotion, (b) distance from a particular emotional event, (c) finding meaning in an event, (d) increased social support, and (e) re-integration into a social environment if a negative emotional event has previously led to social withdrawal. However, those who suffer from depression are far less likely to engage in this process of social sharing than non-depressed individuals (e.g., Kahn & Garrison, 2009), which may contribute to the perpetuation of negative affect and rumination that maintains their depressive symptoms. Thus, because a depressed individual is less likely to engage in social-similarity-seeking behaviors through social sharing, he or she may not be presented with the same opportunities to alleviate his or her negative emotions as a non-depressed person.

This lack of social sharing with others may be attributed to both self- and other-oriented discomforts surrounding self-disclosure. Internally, depressed individuals are more likely to attempt to avoid their negative feelings than non-depressed individuals through thought

suppression (e.g., Purdon, 1999) and attempts to rigidly control and suppress their emotional experiences (e.g., Hayes, 1987). In relation to others, depressed individuals also tend to perceive their negative emotional experiences as being less significant than the negative emotional experiences of others. Because of these tendencies, they may avoid sharing their own negative experiences, in part, because they fear that they will appear to believe that their experiences are more important than the experiences of others (O'Connor et al., 2002). As these individuals continue to avoid experiences of social sharing, they become less socially engaged, thus leading to perceptions of decreased social support and feeling misunderstood by their social circle (e.g., George, Blazer, Hughes, & Fowler, 1989; Williams & Galliher, 2006). This in turn may lead to further social isolation and withdrawal, continuing to fuel the cycle of depression.

The Present Study

The primary question of interest was whether creating a situation in which depressed participants were made explicitly aware of the experiential similarities between themselves and a (fictitious) peer would override the depressive tendency to not engage in empathic responding. Given that individuals with depression tend to avoid seeking out other people with whom to share their emotional experiences, it was thought that perhaps providing a social context in which experiential similarity of depression may promote interpersonal understanding would provide the appropriate opportunity for a depressed person to externally demonstrate their internal experience of empathy? Ultimately, my thesis research attempted to address this gap in the current literature.

Thus far, there indeed appears to be a link between empathy, social functioning, and depression (e.g., O'Connor et al., 2002; O'Connor et al., 2007). However, these relations have primarily been studied in a therapeutic context or when evaluating individuals with depression

on empathic measures more generally as they relate to those who may not know what it is like to be depressed. I feel that it is an oversight to not investigate how individuals with depression may relate to each other. It may indeed be true that these individuals engage in empathy in a systematically depleted manner more generally, but perhaps the demonstrated (i.e., behavioral) empathic deficits are a function of the kinds of relationships most often examined in this line of research. In other words, researchers may simply be asking a different question; if an individual with depression feels that those within their social network will not be able to understand his or her experiences because others simply "haven't been there," it is possible that this may account for the reluctance to disclose the experience of depression and to fully engage in these relationships.

Ultimately, I was interested in examining whether individuals who identified as someone who has experience with depression and/or who displayed depressive symptomology may empathetically engage with a depressed peer differently than individuals who have not had similar depressive experiences to a fictitious peer. It is important to note that only female participants were asked to participate in this study; previous research has shown that women are more likely than men to feel empathetic toward a distressed peer, to assist a distressed peer, and are often more empathetic at baseline compared to men (Trobst, Collins, & Embree, 1994). As such, it was decided that using only female participants would more easily allow us to elicit empathic responding during the study.

Building upon Hodges et al. (2010) and Barnett et al. (1987), I asked female participants to listen to audio clips of a fictitious peer describing either (a) her experiences with depression or (b) her experiences with non-depression-related financial distress to a (fictitious) therapist. Following this, participants responded to empathy-related measures for this fictious client and

wrote a response letter to the confederate describing their reactions to the respective recording (following Hodges et al., 2010). I posited that creating a sense of experiential similarity would lead depressed participants to more empathically engage with another person whom they perceived as similar-to themselves, thus overriding the depressive tendency to disengage from externally observable empathic responses. Investigating this idea may allow for better understanding of how some of the common symptoms of depression may be alleviated through empathic understanding. As such, clinicians, counselors, family members, and friends of depressed individuals may be able to facilitate and support the building of better social relationships by providing a more empathic, supportive network for those suffering from depression.

Hypotheses

I held two primary hypotheses about the proposed study. First, in-line with previous research about depression and empathy (e.g., Connor et al., 2002), I expected that participants with depression would report greater *feelings* of empathy than non-depressed participants regardless of the primary concern presented within each audio condition (i.e., depression or financial distress). Second, following previous findings related to similar experience and empathy (e.g., Barnett et al., 1987; Hodges et al., 2010), I expected that depressed participants who specifically listened to the audio clip of a depressed peer would *express* greater empathy for their peer than depressed participants who listened to the audio clip related to financial distress and non-depressed participants in either recording condition. See Figure 1 below for a graphic representation of these expected outcomes.
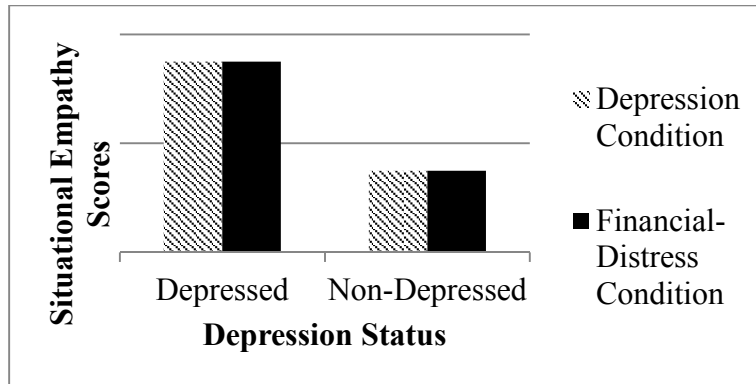
(A)
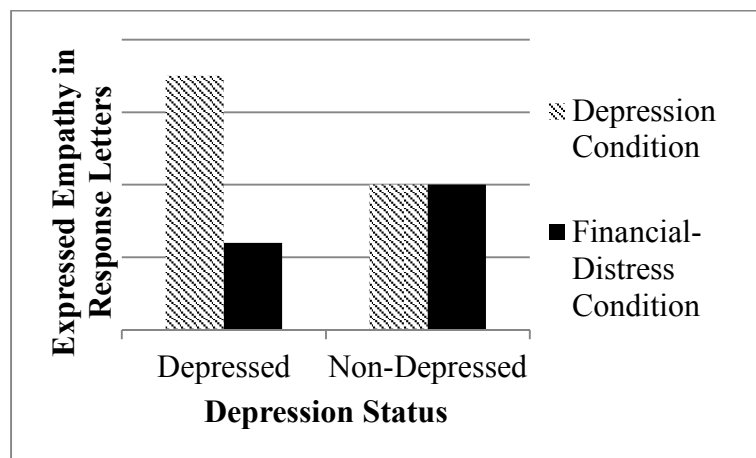
(B)

Figure 1. Predictions. **(A)** I expected a main effect of depression history such that depressed participants would report significantly greater feelings of empathy in both audio conditions than non-depressed participants. **(B)** I expected an interaction effect of audio condition and depression status such that depressed participants who listened to depression-related dialogue would express greater empathy in their response letters than both depressed participants listening to financial-distress-related dialogue and non-depressed participants.

CHAPTER II: METHOD

Participants

Seventy-one female participants from Illinois State University were recruited via SONA – the online research-participation system – and were compensated with extra credit in a psychology course. Three participants of the total 71 were excluded from analyses due to technical issues that prevented them from completing the study. Given the time constraints on this research, it was decided that we would collect data from as many participants as possible during the data-collection period. Participants were of an average age of 20.22 years ($SD = 1.80$). Twelve participants identified as African-American, 2 identified as Asian American or of Asian Descent, 2 identified as Biracial or Multiracial, 45 identified as Caucasian or European American, and 7 identified as Latina.

Design

The primary study used a between-subjects design with an independent variable of audio condition (depression vs. finance distress). In addition, a quasi-independent variable of depression status (depressed vs. non-depressed), categorized via participants' self-identification as someone with depression (measured via a yes-or-no response) and, separately, by categorizing participants into depressed and non-depressed groups based on diagnostic criteria for depression-related items. Dispositional empathy was used as a covariate. All participants responded to measures of feelings and expressions of empathy for the fictious client in each audio condition.

Measures

Although all measures described below were used in this study, it should be noted that I only held specific hypotheses about the relations between depression status and empathy-related

measures. Data from all other measures reflect constructs that may be related to depression and thus may be used in future hypothesis testing that is beyond the scope of the present study.

Initial Measures

The following measures were administered in the first phase of the study, prior to administration of the audio task.

