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ASSESSMENT OF PROBLEM-SOLVING THERAPY, COGNITIVE-
BEHAVIORAL THERAPY AND AN SSRI IN THE TREATMENT
OF A SINGLE SUBJECT PRESENTING WITH MAJOR
DEPRESSIVE DISORDER AND DYSTHYMIA

By
Jennifer Miller

A Thesis

Submitted in partial fulfillment of the requirements of the
Master of Arts Degree
Of
The Graduate School
At Rowan University
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Approved by

Professor

Date Approved 8/12/02

ABSTRACT

Jennifer Miller

Assessment of Problem-Solving Therapy, Cognitive-Behavioral Therapy and an SSRI in the Treatment of a Single Subject Presenting with Major Depressive Disorder and Dysthymia

2002

Dr. Janet Cahill

Applied Psychology

After diagnosis, a review of the literature was conducted to determine empirically supported treatments for depression. Based upon this review, this study examined and evaluated the effectiveness of various treatments determined in the current literature to be the best practice in treating depression in adults. The subject was a 44 year old Caucasian woman who initiated treatment voluntarily following a referral made by her primary care physician. This study was conducted in a community-based agency. A diagnosis of depression and dysthymia was reached through an initial intake interview and use of the DMS-IV. Best practice methodology was determined through an extensive review of the literature and feasible methods were utilized in treating this subject. Cognitive-behavioral therapy techniques, as well as problem-solving therapy techniques were utilized in conjunction with Zoloft, an antidepressant medication.

Outcomes were measured by scores on the Beck Depression Inventory, the Burns Depression Checklist, the Ways of Coping Questionnaire, and a Consumer Satisfaction Inventory was included. Her scores were greatly improved at termination, with the BDI scores no longer falling in the depressed range. Her scores on the coping inventory had improved significantly as well. She reported decreased crying and decreased isolative behavior.

MINI-ABSTRACT

Jennifer Miller

Assessment of Problem-Solving Therapy, Cognitive-Behavioral Therapy and an SSRI in the Treatment of a Single Subject Presenting with Major Depressive Disorder and Dysthymia

2002

Dr. Janet Cahill

Applied Psychology

A single subject presenting with Major Depressive Disorder and Dysthymia was treated with Problem-Solving Therapy techniques, Cognitive-Behavioral techniques, and Zoloft, an antidepressant medication. At the end of treatment, her scores on the Beck Depression Inventory were no longer in the depressed range and coping skills had improved.

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Chapter 1

Psychosocial Assessment

Client Name: Julie

Age: 44

Presenting Problem:

This forty-four year old divorced, Caucasian woman came in to a community-based center for an initial intake. She reported feeling depressed and stated that: "I want to get myself back". She stated that she had been crying more lately and locked herself in her room or house for days at a time. She had lost 18 lbs. in the past two months and has recently been prescribed Zoloft, which she stated had some effect in decreasing her depressive symptoms when it was initially prescribed. More recently, the medication seemed to be less effective. She felt overwhelmed by problems with her family, job and relationships. She reported a decrease in her support system and increased alcohol use. There was no direct input from others since Julie arrived alone.

History of Complaint:

Julie came in for help as a result of her medical doctor's referral. She had never been in treatment for psychological problems before this time. She had noticed an increase in crying and depressed mood for the past two months. She had been withdrawing more as evidenced by the long periods of time spent inside her home. During these periods she would rarely eat, shower, or sleep, sometimes for three to four days at a time.

Julie states that her problems began when she decided to make some changes in her life. She had been working at a factory doing manual labor and was living in an apartment above her

mother. Her mother was the landlord of the apartment. Her daughter, son, son's girlfriend, and their two children had been living with Julie. She was the only adult working in the household and maintained the responsibilities of cooking and cleaning in addition to paying the bills. Over a period of three weeks she had asked everyone to leave the apartment. She stated that while she felt anxious and overwhelmed prior to asking them to leave, the depression came after her family members were gone. She then went out on physical disability from work due to a pinched nerve in her elbow.

At this time she had her boyfriend, Frank move in with her. They lived together for about a month but found they could not live together and continue to have a relationship. Julie said she found herself pushing him away by picking arguments over every little thing. He decided to move out and she stayed in the apartment. During the time Frank lived with Julie and the months that followed, Julie's mother became increasingly verbally abusive. She did not approve of the fact that Julie's boyfriend is black.

Julie states that she felt somewhat guilty about having her children move out. This guilt followed by her unemployment, relationship problems, physical problems, and her more recent altercations with her mother, led to her feeling overwhelmed. Her symptoms seemed to become more severe as more factors were added.

Julie has since been cleared medically to return to work pending the investigation of her disability claim. She has not returned. She has been crying more than usual, about five days a week. Her drinking has increased from less than once a week socially to about twice a week at a bar alone. She does not drink at home with others or alone and very rarely drinks socially anymore. She reports going out to a bar intending to have one drink and finding herself still there at last call. When she is having a particularly "bad day", she closes herself up in her house.

She will not leave or answer the door. She will not answer the telephone or shower. She will not eat. These periods of withdrawal usually last between two and four days. She lays in bed and watches television, sleeping off and on. She cannot identify what it is that finally breaks this cycle and allows her to get up and get moving.

