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Effectiveness of a Treatment Approach for Major Depressive Disorder:
A Case Study

By
Lisa Gail Mazzagatti

A Thesis

Submitted in partial completion of the requirements of the
Master of Arts Degree
Of
The Rowan University Graduate School

Approved by
Dr. Janet Cahill, Ph.D.

Date Approved 5/12/05

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ABSTRACT

Lisa Gail Mazzagatti
Effectiveness of a Treatment Approach for Major Depressive Disorder.
A Case Study
2005
Dr. Janet Cahill
Masters of Arts in Mental Health Counseling

This case study assessed the efficacy of a treatment approach for a thirty-seven year old Caucasian female who was diagnosed with Major Depressive Disorder. The intervention utilized techniques from several therapeutic approaches including cognitive-behavioral, psychoeducational and gestalt. The Beck Depression Inventory II (BDI-II) was used as an outcome measure. It was administered at the third, seventh, eleventh, fifteenth, and nineteenth session. Results indicated a decrease in depressive symptomatology over the course of treatment. Client self-report, clinical observations and a client satisfaction survey also supported the overall effectiveness of the treatment approach. The case study presents a psychosocial assessment, literature review, normative practice and outcomes, normative versus best practice, followed by a summary and conclusion of these topics.

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Chapter One

Psychosocial Assessment

Name: Ms. Lorie Harbone

Age: 37

(Note: name and other demographic information was changed to preserve confidentiality).

Presenting Problem

At intake Lorie was a 37 year old Caucasian female who was self-employed. She stated her reason for coming to treatment was that she was having a great deal of difficulty dealing with her recent divorce. Lorie and her ex-husband, Ed, have been divorced for six months after a ten and a half year marriage. Lorie stated that she felt depressed every day and could not enjoy life anymore.

Lorie reported that her sister, Kate, had seen a significant change in Lorie's mood, stating that to her Lorie appeared to be "sad all of the time." Kate also stated that Lorie no longer engaged in social or family functions.

History of Presenting Problem

Lorie had been experiencing deep feelings of hopelessness and sadness for two years. She began experiencing deep sadness when she realized that her husband was an alcoholic and "loved the bottle more than he loved me." Lorie began to argue with her husband about drinking. These arguments caused her husband to drink more, so she began to cry instead of arguing. Lorie tried to get help for her husband but he refused. A year ago, Lorie, discovered that her husband was having an affair with a close friend of theirs. It was at this point that Lorie decided her marriage had to end. She packed her husbands things and had him move out of their house two weeks later. Lorie recalls feeling angry for a few weeks. She could not believe the

man that moved out of her house was the man she married. Then she became very depressed. She recalled crying everyday and feeling lost. Lorie stated that these feelings had worsened.

Lorie stated that she was depressed all day and she could not recall a day of not feeling depressed for two years. She felt empty and cried all day everyday. Lorie recalled enjoying her work and her educational pursuits throughout life, however, she had not enjoyed anything “in about two years.”

Lorie reported that she had difficulty sleeping almost every night. She had trouble falling asleep. When she did fall asleep she woke up in the middle of the night and could not get back to sleep. She had stated that she had no energy and was constantly exhausted. She struggled to go to work and had to “pretend to be happy while in the company of others.” Lorie went straight home from work and sat on her sofa. She also reported a loss of her appetite. She stated “I eat because I know I have to, but I am not hungry and I fill up fast.” Lorie was unsure exactly how much weight she had lost but stated that her clothes were too big. Lorie also stated that she was so tired all day long that she did not have the energy to do anything. At the time of the assessment, running errands “had become a very tiring experience.” Lorie stated that she felt empty and was very concerned that she would be alone the rest of her life. Additionally, she felt “worthless and unattractive,” and had experienced periods of intense hopelessness nearly everyday for the past two years, but denied any previous suicidal ideation or suicidal attempts. Lorie stated that there had not been a change in her symptoms throughout the past two years. Lorie had reported that this was the first time in her entire life that she had ever felt like this. She recalled always being “upbeat and happy,” and did not like feeling so sad every day, but that it would not disappear.

Lorie had not tried anything in the past to try and address this problem. She tried to get her husband help for his drinking but never sought out help for herself. She had never been in therapy before.

