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CASE STUDY TO EVALUATE EFFECTIVENESS OF A TREATMENT APPROACH
FOR MAJOR DEPRESSION

by
Jennifer R. Laird

A Thesis

Submitted in partial fulfillment of the requirements of the
Master of Arts Degree
of
The Graduate School
at
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Approved by _____
Professor

Date Approved 5/6/02

ABSTRACT

Jennifer R. Laird

Case Study to Evaluate Effectiveness of a Treatment Approach for Major Depression
2002

Janet Cahill, Ph.D.

Applied Psychology and Mental Health Counseling

This case study evaluated the effectiveness of a therapeutic intervention with an adult diagnosed with Major Depressive Disorder. A case study design was used to evaluate treatment for an adult male diagnosed with Major Depressive Disorder and Opioid Dependence in Early Full Remission. The subject voluntarily participated in individual psychotherapy, was given the Beck Depression Inventory during the fourth and final sessions, completed a satisfaction survey during the final session and self-reported his substance use throughout his time in psychotherapy. The literature review indicated that the three psychotherapy modalities were most effective in the treatment of Major Depressive Disorder are: behavior therapy, cognitive behavior therapy (which was used to treat this client), and interpersonal therapy. Selective serotonin reuptake inhibitors were found to be the most highly recommended class of medications for those suffering from Major Depressive Disorder. Those with moderate to severe depression should be given medication and psychotherapy, while psychotherapy alone can be used with those with mild to moderate levels of depression. Methadone is a more effective method of treating heroin use, when supplemented with psychotherapy. The agency in which this client was seen should have had a shorter waiting period for both psychotherapy and psychiatric consultations.

MINI-ABSTRACT

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2002

Janet Cahill, Ph.D.

Applied Psychology and Mental Health Counseling

Treatment approaches for major depression and Opioid Dependence were reviewed. Three modalities are most effective for Major Depressive Disorder. Selective serotonin reuptake inhibitors are recommended for treating depression. Higher levels should be treated with medication and psychotherapy, while psychotherapy alone can treat lower levels of depression. Methadone and psychotherapy is an effective method of treating heroin use.

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Chapter 1

Psychosocial Assessment

Presenting Problem

This client was a 34-year-old Caucasian male of average intelligence who was referred to treatment by a staff member for the Social Security office who helped client file his disability forms. Client's presenting problem was depression; he stated that this was the first time he had suffered from depressive symptomatology. Client stated that his depression began about one year after he got divorced. Client filed for bankruptcy one to three months after getting divorced. He stated his wife had accumulated a large credit card debt and then she had declared bankruptcy, leaving him to pay for the debt. Client did not have enough money to pay the debt, so he had to declare bankruptcy. Client stated that he began to feel depressed about six months before he was fired from his job as a Senior Manager at Wawa. He stated that the reason he was fired was because he began a pattern of coming to work late and leaving early, which was partially due to feelings of fatigue and lack of motivation. After he was fired from this job, he began keeping jobs for shorter and shorter periods of time. He also started using drugs in order to feel less depressed, specifically Oxycontin and Percocet. This drug use resulted in financial problems, including the loss of his house, which led him to move in with his mother. At the intake, he stated feeling intermittent waves of anxiety, inability to work, and significant impairment in functioning. He complained of experiencing difficulty sleeping, and reported that he was always tired. Client stated that, at the time of the intake, he often felt his heart racing and occasionally felt shaky. He stated feeling lonely and panicky. Client reported having difficulty making decisions, as well as difficulty taking pleasure in activities. He felt he needed others too much. Client stated that he was unable to do anything and that he spent most of his day lying in

his room. Client reported that he felt depressed, and that he believed this depression began about two years prior to the intake.

Client described himself as a withdrawn person with impaired memory. He stated that he had no drive for any activities, that he procrastinated, and that he was distant toward his daughter. Client stated that he felt like a “loser” and felt lost. He did report some interpersonal strengths. He was able to identify some interpersonal strengths, indicating he believed he was caring, loving, gentle and intelligent.

Household Description

At intake, client lived at his biological mother’s home with his mother (56 years old) and younger brother (26 years old). Client’s mother had multiple sclerosis and relied on the help of her children for many physical activities, including housework, shopping and driving. She was able to do some things independently, such as cooking and basic cleaning. Although she needed two canes in order to walk, she was mobile.

Family Relationships

Client did not know his biological father and grew up with a stepfather who is now deceased. Client did not know anything about his biological father, and was not clear on why he was not involved in his life. Client’s stepfather passed away when he was 18 years old. He described his stepfather as a quiet and strict man. At the intake, his mother was 56 years old. She was born in Maryland and was diagnosed with multiple sclerosis in 1980. Client described his mother as a nice, caring, loving woman and stated, “She’s a mom.” This comment was used to summarize his description of his mother. He had a full older brother, 39 years old, and a half brother, who was 26 years old. Client stated that he did not get along with his older brother, who he described as manipulating and “using” their mother. They often argue and the client did not

like to see or be around his older brother. Client sometimes got along with his younger brother, but often avoided him. Client's younger brother had not continued his schooling or had many jobs. He was financially unable to support himself at the time of intake.

Client appeared to be fairly close to his daughter and used her as his reason to improve. At the time of intake, client stated that his mother and daughter were the most important people in his life. Although he lived with his younger brother, he did not speak of him. Although client stated having very low energy level and lack of motivation in most areas, he stated that he was able to help his mother around the house when needed, although not as much as he would have liked to or has in the past.

Drugs, Alcohol and Gambling

Client began treatment in a methadone clinic two months prior to beginning mental health treatment, and denied any current drug use. He stated that he attempted to get into a drug and alcohol program, but was unable to do so, as they would not accept him on an inpatient basis because of the substance he was using and the unwillingness of the insurance company to pay for inpatient treatment. Client stated that prior to his recent drug use, he had used marijuana a few times (less than one time a month) and rarely drank in high school, and never drank to intoxication when he did drink. Client stated that he was, however, drinking two to five times a week, eight to nine drinks each night. It is unknown how long client was drinking in this manner. He stopped drinking when he thought that it was becoming a problem, although he denied having ever developed an actual alcohol abuse problem. Client stated that he began using drugs recently when a friend who was also depressed introduced him to drugs, assuring client that they would help him feel better. Client began using Percocet and Oxycontin. He was using these on a daily basis and began using heroin, about one year after beginning to use drugs, when

he felt that he needed something stronger. Client reported that he was snorting four bags of heroin daily for about one year until he quit on his own. He then began using marijuana daily. He also abused a variety of other drugs, including hash, crack, cocaine, ecstasy and dust, although he used these much less regularly during the two years he was abusing Percocet, Oxycontin, and heroin. Client stated that he decided to quit using drugs when the days of physical pain from withdrawal outnumbered those where he felt happier, which was at least one year after he began to use drugs. He stated that he was using heroin one day but then going through two days of withdrawal because he was unable to get more heroin. He began attending a methadone clinic and now receives methadone daily; he also receives individual drug and alcohol counseling a minimum of once a week at this clinic. Client stated that he began using the drugs to try and make himself feel less depressed; he stated that every problem he was experiencing prior to his drug abuse was amplified after he began using drugs.

While client denied any gambling problems, he stated that he would initially gamble one time a month when he received his bonus check from Wawa. He added that he then began gambling twice a month. The client ceased gambling after one night when he had intended to spend a maximum of \$100, but continued gambling until he had spent \$500. He stated that he knew it was becoming a problem and consequently stopped.

There was no reported history of substance abuse in the client's family of origin. The client did not have any information about his biological father, however, so all discussion about his family of origin referred to his mother and her family.

Legal History

At the time of intake, client denied any history of legal charges.