Household Composition:

Julie currently lives alone in an apartment above her mother. Her mother and her step-nephew live downstairs. She has three children, ages 27, 25, and 22 and two grandchildren ages 5 and 3. She has two step-grandchildren ages 3 and 2 and her boyfriend has three children ages 11, 8, and 7 that she spends time with. She has one “aunt” that is important in her life, who is actually her mother’s best friend. Her father is still alive but there is minimal contact. She has three brothers, two younger ages 44 and 35 and one older who is 47 years of age. She has been divorced for twenty years.

Developmental History:

Julie reports that she was a “normal” child, with no delays. She adjusted well in school and did fairly in her subjects. She had no problems making friends and reports that she was more of a tomboy with more male than female friends.

Her pattern of being one of the guys changed when she became an adolescent. Her brothers would not allow her to play with the other boys anymore. She did not know if this change occurred because they felt uncomfortable around her as her body began to change or if it was because of the abuse she suffered as a child that her oldest brother eventually witnessed.

Julie was sexually abused by an uncle for two years, from the age of nine to eleven. At age eleven, her oldest brother walked in on Julie and her uncle. He told their mother and the abuse

ended. Julie was never given the opportunity to talk about or deal with this abuse. Her mother sent her to live with a relative for a few weeks and never spoke about the abuse. As Julie got older, her mother made her go to this uncle's house to help her clean up once a week. She saw him weekly until her early twenties. He made one more advance toward her when she was an adult. She physically threatened him and never saw him again. He has since died.

It was during the two years of abuse that Julie began her pattern of shutting herself in when feeling down. She would spend an excess of time in her room when feeling this way. It was not addressed by anyone because she was the only girl and her mother was emotionally, as well as physically unavailable, most of the time.

Julie's mother was an alcoholic and Julie appeared to have taken on adult responsibilities. Her mother would drink often and have parties. The family often had no money or food and they lived in a one-bedroom shack for four to five years. The children would cook dinner, do the shopping, and clean for themselves. All four children were very close during this time and looked out for each other. After the abuse incident, Julie's oldest brother seemed to distance himself from her. Her father was never married to her mother although he did father two of the four children. The man who was married to Julie's mother was in and out of the picture due to her infidelities but Julie speaks highly of her memory of him as he is now deceased.

Julie got pregnant and married at age 16 and was happy to get away from her mother. She got married because she thought it was the right thing to do and as a way out. She did not marry for love. She soon found that her decision to marry might not have been a good one. Her husband was a few years older than she was. He treated her, in Julie's words, like a prisoner. She was not permitted to leave the house and could not offer any opinion or disagreement toward her husband. He was physically abusive and adulterous. She was finally able to leave him and has

been divorced for over twenty years. She has never remarried, but has had other long-term relationships with similar results. She seems to have a pattern of getting involved in abusive relationships, although as she gets older the men she describes getting involved with seem to be more emotionally unavailable than abusive.

Family Relations:

Julie has never had a good relationship with her mother. Her mother was emotionally immature and unavailable to the children as they were growing up or as adults. Her mother was married to a man but always had another man on the side. Julie found out later that the man all four children assumed was their father only fathered two of the children. Julie learned that her biological father was her mother's boyfriend. She has tried to develop a relationship with him as an adult and sees him occasionally. Her adult relationships with her siblings were less close than they were when they were children. Julie reports still having a close relationship with her brother, Matt, who is two years younger than her.

She herself has three children, two boys and a girl. They are all in their twenties and living on their own. Her oldest son has one daughter and her youngest son has one son and two stepchildren. In terms of her relationship with her own children, she described their family as very close with minimal problems when the children were minors. There were typical teenager problems involving experimentation with drugs, alcohol, and sex; however, she feels they were a cohesive unit overall. In retrospect, she thinks she may have been too permissive with them and may have not given them enough responsibility growing up, which may have led to the problems she encountered later.

Julie decided to try to become more independent and to take care of herself a little more. As a result, she kicked everyone out of her apartment, as she became more frustrated that they were still acting like children despite their ages. She, herself, seems to be a little immature and there may be some question regarding her parenting skills. She had not spoken to her children since she kicked them out. They have not contacted her and she refused to call them. She felt that she is always the one making the first move and keeping everyone together and she doesn't want to do that anymore. Even though she misses her children terribly and became visibly upset when talking about them, she refuses to initiate contact. Julie's pattern of relationships with her children then appears to be more of a peer than that of a parent.

Drugs and Alcohol:

Julie claimed to never have tried any drugs. Her alcohol use has become more prominent as her symptoms worsened. Previously, she never drank much and she attributes this to her mother's alcoholism. She would go out every now and then with friends or dates and would have a few drinks. As she became more depressed over the past two months, she found herself drinking more. She would sometimes have something to drink at home but as the stressors piled up, she started going out to bars, mostly alone but sometimes with friends and would drink much more than she had anticipated. She reports that she typically drinks beer and loses track of exactly how much she has drunk when she has these episodes. They occur about once every two weeks, although she goes out to bars about twice a week alone and drinks about four beers. She never drives home but instead calls a cab or a friend to come get her. She has woken up with the shakes on more than one occasion, but states that she has never done anything she regretted or could not remember while drinking. When she shuts herself in, she does not drink.