Household Composition

Lorie lives alone in a four bedroom Victorian house. She has reported making the effort to visit her sister once every two weeks. Her sister's household consists of her sister, Kate, age 31, her sister's husband, Joe, age 35, her niece Summer, age 5, her niece, Brianna, age 3, and her nephew, Zachary, age 3 months.

Early Development/Neurological Problems

Lorie was not aware of any problems during her infancy. She had reported that there were no complications with her mother's pregnancy or delivery. She reported normal developmental milestones, with no neurological problems or head trauma throughout her life.

Family of Origin

Lorie reported that she has a good relationship with her family of origin. She sees her parents as being supportive and proud of her. Lorie stated she "could tell my parents anything and they always would give me guidance and support". Lorie recalled her parents and her sister having dinner together every night. She had stated that that was her favorite part of the day. They would all discuss their day and anything they were happy or unhappy about. Lorie sees her relationship with her sister as "normal". She stated that they would have their "typical sisterly arguments and that they would be fine a little while later."

Lorie stated that her parents are still very supportive of her. She can go to them if she needs anything. She sees her sister Kate as her best friend. Lorie believes that her family is still very close; however, she does not want to "bring them down with her problems."

Lorie recalled being punished twice during her childhood. These punishments occurred, in the first instance, because she talked back to her mother and, in the other instance, for staying out two hours past her curfew. She recalled the discipline in the house to be “fair.” There was never any hitting or slapping. She reported that she lost her privileges to play with friends for a week as well as the use of the telephone for each infraction. Lorie reported no abuse or neglect nor any substance abuse in the family.

Current Family Relationships

Lorie was married for ten years; throughout her ten years of marriage she had what she considered “many ups and few downs.” Lorie recalled that her marriage was wonderful in the beginning. She had an abundance of emotional support, open communication, shared values, and a “great” sex life. She recalled laughing, smiling, and being happy for the majority of the first eight years of their marriage. She stated that they had “typical marital arguments about money and control of the remote while watching television.” However, Lorie confessed that the bad times in her marriage were very hard for her. She stated that although, the bad things (i.e. not going out with friends, slowing of communication, and decreased sex life) did not become unbearable until the last two years, she always knew they were there. She stated that she accepted the bad things because she loved him. For example, her husband did not like it when she was out of the house for “long periods of time.” Also, she was “not permitted” to go out for a girl’s nights with her friends. Lorie recalled making excuses to her girlfriends about why she could not attend their gatherings. Ed, Lorie’s husband, felt that a married woman should not go to a bar with friends unless her husband was present. Lorie was “permitted” to go to lunch with her girlfriends or to their houses as long as she was not gone the entire day. Weekends were reserved strictly for husband and wife time. Lorie accepted these terms until her husband began

drinking. Then she decided that she had been “held captive from the outside world” for too long. She would go to a friend’s house for a few hours at night and on the weekend to get out of her unhappy home. The abrupt death of Ed’s father had pushed him over the edge and caused him to drink excessively. Lorie recalled trying to comfort her husband in his time of grief but he would just “shut her out.” She reported that during this time not only was she unable to emotionally support her husband but neither was he able to emotionally support her. Lorie concluded that Ed did not care that she was sad as well. She had loved Ed’s father and also felt a great loss when he passed away. Ed told her she did not know what it felt like because it was his father not hers.

Lorie stated that her communication with her ex husband was minimal at that point in their marriage. If they spoke at all, they usually were arguing. The arguments were about his drinking, shutting Lorie out, and Lorie visiting her friends. Lorie felt alone in her marriage. At that point Lorie stated that there was no sexual contact with her and her husband. She began feeling rejected. When Lorie discovered that her husband was having an affair with a friend she knew, she realized that it was time to separate. She was devastated that her husband found comfort in another woman instead of herself, but she stayed in her marriage for two years after things began to “get bad,” because she kept hoping things would “get better.” It was only after the discovery of the affair, did she decide things would not get better. In fact, they continued to get worse. Lorie could not deal with the betrayal or the drinking any longer.