Medical and Psychiatric History

Client denied any medical problems other than an allergy to penicillin. Client stated that he was prescribed Zoloft by a physician two years ago for his depressive symptoms. He stated that he took this medicine regularly for six months, at which point he stopped because he felt he did not need it. He stated that he took Zoloft occasionally after that point, but never regularly. While client denied knowledge of a history of suicide in his family, he stated that his maternal aunt had a “nervous breakdown” and that his maternal grandmother was hospitalized or institutionalized for what he believes was schizophrenia. Client did not have any knowledge or information about his biological father or his paternal side of the family.

Client denied any previous psychiatric treatment and any history of suicide attempts, but stated that he was in a local hospital twice in the past year for overdoses on over-the-counter painkillers. Client denied that this was a suicide attempt, but stated that he wanted “the pain to stop.” Client stated that one of these hospitalizations was due to a car accident. He explained that he went to a physician and complained of symptoms of depression. Client did not inform physician of his drug use and was prescribed Ativan, as the physician did not ask him if he was abusing or using any drugs. He was given a prescription for 100 pills per refill with a limit of five refills. Client took a large quantity of the medication and then left his house to drive to get heroin. Client hit a tree in his driveway prior to reaching the road. When the police arrived, they asked him to go to the hospital. When he refused, they stated that if he did not go to the hospital, they would give him a DWI. Client at that point agreed to be taken to the hospital. No one was hurt in this accident, but client’s car was wrecked. This occurred after client moved into his mother’s house. Client did not present as being suicidal, and this incident appeared to be due to his substance abuse, rather than suicidal ideations.

Education and Job History

At the time of intake, client had been unemployed for two years and was not yet receiving social security benefits. He stated that he had many jobs in his life in either the sales or management fields. Client also served in the Army for nine months in 1991. His longest job was as a Senior Manager at a Wawa, where he was employed for ten years. After client was fired from this job, which occurred shortly after his divorce, he had many jobs which he spent progressively less and less time at. Client reported that he was having difficulty attending work, then had difficulty presenting for an interview, then difficulty scheduling an interview, and was eventually unable to look in the newspaper to apply for jobs. Client continued to be unable to look for jobs in the newspaper classified sections, both before and during therapy.

Client completed thirteen years of school: high school and one year of college. Client dropped out of college after his first year, when his stepfather passed away. Client was not clear on why this led to his dropping out of college, but indicated that he felt that he did not “fit in” in college. His school experiences were described as normal and uneventful. Client reported that his grades were “average.”

Other Agency Involvement

At intake, client was attending a methadone clinic on a daily basis. He received methadone every day, and individual drug and alcohol counseling once a week.

Social Supports

Client stated that he had several good friends, but that he had not seen them in several months and did not speak to them anymore. Client attributed this to his depression, which he reported began about two years prior to intake. Client stated that one friend in particular would

probably listen and understand him, but that he was unwilling/unable to contact this friend and did not want to socialize with anyone at this time.

Client had not been in a significant dating relationship for several years. His most recent relationship lasted for about six months and was in 1999. He stated that they had much in common and that he was “really taken with her,” but that the relationship did not last. Prior to that, he dated a woman who he stated was an alcoholic whom he financially supported for one and a half years. A prior relationship ended after eight months when the woman went back to the father of her child. Another relationship ended after one year, when he discovered that the woman he was living with was having an affair. Client’s first significant relationship was his wife, whom he met when she was 16 years old and he was approximately 20. He stated that they spent seven or eight years together, before and during their marriage. Client stated that he and his wife grew apart as they got older. Client denied feeling depressed prior to the divorce. They have a 9-year-old daughter, who client saw every other weekend.

Psychosocial History

Client was born in Elmer, New Jersey and raised in Southern New Jersey. Client stated that neither he nor his family had any religious affiliations. Although client stated that his childhood and adolescent years were spent having fun with his friends, he also stated that he has a vague memory of being sexually molested by a male cousin when he was about 10 years old in a shower when the family was camping one weekend.

Mental Status

At intake, client appeared as a casually dressed, average-weight man with good hygiene, although he was somewhat unshaven. Client appeared to be drowsy and sad, and sat in a slouched position, often fiddling with his shoelaces. Otherwise, his motor behavior was

underactive. Client had very minimal eye contact. Although withdrawn, client was cooperative and calm. His affect was generally flat; his speech was coherent and his thought process was relevant. Client was oriented in three spheres. Although client reported that his memory was poor, he seemed able to remember clearly all information asked of him, both about recent and remote events. Nevertheless, his timelines did not seem to match. Although client was able to state that he was depressed, he appeared to have little understanding of his condition. Client expressed interest in learning about depression and reported a motivation to change; however, he reported so in disbelief that anything would help him. Client's judgment was moderately impaired and his reality contact was intact. His insight was poor. Client's intellectual functioning was average. Client denied any hallucinations or delusions. No prior evaluations or assessments were available for review.

Chapter 2

Differential Diagnosis

Adjustment Disorder with Mixed Anxiety and Depressed Mood (309.28) was ruled out because client had been depressed for more than six months. While the client's depression may initially have been triggered by his divorce, this is a time-limited diagnosis and his symptoms are better explained by another diagnosis — Major Depressive Disorder. Client also stated that the divorce was a mutual decision and that he did not experience great distress over it. Contradicting this is the fact that he also stated that the divorce preceded the depression.

Panic Disorder without Agoraphobia (300.01) had also been ruled out. Client reported having physical symptoms of panic attacks, such as fast heart beat, but these physical symptoms did not appear to be as severe as would be necessary to be considered a panic attack. Client did not complain of fear of these physical symptoms and did not seek medical attention for these symptoms.

Dysthymic Disorder (300.40) had been ruled out because the symptoms the client had been experiencing are better explained by Major Depressive Disorder. Specifically, client had been feeling depressed for an extended period of time, had become less motivated, slept more than he did prior to the depressive episode and had experienced significant impairment in many areas of his life.

Bipolar I Disorder (296.5) had been ruled out as client denied any episodes of mania or of hypomania. Client stated that he was happy prior to the onset of this depressive episode, but that he never had periods where he did not sleep, or periods where he had excessive amounts of energy or racing thoughts.

Opioid-Induced Mood Disorder (292.84) had been ruled out as client experienced the depression prior to using opiates, and this diagnosis requires that the mood disorder begin after the client has become intoxicated or has experienced withdrawal from the opiate. Client also continued to experience a state of depressed mood after ceasing to use opiates.

Axis I: 296.20 Major Depressive Disorder, Single Episode

304.00 Opioid Dependence, Early Full Remission

Axis II: V71.09 No diagnosis

Axis III: Allergy to penicillin

Axis IV: Severe: housing, financial, occupational, social, relationship problems, possible victim of childhood sexual molestation

Axis V: GAF = 45 (current)

Many symptoms and facts that were gathered during the assessment period support the diagnosis of Major Depressive Disorder. Client reported feeling depressed for more than six months. He stated that he was tired, lacked energy, felt poorly about himself, and experienced sadness. Client stated that he had not experienced a depressive episode prior to this one and denied any episodes of mania. Throughout treatment, the client was unable to work, to meet with friends or to live on his own. Nevertheless, he denied any suicidal ideations. He was able to aid his mother, and continued to see his daughter, as well as engage in activities with her. Client's speech was not illogical or irrelevant.

Client admitted to using several different drugs, many in the class of opiates, on a daily basis for an extended period of time — about two years. He suffered through withdrawal symptoms, such as nausea, cramping and sweating, when he stopped taking these drugs. Client denied any drug use in the past several months. Client did not present with any indications of

current drug use, such as alertness, sleepiness or droopiness in the eyes. During the last therapy session, client stated that he had used marijuana two weeks prior.

Client lost his house, forcing him to move in with his mother. He was not able to hold a job, which also resulted in limited financial stability. He often needed to borrow money from his mother. Client was unable to enjoy or participate in social activities, such as dinner with friends and he was unable to hold an intimate relationship.