Medical and Psychiatric History:

Julie reports that her pattern of shutting herself in began in early adolescence during her sexual abuse. She cannot remember many happy periods in her life and describes herself as fairly numb most of the time. She has never been hospitalized, in treatment, or on medication. Her family physician started her on Zoloft a month prior to her coming in to the mental health center. She was very frightened of what therapy would consist of and openly cried in the intake. She has a pinched nerve in her elbow that needs to be surgically corrected. Julie had the same surgery on her other arm three years ago.

She is not aware of medical or psychiatric problems in her family aside from her mother's alcoholism.

Education and Job History:

Julie dropped out of school in tenth grade because she was pregnant. She attempted to get her GED once but did not complete the program. She is interested in trying again. She did not work early in her life because she was married to a very controlling man who would not let her leave the house. She later got a job as a bartender and tended bar at a few different places. For the past eleven years she has been employed by a glass company performing manual labor tasks. She states that she makes very good money because she has been there for so long but it is physically taxing. She would like to go back to bartending someplace warm, possibly Florida or Las Vegas.

Other Agency Involvement:

No other agencies are involved at this time.

Social Supports:

Julie currently has limited social support. She has a large family but presently has no contact with most of them. She describes her actions as maintaining her “bubble”. She feels safest when inside her bubble where no one can bother her. She has contact with her boyfriend, Frank, who seems to be sporadic when it comes to supporting Julie emotionally. She has remained in contact with one of her brothers but does not see him often and she does not seem to talk with him about her feelings. Julie has some friends that she can talk to but they seem to be more of drinking buddies than supports. She has an “aunt” who is her mom’s best friend who seems to be helpful to Julie. All in all, her support system is strained at this time.

Situational Stressors:

Most of the time Julie does not know what causes her severe feelings of depression. She believes it to be a combination of all the stressors that finally causes a reaction. Her relationship with her family is a stressor, although she refuses to try to remedy this situation. Her relationship with her boyfriend can be a stressor when things are not going well, for example if she can’t find him for a few days and he doesn’t return her calls. Since Julie is on medical disability sometimes finances are a stressor because she has to wait for her disability checks to arrive before she can pay her bills. She is also involved in a legal battle with her place of employment. She is trying to get them to pay for her surgery but they are saying it is not a work-related injury. She also has feelings of depression when she wakes up after a night of drinking when she’s had more than she intended to.

Coping Mechanisms:

Julie's coping mechanisms were poor. She drinks too much when feeling depressed and if she is overwhelmed with depression, she closes herself up in her home. She will not answer the door or the phone and will not get out of bed. During these times the phone does ring and messages are left by her boyfriend or friends, so it is obvious that someone is reaching out to her but she does not allow that to happen. If too many messages are left, she takes the phone off the hook.

Summary and Recommendations:

Julie is a forty-four year old woman with poor coping skills and an inadequate social network. She has come in for therapy and is medication compliant, which were significant strengths. She seems to have some unmet childhood needs as well as symptoms of depression and alcohol abuse. I think Julie would benefit from individual therapy to address the source of her feelings of depression and working together to come up with more effective ways of dealing with these feelings. Supportive therapy techniques should be used due to her unmet childhood needs, in addition to cognitive behavioral therapy to introduce new ways of coping as well as how to identify her feelings before they become overwhelming. We will also address her alcohol use when identifying more effective ways of coping.

Review of Prior Assessments

Julie reports having no prior evaluations.

Chapter 2

Differential Diagnosis

Julie is suffering from Major Depressive Disorder Single Episode - Moderate Type (296.22). This diagnosis is supported by her reported feelings of depression most of the day every day for the past two months, a significant weight loss of 18 lbs, and periods of insomnia. She reports not being interested in previous hobbies or activities she once enjoyed. She has feelings of worthlessness and guilt over her lapse in relationships with family members. She currently has decreased social supports from her children, boyfriend, and mother and has been out of work due to an injury. There is a pattern of her becoming depressed and shutting herself in, although she has never been in treatment before for these feelings. This coupled with her description of herself as being numb with few memorable feelings of happiness also calls for a diagnosis of Dysthymic Disorder (300.4). She is currently using alcohol to circumvent her feeling of depression, without much success, however, does not meet the requirements for alcohol abuse. She has not had legal or interpersonal problems as a result of her drinking and, as stated above, does not drive or do anything hazardous while drinking.

AXIS I: 296.22 Major Depressive Disorder - Single Episode - Moderate Type

300.4 Dysthymic Disorder

AXIS II: V71.09 No diagnosis

AXIS III: Pinched nerve in elbow

AXIS IV: Inadequate social support

Current unemployment due to physical disability

AXIS V: GAF = 65 (on intake)

Chapter 3

Literature Review

Research on treatment approaches for depression has concluded that several empirically supported, as well as experimental treatments are available for mood disorders. Those include psychotropic medication, psychological techniques and biological treatments. Some treatments are more specific to severe depression and suicidality, while others can be utilized to treat a wide range of mood disorders.

Antidepressant Medications

Antidepressant medications were formulated to combat depression by changing neurotransmitter levels on receptor sites.