Lorie did not have children because her husband did not want them. She was certain that they had the discussion about having children prior to their marriage. She stated that Ed had always said that he wanted children. But Lorie was angry when her husband would always tell her “now is not the time to have children.” She hoped that the day would come when Ed would

say it was time to have children. When Ed began to drink excessively, Lorie knew this day would never come; she would not want to bring a child into the world if his or her father would reject him or her. She wanted her child to be raised in a loving environment. Lorie felt like a part of her was missing, because she always wanted to be a mother. She stated that at the age of thirty-seven, she still yearns to be a mother. She felt that with modern medicine the way it is, she would be able to try and conceive. She felt that if she could not conceive a child, she would like to take in foster children. Although, she knew that she would have trouble adopting because of her age. She said that it would be wonderful to help those children that needed a place to live while they were in the custody of the state. Lorie would only consider getting pregnant, if she were remarried or if her significant other and she lived together. Since Lorie was not dating at the time of the assessment, these goals were not an option at that time.

Lorie stated that she needed the courage to go back into the dating world. Lorie also stated that one of her main goals to reach in therapy was to learn to be social again. She wanted to be able to date to potentially achieve the goal of being a mother.

Drugs, Alcohol, and Addictive Behavior

Lorie stated that she has never used drugs of any kind. She felt that drugs can ruin a person's life and she would want no part of that. She would, however, have a glass of wine when she would go to a nice restaurant with her ex-husband or on a special occasion, but she never drank on a weekly basis. Now, Lorie will not even have a glass of wine because she saw the effect alcohol had on her ex-husband. She reported she does not gamble, nor does she compulsively shop. She does not have any food addictions, or any other addictive behaviors.

Lorie reported that her family rarely drank and did not use drugs. She has never been aware of any substance abuse in her family.

Medical and Psychiatric History

Lorie's reported that she used to be in excellent health. However, she now reports a change in her health over the course of the last six months in that she had lost some weight and now appears to be slightly underweight. She receives annual checkups from her family physician and visits her dentist every six months.

Lorie is currently taking Allegra 180mg, for her seasonal allergies and a daily multivitamin.

Lorie is unaware of any psychological problems within her family.

Education and Job History

Lorie always enjoyed school and excelled in all subjects. Her strengths were in math and science. She stated that her weakness was in history. Lorie graduated from high school and went straight to a four year college. Throughout this time she worked in retail stores and on campus. When she graduated from college she worked as a Human Resource Director at a large advertising company. At the age of thirty, she left her job after eight years to become a graduate student in the field of business. She stopped her education by the age of thirty-one to become a homemaker.

She became self employed in home restoration at the age of thirty-three and is currently in the same career. Lorie ended up in this field because it was something she always dreamed of doing. Lorie wanted to turn something she loved into a career. She had business cards made and handed them out to friends. She gets her clients through word of mouth. She plans to advertise in the phone book, online, and in magazines. Her long term career goal is to continue her business and eventually hire people to work for her.

She would like to finish graduate school at some point in the future. Lorie worked outside of the home prior to becoming a homemaker. She enjoyed this very much as she likes interacting with people. However, she also stated she enjoyed being a homemaker. Lorie decided that she would get into home restoration because she could create her own schedule that would allow her to be a homemaker and have a career on the side. She loved using her creativity to restore people's houses. It brought her great pleasure and satisfaction. In the past two years, she has not found that pleasure or satisfaction in her work.

Lorie's employment pattern has been consistent. She has reported always getting along well with co-workers.

Other Agency Involvement

No other agencies are involved with Lorie. She has no prior treatment history.

Social Supports and Pattern of Relationships

Lorie had limited social support outside of her family. She had been out of touch with most of her friends in the past two years. She wanted to deal with things on her own and drove the majority of her friends away. She was reluctant to go out to social events because she had no energy and feels so empty. She was not sexually active. She had expressed an interest in dating but was uncertain when she would begin the dating process. She did not belong to any organizations. Her primary sources of social support were her mother, father, and sister. Lorie stated that she never had trouble making friends throughout her life. She has even kept ties with a few friends from elementary and high school. Lorie has stated that she enjoys being with her friends but has not had the energy lately to do so.

Two of Lorie's three serious relationships prior to her marriage ended because of different values about life. She wanted children and both previous boyfriends did not. She

wanted to be independent with her money; these boyfriends wanted her to be dependent on them for money. The third boyfriend moved out of state and Lorie could not leave her family. She reported that her relationships were excellent in the beginning, but died off in the end because of wanting different things out of life. Taken together with her relationship with the husband, Lori seemed to have a pattern of becoming involved in relationship with domineering men who did not support her independence.

Lorie stated that she was unaware of her ex-husbands drinking problem until the end of their marriage. She stated that he very rarely had a drink at home. The usual pattern was that they would drink socially but not on a daily or weekly basis. Lorie recalled being very confused about Ed's drinking. She could not understand how he could go from drinking once in a while to drinking excessively every day.