Chapter 3

Literature Review

In regards to substance dependence, most experts feel that psychotherapy must be used in conjunction with medication interventions, such as methadone, in order to be successful. Medication, however, is often the only intervention used in the treatment of opioid dependence, particularly heroin dependence. Several different drugs are available: methadone, naltrexone and levo-alpha-acetylmethadol (LAAM). Although all have positive and negative qualities, methadone is the most commonly used medication. O'Brien and McKay (1998) found that while naltrexone has had the worst results in studies, it has few side effects and has good results when used by health care workers and middle-class opiate addicts (Lerner, Sigal, Bacalul, et al., 1991; Washton, Pottash, & Gold, 1984; Ling & Wesson, 1984). O'Brien and McKay (1998) found that studies comparing levo-alpha-acetylmethadol and methadone have shown mixed results. In some studies, methadone has resulted in a lower relapse rate; yet in other studies, both medications have shown similar success rates. One benefit to levo-alpha-acetylmethadol over methadone is the length of its effects after one dose. While methadone must be taken once daily, levo-alpha-acetylmethadol needs to only be taken once every three days (Ling, Charuvastra, Kaim, & Klett, 1976; Marcovici, O'Brien, McLellan, & Kacio, 1981; Ling, Klett, & Gillis, 1978). Overall, methadone has been shown to greatly reduce drug use and to increase the addict's ability to function in society (O'Brien & McKay, 1998).

Much research has been done regarding major depression, the most effective treatments, the possible causes and the personal characteristics of those suffering from it. As depression was "the largest determinate of disability in the world" in 1990, there is no doubt that further research needs to be completed and better treatments found (Andrews, 2001, p. 419). Andrews (2001)

reviewed a study completed by Kiloh, Andrews and Neilson (1988), which followed clients with major depression for fifteen years and found that there were variations in the course of the disorder. While one-fifth of all clients had fully recovered, three-fifths had recovered but suffered relapses, and the last fifth either committed suicide or were permanently incapacitated by the mental illness. Andrews also found that three-quarters of all who had ever met criteria for major depression had more than one episode, with each episode lasting a mean of sixteen weeks (Kendler, Walters, & Kessler, 1997; McLeod, Kessler, & Landis, 1992; Kessler, Zhao, Blazer, & Swartz, 1997). These results are very challenging for therapists and clients alike, as it appears that major depression can be an on-going, recurrent illness that is difficult to treat.

Some studies have shown a very high relapse rate among outpatient clients, diagnosed with major depression at intake, who no longer had depressive symptoms after twenty treatment sessions — many relapsed within six to eight months after ending treatment (Jarrett & Kraft, 1997). Different personality characteristics of those suffering from major depression have been studied in respect to relapse rates. Teasdale, Scott, Moore, Hayhurst, Pope and Paykel (2001) have found that those with extreme thinking (who either “totally agreed” or “totally disagreed”) on depression-related cognitive questionnaires were more likely to relapse than those who were less extreme in their thinking. The direction of the answers (i.e. “totally agree” or “totally disagree”) did not predict relapse. While some studies have shown that those diagnosed with major depression and with one or more personality disorders are more likely to have poor treatment outcomes, Kuyken, Kurzer, DeRubeis, Beck and Brown (2001) did not find any significant results confirming the past studies, although they did find a non-significant trend indicating that dually-diagnosed clients had more depressive symptoms. Their research also

suggests that avoidant and paranoid belief systems were associated with poor treatment outcomes.

Research has shown that those suffering from major depression can often trace it back to a stressful event in their life. The causality between the depression and the life event, however, is unknown (Kessler, 1997). While many clients can state what was occurring in their life around the time during which they first started noticing the depressive symptoms and feelings, they may not be accurate in their memories. They also may not have noticed when the depression truly started. It is very difficult to accurately determine whether the life events caused the depression or whether the depression caused the life events.

The individual characteristics of clients prior to the start of the depressive episode also contribute to the progression of the depressive symptoms (Kessler, 1997). It will also affect the sense of self, which Blatt and Segal (1997) have found changes through the depression. Therapy needs to cultivate a new sense of self, in which one is able to accept their needs and experiences. Those suffering from major depression must also learn some new coping and communication skills. Some researchers suggest that one aspect of depression is the inability to express anger, which results in turning the anger felt towards others inward onto oneself (e.g., Blatt & Segal, 1997). The knowledge that one is doing this is very important in order to begin learning how to end this cycle.

Further research has begun to suggest which treatments work the most effectively for those suffering from depression. Research on antidepressant medications is extensive, both comparing the different medications, and classes of drugs, and comparing the medications to psychotherapy. Several groups of drugs are available for the treatment of depression: tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), monoamine oxidase

inhibitors (MAOIs) and several atypical antidepressants, which do not fit into any of the other categories of medications. Selective serotonin reuptake inhibitors are the most commonly used medications for depression, as the safety of these medications is significantly higher than that of the others (Nemeroff & Schatzberg, 1998). Although some studies suggest that tricyclic antidepressants are more effective than selective serotonin reuptake inhibitors, one major disadvantage of tricyclic antidepressants involves the susceptibility to overdose. For this reason, many clinicians today are more likely to prescribe selective serotonin reuptake inhibitors than tricyclic antidepressants. Monoamine oxidase inhibitors are also rarely used because of their side effects, including dietary constraints and the need to take them multiple times a day. Selective serotonin reuptake inhibitors are more commonly used today, although they also have some side effects, such as nausea, diarrhea, insomnia, nervousness and sexual dysfunction. In an overdose, however, selective serotonin reuptake inhibitors are not deadly. Research has not shown any one selective serotonin reuptake inhibitor to be more effective than others (Paton, 2000). One of the atypical antidepressants, bupropion (Wellbutrin), appears to have similar effectiveness to the tricyclic antidepressants without the negative side effects. This medication is often prescribed to people suffering from major depression. Some of the other atypical antidepressants, although they have fewer side effects, have been shown to be less effective with moderate to severe depression (Nemeroff & Schatzberg, 1998).

Studies have shown that twenty to 59% of those in primary care stop taking their medication within three weeks of it being prescribed (Lawlor & Hopker, 2001). These statistics call into question whether medication, at least when used alone — without psychotherapy, is a viable form of treating major depression. Given that many medications take about four weeks to begin working, almost two-thirds of all who were prescribed medication alone could have

experienced very little, if any, improvement in their depressive symptoms. Interestingly, up to 30% of clients do not respond to the first medication that is prescribed and 5% to 10% of clients do not respond after many medicine trials (Paton, 2000). When clients stop taking the medication that has been prescribed, particularly prior to when effects would begin to be noticeable, they are unable to find the best medication.

Different types of therapy have been researched and shown to have different levels of effectiveness. Traditional psychotherapy, such as psychoanalysis or other “talk therapies,” has been shown to be much less effective for major depression than other therapies, such as cognitive therapy, also referred to as cognitive behavior therapy (Craighead, Craighead, & Ilardi, 1998). Cognitive behavior therapy has also been shown to have as good as, or even better, outcomes than medication alone (Teasdale, Scott, Moore, Hayhurst, Pope, & Paykel, 2001; McGinn, 2000), and may have lower relapse rates than medication. Those who respond partially to medication, then have cognitive behavior therapy added and medication continued also have significantly reduced relapse rates (Teasdale, Scott, Moore, Hayhurst, Pope, & Paykel, 2001).

Several aspects of cognitive behavior therapy seem to help clients suffering from major depression. Most significantly, relapse may be reduced or prevented by changing the way experiences are processed — by changing clients’ thinking style, particularly when that style is extreme in nature (Teasdale, Scott, Moore, Hayhurst, Pope, & Paykel, 2001). Many cognitive therapists also approach depression with the idea that it is a medical illness. This is shown to help clients because it allows for less opportunity for those suffering from major depression to blame themselves (Jarrett & Kraft, 1997). Instead, clients can look externally for the causes of their illness while continuing to look internally for the reduction in symptoms and prevention of relapse necessary for recovery.