In a study by Anisman, Ravindran, Griffiths and Merali (1999), Sertraline, a selective-serotonin reuptake inhibitor (SSRI) was prescribed to 93 subjects in a double-blind placebo-controlled study. Sertraline effectively reduced the clinical symptoms of dysthymia and subjects reported few side effects. A review of the literature conducted by Brunello, Akiskal, Boyer, Gessa, Howland, Langer, Mendlewicz, Paes de Souza, Placidi, Racagni, and Wessely (1999) found that antidepressants were deemed effective at decreasing symptoms of dysthymic disorder in 65% of cases. Monoamine oxidase inhibitors (MAOI's) were found to be as effective as tricyclic antidepressants (TCA's) at decreasing symptoms. Both were superior to placebo.

In a separate review, Invernizzi, Mauri, and Weintraub (1997) found that all antidepressants included in their review decreased depressive symptoms in dysthymia, however, MAOI's were deemed superior to TCA's and SSRI's were found to be more effective when compared with

placebo. Sonowalla and Fava (2001) supported this finding that SSRI's are superior to placebo and although many studies find that SSRI's and TCA's are similar in efficacy, SSRI's offer less side effects and are safer for the client. A review by Stewart and Quitkin (1992) offer similar findings.

Buongiorno, Plewes, and Wilson (2002) conducted a small study on 39 outpatients diagnosed with Major Depressive Disorder to test the efficacy of once-weekly fluoxetine, an SSRI. Thirty-two of the subjects had been taking fluoxetine daily and were, at the time of the study, stable. All 39 patients were switched to the once weekly dose and remained in remission from depressive symptoms at a three-month follow-up. No formal outcome measures were used. Outcome was assessed by observation and questioning during the monthly clinic visits. A study by Smeraldi (1998) compared amisulpride with fluoxetine in patients with dysthymic disorder or major depressive disorder in partial remission. "Amisulpride is an orthomethoxy-benzamide compound, chemically related to sulpride, with higher affinity for the D2/D3 receptors in the limbic system than in the striatum" (Smeraldi, 1998). Of the 281 subjects, most (94%) had been diagnosed with dysthymic disorder. All subjects received three months of treatment. Depressive symptoms decreased, however, there was no significant difference between treatments. It was determined that fluoxetine produced more gastrointestinal problems while amulsipride was more likely to induce endocrine-like disorders in women.

Desipramine, a tricyclic antidepressant, was studied by Friedman, Markowitz, Parides, Gniwesch, and Kocsis (1999). Forty six subjects diagnosed with dysthymia (70% with superimposed major depression) who had taken desipramine for 10 weeks were prescribed the same medication for an additional 16 weeks. The subjects had improved in depressive symptoms and social functioning during the first ten weeks and researchers were curious to see if symptoms

would continue to improve. They found that during the subsequent 16 weeks, subjects did continue to improve in social functioning and depressive symptoms, however, few subjects achieved functioning comparable to controls. Controls were used from a study by Weissman, Prusoff, Thompson, Harding & Myers (1978) as cited in Friedman, et al. These controls were described as "a randomly selected sample representative of the New Haven Connecticut community" (Friedman et al., 1999). Subjects' improvement was measured by scores on the Hamilton Depression Rating Scale and the Global Assessment Scale, as well as the presence of symptom criteria meeting the DSMIII-R criteria for dysthymia. Another study that examined the efficacy of desipramine was conducted by Miller, Kocsis, Leon, Portera, Dauber, and Markowitz (2001). Subjects were diagnosed with dysthymic disorder and had responded to an initial prescription of desipramine for 10 weeks as evidenced by their scores on the Hamilton Depression Rating Scale and Global Assessment Scale. They then entered a four-month continuation phase, after which they were eligible for the two year placebo-controlled study. This was a small study, consisting of only 27 subjects. Six of the 13 subjects receiving placebo experienced a recurrence of depressive symptoms. Five of the six recurrences occurred within the first six months of receiving the placebo. None of the subjects receiving on-going desipramine experienced a recurrence of depressive symptoms. These findings suggests that desipramine is an effective maintenance treatment for dysthymia.

A large study by Waintraub, Septien, and Azoulay (2002) compared the efficacy of tianeptine with paroxetine, an SSRI. Tianeptine is also an antidepressant, although it "does not inhibit the reuptake of of serotonin but has neurotrophic properties as has been reported for other antidepressant therapies" (Malberg, Eisch, Nestler, et al., 2000 as cited in Waintraub, et al., 2002). A total of 277 clients diagnosed with major depressive disorder were included in this

study. This was a double-blind design and subjects were also prescribed zopiclone to assess sleep disturbance caused by both medications. The study did not define this medication further. At the end of the three month trial, symptoms had decreased significantly in both groups as evidenced by decreased scores on the Montgomery-Asberg Depression Rating Scale and the Hamilton Depression Rating Scale . There was no significant difference between the two medications and neither had a significant effect on quality of sleep.