Socially Desirable Response Set Five-Item Survey (SDRS-5). The SDRS-5 is a short questionnaire (α = .63) designed to measure an individual's level of social desirability (i.e., a tendency to present one's self favorably) (Haghighat, 2007). This measure comprises 5 items to which participants responded on a 1 (*Definitely true*) to 5 (*Definitely false*) Likert scale; scores could range from a minimum of 5 to a maximum of 25 points.

Difficulties in Emotion Regulation Scale – Short Form (DERS-SF). DERS-SF is a reliable (α = .89), 18-item questionnaire designed to measure an individual's emotional-regulation strategies (Kaufman et al., 2015). Responses were made on a 1 (*Almost never*) to 5 (*Almost always*) Likert scale; scores could range from a minimum of 18 to a maximum of 90 points.

Center for Epidemiologic Studies Depression Scale – Revised (CESD-R). The CESD-R (Eaton, Smith, Ybarra, Muntaner, & Tien, 2004) is a 20-item, reliable measure (α = .97) of depressive symptoms as they have occurred within the past two weeks. Reponses were made on a 0 (*Not at all or less than 1 day*) to 3 (*5-7 days* OR *Almost every day for 2 weeks*) Likert scale; the measure is designed in such a way that scores could range from a minimum of 0 to a maximum of 60 points. According to diagnostic criteria, participants who scored 16 or more points were classified as having experienced a clinically significant depressive episode. This provided a measure of *recent* depressive experiences.

History of depression questionnaire. This questionnaire, developed specifically for this study, includes items that have been adapted from the Structured Clinical Interview for the *Diagnostic and Statistical Manual of Mental Disorders* for Patients (SCID-I/P; First, Spitzer, Gibbon, & Williams, 2002), designed to assess the presence of *previous* major-depressive episodes. Participants indicated yes-or-no responses for each item. Following scoring guidelines, participants who indicated having experienced five or more symptoms within a two-week period qualified as having had a major-depressive episode. Participants also responded to two additional questions regarding medication history in which they indicated (yes or no) whether they had previously or were currently taking anti-depressant medication and whether or not they personally identified as someone who has experienced depressive symptoms. In short, it was decided that although a participant may display appropriate symptomology for depression via CESD-R and SCID-I/P measures, it was important that participants also personally identified as someone with depression in order to establish perceived interpersonal similarity to the fictious therapy client.

Interpersonal Reactivity Index (IRI). The IRI (Davis, 1980) is a 28-item, multi-dimensional questionnaire commonly used to assess dispositional levels of empathy. The IRI comprises seven questions within four subscales of empathy (i.e., *perspective taking, fantasy, empathic concern,* and *personal distress*). The present study used only the most relevant subscales of *empathic concern* and *personal distress* in subsequent analyses ($\alpha = .71$). Responses were made on a Likert scale that ranged from 0 (*Does not describe me well*) to 4 (*Describes me very well*); scores on the relevant subscales could range from a minimum of 0 to a maximum of 56 points. I used the data from this measure to control for participants' dispositional empathy

when assessing relations between depression, similarity, and situational empathy (following Barnett et al., 1987).

Multidimensional Scale of Perceived Social Support (MSPSS). The MSPSS is a 12-item questionnaire ($\alpha = .92$) designed to measure one's perceived level of social support from a significant other, family, and friends (Zimet, Dahlem, Zimet, & Farley, 1988). Total perceived social support can also be calculated from responses across these three sources of support. Responses were made on a 1 (*Very strongly disagree*) to 7 (*Very strongly agree*) Likert scale; scores could range from a minimum of 12 to a maximum of 84 points.

Brief Resilience Scale (BRS). The BRS (Smith et al., 2008) is a 6-item questionnaire ($\alpha = .84$) designed to measure one's ability to recover from stress. Responses were made on a 1 (*Strongly disagree*) to 5 (*Strongly agree*) Likert scale; scores could range from a minimum of 6 to a maximum of 30 points.

Demographics and other measures. In addition to all measures listed above, participants were asked to provide some demographic information (e.g., age, race, year in school, etc.) and to indicate whether or not they had ever experienced worry about financial distress in order to control for potential similarity within the control (financial-distress) condition. I again note that although I did not hold specific hypotheses about each of the pre-test measures, data from each item was collected for possible hypothesis testing in the future as they may relate to depression and empathy.

Primary Study Measures

The following measures were administered in the second phase of the study.

Situational empathy. To assess internal feelings of empathy following the presentation of each audio clip (i.e., financial-distress or depression conditions), participants responded to

Batson et al.'s (1996) self-reported, situational empathy measure. This measure includes 14 total questions (6 questions related to feelings of empathy, 8 questions related to feelings of personal distress) designed to assess participants' empathic responses as they may have arisen by listening to the respective audio clip. Responses were made on a 7-point Likert scale from 0 (*Not at all*) to 6 (*Extremely*); scores could range from a minimum of 0 to a maximum of 84 points. Although participants responded to all items in the questionnaire, only those items categorized as "empathic concern" items were used in relevant analyses ($\alpha = .84$), for a total of 6 items ranging from 0 to 36 points.

Empathic expression questionnaire. Participants concluded their experimental sessions with a questionnaire comprising five total questions ($\alpha = .85$) with which they evaluated the degree of empathy perceived to be expressed in their written response letters (adapted from Hodges et al., 2010). Participants responded to this questionnaire immediately after reviewing the letter that they had just written to the fictitious female client. Responses were made on a 9-point Likert scale ranging from 0 (*Not at all*) to 8 (*Very much*); scores could range from a minimum of 0 to a maximum of 40 points.

Procedure

Initial Measures

All participants were recruited via SONA to participate in this study. Upon arriving to the lab, they first provided informed consent before beginning the experiment and were told that they could cease participation at any time without penalty. Participants were first asked to respond to a series of computer-administrated questionnaires. This initial phase contained the SDRS-5, DERS-SF, CESD-R, history of depression questionnaire, IRI, MSPSS, BRS, and other measures related to demographic information and history of financial distress (to control for

similarity to the financial-distress condition; all as described above). All measures were administered via the Qualtrics online survey platform. When participants had completed this initial phase, a research assistant directed them to begin the second phase of the study.

Presentation of Audio of Intake Interview

In the second phase, participants were first asked to use a pair of headphones to listen to audio clips of a simulated counseling session for a (fictitious) peer who was experiencing a particular life stressor (i.e., depression or financial distress) under the following instructions:

> For the next part of the study, you will listen to a simulated counseling session for a fictitious client who is experiencing a particular life stressor. Please imagine that the client in the audio clip is an actual woman who sought guidance from a therapist and imagine what you might say to the client in response to her experiences.

> Then, participants were randomly assigned to listen to one of the two audio clips (see Appendix A for a dialogue script for the depression condition; see Appendix B for a dialogue script for the financial-distress condition). Each audio clip was approximately 7 min in length. By using the same female client across both conditions, this allowed us to maintain better control over the presentation of the described stressors in hopes of being better able to tease apart any effects due to either depression status or perception of similarity to the client.

Post-Recording

Following the presentation of the respective audio clip, participants then responded to Batson et al.'s (1996) self-reported measure of situational empathy to assess feelings of empathic concern and personal distress as they may have arisen while hearing the fictious therapy session. In order to assess expressions of empathy toward the client, participants were then asked to write a letter to the client under the following instructions:

We would like you to write a letter to the woman in the recording you heard. Although this woman is not a real therapy client, her description of her concerns represents what an actual client in her situation might express and is representative of actual clients. Try to write the kind of letter that you would write if she were to actually read it. What do you think about her experience? What do you want to tell her? Please write it directly **to her**. (adapted from Hodges et al., 2010).

Participants were asked to write continuously for a minimum of 5 min. At the end of this writing task, participants were instructed to read and review the letters that they had just written before completing the empathic-expression questionnaire that was designed to measure how well they felt that they communicated any internal feelings of empathy for the client. All participants were fully debriefed at the conclusion of their session.

CHAPTER III: RESULTS

The primary purpose of the present study was to determine (a) whether depressed participants would report significantly greater feelings of empathy in both audio conditions than non-depressed participants and (b) whether depressed participants who listened to depression-related therapeutic dialogue would express greater empathy in their response letters than both depressed participants in the financial-distress condition and relative to non-depressed participants.

Preliminary Analyses

To assess group differences on my two dependent variables (i.e., feelings and expressions of empathy), I used two distinctive measures of depression status: participants' self-identification as someone who has experienced depression (yes vs. no) and diagnostic criteria for CESD-R items that categorized participants into depressed and non-depressed groups (clinical vs. non-clinical). In doing so, I was able to compare possible differences between self-identification and objective symptomology (as measured by CESD-R items) of depression on my measures of interest.