Situational Stressors

This is the first time that Lorie has lived alone. Prior to her marriage she lived with her parents, in a dorm, and then an apartment with a friend. Living alone has been quite stressful for her. Four months ago, Lorie's sister Kate had another baby, this has been stressful for Lorie because she has always wanted a child and feels as though time is running out for her.

Coping Mechanisms

Lorie has reported that the key way that she tries to cope is by talking to her sister and her parents. She talks to her sister for a half an hour every other day and visits with her once every two weeks. She talks to her parents every day for a half an hour to an hour. Her parents come to her house once a week for a visit. Lorie tends to sleep when she feels too stressed. She feels that these coping skills are not helping to relieve her feelings of depression.

Lorie was motivated for change, and, wanted to “be happy again”. She did not exercise, meditate, or use any other healthy coping mechanism. She used to have friends she could talk to for years but had chosen not to. Lorie did not want to burden her friends with her problems. Lorie also felt some embarrassment to call or talk to her friends because she felt that she had failed as a wife.

Self Concept and Motivation for Treatment

On interview, Lorie viewed herself as a failure. She felt that she failed as a wife and a woman. Lorie reported that she also failed as a caretaker and a lover. Lorie felt that she should have been able to stop Ed’s drinking problem herself. Lorie stated that she felt like she abandoned Ed when he needed her to stand by him, even if he was drinking and having an affair. Lorie also stated that she failed herself by not having children. She had always wanted children and she let her dream slip away.

Lorie blamed herself for not trying hard enough to help Ed become sober. She blamed herself for allowing Ed to create distance between her friends and herself. She blamed Ed for not wanting to have the family she had desired to have.

At the time of the interview, Lorie was not pursuing another relationship because she felt too sad to go out and meet other people. As noted above, she did not know how to “be single” again. She was also afraid to start a new relationship because she did not want to fail again. Lorie was afraid that she would not be an adequate lover for a new boyfriend. Because of her perceived failures with Ed, Lorie also feared not being able to be comforting in another person’s time of need. Finally, Lorie did not want to disappoint anyone again, especially herself again.

Summary

Lorie is a 37 year old self-employed woman who was experiencing feelings of depression. She was having great difficulty dealing with her divorce from her husband of ten and half years. She was experiencing high levels of sadness and emptiness that was negatively impacting on her daily functioning. In addition, Lorie isolated herself from any social activity outside of the house, with the exception of contact with her parents, sister, and her work.

Chapter 2

Diagnostic Considerations and Differential Diagnosis

Lorie's symptoms met the criteria for a Major Depressive Episode. Criterion A1, of the major depressive episode specifies depressed mood most of the day nearly every day. Lorie stated that she was depressed every day and did not enjoy life anymore. In addition, Lorie reported that she felt empty and cried every day. Criterion A2, specifies a diminished interest and pleasure in all, or almost all, activities most of the day every day. Lorie reported she derived no pleasure or satisfaction from her work for the last two years. She also stated that she had to pretend to be happy while in the company of others, when in the past she thoroughly enjoyed being in the company of others. This indicated a change in previous functioning, a key characteristic of a major depressive episode. Lorie reported experiencing little pleasure in any of her activities in life. She would go home and sit on the sofa instead of going out, or engaging in a pleasurable activity. Criterion A3, specifies significant weight loss (or weight gain) when not dieting and decrease in appetite. Lorie reported that she had lost her appetite completely. She reported eating because she knew she had to eat not because she was hungry. Lorie also reported being full quickly. Although Lorie was not aware of exactly how much weight she had lost, she knew she lost weight because all of her clothes were too big. Lorie also met criterion A4- insomnia nearly every day. She reported having difficulty sleeping almost every night, and having trouble falling asleep. When Lorie did fall asleep, she would awake in the middle of the night and was unable to fall back to sleep. Criterion A6, specifies fatigue or loss of energy nearly everyday. Lorie stated she had no energy and felt constantly exhausted. She reported feeling extremely tired all day long and lacking the energy to do anything. Even running errands

had become a tiring experience because of her fatigue. Lorie met criterion A7, feelings of worthlessness and inappropriate guilt. She reported deep feelings of hopelessness, and felt worthless and unattractive. She reported feeling guilty about not being able to help her husband become sober. She also reported feeling guilty about not being a good wife, lover, and caretaker.