Geddes and Butler (2002) discussed many different techniques for treating depression. Their comprehensive review of the literature concluded that while antidepressant medications were effective in treating the symptoms of depression, no clinical significance had been determined between different subtypes of antidepressants. They concluded that SSRI's were better tolerated than older medications, but the difference was minimal. A review of the literature by Mulrow, Williams, Chiquette, Aquilar, Hitchcock-Noel, Lee, Cornell, and Stamm (2000) arrived at a similar conclusion. There were no significant differences between SSRI's and TCA's, however both were significantly better than placebo, supporting the conclusion that antidepressants were effective in treating the symptoms of depression.

There is sufficient evidence supporting the use of antidepressant medications to relieve symptoms of depression in clients diagnosed with dysthymic disorder or major depressive disorder or both. Currently there is conflicting evidence about which types of medications are better than others. Some research concluded no difference and still others finding one class of antidepressants superior. Bhatia and Bhatia (1997) provided guidelines for selecting an antidepressant while taking into account the client's history, possible side effects, and possible drug interactions. They recommended the use of SSRI's as a starting point prior to trying other classes of medications. As SSRI's offer the least side effects, they are the first choice in selecting

an antidepressant. If drugs from this class do not provide the desired results, tricyclic antidepressants or monoamine oxidase inhibitors may need to be considered even though the side effects can be greater and food restrictions are more rigid.

Medications versus Psychological Treatments

Some studies compared the use of medications with other types of treatments, such as psychological techniques. A study detailing an experimental design by Barrett, Williams, Oxman, Katon, Frank, Hegel, Sullivan, and Schulberg (1999) and the later accompanying research by Oxman, Barrett, Sengupta, Katon, Williams, Frank, and Hegel (2001) compares the efficacy of paroxetine, problem-solving therapy, and placebo in treating depression. Paroxetine was chosen in this study for its favorable side-effect profile and its determined efficacy in other research. Problem-solving therapy in this study is administered in the primary care setting. This method teaches clients that there may be a relationship between the problems they experience and their emotional symptoms. In overview, this is a collaborative technique between therapist and client where the client's symptoms are linked to their problems in life. These problems are then defined, clarified, and an attempt is made to solve the problem in a structured way. This treatment is often brief and is designed to teach clients skills they can then use on their own. They found that paroxetine showed moderate benefit compared with placebo for depressive symptoms and mental health function in patients with dysthymia and minor depression. Problem-solving therapy produced benefits that were smaller and less consistent than paroxetine. This study was replicated by Williams, Barrett, Oxman, Frank, Katon, Sullivan, Cornell, and Sengupta (2000) with the focus on older adults suffering from dysthymia and minor depression. 415 patients were randomly assigned to either paroxetine, placebo, or problem-solving therapy. All groups showed improvement over the 11 week treatment period. Paroxetine was

significantly more effective at reducing symptoms of depression than placebo. Problem-solving therapy did not differ significantly from paroxetine or placebo as measured by scores on the 20-item Hopkins Symptom Checklist Depression Scale and the Hamilton Rating Depression Scale. The problem-solving group did show more rapid symptom resolution than others.

A study by Mohr, Boudewyn, Goodkin, Bostrom, and Epstein (2001) compared outcome efficacy between cognitive-behavioral therapy, supportive-expressive group psychotherapy and sertraline with depressed patients also suffering from Multiple Sclerosis. In the cognitive-behavioral group, subjects met with a therapist individually 50 minutes weekly for 16 weeks. The focus was on behavioral activation as well as cognitive restructuring procedures.

Supportive-expressive group therapy is a group therapy model for people with a medical diagnosis. Groups of 5-9 subjects met for 16 weekly 90 minute sessions. Supportive-expressive group psychotherapy facilitates emotional expression related to the disorder and the social and personal aspects of the disorder. Processes described by Yalom (1995) are modeled. Sertraline was initiated at 50 mg. daily and increased every four weeks to 200mg. Cognitive-behavioral therapy and sertraline were significantly more effective at decreasing depressive symptoms than supportive-expressive group therapy but the two did not differ significantly from each other.

Cognitive-behavior therapy approaches are widely used in the treatment of many symptoms and disorders. Evans, Velsor, and Schumacher (2002) outlined a prospective cognitive-behavioral program for use in school-age children with depressive symptoms. This type of therapy can be incredibly important in the early intervention of depression, and especially dysthymia. This article focused on educating students about depression and the stressors that can accompany normal growing up as well as ideas for group activities with children that are more at risk than others. A similar article by Maag (2002) used cognitive-behavioral skills in the school

setting to combat feelings of depression. These techniques can be used with adults as well. Using verbal directives, the teacher or therapist helps the client realize that the feelings of depression are within their control. Exercises are performed requiring students to feel depressed during certain designated time periods. If they do it, they are able to see that the feeling is within their control. If they refuse to comply, the feeling is still within their control because they are refusing to feel depressed during that designated time period. This allows clients to identify, reality-test, and modify a distorted belief. Another example of this is described in an article by O'Connor (2001). He advocates for the use of a mood journal in depressed people to attempt to help them regain some control and understanding over their mood changes. Subjects were instructed to record not only their sad moods but also their good moods. Most important was recording the circumstances in which these moods occur to allow the client to begin making their own connections between their external environment and their reactions to that environment.