Each stage in cognitive behavior therapy has a goal, a schedule and a time frame. Although many therapists today take techniques from many different modalities, a strict, traditional cognitive behavior therapist would use the following steps in the treatment of major depression. The first eight to twelve sessions are scheduled twice a week, for four to six weeks (Ilardi & Craighead, 1999). During this time, a state of partial remission is achieved and the therapist sees a response to treatment. At this point, sessions are reduced to one a week. The therapist's goal is for full remission by the twentieth session. The client then would no longer meet DSM-IV criteria for major depression and few symptoms would be apparent. After full remission is reached, the sessions would be further reduced to once a month or less, and a maintenance stage would be reached. The goal would change to relapse prevention and maintenance of full remission (Jarrett & Kraft, 1997). This last stage is necessary given the high rate of relapse seen in those suffering from major depression. Given today's trends in health insurance, however, this stage may not be available to many who would benefit from it.

Cognitive behavior therapy relies heavily on homework assignments to help clients progress farther over a shorter period of time. It is believed that homework helps the clients make cognitive and behavioral changes necessary to reduce the depressive symptoms. This is one aspect to this type of therapy that makes it highly effective for those suffering from major depression. Studies have suggested that completing homework assignments leads to a more successful treatment outcome; those who completed homework improved three times more than those who did not complete the assignments (Lawlor & Hopker, 2001). The stage of treatment during which the homework is completed also affects the outcome: those completing the assignments during the beginning or the beginning and middle of treatment had a better treatment outcome than those who did not complete it. These results, however, call into question

whether those who complete the tasks are more likely to improve regardless of their compliance to homework. In other words, those completing homework may be more likely to improve in any treatment modality due to personal characteristics (Detweiler & Whisman, 1999).

Some research has shown the populations or individual characteristics that may respond well to cognitive behavior therapy. Past studies have suggested that those scoring high on the Dysfunctional Attitudes Scale, which is a scale that measures the way experiences are viewed, did not respond well to cognitive behavior therapy, although interpersonal dysfunction and social dysfunction did not seem to affect treatment outcomes. The research by Hardy, Cahill, Shapiro, Barkham, Rees, and Macaskill (2001) suggests that there is a lack of a relationship between initial cognitive functioning and the outcome of therapy. While many believe that lower functioning individuals may not be appropriate for, or respond well to, cognitive behavior therapy, these results suggest otherwise. This form of therapy may be well suited to a wider range of individuals than was first believed. If this is the case, cognitive behavior therapy would be a feasible option for therapists to use for many clients suffering from major depression.

Behavioral medicine, which uses many techniques similar to that of cognitive behavior therapy, has also been shown to benefit those suffering from major depression. Some research suggests that clients who completed treatment, compared to those who did not, had a higher level of education, were married, were gainfully employed and had lower initial depression (Nakao, Fricchione, Myers, Zuttermeister, Barsky, & Benson, 2001). These researchers, however, seem to be generalizing the results to all who suffer from major depression. They infer from their results that Behavioral Medicine is good for all, while the results seem to actually suggest that those who were more severely depressed were more likely to leave treatment prior to reaching a state of remission. Contrary to the researchers' interpretation, this seems to suggest that

behavioral medicine, while appropriate for those less severely depressed, is not an effective form of treatment for those who have more severe initial depression.

Research has compared several different forms of therapy. Typically, behavior therapy, cognitive behavior therapy, and interpersonal therapy are considered the most effective for the treatment of major depression. Behavior therapy has been shown to be as effective, if not more so than, medication in both the short- and long-term. While cognitive behavior therapy has been found to have similar results, this type of therapy as well as interpersonal therapy, have overshadowed behavior therapy in practice (Craighead, Craighead, & Ilardi, 1998). While all three therapies have shown to be effective as indicated by the research, those actually treating clients tend to use either cognitive behavior therapy or interpersonal therapy. There are two possible explanations for this: more therapists are trained, and therefore comfortable, in those two modalities; or therapists believe that they see more clients recovering from the use of those treatment modalities than they do with the use of behavior therapy. Regardless of the reason, behavior therapy, although shown through research to be effective, is not used as often for the treatment of major depression.

Further research has compared control groups to those in problem solving-oriented individual therapy and to those in depression prevention psychoeducational groups. While a significant difference between the controls and the two groups was not found at 6 and 12 month follow-ups, the two non-control groups were more likely to have improved mental and social functioning. When the two non-control groups are compared, those in the problem solving therapy are significantly more likely to complete treatment and are less likely to report depressive symptoms at follow-up (Dowrick, Dunn, Ayuso-Mateos, Dalgard, Page, Lehtinen, Casey, Wilkinson, Vazquez-Barquero, Wilkinson, & Outcomes of Depression International

Network Group, 2000). While education of major depression should be incorporated into treatment, education alone is not enough. Beyond being informed of the illness, clients need to be instructed on what to do with that information and helped through the recovery process.

Craighead, Craighead, and Ilardi (1998) found, in their research on the treatment of major depression, that behavior therapy, cognitive behavior therapy and interpersonal therapy have all been shown to be effective treatment approaches (Elkin, Shea, Watkins, Imber, Sotsky, Collins, Glass, Pilkonis, Leber, Docherty, Fiester, & Parloff, 1989; Hersen, Bellack, Himmelhoch, & Thase, 1984; McLean & Hakstian, 1990; Simons, Murphy, Levine, & Wetzel, 1986). It is questionable however, what the most effective treatment is: these therapies alone, these therapies with medication, or medication alone.

Unfortunately, very little research has been done comparing medication only, therapy only, and therapy and medication. Also, many studies do not have a pure medication only or placebo group: these are usually combined with a clinical management aspect. While clinical management is not as frequent or in-depth as therapy, it provides a source of support, a time for advice from a professional, and a time for a professional to listen to the problems of the patient participating in the study. The fact that the effects of clinical management alone are not known or controlled for, calls into question the outcomes of any medication or placebo groups.

Much of the research that has been done has contradicting results. Different medications, different therapists — with a range of proficiencies in the studied treatment modalities, and different methods within the research — probably explain some of the variety between studies and results. At this point, it is still difficult to determine what works best for major depression. Working on a client-by-client basis is probably the most effective approach at this time — therapists and psychiatrists should be doing what seems to work for each individual person.

Some research has shown that at the eighth week of a sixteen-week treatment program, patients being treated with medication alone had made the most progress, as compared to those in psychotherapy conditions. This changes, however, when the patients are re-evaluated at follow-up. Results at follow-up suggest that the psychotherapy conditions are much more effective than the condition of medication alone, even with clinical management (Blatt, Zuroff, Bondi, & Sanislow III, 2000). These results suggest that using medication and psychotherapy, such as cognitive behavior therapy or interpersonal therapy, in conjunction with one another, would be the most beneficial treatment method. The medication would raise the patient's level of functioning, or coping, in the first stage of treatment, while therapy would stabilize the patient over the long-term.

The results of this study also suggested, however, that patients in a therapy condition reported greater satisfaction with treatment. Those in therapy conditions stated feeling that treatment had more of a positive effect on their coping skills, relationships, and recognition of symptoms than did those in medication conditions. This suggests that, while symptoms may not have been reduced more than in those clients in the medication conditions, the overall happiness and quality of life of those in therapy conditions is improved significantly more than it is in those in medication conditions.

While some research has supported the finding that medications initially work faster than counseling (Chilvers, Dewey, Fielding, Gretton, Miller, Palmer, Weller, Churchill, Williams, Bedi, Duggan, Lee, & Harrison, 2001), others have found the opposite to be suggested (e.g., Ward, King, Lloyd, Bower, Sibbald, Farrelly, Gabbay, TARRIER, & Addington-Hall, 2000; Bower, Byford, Sibbald, Ward, King, Lloyd, & Gabbay, 2000). Another difference found was in long-term results. At follow-up, other studies have found that there is not a difference between

psychotherapy and medication on either cost or effectiveness (Chilvers, Dewey, Fielding, Gretton, Miller, Palmer, Weller, Churchill, Williams, Bedi, Duggan, Lee, & Harrison, 2001; Bower, Byford, Sibbald, Ward, King, Lloyd, & Gabbay, 2000).