Since Lorie did not report any symptoms of mania or hypomania, there was not evidence that she met criteria for a Mixed Episode. Criterion C, specifies symptoms that cause significant distress in social and occupational area of functioning. She reported that she did not go out for social events, and did not enjoy her job as much as she did in the past. Lorie met criterion D, since there was no evidence that her symptoms were due to the direct physiological effects of substance abuse or a general medical condition. Lorie met criterion E, her symptoms are not better accounted for by Bereavement.

Since Lorie met the criteria for a major depressive episode, the next step was to determine if she met the criteria for a Major Depressive Disorder. She did not present with any psychotic features or manic episodes. In addition, her depressive symptoms lasted for more than two weeks. Therefore, her symptoms are best accounted for by Major Depressive Disorder.

Lorie was given the specifier Single Episode, because Lorie reported that this was the first time she had experienced these symptoms. The specifier Chronic was assigned because she met the full criteria for Major Depressive Disorder continuously for at least the past two years.

According to the information that was given during Lorie's assessment, no criteria were met for Personality Disorders or Mental Retardation, therefore, no diagnosis was given for Axis II. In addition, Lorie denied having any general medical conditions. As a result, no diagnosis was given for Axis III.

A number of psychosocial stressors were impacting on Lorie. She reported problems with her primary support group. She also had experienced a disruption in her family due to her recent divorce. Lorie also had problems related to her social environment, specifically, inadequate social support. She had her family who supported her in the family constellation; however, she did not like to “burden” them. Lorie also had some friends that she did not want to burden. Lorie tended to keep her problems to herself. In addition, this was the first time that Lorie had ever lived alone.

Lorie was functioning at 58 on the GAF scale. She was having moderate difficulty with social functioning. She would not attend social functions or interact socially. Lorie would stay at home rather than go out with friends or on dates. She felt like a failure in regard to friendships and relationships. Lorie reported that she felt it would be better to stay at home on the sofa because she had no energy and was so tired. Lorie had few friends that she was in contact with and did not feel that she should bother anyone with her problems. Lorie kept to herself instead of letting others in her life.

Based upon the above information, Lorie was given the following DSM-IV diagnosis:

Axis I: 296.22 Major Depressive Disorder, Single Episode, Chronic

Axis II: V71.09 No diagnosis

Axis III: None

Axis IV: Divorce, inadequate social support, problems related to social environment.

Axis V: 58

In reference to ruling out other disorders, dysthymia was ruled out because a major depressive episode occurred in the initial two year period of the symptoms.

Adjustment disorder was also ruled out because Lorie had symptoms that met the criteria for a Major Depressive Episode in response to her stressor, the divorce.

Anxiety disorders had been ruled out because Lorie did not meet the criteria for any of the anxiety disorders. Lorie did not meet the criteria for panic attacks, agoraphobia, or panic disorder. Lorie did not suffer from palpitations, sweating, trembling or shaking, shortness of breath, feelings of choking, chest pain, nausea, feeling dizzy, derealization, fear of losing control, fear of dying, paresthesias, or chills/hot flashes. Therefore, anxiety disorders as a category was ruled out. Lorie did not meet the criteria for a specific phobia, since she did not have a marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation. Lorie did not meet the criteria for Social Phobia, she did not report any marked or persistent fear of one or more social or performance situations. Lorie did not have any symptoms that meet Obsessive Compulsive Disorder. Lorie was not suffering from Posttraumatic Stress Disorder or Acute Stress Disorder. She did not experience, witness, or was confronted with an event that involved actual or threatened death, serious injury, or a threat to the physical integrity of her or others. Lorie did not meet the criteria for Generalized Anxiety Disorder. She did not report excessive anxiety and worry about a number of events or activities. She did not report finding it too difficult to control her worries. Lorie was not suffering from an anxiety disorder due to a medical condition. Lorie did not report any abnormal medical conditions. Lorie was not suffering from Substance-Induced Anxiety Disorder. She denied any use or abuse of drugs, alcohol, or prescription medication.

Chapter 3

Literature Review

A literature review was completed to determine the empirically supported treatments for Lorie's diagnosis of major depressive disorder. Outcome research for MDD generally utilizes three types of analysis: comparison of psychotherapy approaches, psychotherapy versus psychopharmacology and the effects of both psychotherapy and psychopharmacology combined. All three approaches will be reviewed below.