A study by Walling (2001) compared non-directed therapy, cognitive-behavioral therapy and the usual care one receives from their family physician. Most clients with depression wanted to receive a psychological treatment, however, the 237 clients were randomized across treatment groups. At four months, all clients showed improvement. Subjects in the psychological therapy groups showed greater improvement in their Beck Depression Inventory (BDI) scores than usual care clients but there were no significant differences between psychological therapies. At twelve months, there was no significant difference across groups or in client satisfaction. This implies that psychological treatments are effective in the acute care of clients with depressive symptoms but not for long-term care. This lack of long-term improvement is also evident in a meta-analysis conducted by Westen and Morrison (2001) and the chapter by Geddes and Butler (2002).

A study by Wright, Wright, Salmon, Beck, Kuykendall, Goldsmith, and Zickel (2002) evaluated the effectiveness of computer-assisted cognitive therapy. Ninety-six inpatient and outpatient clients with major depression, dysthymia, bipolar disorder-depressed phase, panic disorder, generalized-anxiety disorder or social phobia with at least a tenth grade education or GED participated. They utilized computer software designed to teach them cognitive-behavioral techniques. The subjects were permitted to work at their own pace. Mean scores on the BDI were substantially reduced in subjects who used the software in conjunction with their regular treatment. There were high levels of satisfaction with the program and self-reported levels of knowledge about cognitive-behavioral skills increased upon completion of the program.

Other therapies have also been the focus of research. A study by Dowrick (2000) reviewed the effectiveness of problem-solving treatment and group psychoeducation in depressed subjects. There were 452 participants assigned to either six individual problem-solving sessions, eight group sessions on the prevention of depression, or a control group. Group psychoeducation emphasizes instruction, not therapy, and promotes the use of relaxation, positive thinking and positive activities. Both interventions improved function and outcomes at six months were positive for both. Compared with controls, they were less likely to remain depressed and more likely to report improved subjective mental and social functioning.

As detailed above in the group psychoeducation model, relaxation can be viewed as an effective technique for combating depression. A study by Field and Grizzle (1997) compared relaxation training with massage therapy in treating depressed patients. Patients were randomly assigned to either group and received ten 30-minute sessions of either treatment over five weeks. Both treatments resulted in decreased anxiety, however, massage also resulted in a reduction in depressive states and stress. Stress levels were measured by lower urinary cortisol levels.

The use of exercise to decrease depressive symptoms has also been addressed in the literature. A pilot study by Shrier (2002) utilized an exercise routine with twelve patients suffering from depressive symptoms. The patients performed a supervised program of interval walking on a treadmill thirty minutes a day for ten days. After training, all patients experienced a clinically relevant and statistically significant decrease in depression scores. An article by Pollock (2001) also outlined an approach to integrate exercise into the therapeutic relationship with the focus on the collaborative problem-solving relationship between the therapist and the client.

Biological Treatments

In more severe forms of depression, there are more controversial techniques in use. Electroconvulsive therapy (ECT) is a method for treating depression. A review by Sharma (2001) stated that there was no empirical evidence supporting the effectiveness of ECT in reducing suicide rates compared with other treatments. There did appear to be short-term effects on patients with suicide risks but no long-term evidence. Rabheru (2001) offers conflicting evidence in his review, stating that ECT is relatively safe and extremely effective in treating severe, refractory depression, particularly in the elderly. Sonawalla and Fava's (2001) chapter on best practice emphasizes that ECT must be considered for the severely depressed, suicidal patient. The chapter by Geddes and Butler (2002) states that ECT has been deemed effective in the acute treatment of depressive illness. Sable, Dunn, and Zisook (2002) states that, in older patients, pharmacotherapy, ECT, and light therapy should be considered effective biological treatments for the symptoms of depression. Sable, et al also concluded that ECT is a viable alternative in older patients who do not respond to antidepressants or who cannot tolerate the side effects.

A review compiled by Hasey(2001) compared the effects of ECT with repetitive transcranial magnetic stimulation (rTMS) in treating depression. RTMS is still regarded as an experimental treatment as not enough research has been conducted to ensure its effectiveness or safety. Preliminary research finds rTMS and ECT equally efficacious in decreasing symptoms of depression in persons not also experiencing psychosis. "RTMS uses magnetic energy to alter cortical neuronal activity and it can be delivered to more discrete brain regions in a relatively controlled manner without the use of conductors" (Hasey, 2001). ECT is not a very specific, controlled process and requires the use of conductors to transfer energy from the source to the subject.

Another relatively new, experimental procedure is thought-field therapy (TFT). It is "a self-administered, brief treatment that uses energy meridian treatment points and bilateral optical-cortical stimulation while focusing on the targeted negative emotion or symptom" (Sakai, Paperny, Mathews, Tanida, Boyd, Simons, Yamamoto, Mau, and Nutter, 2001) A non-controlled study by Sakai, et al, involving 714 subjects found that TFT treatments produced a self-reported reduction in distress for a wide variety of symptoms and conditions, including depression. Significant reductions in symptoms were found within one treatment session for each of the 31 conditions included in this study. There was no discussion of how long these improvements in symptoms lasted after the treatment.