DeRubeis, Gelfand, Tang and Simons (1999) examined original data from four different studies (Elkin, Shea, Watkins, Imber, Sotsky, Collins, Glass, Pilkonis, Leber, Docherty, Fiester, & Parloff, 1989; Hollon, DeRubeis, Evans, Wiemer, Garvey, Grove, & Tuason, 1992; Murphy, Simons, Wetzel, & Lustman, 1984; Rush, Beck, Kovacs, & Hollon, 1977) and ran a meta-analysis on that data. This research compared cognitive behavior therapy and medication. While there was a trend for cognitive behavior therapy to be more effective than medication, this trend was not significant — both medication and cognitive behavior therapy were determined to be equally effective in the treatment of major depression.

Further research has compared cognitive therapy to a monoamine oxidase inhibitor and a placebo condition. Both cognitive therapy and medication were found to be significantly better than the placebo. Again, this research suggested that both cognitive therapy and medication were an equally effective form of treatment. The medication appeared to work somewhat faster than the cognitive therapy, but by the final session, the results were almost exactly the same. At no point during this research were the medication and cognitive therapy conditions significantly different (Jarrett, Schaffer, McIntire, Witt-Browder, Kraft, & Risser, 1999). The results of these studies leaves the question to which treatment, or combination of treatments, is most effective for those suffering from major depression unanswered, and very unclear. It will most likely take much further research, and clinician trial and error, before this is known.

Little research has been completed which has a therapy and medication condition. The research that has been done has some conflicting results. One study that compared therapy to

medication used five different conditions: interpersonal therapy and medication, interpersonal therapy, interpersonal therapy and placebo, medication, and placebo. The results of this study suggested that both medication conditions (with and without therapy) were more effective than the psychotherapy and placebo condition, the psychotherapy condition, and the placebo condition. There was a non-significant trend for the interpersonal therapy and medication to be more effective than medication alone. As the interpersonal therapy condition had better results than would have been seen for someone without any treatment, the researchers suggest that this is an effective option for patients who do not wish to, or cannot, take medications (Frank, Kupfer, Perel, Cornes, Jarrett, Mallinger, Thase, McEachran, & Grochocinski, 1990).

Persons, Thase, and Crits-Christoph (1996) examined the treatment guidelines published by the American Psychiatric Association and by the Depression Guideline Panel of the Agency for Health Care Policy and Research and then examined research on the treatment of major depression. They found that the treatment guidelines often had contradicting recommendations. This research team also felt that the American Psychiatric Associations guidelines usually did not seem to coincide with the current research. While the American Psychiatric Association, prior to developing the guidelines, had completed extensive research, the recommendations were often contradictory to the research that they cited. For example, one statement indicated that cognitive therapy does not differ significantly from placebo conditions. Research has clearly suggested that the opposite is actually true, with some studies suggesting that cognitive therapy is better than medication (see the above research). Persons, Thase and Crits-Cristoph (1996) examined other research and found that, while patients receiving both medication and behavior therapy improved faster than patients in other conditions, that condition was not significantly

more effective than psychotherapy or medication conditions (Hersen, Bellack, Himmelhoch, & Thase, 1984; Roth, Bielski, Jones, Parker, & Osborn, 1982).

Both guidelines stated that patients with mild to moderately severe depression might be treated with psychotherapy alone, while those with moderate to severe depression should be treated with a combination of medication and psychotherapy. Persons, Thase, and Crits-Christoph (1996) found that research did support this recommendation (Robinson, Berman, & Neimeyer, 1990). Other research found that psychotherapy and medication were equally effective in treating those with severe depression (Hollon, DeRubeis, Evans, Wiemer, Garvey, Grove, & Tuason, 1992; Elkin, Shea, Watkins, Imber, Sotsky, Collins, Glass, Pilkonis, Leber, Docherty, Fiester, & Parloff, 1989). As this research continues to need clarification, the guidelines seem to be the safe choice for therapists at this point.

If medication is as, or even less, effective than therapy, the use of medication is called into question. Clients who could achieve the same outcome without medication could have chemicals, many with negative side effects or addictive qualities, introduced into their bodies. Therapy would be, then, a less invasive, and therefore preferable option. More research needs to be done comparing therapy alone, therapy combined with medication, and medication alone in order to determine the effectiveness of each. The initial functioning level of each individual client also needs to be considered. Someone who presents as extremely symptomatic might need an option that would immediately start to affect the way they are feeling, while someone who is somewhat stabilized at intake would be able to remain unmedicated.

As if the treatment of those with pure major depression was not complicated enough, treatment for those who are dually-diagnosed with substance abuse and depression must also be examined. Substance abuse and depression are often closely linked. Research has shown that

those using multiple substances, or those addicted to heroin, had much higher levels of depression, as compared to the general population. When surveyed, 63% of inpatient substance abusers stated they used non-prescription drugs to counter the depression that they felt (Mehrabian, 2001). These results suggest that many suffering from major depression self-medicate in order to feel better. While this may initially help, it is a severe detriment over time. Furthermore, clients who did not relapse in their substance use were found to have no difference in their level of depressive symptoms, when compared to the general population, but those who relapsed were shown to have significantly higher levels of depressive symptoms (Mehrabian, 2001). This further links depression and substance abuse.

Many studies seem to suggest that depression is more likely the cause of the substance abuse rather than the other way around, but Mehrabian (2001) also found that depressive symptoms declined over the course of substance abuse treatment. While this could suggest that the depression is being directed, most likely indirectly, by the substance abuse treatment, it could also suggest that the cause of the depression is the substance abuse. Further research needs to be completed which examines the specifics of substance abuse treatment to help answer this question.

Pantesco (1989) found that a holistic treatment approach must be used in dually-diagnosed clients. All aspects must be addressed, including addiction, mental health and medical health. It is stressed that, for treatment to be fully effective, all areas of a client's life must be treated rather than merely the presenting problem, as often happens. Should this be followed, relapse of both the substance abuse and the depression would likely be much lower.

Much information regarding the treatment of substance abuse, depression and dually-diagnosed clients is available for therapists to use. Unfortunately, much of this information also

contradicts other studies and makes it difficult to determine what, if any in particular, treatment modality would be most effective for a given population. Over time, hopefully more questions will be answered and therapists will have fewer contradicting results to base their choice of treatments on.

Currently, the research suggests that one of three modalities is ideal for the treatment of major depression: cognitive behavior therapy, interpersonal therapy, and behavior therapy. Although further research needs to be completed to clarify the contradictions seen in the current research, it also appears that a combination of medication and one of the above-named psychotherapies would be most effective for those suffering from major depression, particularly if the symptoms are moderate to severe. Research also suggests that medication should also be used in the treatment of Opioid Dependence, along with psychotherapy in order to prevent relapse. Clients who are dually diagnosed with major depression and substance abuse should be treated in a holistic manner, allowing for all of the problems and symptoms to be addressed as an interconnecting whole, treating the person completely, rather than in pieces.

Chapter 4

Normative Practice and Outcomes

The agency at which this client was seen had a waiting list for adult individual therapy. After clients had called for the initial referral, which was completed over the telephone, they generally were not called to schedule their first appointment for one to two months. The agency's procedure also stated that a client should not schedule an appointment with the psychiatrist until their third individual session was completed. This was due to the large number of people who cancelled or did not show for their psychiatrist appointments. A psychiatrist appointment also needed to be scheduled one to two months in advance because of the large volume of people seen versus the number of psychiatrists available. This client's psychiatrist appointment was scheduled at the end of the first session, as he was interested in medication and it was thought that medication might be of help to him. The earliest appointment was one month later. Approval was not needed to bypass standard policy, nor did any staff member or administrative staff question the immediate scheduling of the psychiatrist appointment.

During the first session an intake assessment was completed for all clients, new or returning. This assessment asked a variety of questions, geared towards gathering a comprehensive psychosocial assessment. Other assessments were not standard at this agency.