Self-identification of depression was significantly related to CESD-R scores, $r(66) = .42$, $p < .001$; thus, it was determined that self-identification of depression was itself an adequate measure of depression. Table 1 displays means, standard deviations, and sample sizes for participants who did and did not identify as having depression within each audio condition. In order to compare participants who demonstrated clinical and non-clinical levels of depressive symptomology, I followed diagnostic guidelines for CESD-R items such that participants who scored ≤ 15 points were categorized into a non-clinical group, and participants who scored ≥ 16

points were categorized in a clinically significant group for depressive symptoms. Table 2 displays relevant descriptive statistics for participants who did and did not meet diagnostic criteria for a major-depressive episode on feelings of and expressed empathy.

Table 1

Means, Standard Deviations, and Sample Sizes of Participants who Did and Did Not Self-Identify as Depressed on Feelings and Expressions of Empathy

Self-Identification of Depression	Audio Condition	Feelings of Empathy			Expressions of Empathy		
		M	*SD*	*n*	*M*	*SD*	*n*
Yes	Depression	23.05	8.02	20	30.90	7.92	20
	Financial distress	21.72	8.84	25	30.03	6.99	25
No	Depression	20.50	6.27	14	28.14	7.62	14
	Financial distress	26.33	4.95	9	32.11	8.74	9

Table 2

Means, Standard Deviations, and Sample Sizes of Participants who Did and Did Not Meet

Diagnostic Criteria for Depressive Symptoms on Feelings and Expressions of Empathy

Diagnostic Group of Depressive Symptoms	Audio Condition	Feelings of Empathy			Expressions of Empathy		
		M	*SD*	*n*	*M*	*SD*	*n*
Clinical	Depression	22.62	6.13	16	29.38	6.97	16
	Financial distress	23.06	8.21	18	21.72	6.39	18
Non-Clinical	Depression	21.44	8.44	18	30.11	8.67	18
	Financial distress	22.81	8.43	16	29.31	8.44	16

I next conducted a series of correlational analyses among all of my variables of interest to assess relations between each of these variables. Significant, positive correlations were observed between self-identification of depression and clinical divisions of CESD-R scores, continuous CESD-R scores and clinical divisions of CESD-R scores, IRI scores (i.e., dispositional empathy) and feelings of empathy, IRI scores and expressions of empathy, and scores of feelings and expressions of empathy. See Table 3 for a summary of all correlations.

Table 3

Correlations among all Variables of Interest

Measure	1	2	3	4	5	6	7
1. Audio condition	--						
2. Self-identification of depression	-.16	--					
3. Diagnostic division of CESD-R scores	-.06	.34*	--				
4. CESD-R scores	-.11	.42**	.81**	--			
5. IRI scores	.00	.03	.12	.10	--		
6. Feelings of empathy	-.06	-.03	.05	-.03	.34*	--	
7. Expression of empathy	-.06	.05	.06	.00	.44**	.60**	--

Note. *$p < .01$ **$p < .001$; Diagnostic Division of CESD-R scores reflects division into clinical and non-clinical groups following diagnostic guidelines; CESD-R Scores reflects continuous scores that do not reflect this diagnostic grouping; IRI scores reflect scores on Davis' (1980) Interpersonal Reactivity Index, designed to measure dispositional empathy.

Primary Analyses

Feelings of Empathy

For all analyses, I used dispositional empathy as a covariate so that participants with naturally very high or very low dispositional empathy would not disproportionally influence results (following Barnett et al., 1987). The assumption of homogeneity of regression slopes was not violated for either outcome of felt and expressed empathy. First, I evaluated group

differences on scores of situational (i.e., feelings of) empathy. To do this, I conducted a 2 (audio condition: depression vs. financial distress) x 2 (self-identification of depression: yes vs. no) ANCOVA, using dispositional empathy (i.e., IRI scores) as a covariate. There was a significant, positive relation between dispositional empathy and feelings of empathy such that participants who scored more highly on IRI items also reported greater feelings of situational empathy, $F(1, 63) = 11.35$, $p < .01$, $b = .45$, $\eta_p^2 = .15$, power = .91 . No significant main effect was observed for audio condition, $F(1, 63) = 1.89$, $p = .18$, $\eta_p^2 = .03$, power = .27, and no significant main effect was observed for self-identification of depression, $F(1, 63) = .48$, $p = .49$, $\eta_p^2 = .01$, power = .10. However, there was a significant interaction between audio condition and self-identification of depression $F(1, 63) = 5.17$, $p = .02$, $\eta_p^2 = .08$, power = .65.

I then conducted follow-up pairwise comparisons with Bonferroni corrections for this interaction. Participants in the financial-distress audio condition who did not self-identify as having depression ($M = 27.19$, $SE = 2.40$) reported significantly greater feelings of empathy than participants in the depression audio condition who did not self-identify as having depression ($M = 20.12$, $SE = 1.92$, $p = .03$). The mean for participants in the depression audio condition who self-identified as depressed ($M = 23.34$, $SE = 1.60$) did not significantly differ from the mean for participants in the financial-distress audio condition who self-identified as depressed ($M = 21.39$, $SE = 1.43$, $p = .37$). Figure 2 summarizes these results.

Figure 2. A comparison of adjusted mean scores of feelings of empathy between audio condition

and participants who did and did not self-identify as someone with depression, controlling for

dispositional empathy as measured by IRI scores.

* *p* < .05.

Still assessing group differences on scores of empathetic feelings, I then conducted a 2

(audio condition: depression vs. financial distress) x 2 (depression: clinical vs. non-clinical)

ANCOVA using dispositional empathy as a covariate in order to examine differences in

depression symptomology on feelings of empathy. This analysis was similar to the analysis

described above, yet the measure of depression was based on CESD-R scores rather than self-

identification of depression. There was a significant, positive relation between dispositional

empathy and feelings of empathy such that participants who scored more highly on IRI items

also reported greater feelings of empathy, $F(1, 63) = 8.75$, $p < .01$. $b = .42$, $\eta_p^2 = .12$, power =

.83. There was no significant main effect for audio condition, $F(1, 63) = .25$, $p = .62$, $\eta_p^2 = .00$,

power = .08, and no significant main effect for depression, $F(1, 63) = .00$, $p = .97$, $\eta_p^2 = .00$, power = .05. There was also no significant interaction between audio condition and depression $F(1, 63) = .44$, $p = .57$, $\eta_p^2 = .01$, power = .10. Figure 3 summarizes this analysis.
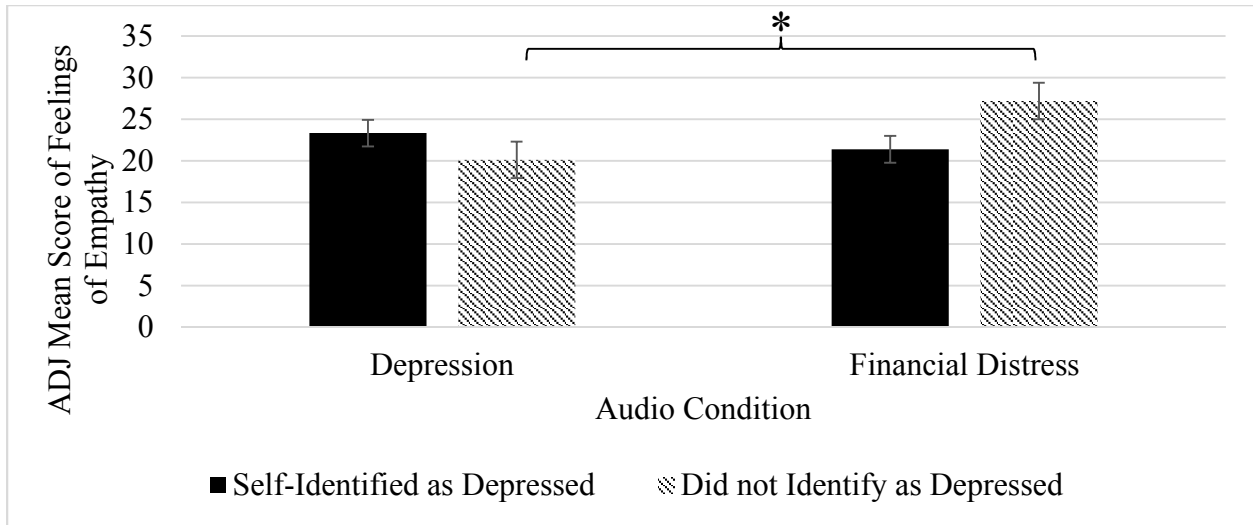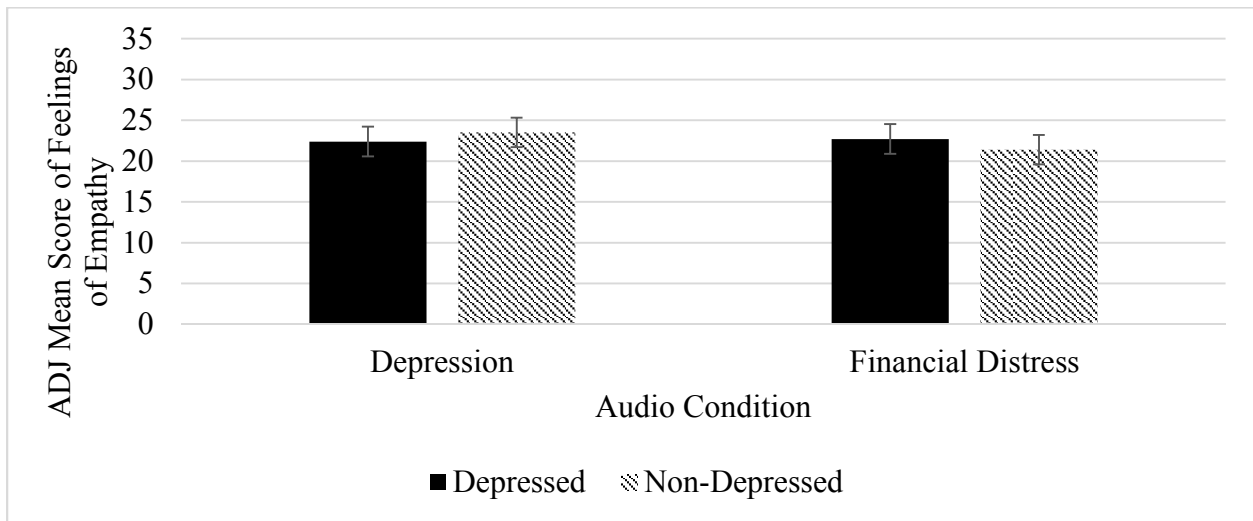