Treatment Summary and Implications for Best Practice

In summary, there are a wide variety of treatment options available for clients suffering from the symptoms of depression. Medications were clearly indicated and supported, with the SSRI's being the drug class of choice in the current literature. Psychological therapies, such as cognitive-behavioral therapy and problem-solving treatment have been found to be as effective as

medication in the reviewed studies and both treatments, as well as medications, are superior to placebo. The more biological treatments, such as massage therapy, ECT, and rTMS have been shown to be effective in limited studies and special populations.

The current best practice when reviewing the literature appears to be either traditional therapy or pharmacotherapy. Due to the possibility of serious adverse side effects, it may be more beneficial to the client to begin with psychological therapies and add medications if there is no significant improvement. There is conflicting research about the best type of medication for any given client, however, SSRI's have been shown to be tolerated better than tricyclic antidepressants or the mono-amine oxidase inhibitors. With any medication, it is somewhat of an experiment. If there is no relief of symptoms with any given medication or a reaction to certain side effects, doctors typically change the medication until one is found that is effective in reducing symptoms and is well-tolerated by that particular individual. Cognitive-behavioral therapy techniques as well as problem-solving therapy have proven effective in reducing depressive symptoms in the research. ECT provides benefits for those suffering from severe depression or suicidal thoughts and attempts.

Chapter 4

Normative Practice/Outcomes

The community based agency in which this study was conducted offers the services of a psychiatrist as well as mental health therapists. Typically, an intake is conducted at which time it is determined between therapist and client whether a medication evaluation is needed or agreed to. During this initial intake, it is also the choice of the client to continue with individual therapy, transfer to medication only, or possibly participate in one of the groups available for more specific, focused concerns.

The individual of focus in this study, Julie, arrived for an intake at this agency after receiving encouragement from her family physician to do so. She was already taking medication, Zoloft, an SSRI, when she arrived and did not want to see the agency's psychiatrist as she was satisfied with the treatment and medication she was receiving from her family physician.

The standard intake was completed and a diagnosis was made, with Julie presenting symptoms of a major depressive episode superimposed on dysthymic disorder. Due to her self-described history of neglect by parents and subsequent unmet childhood needs compounded with the fact that she was extremely fearful about entering therapy, it was very important to utilize supportive therapy techniques initially and to develop a therapeutic rapport with Julie. Two 50 minute sessions were devoted entirely to developing a relationship with Julie and support was offered. Supportive therapy techniques and empathic listening were utilized during these sessions. There were no demands made upon the client at this time. She appeared to be stabilizing on her medication as well.

Over the following 12 sessions, different therapeutic techniques were introduced. In an attempt to allow Julie to identify the circumstances surrounding her depressive breaks (when she isolates herself from others for days at a time), the concept of a journal was introduced. Its purpose was discussed and the use of it was encouraged. She did not follow through nor did she offer any explanation for not trying this technique. Problem-solving techniques were introduced in an attempt to show Julie that the problems in her life were the source of her depressive symptoms. We worked together on identifying and isolating certain behaviors and attempting to determine how these behaviors or problems were directly related to her feelings. She would become very depressed and at times angry over things such as her injury or not receiving her disability check on time. The most important issue was her relationships with others. She actually responded very well to this technique and was able, over time, to make her own connections between her problems and her feelings and we were able to work towards formulating solutions to these problems. She stated in a session that all she ever knew was control (by mom and her abusive uncle) and she naturally went into a controlling relationship with her first husband and thereafter. While she was increasingly able to make these connections and formulate solutions, she had a hard time putting these ideas into action. She recognized her pattern of getting involved in abusive relationships but was unwilling to admit that she was continuing this pattern with her current boyfriend.

Cognitive-behavioral techniques were introduced as well. The focus of this was her isolating behavior. We worked together on recognizing her feelings prior to these isolative episodes and actively stopping the chain of behaviors. At the end of six months she was able to, the majority of the time, do something more proactive, such as taking a walk or going for a drive instead of shutting her herself in.

As a result of her changed behaviors, she gained more confidence and strength and was able to reconnect with the family members that she had actively pushed away during her depressive episode. These changes were small but it is important to recognize that Julie initiated these changes which had been a big point of contention earlier in treatment. She wrote a letter to her mother expressing her feelings, both recently and earlier in their relationship. She called both of her sons on the phone in an attempt to reconnect with them and these attempts were both successful. She had still not attempted to reconnect with her daughter but did often talk about how she would like to do this. She wanted to send her daughter flowers but never followed through. Julie seemed to remain immature throughout treatment with regard to this particular relationship. She would see her daughter's friends out sometimes and talk to them knowing they would report back to her daughter. She would then wait for her daughter to contact her, knowing that she would, only to be met with disappointment and anger when this did not happen.

Her treatment plan focused on the decrease of depressive symptoms, such as crying, and isolative behavior by learning some problem-solving techniques, cognitive-behavioral techniques, and taking her antidepressant medication as prescribed. A great emphasis was put on support, mainly in the initial sessions, and there was an underlying current of support throughout treatment.