This agency treated each problem individually: strictly mental health concerns were addressed in individual therapy, while any drug and alcohol abuse concerns were referred to the agency's drug and alcohol treatment department. Nevertheless, therapists in the different departments regularly communicated about mutual clients, and psychiatrists were often consulted (Pantesco, 1989).

There was not one standard modality that was practiced at this agency. Therapists could use the treatment they felt would be the most effective for each client. Most therapists used many techniques from several different therapies, although they would tailor them towards each client's personality and diagnosis. The primary therapy used for this client was cognitive behavior therapy (Craighead, Craighead, & Ilardi, 1998).

The client was seen over a period of fourteen weeks, although he only attended ten sessions. He called to cancel four, due to a variety of reasons: he was running too late, illness, lack of money, and his car broke down. At the end of the fourteen weeks, he was transferred to another therapist because the practicum was ending. He did not continue in individual therapy with that therapist, although he did continue seeing the psychiatrist.

Homework assignments were given after every session. The goal of these tasks was to change the behaviors and thought processes of the client to more adaptive ones, thereby changing the way he felt (Detweiler & Whisman, 1999). The client was often asked to attempt to change his self-talk, to re-word what he said to himself so that it was more positive. These assignments lasted throughout the therapy.

Other tasks were related directly to specific problems the client was facing. Late in therapy the client became very concerned that he had a serious medical problem as he noticed a spot on the left side of his torso. The client was asked to make an appointment with a doctor at a local clinic that offered a sliding scale fee. This assignment was given for several weeks, at which point it could be modified as the client had called and scheduled an appointment; the client was then asked to go to the appointment and see the doctor.

Socialization was addressed in homework. The client was lonely, yet afraid to see his friends. Homework started with the goal of improving social relationships: the client was asked

to determine which friend he would feel most comfortable contacting. The client slowly worked his way through the necessary steps, with both successes and minor setbacks. He spoke to a friend on the phone, they made plans with several others, he went to the meeting place, but then did not go in and instead turned around and went home. Later on he was able to see one friend and they met individually. Through small steps, and many repeated steps, the client slowly began to renew some friendships.

Much of the client's self concept was related to his occupational functioning and financial well-being. As he was not yet ready to re-enter the workforce, the client was asked to look through classifieds merely to see what was available. He was instructed to identify jobs of interest. Further schooling and the pros and cons of different job responsibilities were discussed. The client was given the telephone number to his local Department of Vocational Rehabilitation Services office, and informed that many training services, as well as school financial assistance, were available through that state office.

Physical activity was also discussed in homework assignments. The client often complained of excessive tiredness, lack of energy, lack of physical stamina and endurance, and generally of being "out of shape." The client was asked to begin a light exercise routine, such as walking for ten to twenty minutes a day. On this task, the client tended to overexert himself and to then be very tired and sore from it for a period of time. The client also had difficulty with setting realistic goals for himself in this area. He seemed to think he could physically do everything he had been able to do one year earlier, prior to the onset of his depression and when he had been exercising regularly. There is some evidence that exercise may help, at least minimally, to reduce depressive symptoms (Lawlor & Hopker, 2001).

All of the homework assignments were discussed in session. The way the client felt about them and any resistance to completing them were addressed. The client wished to see results immediately, but did not always complete the tasks or want to move deeper into his feelings in sessions. A great amount of resistance to change was seen, as he often did not complete, or even attempt, homework tasks and did not wish to talk about feelings during sessions (Lawlor & Hopker, 2001).

Many of the homework assignments were brought into sessions. Self-talk was addressed on a regular basis. During sessions, the reasoning behind the task was discussed: essentially, speaking more positively to oneself will lead to feeling better about oneself and a greater motivation to change. This is a technique used in cognitive behavior therapy (Fennell, 2000). The client was redirected during sessions when rephrasing was necessary and was given examples of how different comments or sentiments could be stated in a new manner.

The client was also taught relaxation techniques and was asked what activities or hobbies he could complete in order to relax and de-stress. The client began to occasionally play games on his brother's computer and stated that this helped to take his mind off of other problems. He also helped his mother around the house by fixing things for her, chopping wood, and taking her to the grocery store. The client appeared to enjoy using physical activities in order to relax. These activities also allowed the client to take his mind off other things, such as his depressive symptomatology, which also helps to minimize the amount of poor self-talk, or thoughts that made him feel depressed (Fennell, 2000). The client was also taught a muscle relaxation technique called Progressive Relaxation (Davis, Eshelman, & McKay, 1995). This technique was reviewed and the client was asked to practice it at home.

These skills were developed in order to equip the client with additional coping skills for current and future use (Blatt & Segal, 1997). Asking for help from friends, family and professionals when needed was also discussed, particularly in the context of socialization. The client appeared ashamed to need to ask for help and did not want to do so. The client did not ask for help from others until he reached a point where he no longer had a choice. When the client was having problems with depression, drugs and finances, he did not seek help from his mother until he lost his house. At that point, he asked to move into his mother's home. He did not have any money, was unemployed, was addicted to heroin, and was suffering from major depression. After beginning therapy, the client continued to be resistant in asking others for help and seemed to feel that any form of dependence on others was a weakness in himself. The client felt that he should be able to rely solely on himself in every life situation. While the client may have begun to realize that this was an unrealistic expectation to have of himself at the time he left treatment, these expectations had not yet changed and he still felt that he should not seek help from those around him.

A treatment plan was developed with the client during the fourth session. The plan outlined three goals, each addressing a different area of the client's life. The first goal targeted the client's wish to "be where [he] was" prior to becoming depressed. This goal was to reduce the depressive symptoms. The client's objective was to identify three triggers of depression. Progress was to be measured by how active the client was and by whether or not he had acquired coping skills. The final outcome was anticipated for the client to be active for 50% of his day and to have acquired three new coping skills. The interventions of the staff were to include the facilitation of learning and mastering the coping skills.

Continued sobriety from all substances was the second goal. The client was to attend a minimum of 75% of his drug and alcohol treatment sessions. Progress was to be measured by session attendance and whether or not he relapsed in his drug use. Staff were to monitor his attendance and progress with the drug and alcohol counseling.

The third and final goal targeted the client's medication regimen. The client was to attend a minimum of 75% of his sessions with the psychiatrist. The client was also to comply with all psychiatrist recommendations. Staff were to consult with the psychiatrist to monitor progress, changes in medications, and progress in both session attendance and medication compliance.

The client was given some education on major depression. He did ask questions about his medication (particularly side effects) and about the disorder in general. Side effects were researched and discussed with him. He was informed that determining the cause of depression is very difficult and examples were given. The client was also given an idea of what to expect in therapy and in the course of the depression, such as both forward and some backward progress toward recovery. It was explained that the depression may not immediately begin to dissipate and that his symptoms may not steadily decrease (Dowrick, Dunn, Ayuso-Mateos, Dalgard, Page, Lehtinen, Casey, Wilkinson, Vazquez-Barquero, Wilkinson, & Outcomes of Depression International Network Group, 2000).

At the time of termination, the client had not been able to maintain a consistent level of activity and tended to sleep and lie on his bed often during the day. While he had learned several new coping skills, such as relaxation techniques and changing of self-talk, the client had not been able to master them or to use them with any frequency.

The Beck Depression Inventory, a reliable and widely used inventory, was also used to assess levels of depression as an outcome measure (Steer, Ball, Ranieri, & Beck, 1999; Plake & Impara, 2001). This inventory was chosen, as it is both valid and reliable. It is also a short, self-administered inventory that gives a fairly accurate idea of the client's level of depression. When looking at the answers the client has marked on the Beck Depression Inventory, the therapist is also able to get more information regarding the depressive symptoms the client is experiencing, as the symptoms are listed in varying severity for each question. As this is not a standard inventory for this agency to use, it was not immediately available. The client was given the Beck Depression Inventory during the fourth and last sessions. The score for the first and second testing were, respectively, twenty-seven and thirty-three. While the score at termination was higher, suggesting a higher level of depressive symptoms, there may be an alternative explanation for this change in score. The second testing may actually indicate a deeper understanding and ability to accurately see the level of the depressive symptoms. In other words, at the first testing, the client may have been in a state of denial, or of attempting to minimize, the symptoms that he was experiencing. By the time of termination, the client may have been entering into a state of acceptance of his illness and of the level of his symptoms. This may have produced a higher score on the Beck Depression Inventory. In the second to last session that the client attended (he had missed two between that and the last session), the client began to delve more deeply into the problems and emotions he was experiencing. He appeared better able to identify and understand his symptoms.