Figure 3. A comparison of adjusted mean scores of feelings of empathy between audio condition and participants who did and did not meet diagnostic criteria for depression as measured by CESD-R items, controlling for dispositional empathy as measured by IRI scores.

Expressions of Empathy

Next, I evaluated group differences on self-reported scores of expressed empathy. Following similar procedures as described above, I first conducted a 2 (audio condition: depression vs. financial distress) x 2 (self-identification of depression: yes vs. no) ANCOVA,

using dispositional empathy as a covariate. There was a significant, positive relation between dispositional empathy and expressions of empathy such that participants who scored more highly on IRI items also reported having expressed greater empathy in their written letters, $F(1, 63) = 18.35$, $p < .001$, $b = .54$, $\eta_p^2 = .23$, power = .99. No significant main effect was observed for audio condition, $F(1, 63) = 1.19$, $p = .28$, $\eta_p^2 = .02$, power = .19, and no significant main effect was observed for self-identification of depression $F(1, 63) = .00$, $p = .99$, $\eta_p^2 = .00$, power = .05. There was also no significant interaction between audio condition and self-identification of depression, $F(1, 63) = 3.91$, $p = .52$, $\eta_p^2 = .06$, power = .50. Figure 4 summarizes this analysis.

Figure 4. A comparison of adjusted mean expressed empathy between audio condition and participants who did and did not self-identify as someone with depression, controlling for dispositional empathy as measured by IRI scores.

Then, I conducted a 2 (audio condition: depression vs. financial distress) x 2 (depression: clinical vs. non-clinical) ANCOVA using dispositional empathy as a covariate. This analysis used the CESD-R-based categorization of depression group. There was a significant, positive relation between dispositional empathy and expressions of empathy such that participants who scored more highly on IRI items also reported having expressed greater empathy in their written letters, $F(1, 63) = 14.48$, $p < .001$, $b = .50$, $\eta_p^2 = .20$, power = .96. There was no significant main effect for audio condition, $F(1, 63) = .22$, $p = .64$, $\eta_p^2 = .00$, power = .07, and no significant main effect for depression, $F(1, 63) = .00$, $p = .97$, $\eta_p^2 = .00$, power = .05. There was also no significant interaction between audio condition and depression, $F(1, 63) = .16$, $p = .69$, $\eta_p^2 = .69$, power = .07. Figure 5 summarizes this analysis.
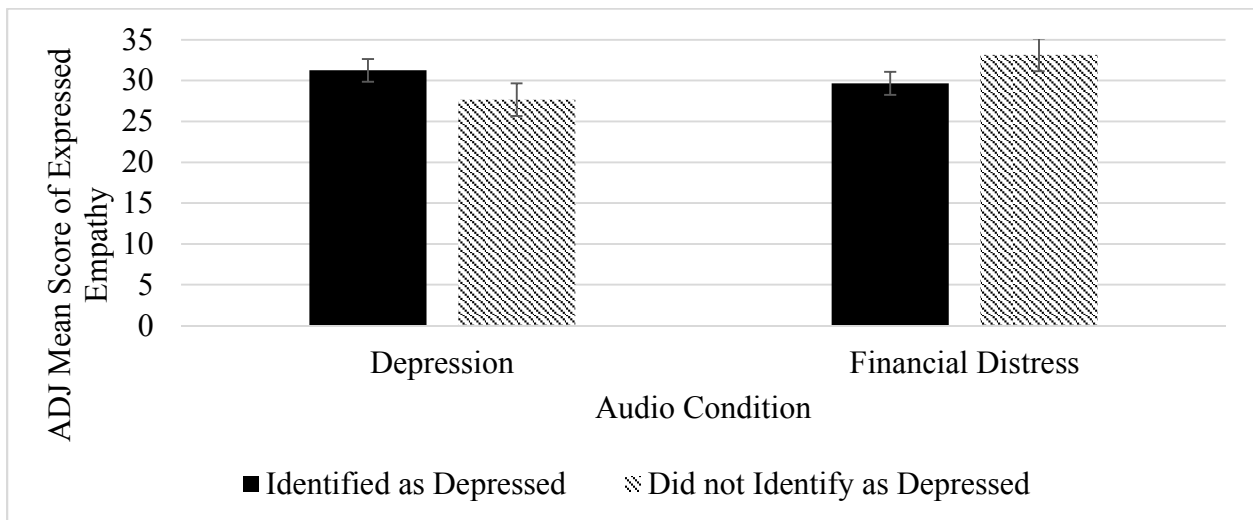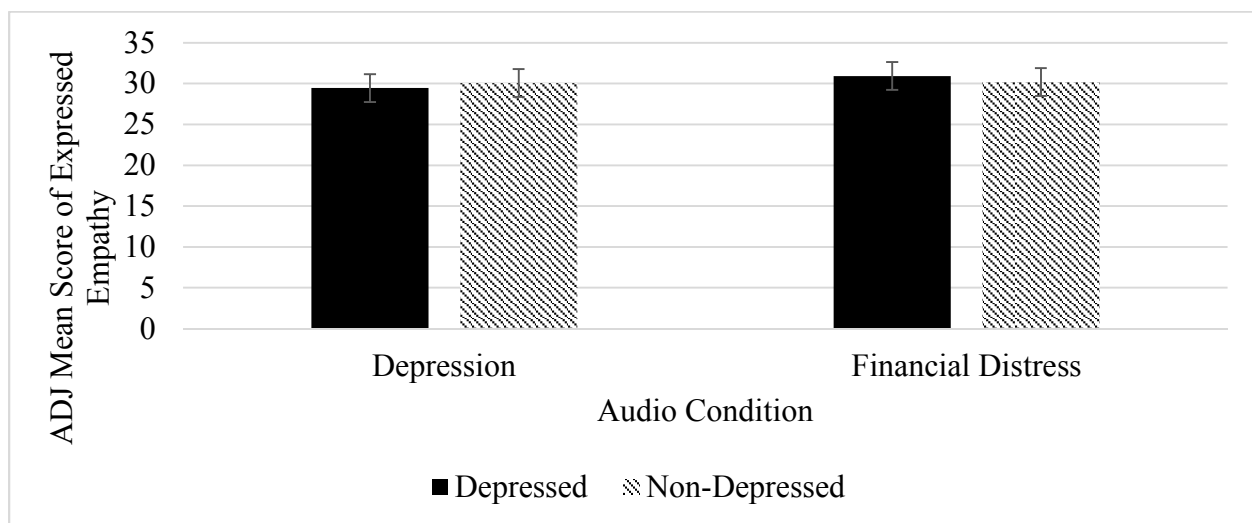

Figure 5. A comparison of adjusted mean scores of expressed empathy between audio condition and participants who did and did not meet diagnostic criteria for depression as measured by CESD-R items, controlling for dispositional empathy as measured by IRI scores.