As stated above, Julie reported that she was more able to replace her isolative behavior with proactive behavior as treatment progressed. She also reported a decrease in crying, down to zero occurrences in the last three weeks of treatment from three times a week at the initial visit. Julie did discontinue her medication after five months of compliance and, has not as of the time of termination, experienced any recurrence of symptoms. She had gotten a cold and was taking over-the-counter medication. She was unsure if she should mix these medications so she stopped

taking her Zoloft. She was encouraged to share her actions with her physician, which she stated she had. Julie remained in treatment for six months and understands that she should return to treatment if her symptoms of depression resume.

Chapter 5

Outcome Measures

The Beck Depression Inventory was chosen for its widespread use in the literature. As stated in the BDI manual, scores of 0-9 are described as minimal severity. Scores of 10-16 are referred to as mild while scores of 17-29 are classified as moderate. Scores of 30-63 indicate severe depressive symptoms. The Burns Depression Checklist was used to have another outcome measure of depression. It was selected initially because of its brevity in case the subject could not tolerate the longer format of the BDI. In the end, both were used and both sets of results will be discussed. Her progress was also assessed with the Beck Depression Inventory, the Burns Depression Checklist, the Ways of Coping Questionnaire, and a Client Satisfaction Questionnaire. The first three measures were given near the beginning of treatment and again near the end of treatment. The satisfaction measure was given at the end of treatment only. The Ways of Coping Questionnaire was used to assess any changes in Julie's coping style. This was a key focus of the therapeutic intervention. A coping measure was used because of Julie's poor coping skills as evidenced by her isolative behavior. She typically would shut herself in her house and deny herself outside help in coping by not answering the door or phone when others reached out to her. It was important to determine, not only if her depressive symptoms were decreasing, but also if she was learning skills necessary to combat stressors in the future.

At the beginning of treatment, Julie scored a 13 on the Burns Depression Checklist. At termination her score was a 4. This showed a significant decrease in depressive symptoms. At the beginning of treatment, Julie received a score of 28 on the BDI, falling in the moderate range of depression. At termination, her score was 7 placing her in the minimal range of depressive symptoms. On the Ways of Coping Questionnaire, her original score was 42 with deficits in all

areas of coping. Not surprisingly, her biggest areas of weakness were in distancing, seeking social support, escape-avoidance, and positive reappraisal. At termination, her score was a 91 with dramatic increases in all areas listed above. Overall she was satisfied with treatment, feeling that the services she received helped her to effectively deal with her problems.

Chapter 6

Comparison of Best and Normative Practice

The best practice protocols described in the literature were generally followed in this study. Medication was prescribed and, by chance, it was an SSRI which, as a drug class, seems to be the frontrunner in treatment for depression. Problem-solving techniques, as well as cognitive-behavior techniques were introduced and the subject was receptive to learning and utilizing these techniques. She did not, however, respond well to the idea of the use of a journal. It may have been too early in the relationship to suggest that she write things down about herself. She may have perceived this as a threat as she was already suffering from low self esteem and perceived criticism of her “homework” may have deterred her from completing it.

The use of certain biological treatments described in the literature were not applicable. Electroconvulsive therapy is recommended for use in severe depression and suicidal patients. The subject of this study was neither suicidal nor deemed to be suffering from severe depression. Also, the location of this study was a community based facility which does not have the equipment nor the trained personnel to perform things such as ECT, repetitive transcranial magnetic stimulation or massage therapy.

Chapter 7

Summary and Conclusions

The outcome of this study provided positive changes in the subject. Julie came in for an initial intake at a community mental health setting. She had never been in treatment before despite her chronic dysthymia. When this became further complicated with a major depressive disorder, she followed her physician's advice and came in for help. During the course of six months of treatment, Julie was compliant with her antidepressant medications and was a willing and active participant in the therapeutic process. She learned new coping skills through the use of problem-solving techniques and cognitive-behavioral skills. She was able, at the end of treatment, to identify her triggers and stop her typical chain of behaviors. Her score on all measures were greatly improved. It would have been interesting to see whether the use of a journal might have sped up the process of identifying feelings and their origination. In future trials with other depressed clients, it might be helpful to wait until more time has passed and the relationship is stronger prior to introducing homework assignments.

APPENDIX

Consumer Satisfaction Questionnaire

Date _____

We want to have your input regarding the services you received from the Outpatient Department. Please indicate your responses by circling one number for each question. Thank you!

1. How would you rate the quality of services you received?

Excellent Good Fair Poor

2. Do you feel that the therapist was sensitive to your personal issues?

Totally Mostly Somewhat Very little

3. To what extent has therapy met your needs?

Totally Mostly Somewhat Very little

4. If a friend were in need of similar help, would you recommend therapy to him or her?

Yes Probably Unsure No

5. How satisfied are you with the amount of help you received?

Very Satisfied Satisfied Partially satisfied Unsatisfied

6. Have the services you received helped you to deal more effectively with problems?

Yes Probably Unsure No

7. In an overall, general sense, how satisfied are you with the services you received?

Very Satisfied Satisfied Partially satisfied Unsatisfied

8. If you were to seek help again, would you come back to the same agency?

Yes Probably Unsure No

9. When you first came to the program, were you seen as promptly as you felt necessary?

Yes Probably Unsure No

10. How competent and knowledgeable was the person with whom you worked most closely?

Excellent Good Fair Poor

Any additional comments can be placed on the reverse of this sheet.

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