The client was referred to the agency's drug and alcohol treatment program, but the client refused treatment, stating that he could not afford to pay for both. The client was, however, involved in a methadone maintenance program, where he received methadone on a daily basis

and received individual counseling at least once a week. The client denied using any substances during treatment; however, during the last session, he admitted to having smoked marijuana several weeks before. This would change the diagnosis given, by including Cannabis Abuse (305.20). This recent use could have been an explanation for why the client cancelled the two sessions prior to the last one. The client may not have wanted to admit to himself and to the therapist that he had used drugs. At the time of termination, the client was still attending the methadone clinic, but he was in the process of discontinuing the methadone and had begun to reduce his daily dose. The client continued to be, at least on some level, in denial over his substance abuse. The client admitted that he had stopped drinking alcohol prior to starting individual counseling because he knew it was becoming a problem, but client was not able to see that his problems with substances likely extended further than opiates. He insisted that while he knew that alcohol was becoming a problem, it had not yet done so, and therefore felt that he did not have abuse issues with any other substances.

The client was prescribed Wellbutrin SR at 100mg by the psychiatrist at the agency approximately one month after beginning individual therapy. After one month of complying with this medication regimen, the dose was doubled to 100mg two times a day, as it did not appear to be assisting in the reduction of depressive symptoms. After one more month, which was the same week as the client's last individual session, the dose was increased to 150mg two times a day; as the desired results were not seen one and one-half months after this increase in dosage, and the client was complaining of distressing side effects, such as vomiting and diarrhea, the Wellbutrin SR was discontinued and the client was prescribed Remeron, 15mg once a day, and Vistaril, 25mg once a day. The client missed his most recent session with the psychiatrist.

While in individual therapy, he reported that he took his medication as prescribed. A significant change was not seen in the client while he was in individual therapy.

A client satisfaction questionnaire was given to the client at the end of the final session with the current therapist (Appendix A). Although, he was expected to transfer to a new therapist, a rating of how he currently felt about the therapist, and the therapy in general, was desired at that point in time. This questionnaire asked the client a variety of questions on how he felt about the agency in general, his therapist specifically, the progress he was making and therapy in general. Each question was based on a one to five scale, with one being the lowest and five the highest in satisfaction. The client rated the agency's speed in scheduling the first appointment satisfactorily. He rated each aspect of his therapist either a "4" or a "5." Overall, the client stated that he felt the same as when he first started in individual therapy.

Primarily, cognitive behavior therapy was used with this client. Overall, little progress was made towards reducing the depressive symptoms. Several different medications and psychotherapy techniques were used, but the client appeared to remain at approximately the same level of depression throughout the therapy. This client may not have responded well to cognitive behavior therapy, and possibly would have progressed further with a different modality, such as interpersonal therapy. There is also a possibility, however, that the client was not yet ready to make the changes necessary to affect his mood disorder, and he would have benefited most from a supportive therapy geared towards maintaining his current level of depression, in order to ensure his depression did not worsen, while working towards breaking the resistance he felt toward change. This hopefully would have kept the client in therapy long enough for an effective medication to be found, at which point the goal of therapy could be changed to decreasing the client's level of depression.

Chapter 5

Comparison of Best and Normative Practice

There are several differences between the normative practices of the agency in which the client was seen and the best practices described by the research on treating major depression and substance abuse. Some of these could easily be altered; others would take more time and possibly finances on the part of the agency.

The clients should be seen within one week of calling for an initial telephone referral; there should not be a waiting list in place. This would allow for the best treatment of the client. When a client calls, they are seeking help, and most likely feel on some level that they need it, even if that reason is because they are court-ordered to treatment. A client who is feeling extremely depressed may also be feeling suicidal. Because of the waiting list, a suicidal client would not be able to be seen immediately; they would, however, be referred to the agency's crisis department. Seeing the client immediately would be necessary in order to alleviate those suicidal ideations. For any person, with any psychiatric illness or reason for seeking therapy, an appointment should be made as soon as possible. They are seeking help and should be able to receive it as quickly as possible.

Unfortunately, it is not always realistic for this to occur. This agency was the only one serving several counties in the state. There were too many people who needed services and not enough therapists to provide those services. The agency was greatly understaffed and could not afford to hire new therapists. In addition to this, the building did not have enough office space to support the staff that were currently employed, let alone any new therapists.

Often, people who were currently being seen did not show for appointments. This could be due to the schedule their treatment was on. If their symptoms were more severe, one time a

week may not have been enough for them, leading to a higher dropout rate (Ilardi & Craighead, 1999). After missing more than one quarter of their scheduled appointments, clients were generally discharged from therapy, due to a lack of commitment and compliance and because of the large waiting list. This rule was not strict and could be open for interpretation, depending on the circumstances and reasons for missed appointments, but many current clients who were not showing were involuntarily terminated from treatment. While this, and the people who completed treatment, freed some space for the therapists, it was not nearly enough for all who wished to be involved in therapy.

The same practice should have occurred for the psychiatrist appointments. Each client should have seen the psychiatrist much earlier than they did, due to the large waiting list. A diagnosis was necessary to determine whether the person would benefit from medication or not, but the clients should have been seen much earlier than they were. This is even more important since many medications take an average of four weeks or more before they begin to affect the client (Silverman, 2000). If medications begin to work to reduce the depressive symptoms, the client will also be more likely to respond to psychotherapy.

Standard assessments should be used regularly, although this is not currently the practice at this agency. The agency has an intake form that they created that is used during the first session. Other than this intake, however, little else is used. Even the intake could be improved, as it is not as thorough as it should be. The section on substance use should be much more detailed, as it currently asks very minimal, basic questions on recent substance use, and does not provide much space for the therapist to write in if the client has experimented with, let alone abused, any substances. The section on symptoms should be more detailed, and many of the questions asked should gather further information. One example is whether the person is, or has

ever been, in the military. The question is very general, and does not ask how long, or why the person left or was discharged. Rather than asking what the client does when they are angry, the intake asks, "Has your anger ever been destructive?" This question relies on the client's idea of what destructive is, as opposed to getting an idea as to how the person copes when they are upset or angry. Inventories and assessments, such as the Beck Depression Inventory, can be very helpful to therapists. These forms can help a therapist determine a more accurate diagnosis, or at least provide them with more information on the symptoms and feelings of the client when a diagnosis has already been determined. Assessments can also help the therapists determine whether or not the client is making progress. If they were given during the first session, and then perhaps ten sessions into therapy, the therapist may have a more accurate idea of the client's progress. If they appear to have remained at the same functioning level, or have become more symptomatic, the therapist may need to change modalities for that particular client, or refer them to another therapist or agency if they are not a good match for the client.

While the therapists at the agency were licensed, had their Master's degrees, and had much experience, they did not have one specific treatment modality that they used. Most therapists seemed to use many different techniques from many different modalities. While for some clients this may be helpful, research has shown what the best treatments are for major depression (Craighead, Craighead, & Ilardi, 1998). These three modalities, interpersonal therapy, cognitive behavior therapy and behavior therapy, should be used for those diagnosed with major depression. The therapists should more often be looking to the current research in the field when deciding which modality to use with a particular client, particularly if they have much experience with many different modalities of treatment. Clearly, a therapist who is inexperienced with a certain modality should refrain from using it until they have received the

proper training, but once they have, that training should be used for the diagnoses that responds best to it.