CHAPTER IV: DISCUSSION

In the present study, I investigated whether female participants with experiential similarity of depression with a fictitious female therapy client would feel and express greater empathy than non-depressed participants. To do this, I asked participants to respond to depression-related measures, to listen to audio clips of fictitious therapy sessions in which a female client discussed either her struggles with depressive symptoms or with financial distress, then to indicate any feelings of empathy toward the client, and finally to write a letter to express her thoughts and feelings about the client's experiences. I hypothesized that (a) depressed participants would report significantly greater feelings of empathy in both audio conditions than non-depressed participants and that (b) depressed participants who listened to a depression-related audio clip would express greater empathy in their response letters than both depressed participants who listened to a financial-distress-related audio clip and non-depressed participants across both audio conditions. However, results did not support either of these hypotheses.

Nonetheless, there are some findings of the present study that may contribute to current knowledge in this line of research. First, I found significant, positive correlations between self-identification of depression and clinical divisions of CESD-R scores, IRI scores (i.e., dispositional empathy) and both feelings and expressions of empathy, and a significant correlation between feelings and expressions of empathy themselves. It was no surprise that participants who scored highly on dispositional empathy reported having felt and expressed greater empathy toward the client in each audio condition. This both replicates and strengthens previous findings that the IRI (Davis, 1980) is a valuable measure that can be used to establish a person's empathetic nature. In addition, it also appears that participants who scored highly on

CESD-R items (i.e., reported clinically significant, recent depressive symptoms) were also able to self-identify as someone who has experienced depression. Thus, participants' subjective perceptions of their depressive experiences coincided with their reported symptomology of depression. Finally, if participants reported having felt greater empathy toward the female client on Batson et al.'s (1996) situational-empathy measure, they were (unsurprisingly) more likely to report greater expressions of empathy in their written response letters. It is important to note that, contrary to previous research that would have suggested that participants with depression would have felt and/or reported significantly *less* empathy than non-depressed participants (e.g., O'Connor et al., 2007), results of the present study did not show a significant, negative correlation between either measure of depression (i.e., self-identification and CESD-R scores) and measures of feelings and expressions of empathy. In other words, participants who reported clinically significant depressive symptoms did not appear to report significantly low levels of empathic engagement. It is possible that my methodology of eliciting empathic responding via experiential similarity of an emotional experience may have allowed these participants to more effectively engage in empathic responding to the fictitious therapy client's experiences.

Results also demonstrated a significant interaction between audio condition and self-identification of depression such that participants in the financial-distress audio condition who did not self-identify as having depression reported significantly greater feelings of empathy than participants in the depression audio condition who did not self-identify as having depression. This difference may be explained by feelings of interpersonal similarity (although, not in the predicted direction). According to the Federal Reserve Board's Survey of Household Economics and Decision-Making (2018), it was reported that in 2017, more than half of U.S. adults under the age of 30 had accrued debt from student loans that assisted with education-related expenses.

Of this group, one-fifth of those with outstanding student loans were behind on their monthly payments. In the same survey published for 2016 (Federal Reserve Board, 2017), recent college graduates with outstanding loans reported struggling financially and were more likely to hold two jobs simultaneously compared to those without loans. In fact, according to the National Center for Education Statistics (2018), current students are, in general, much more likely to take out student loans than in previous years (e.g., students in the 2011-2012 school year were twice as likely to have taken out loans than in the 1989-1990 school year). Thus, given the likelihood of financial distress that coincides with currently pursuing a college education (possibly also in addition to living expenses), it is plausible that hearing a fictitious therapy client discuss her struggles with this issue elicited more empathy in college-aged participants as a result of perceived similarity in financial concerns than was initially expected when designing this study.

Finally, there were some results related to *non*-significant differences that are worth further exploration. First, it is interesting that although there were significant differences in feelings of empathy between those who did and did not self-identify as depressed in the financial-distress condition, a similar pattern was not observed for depression symptomology demonstrated by CESD-R scores (i.e., diagnostic division into clinical and non-clinical groups). To be sure, although I found a significant, positive correlation between CESD-R scores and (subjective) self-identification of depression, this relation is not perfectly linear; diagnostic criteria and subjective experience are not necessarily a one-to-one function (see Beck & Beamesderfer, 1974 for further discussion). It is for this reason that I initially decided to collect data for both of these measures to represent depression status. In short, I felt it necessary to establish that participants recognized any personal experiences with depression in order for these participants to recognize interpersonal similarity with someone who has shared a similar

experience. It may be the case that, following discussion above, perceptions of similarity (of depression) may have a stronger influence on those who personally, subjectively identify as someone with depression than on those who demonstrate (more objective) clinical symptomology.

Second, it was interesting that the pattern of results for feelings of empathy did not appear for expressions of empathy. This particular finding is a bit more difficult to interpret. On the one hand, it is certainly possible that these results are due to a disparity between internal emotional reactions and behavioral emotional responses (e.g., Carthy et al., 2010;Gross, 2002; Gross & John, 2003) that allowed for significant increases only in the former. However, due to the self-reported nature of these measures, it is difficult to determine whether or not these results accurately represent participants' empathic engagement in this study. In short, data for expressions of empathy were collected by asking participants to review their written response letters to the fictitious therapy client and then to provide a self-reported measure of how well they felt that they expressed any internal feelings of empathy in this letter. This, of course, makes it difficult for participants to objectively separate what they (subjectively) experienced during the writing of their letter and what was *actually* expressed in their written text. For this reason, a better measure of expressed empathy may be to ask independent judges to create a qualitative coding scheme with which more objective judgments can be made about the contents of response letters.

Strengths of the Present Study

Although initial hypotheses were not supported, it is important to note some of the strengths of this research and why it is worthwhile to explore relations between depression, similarity, and interpersonal empathy. First, the present study was designed to address novel

hypotheses not about empathic relationships between therapists and therapy clients (as has been more thoroughly explored in previous research; e.g., Grantham, 1973; Robiner & Storandt, 1983) but between *peers* who share depression-related experiences. Given the foundational role of interpersonal empathy in successful social relationships and the established empathy-related issues among individuals with depression (e.g., O'Connor et al., 2002), promoting empathic reactions within everyday relationships may be a critical tool in ameliorating some of the negative social effects of MDD. Second, although entirely by chance, the present sample comprised an unusually large number of participants who displayed clinically significant depressive symptoms. Of the 68 total participants whose data were used in all analyses, exactly half ($n = 34$) were placed into clinical and non-clinical depression groups using responses to CESD-R items. Not only did this make for equitable comparisons between depression groups in addressing initial hypotheses, but this may also be useful in any future hypothesis testing using data from questionnaires related to participants' general history of depressive episodes and other relevant constructs (i.e., data from the BRS, MPSS, and other items that were included in the first phase of the present study but that were not included in present hypotheses). Finally, the audio materials created for this research may be of service in future projects related-to or that continue this line of research. The dialogue within each audio clip provides a useful depiction of what may occur during a therapeutic intake session that may be used to represent a peer's experience of depression, stress, and anxiety in a way that is relatable to many young adults.

Limitations and Future Directions

In evaluating the design and implementation of this research, there are several points of improvement that can be made that may provide a better test of the constructs of the interest. First, I did not conduct a pilot test to evaluate whether the depression and financial-distress

35

conditions were differentiated enough such that they would indeed elicit differing levels of empathy. As displayed in Appendices A and B, much of the language in the dialogue between client and therapist remained the same – an initial attempt to maintain control over less-relevant portions of the dialogue – but it is possible that if the client's primary concern was made more explicit, this might have evoked more differentiated empathic responding across conditions. For example, following the American Psychiatric Association's (2013) diagnostic criteria, the fictitious client in the depression condition could explicitly state that she feels worthless, helpless, or hopeless. To make her concerns even more explicit, perhaps she could have included that she has held suicidal or self-injurious ideation because of her depression. The therapist may also explicitly state that what the client is describing indeed suggests that she may be struggling with depression. Although the client does explain that she feels tired, unmotivated, and sluggish, perhaps it is the case that participants did not fully understand that the client was indeed experiencing depressive symptoms given that her described concerns may not have been perceived as "severe enough" to constitute a diagnosis of depression? In addition to these changes, it may also be beneficial to include an item that asks participants to indicate what they perceive to be the client's primary concern after having listened to the respective audio clip. In doing so, it may be clearer that participants did (or did not) fully understand the relevant dialogue.

Second, in designing the audio materials, there may have been a better choice of dialogue topic for a more effective control condition. In short, selecting financial distress as the fictitious therapy client's primary concern in what was intended to be a more emotionally neutral control condition (in comparison to the depression condition) may have fallen short. This may be supported by the finding that participants in the financial-distress condition who did not self-

identify as depressed reported feeling the most empathetic toward the fictitious therapy client in comparison to all other groups. Future research may design a more emotionally neutral control condition for more appropriate comparison to the depression condition.

Finally, although the present study evaluated expressions of empathy via participants' own evaluations of the letters they wrote to the client in the audio clips, future hypothesis testing will likely use the qualitative data provided in the letters themselves. It would seem unlikely that participants who responded that they felt highly empathetic toward the woman in the audio clip would report that they failed to express any of this empathy in their response letters. Independent judges who can create a coding scheme with which more objective judgments can be made about the contents of participants' letters would likely be able to provide a more accurate depiction of expressed empathy.

Implications and Conclusions

This study was designed to provide a better understanding of depression – a widespread and pervasive affliction – and its relation to interpersonal empathy, a foundational component of successful social relationships. As previously discussed, given previous findings that have suggested that (a) empathy is a cornerstone of successful social interaction, (b) interpersonal similarity can positively affect empathic responding, and (c) individuals with depression struggle to maintain healthy social relationships, I sought to elucidate a connection between depression and interpersonal similarity such that participants who recognized that they shared experiences of depression with a (fictitious) peer would be able to feel and express greater empathy towards this peer than non-depressed participants.

Thus, clinicians, counselors, family members, and friends of depressed individuals may be better able to facilitate healthier social relationships and to provide more effective support for

those suffering from depression by making it clear that they are not alone. Although there are large bodies of data (e.g., American Psychiatric Association, 2013) that demonstrate the national pervasiveness of MDD, this may not necessarily translate to feelings of similarity and unification at the individual level. Whether support is provided through group-sharing of experiences in a therapeutic setting or in everyday social relationships, sharing that, "I've been there, too" may indeed open the door for empathic engagement. Further investigation of this topic may allow for better understanding of how to alleviate some of the common symptoms of depression through empathic understanding.

REFERENCES

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders*
(5th ed.). Arlington, VA: American Psychiatric Publishing.

Bailey, P. E., Henry, J. D., & Von Hippel, W. (2008). Empathy and social functioning in late
adulthood. *Aging & Mental Health, 12,* 499-503. DOI: 10.1080/13607860802224243

Barnett, M. A., Tetreault, P. A., & Masbad, I. (1987). Empathy with a rape victim: The role of
similar experience. *Violence and Victims, 2,* 255-262.

Batson, C. D., Sympson, S. C., Hindman, J. L., Decruz, P., Todd, R. M., Weeks, J. L., et al.
(1996). "I've been there, too": Effect on empathy of prior experience with a need.
Personality and Social Psychology Bulletin, *22*, 474–482. DOI:
10.1177/0146167296225005

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: Desire for interpersonal
attachments as a fundamental human motivation. *Psychological Bulletin, 117,* 497-529.
http://dx.doi.org/10.1037/0033-2909.117.3.497

Brewer, M. B. (1979). In-group bias in the minimal intergroup situation: A cognitive-
motivational analysis. *Psychological Bulletin, 86,* 307-324. DOI: 10.1037/0033-
2909.86.2.307

Brummett, B. H., Barefoot, J. C., Siegler, I. C., Clapp-Channing, N. E., Lytle, B. L., Bosworth,
H. B., Williams, R. B., Mark, D. B. (2001). Characteristics of socially isolated patients
with coronary artery disease who are at elevated risk for mortality. *Psychosomatic*
Medicine, *63*, 267–72. DOI: 10.1097/00006842-200103000-00010

Carthy, T., Horesh, N., Apter., A., & Gross, J. (2010). Patterns of emotional reactivity and

 regulation in children with anxiety disorders. *Journal of Psychopathology and Behavioral*

 Assessment, 32, 23-26. http://dx.doi.org/10.1007/s10862-009-9167-8

Cliffordson, C. (2002). The hierarchical structure of empathy: Dimensional organization and

 relations to social functioning. *Scandinavian Journal of Psychology, 43,* 49-59. DOI:

 10.1037//0022-3514.45.6.1299

Davis, M. H. (1980). A multidimensional approach to individual differences in empathy. *JSAS*

 Catalog of Selected Documents in Psychology, *10*, 85.

Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a

 multidimensional approach. *Journal of Personality and Social Psychology*, *44*, 113–126.

 DOI: 10.1037/0022-3514.44.1.113

Davis, M. H. (1994). *Empathy: A social psychological approach*. Madison, WI: Brown &

 Benchmark.

Decety, J. (2010). The neurodevelopment of empathy in humans. *Developmental Neuroscience,*

 32, 257–267. DOI: 10.1159/000317771

Eaton, W. W., Smith, C., Ybarra, M., Muntaner, C., Tien, A. (2004). Center for Epidemiologic

 Studies Depression Scale: review and revision (CESD and CESD-R). In ME Maruish

 (Ed.). *The Use of Psychological Testing for Treatment Planning and Outcomes*

 Assessment (3rd Ed.), Volume 3: Instruments for Adults, pp. 363-377. Mahwah, NJ:

 Lawrence Erlbaum.

Eisenberg, N., & Eggum, N.D. (2009). Empathic responding: sympathy and personal distress. In

 Decety, J., Ickes, W. (eds). *The Social Neuroscience of Empathy*. Cambridge, MIT Press,

 pp 71–83. DOI: 10.7551/mitpress/9780262012973.003.0007

Elliot, R., Watson, J. C., Bohart, A. C., & Greenburg, L. S. (2011). Empathy. *Psychotherapy, 48,* 43-49. DOI: 10.1037/a0022187

Escalas, J. E., & Stern, B. B. (2003). Sympathy and empathy: emotional responses to advertising dramas. *Journal of Consumer Research, 29,* 566-578. DOI: 10.1086/346251

Federal Reserve Board (2017). *Report on the Economic Well-Being of U.S. Households in 2016.* Washington, D.C.: Board of Governors of the Federal Reserve System

Federal Reserve Board (2018). *Report on the Economic Well-Being of U.S. Households in 2017.* Washington, D.C.: Board of Governors of the Federal Reserve System.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (2002). Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition (SCID-I/P). New York: Biometrics Research, New York State Psychiatric Institute, November 2002.

Flory, J. D., Räikkönen, K., Matthews, K. A., Owens, J. F., 2000. Self-focused attention and mood during everyday social interactions. *Personality and Social Psychology Bulletin*, *26*, 875–883. https://doi.org/10.1177/0146167200269012

George, L. K., Blazer, D. G., Hughes, D. C., & Fowler, N. (1989). Social support and the outcome of major depression. *British Journal of Psychiatry*, *154*, 478-485. https://doi.org/10.1192/bjp.154.4.478

Goldin, P. R., McRae, K., Ramel, W., & Gross, J. J. (2008). The neural bases of emotion regulation: Reappraisal and suppression of negative emotion. *Biological Psychiatry, 63,* 577-586. DOI: 10.1016/j.biopsych.2007.05.031

Grantham, R. J. (1973). Effects of counselor sex, race, and language style on black students in initial interviews. *Journal of Counseling Psychology, 20,* 553-559.

Gross, J. J. (2002). Emotion regulation: Affective, cognitive, and social consequences. *Psychophysiology, 39,* 281-291. DOI: 10.1017.S0048577201393198

Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology, 85,* 348-362. DOI: 10.1037/0022-3514.85.2.348

Haghighat, R. (2007). The development of the Brief Social Desirability Scale (BSDS). *Europe's Journal of Psychology, 3,* DOI: 10.5964/ejop.v3i4.417

Halevy, N., Bornstein, G., & Sagiv, L. (2008). ''In-group love'' and ''out-group hate'' as motives for individual participation in intergroup conflict. *Psychological Science, 19,* 405-411. DOI: 10.1111/j.1467-9280.2008.02100.x.

Hayes, S. C. (1987). A contextual approach to therapeutic change. In N. S. Jacobson (Ed.), *Psychotherapists in clinical practice: Cognitive and behavioural perspectives* (pp. 327–387). New York: Guilford Press.