The frequency of treatment at this agency should be reevaluated. Cognitive behavior therapy specifically recommends that the client be seen twice a week for at least the first eight weeks, and then be seen once a week for the next eight weeks. Clients at this agency were usually seen once a week or less. Research has shown that this is not enough for those suffering from major depression (Ilardi & Craighead, 1999). While the standard length of treatment is sixteen weeks, this does not translate into sixteen sessions — research actually recommends twenty-four sessions. At the beginning of treatment, the client needs more support and reinforcement of skills they are learning. By seeing the client only once a week, the client is not getting the level of therapy needed. This may lead to them dropping out of therapy prior to completion or to therapy lasting much longer than twenty-four sessions. Both of these options come with increased financial and emotional expenses to the client, as the client would actually be paying for more treatment and would likely not be making improvements as quickly. In addition, if the therapist needs to see someone for a longer period of time, those currently on the waiting list have more time before they are able to begin therapy. Seeing clients with major depression more frequently in the beginning of treatment helps both the client and the agency in the long run.

This agency does not take a holistic approach to treatment. Drug and alcohol abuse is addressed in one department, while other mental health concerns are addressed in another. To some extent, both departments must, and do, overlap. This is kept to a minimum, however. Both departments should be fully addressing all concerns as they are often very much linked together. This client, for example, began using drugs in order to “feel better,” to feel less

depressed. Should he be seen in the drug and alcohol treatment department, his major depression would not be treated. This would start the cycle all over again. The opposite could also be true: someone seen in the adult outpatient department who was experiencing depressive symptoms due to drug and/or alcohol abuse would likely not benefit by having their substance abuse ignored. Neither area should be neglected in treating the other. If this is done, therapists will see their clients continuously rotating through the different departments, rarely making any permanent progress in any aspect of their life (Pantesco, 1989).

Education of the disorders should more frequently be used throughout the treatment. While clients often ask questions, which are answered, education is not always a part of the treatment program for those who do not question their therapist (Dowrick, Dunn, Ayuso-Mateos, Dalgard, Page, Lehtinen, Casey, Wilkinson, Vazquez-Barquero, Wilkinson, & Outcomes of Depression International Network Group, 2000).

The Beck Depression Inventory has been widely used and accepted for many years. The Beck Depression Inventory II, created in 1996, encompasses all areas of the diagnosis for major depression, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. This improvement from the original Beck Depression Inventory, which was created in 1978, makes it a more accurate assessment of major depression (Steer, Ball, Ranieri, & Beck, 1999). The most recent version of the Beck Depression Inventory was found to be more valid and reliable than previous versions (Plake & Impara, 2001). In addition, demographic information, such as ethnicity and age, were not found to correlate to the scores (Steer, Ball, Ranieri, & Beck, 1999). This suggests that this inventory would be appropriate for a wide range of people.

The client satisfaction questionnaire given to this client was developed for this study. While the agency had a satisfaction questionnaire, it was not widely used. The agency's questionnaire was not as thorough as was necessary in order to determine how the client felt about many different aspects of therapy. The questionnaire developed for this study targeted how the client felt about therapy, and different aspects of the therapist, such as techniques and comfort level. This questionnaire was helpful in determining how the client felt about therapy, the therapist and his progress. While this client stated that he felt "good" about both therapy in general and the therapist specifically, he also stated that he felt the same at the end of treatment as he had at the beginning. This suggests that a different modality may have benefited this client. His missed sessions and resistance to homework could also have affected his lack of improvement in his depression.

Client satisfaction questionnaires are helpful for all agencies to use, as they give the agency information that can be used in order to make changes that would benefit the clients. Clients may be able to point out problem areas that the agency would not otherwise recognize. This agency, while they had developed a client satisfaction questionnaire, did not often ask clients to fill it out when they left treatment. This should become standard practice for as many clients as possible. It is understood that clients who simply stop coming to treatment, and are unable to be reached, most likely would not be able or willing to complete the questionnaire, but all others should. These questionnaires should be looked at by one staff member, or a committee, and evaluated to determine what changes need to occur. The number of people who discontinue treatment prior to the therapist recommending that they do so should also be determined and taken into consideration when looking into changes.

Chapter 6

Summary and Conclusions

This case study reviewed the diagnosis and treatment of a 34-year-old Caucasian male diagnosed with Major Depressive Disorder and Opioid Dependence. The trigger for the depressive symptoms is unknown, although it may stem from his recent divorce. The client stated that he began using drugs in order to “feel better,” and to lessen his depression. He was treated with cognitive behavior therapy, and was given the Beck Depression Inventory after several sessions and again during the final session.

Current research suggests that the most effective treatment of major depression is one of three psychotherapy modalities: cognitive behavior therapy, behavior therapy and interpersonal therapy (Craighead, Craighead, & Ilardi, 1998). These psychotherapies should be combined with an antidepressant medication for those with moderate to severe levels of depression (Persons, Thase, & Crits-Christoph, 1996). Selective serotonin reuptake inhibitors are the most commonly used medications today, as the side effects are much more tolerable than those in other medications. There is some evidence that tricyclic antidepressants are more effective, but, due to the susceptibility to overdose, these medications are not used as frequently (Nemeroff, & Schatzberg, 1998).

Substance abuse should also often be treated with medications, and should be treated with psychotherapy. A client who is dually-diagnosed should be treated in a holistic manner (Pantescio, 1989). One therapist, along with a psychiatrist, should treat all diagnoses in order to provide the most efficient, complete therapy possible. A client who is dually-diagnosed should not be prescribed any medications that are addicting.

Much more research needs to be completed on the treatment of major depression and substance abuse. Psychotherapy and medication need to be researched individually and together, and all combinations need to be compared. Further research needs to investigate which modalities of psychotherapy are most effective, with which populations, and the reasons why this is so. Whether medication, psychotherapy, or a combination of both is most effective also needs to be further researched. The research on both of these topics is currently contradictory. Many questions are left unanswered for the therapists who are relying on it in order to provide the most effective treatment possible for their clients. Future research should strive to clarify the many questions on what is truly most effective that have been left out by the initial stages of investigation into these ideas.

Many people do not respond to the first medication that they are prescribed, and it is unknown why they do not respond to each individual medication. Determining what personal or medical characteristics of a person will signal that they will or will not tolerate a specific medication would be very helpful. The number of medication trials prior to finding the appropriate medication would be greatly reduced, leading to a faster recovery and less expenses by the individual and society due to depression.

Agencies also need to examine their treatment policies. Waiting lists need to be greatly reduced, treatment needs to become more holistic, with different diagnoses all treated in one setting, rather than each person being sent from one therapist to the next, trying to address each problem that they are experiencing individually. Therapists should be educated on the current research findings on the most effective treatments for different disorders, and should be able to use the appropriate techniques for each individual, as needed.

While research has made great strides in determining the most effective form of treatment for both major depression and for substance abuse, much more needs to be learned in the future. Therapists need to keep up-to-date on the current research in order to be more knowledgeable on the disorders that they are treating.

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Appendix

Appendix A: Client Satisfaction Questionnaire

Client Satisfaction Questionnaire

Date: _____

Therapist's Name: _____

Please answer the following questions as honestly as possible. Please note that your answers will not effect any further treatment that you receive.

1. The quality of therapy that I received was: 1 2 3 4 5
poor satisfactory excellent

2. My treatment schedule was: 1 2 3 4 5
poor satisfactory excellent

3. The time between my first contact and first session was:
1 2 3 4 5
poor satisfactory excellent

4. Compared to when I first started therapy, I feel:
1 2 3 4 5
much worse same much better

5. My level of comfort with my therapist was:
1 2 3 4 5
low moderate high

6. Please rate how likely you would be to return to/ continue in counseling should you feel the need for it: 1 2 3 4 5
would not maybe would

7. Phone calls were returned promptly by my therapist:
1 2 3 4 5
completely disagree neutral completely agree

8. The speed in which I was able to see the psychiatrist was:
1 2 3 4 5
poor satisfactory excellent