Hays, R. D., Hayashi, T., & Steward, A. L. (1989). A five-item measure of socially desirable response set. *Educational and Psychological Measurement, 49,* 629-636. https://doi.org/10.1177/001316448904900315

Hodges, S. D., Kiel, K. J., Kramer, A. D. I., Veach, D., & Villanueva, B. R. (2010). Giving birth to empathy: The effects of similar experience on empathic accuracy, empathic concern, and perceived empathy. *Personality and Social Psychology Bulletin, 36,* 398-409. https://doi.org/10.1177/0146167209350326

Hohmana, Z. P., Gaffney, A. M., & Hogg, M. A. (2017). Who am I if I am not like my group? Self-uncertainty and feeling peripheral in a group. *Journal of Experimental Social Psychology, 72,* 125-132. http://dx.doi.org/10.1016/j.jesp.2017.05.002

House, J. S., Landis, K., Umberson, D. (1988). Social relationships and health. *Science, 241*, 540–545. DOI: 10.1126/science.3399889

Kahn, J. H., & Garrison, A. M. (2009). Emotional self-disclosure and emotional avoidance: relations with symptoms of depression and anxiety. *Journal of Counseling Psychology, 56,* 573-584. DOI: http://dx.doi.org/10.1037/a0016574

Kaufman, E. A., Xia, M., Fosco, G., Yaptangco, M., Skidmore, C. R., & Crowell, S. E. (2015). The difficulties in emotion regulation scale short form (DERS-SF): Validation and replication in adolescent and adult samples. *Journal of Psychopathology and Behavioral Assessment*, 443-455. DOI: :10.1007/s10862-015-9529-3

Kawachi, L., & Berkman, L. F. (2001). Social ties and mental health. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 78,* 458-467. DOI: 10.1093/jurban/78.3.458

Liviatan, I. Trope, Y., Liberman, A. (2008). Interpersonal similarity as a social distance dimension: Implications for perception of others' actions. *Journal of Experimental Social Psychology, 44,* 1256-1269. DOI: 10.1016/j.jesp.2008.04.007

Miller, D. T., Downs, J. S., & Prentice, D. A. (1998). Minimal conditions for creation of a unit relationships: The social bond between birthdaymates. *European Journal of Social Psychology, 28,* 475-481. http://dx.doi.org/10.1002/(SICI)1099-0992(199805/06)28:3<475::AID-EJSP881>3.0.CO;2-M

Murphy, B. C., Shepard, S. A., Eisenberg, N., Fabes, R. A., & Guthrie, I. K. (1999). Contemporaneous and longitudinal relations of dispositional sympathy to emotionality, regulation, and social functioning. *Journal of Early Adolescence, 19,* 66-97. https://doi.org/10.1177/0272431699019001004

National Center for Education Statistics (2018). *Digest of Education Statistics: 2016.*

    Washington, D.C.: Annual Reports and Information, NCES.

Nezlek, J. B., Hampton, C. P., & Shean, G. D. (2000). Clinical depression and day-to-day social

    interaction in a community sample. *Journal of Abnormal Psychology, 109,* 11-19.

    https://doi.org/10.1177/0272431699019001004

O'Connor, L. E., Berry, J. W., Weiss, J., & Gilbert, P. (2002). Guilt, fear, submission, and

    empathy in depression. *Journal of Affective Disorders, 71,* 19-27.

    http://dx.doi.org/10.1016/S0165-0327(01)00408-6

O'Connor, L. E., Berry, J. W., Lewis, T., Mulherin, K., & Crisostomo, P.S. (2007). Empathy and

    depression: The moral system on overdrive. In T. F. D. Farrow and P. W. R. Woodruff

    (Eds.) *Empathy in Mental Illness* (pp 49-75). Cambridge University Press.

    http://dx.doi.org/10.1017/CBO9780511543753.005

Papp, L. M., Kouros, C. D., Cummings, E. M. (2010). Emotions in marital conflict interaction:

    Empathic accuracy, assumed similarity, and the moderating context of depressive

    symptoms. *Journal of Social and Personal Relationships*, 27, 367-387.

    https://doi.org/10.1177/0265407509348810

Purdon, C. (1999) Thought suppression and psychopathology. *Behaviour Research and Therapy*,

    37, 1029–1054. DOI: 10.1016/j.cpr.2012.01.001

Rime´, B., Finkenauer, C., Luminet, O., Zech, E., & Philippot, P. (1998). Social sharing of

    emotion: New evidence and new questions. In W. Stroebe & M. Hewstone (Eds.),

    European Review of Social Psychology (Vol. 9, pp. 145–189). New York: Wiley. DOI:

    10.1080/14792779843000072

Robiner, W. N., & Storandt, M. (1983).Client perceptions of the therapeutic relationship as a

      function of client and counselor age. *Journal of Counseling Psychology, 30,* 96-99.

      http://dx.doi.org/10.1037/0022-0167.30.1.96

Segrin, C. (2000). Social skills deficits associated with depression. *Clinical Psychology Review,*

      20, 379-403. DOI: 10.1016/S0272-7358(98)00104-4

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., Bernard, J. (2008). The Brief

      Resilience Scale: Assessing the ability to bounce back. *International Journal of*

      Behavioral Medicine, 15, 194-200. DOI: 10.1080/10705500802222972

Substance Abuse and Mental Health Services Administration (2016). Reports and Detailed tables

      from the 2015 national survey on drug use and health. Retrieved from

      https://www.samhsa.gov/samhsa-data-outcomes-quality/major-data-collections/reports-

      detailed-tables-2015-NSDUH

Trobst, K. K., Collins, R. L., Embree, J. M. (1994). The role of emotion in social support

      provision: Gender, empathy and expressions of distress. *Journal of Social and Personal*

      Relationships, 11, 45-62. http://dx.doi.org/10.1177/0265407594111003

Vanderhorst, R. K., & McLaren, S. (2005). Social relationships as predictors of depression and

      suicidal ideation in older adults. *Aging & Mental Health, 9,* 617-525. DOI:

      10.1080/13607860500193062

Williams, K., & Galliher, R. V. (2006). Predicting depression and self-esteem from social

      connectedness, support, and competence. *Journal of Social and Clinical Psychology*, *25*,

      855-874. https://doi.org/10.1521/jscp.2006.25.8.855

Wright, J. C., Giammarino, M., & Parad, H. W. (1986). Social status in small groups:

    Individual–group similarity and the social "misfit." *Journal of Personality and Social*

    Psychology, 50, 523-536. http://dx.doi.org/10.1037/0022-3514.50.3.523

Zimet, G. D., Dahlem, N. W., Zimet, S. G., Farley, G., K. (1988). The Multidimensional Scale of

    Perceived Social Support. *Journal of Personality Assessment, 52,* 30-41. DOI:

    10.1080/13607860500193062

APPENDIX A: SCRIPT FOR DEPRESSION CONDITION

(Start recording)

Therapist: Hi Kaitlyn, it's nice to meet you today.

Client: (*Nervously laughing)* Nice to meet you too. I feel nervous, but it's nice to meet you.

Therapist: It's ok to be nervous. We'll take things slowly to find out what's been going on. Can we start with having you tell me about your main concerns that brought you here today?

Client: Well… I honestly probably should have made an appointment sooner, but I didn't think that the way I've been feeling was 'bad enough' to see a counselor. But… I don't know… I guess things have gotten overwhelming enough that I just didn't feel like I could keep ignoring them anymore.

Therapist: What kinds of things have been overwhelming for you?

Client: Um… a lot of things, really. I just haven't felt good for quite a while. I've always been someone who's been able to get things done and who's succeeded in a lot of things, but lately, it's been a huge struggle to keep going at the same pace. And I tend to beat myself up about it a lot.

Therapist: When you say that you haven't been feeling good, could you describe what you mean by that?

Client: Um… well, I definitely haven't been sleeping, which hasn't helped. But… I don't know, it's just like I don't feel motivated to do the things I used to be able to do. I feel tired all the time, I feel irritated by everything, and I don't understand why I can't just make myself get up and do things.

Therapist: You feel like you can't find the same motivation that you used to.

Client: Yeah. It's like… I mean it's not *so* bad that like, I can't get out of bed or like, shower or anything, but I've missed more class these past few weeks than I ever have before. That's just not me. But I don't know, I just couldn't force myself to get dressed and just… go. I would get up, but couldn't get out the door because of how awful I felt. It's like… even though I can get myself to do certain small things, it's just *so hard* to do them. And it's weird, it's not just like I'm feeling sad. It's like my entire body feels heavy. Like, the very thought of even raising my arms to wash my hair in the shower is just so difficult. Even though I can still make myself do it.

Therapist: It sounds like how you've been feeling has made a lot of things really difficult for you.

Client: It really has. And I just don't understand why. *(Nervous laughter)* I mean… no one died, I haven't been fighting with anyone, nothing devastating has happened, but… I don't know, I just find myself really getting stuck in this rut and I just can't seem to get out.

Therapist: Yeah. Have you talked to anyone about this?

Client: Um… I mean, not really. My family isn't the kind of family that ever really talks about stuff like this. I can remember feeling like things were wrong even when I was younger, but it just wasn't something that we ever talked about. And honestly, I would be surprised if neither of my parents struggled with depression and anxiety, but yeah, there's just never been a real discussion about it. Um… and with my friends… I don't know, it's not that I'm scared to tell them how I feel, but it just feels like I'm complaining for no reason. Like I said, there's nothing that has clearly led to me feeling how I'm feeling, and I worry that I'm just blowing something out of proportion that's just not a big deal.

Therapist: So it sounds like you've struggled with feeling with way this before.

Client: I mean, it's something I've kind of always struggled with to varying degrees. Um… I think my habit is to just stay busy and distract myself with school or work or whatever, but that hasn't really been working lately.

Therapist: Could you tell me more about that?

Client: Well, it's… it's just a lot easier to deal with feeling crappy when I'm not sitting and constantly thinking about feeling crappy. And maybe that's partly why I've been able to be successful because I've often just buried myself in school work or whatever, but I just can't seem to do that lately. Like, I have all of these things on my to-do list that I know I *should* be doing, but I just can't make myself do any of them. I mean… I don't know, I just know that there are lots of people who have gone through worse things than I have. So comparatively, it's like, who am I to complain just because I feel a little crummy? Even coming here today was really, really hard. I just don't want to waste anyone's time with something silly.

Therapist: I promise you that you're not wasting anyone's time. You are important and I want to help you.

Client: *(Laughs)* Well… thanks. I appreciate that.

Therapist: Of course. So you mentioned earlier that you haven't been able to talk to your parents. Can you tell me a little more about your relationship with them?

Client: Yeah. Um… I mean I have what I would consider a pretty normal relationship with my parents. I had a normal childhood, *(nervous laughter)* you know… nothing traumatic. I've always considered myself to be closer with my dad than my mom – we have a similar sense of humor, he tends to be a bit more logical than my mom who tends to get super worried about everything. Which is partially why I haven't said anything to them about what's been going on. I

just don't want them to worry and I know it would be made into this huge thing and that's just not something I really want to deal with right now.

Therapist: Yeah. Have you tried anything else that's been helpful?

Client: Um… yeah, I mean I try to eat well and exercise regularly. But that's been really hard to keep doing. I also try to get enough sleep even when I'm really busy, but like I mentioned, that's also been really hard lately. And of course, that only makes it worse because *everything* looks bleak when I'm low on sleep.

Therapist: Well I do think that's really great that you've tried different things and tried to keep a routine. Have you ever taken medication like an anti-depressant?

Client: No, I haven't. And… *(laughs)* I honestly don't know why I have such a hesitation to try medication, but I just haven't. I don't know, I guess I'm worried about side effects and in some ways, even though I know this sounds weird, I guess it feels like I'm somehow cheating? Like, I guess I have this feeling like medication is for those people who *can't* get out of bed or who are *way* worse-off than I am. But I guess… I mean I've tried all of these things lifestyle changes – you know, diet, exercise, etc. – but maybe I should consider it an option since none of those other things have seemed to work.

Therapist: Well, medication is often a good option for people who are struggling with symptoms of depression. That can certainly be something you can discuss with your counselor if that's something you want to explore.

Client: Maybe, yeah. *(Laughing)* Just… baby steps. I'm curious to see if counseling would help first before I try anything else.

Therapist: Of course. So what kinds of changes would you like to see happen if you decide to start counseling here?

Client: Um… really, I just want to feel better. I don't like feeling this way and just want to feel like myself again. I'm hoping that being able to have someone who I can just vent to and who will just listen without trying to throw a bunch of solutions at me could be really helpful.

Therapist: Sure, yeah. So Kaitlyn, is there anything else that you'd like us to know before we try to match you with one of our counselors?

Client: Um… not really. But I appreciate you meeting with me today.

Therapist: Of course. It was very nice to meet you and I hope we can work with you to help you feel better.

Client: Thanks, I hope so too.

(End recording)

APPENDIX B: SCRIPT FOR FINANCIAL-DISTRESS CONDITION

(Start recording)

Therapist: Hi Kaitlyn, it's nice to meet you today.

Client: (*Nervously laughing)*** Nice to meet you too. I feel nervous, but it's nice to meet you.

Therapist: It's ok to be nervous. We'll take things slowly to find out what's been going on. Can we start with having you tell me about your main concerns that brought you here today?

Client: Well… I honestly probably should have made an appointment sooner, but I didn't think that my situation was 'bad enough' to see a counselor. But… I don't know… I guess things have gotten overwhelming enough that I just didn't feel like I could keep trying to handle them on my own.

Therapist: What kinds of things have been overwhelming for you?

Client: Um… well, it's mainly stress about finances. I've been really worried about it for quite a while. I've always been someone who's been able to support myself in a lot of ways but lately, it's been a huge struggle.

Therapist: When you say that you've been feeling stressed, could you describe what you mean by that?

Client: Um… I don't know, it's just like, I can't stop thinking about it. It's on my mind all the time, I don't know who to turn to, and I'm worried that if I don't figure it all out soon, I won't be able to afford to stay in school.

Therapist: You're worried about the impact that your finances could have on your future.

Client: Yeah. It's like… I mean it's not *so* bad that like, I'm about to declare bankruptcy or something, but I've had to miss more class these past few weeks than I ever have before because

there's just not enough time in the day to work *and* go to school. It's just really hard. I have class during the day and then have to go to work at night, and by the time I finally get home, I'm so tired that there's just no way I could stay up and do homework. And the next day, it just starts all over again. My grades are tanking and I'm worried that I'll get kicked out.

Therapist: It sounds like this has made a lot of things really difficult for you.

Client: It really has. And I just don't know what to do about it. Nothing devastating has happened yet, but… I don't know, I just feel stuck in a hole that I don't know how to get out of.

Therapist: Yeah. Have you talked to anyone about this?

Client: Um… I mean, not really. I can't really talk about it with my family. It's not that we aren't close, but they just can't afford to help me pay for school like other people's parents and I don't want to make them feel guilty about it. I knew from the start that it would be my responsibility to pay for my schooling, even though it's been really hard. Um… and with my friends… I don't know, it's not that I'm scared to tell them about it, but it just feels uncomfortable. They all have support from their parents and I just don't think they would understand what it's like to have to juggle all of this by myself. So I usually just keep it to myself. And I don't usually have to tell them that I can't afford to do things with them because I'm usually at work anyway, so I don't think they really know.

Therapist: So it sounds like you're going through this on your own.

Client: Yeah. Um… I think my habit is to just stay busy and distract myself from feeling the stress with school or work or whatever, but that hasn't really been working lately.

Therapist: Could you tell me more about that?

Client: Well, it's… it's just a lot easier to deal with it when I'm not sitting and thinking about it. But lately, I've just been feeling really overwhelmed and it's made it really hard to focus on what

I'm doing. I'm constantly worried about how I'm going to pay my rent or buy food or any of those things. I mean… I don't know, I know that there are lots of people who have gone through this or through worse things than I have. So it's like, do I really have a right to complain? Even coming here today was really, really hard. I just don't want to waste anyone's time with something silly.

Therapist: I promise you that you're not wasting anyone's time. You are important and I want to help you.

Client: *(Laughs)* Well… thanks. I appreciate that.

Therapist: Of course. So you mentioned earlier that you haven't been able to talk to your parents. Can you tell me a little more about your relationship with them?

Client: Yeah. Um… I mean I have what I would consider a pretty normal relationship with my parents. I had a normal childhood, *(nervous laughter)* you know… nothing abnormal. I've always considered myself to be closer with my dad than my mom – we have a similar sense of humor, he tends to be a bit more logical than my mom who tends to get super worried about everything. Which is partially why I haven't said anything to them about my situation. I just don't want them to worry and feel bad about not being able to help me. Financially, I mean. I know it would be made into this huge thing and that's just not something I really want to deal with right now.

Therapist: Yeah. Have you tried anything else that's been helpful in managing the stress?

Client: Um… yeah, I mean I try to eat well and exercise regularly. But that's been really hard to keep doing with my work and school schedule. I also try to get enough sleep even when I'm really busy, but that's also been really hard lately. And of course, that only makes it worse because *everything* looks bleak when I'm low on sleep.

Therapist: Well I do think that's really great that you've tried to keep a routine. Have you ever considered taking out loans to help with expenses?

Client: No, I haven't. And… *(laughs)* I honestly don't know why I have such a hesitation to do it, but I just haven't. I don't know, I guess I'm worried about getting myself into a ton of debt when I don't know what kind of job I'll be able to get after college. What happens if I end up like those people who are in so much debt that they can't ever buy a house or a car or afford to have a family? I don't want that for myself.

Therapist: Yeah. Well, I see that you're really trying to keep yourself in a good position for the future. But, of course, if you do decide that you want to try something different like exploring student loans, I know that your counselor would be able to support you through whatever it is you choose.

Client: Yeah. *(Laughing)* Just… baby steps. I'm curious to see if counseling can at least help me manage the stress a bit better before I try anything else.

Therapist: Of course. So what kinds of changes would you like to see happen if you decide to start counseling here?

Client: Um… really, I just want to feel less stressed. I feel really overwhelmed and I'm hoping that being able to have someone who I can just vent to and who will just listen without trying to throw a bunch of solutions at me could be really helpful.

Therapist: Sure, yeah. So Kaitlyn, is there anything else that you'd like us to know before we try to match you with one of our counselors?

Client: Um… not really. But I appreciate you meeting with me today.

Therapist: Of course. It was very nice to meet you and I hope we can work with you to help you find some ways to feel better.

Client: Thanks, I hope so too.

(End recording)