Psychotherapy Approaches

Robinson, Berman and Neimeyer (1990) compared psychotherapies for depression. They divided the therapies into four groups. Group one: Cognitive-included treatments that focused on the evaluation and modification of cognitive patterns. Group two: Behavioral therapy, this group included therapies that changed behaviors (increasing assertive behaviors) that would result in less depressive symptoms. Group three: Cognitive-Behavioral, this group included both cognitive and behavioral techniques in combination. Group four: General verbal therapy, this group had client center approaches, psychodynamic therapy, and other interpersonal therapies. The findings of the study suggest that these are the best therapies for depression. Depending on the severity and the way the client responds to treatment would determine which therapy would be utilized. This study strongly recommends therapy over no therapy at all and recommends the therapist to choose the appropriate treatment for the appropriate client.

Chambless and Ollendick (2001) completed a study on empirically supported psychological interventions. They found the empirically supported treatments for adults suffering from major depressive disorder are: behavioral therapy, brief dynamic therapy, cognitive-behavioral therapy, interpersonal therapy, self-control therapy, and social problem

solving. For patients diagnosed with major depressive disorder that are in couple's therapy, behavioral marital therapy is utilized. This study found these therapies to be the best empirically supported treatments for major depressive disorder.

Crits-Cristoph, Frank, Chambless, and Brody (1995) conducted a study on the training of empirically validated treatments. Cognitive therapy was taught in 90% of the programs that were surveyed. Only 16% of the programs taught interpersonal therapy. Although other treatments are being taught throughout training programs there is not enough information of some therapies being taught to students. For example, there were low rates of didactic and clinical training with regards to psychodynamic approaches. Specifically, interpersonal therapy in brief dynamic therapies. Therefore, more treatment approaches must be taught to today's psychology students to ensure a wide variety of options when treating patients diagnosed with major depressive disorder.

Shapiro, Barkham, Rees, Hardy, Reynolds, and Startup (1994) conducted a study of 117 individuals diagnosed with depressive disorders. The sample of individuals were randomly assigned to either Cognitive Behavior treatment (CB) or Psychodynamic-Interpersonal treatment (PI). The CB treatment was defined as "a multimodal method somewhat more behavioral in emphasis than is cognitive therapy" (Shapiro, Barkham, Rees, Hardy, Reynolds, & Startup, 1994, p.528). A wide range of techniques are available to the therapist. These techniques include cognitive restructuring, self-management procedures, anxiety-control training, and a job-strain package. The PI technique was defined by, "Using psychodynamic, interpersonal, and experiential concepts, it focuses on the therapist-client relationship as a vehicle for revealing and resolving interpersonal difficulties viewed as primary in the origins of depression. The method emphasizes negotiation (therapists views expressed as tentative statements, open to correction,

inviting elaboration and feedback), a language of mutuality, the use of statements rather than questions, and the offering of hypotheses about the client's experiences and their interconnections"(Shapiro, Barkham, Rees, Hardy, Reynolds, & Startup, 1994, p.528). Results indicated that both CB and PI were equal in effectiveness. For more severe cases the study showed that a 16 week period of treatment was more effective than an eight week treatment. This suggests longer treatment periods may be a better solution to individuals with more severe depression.

There were two outcome measures used in the study. The Beck Depression Inventory (BDI) and the Depression subscale of the SCL-90-R.. The mean BDI was 30.0 for both treatment groups at the onset of this assessment. The mean BDI was 21.4 at the completion of their assessment. The SCL-90-R was administered at the beginning of treatment, and again at termination. By the end of the assessment the SCL-90-R improved by .30. Clients were assigned to one of two treatment lengths; either eight or sixteen week sessions. Results indicated that individuals participating in the CB therapy had higher improvement scores on the BDI. The severe depression cases had more benefits with sixteen weeks of therapy rather than eight weeks of therapy for both CB and IP.

Bright, Baker and Neimeyer (1999) conducted a study comparing cognitive-behavioral interventions (CBT) to mutual support interventions (MSG). Ninety-eight individuals with depressive symptoms were randomly assigned to CBT or MSG groups. The groups were either led by professionals, defined as having a master's degree in clinical or counseling psychology and several years of experience with individual psychotherapy, or paraprofessional, defined as not having advanced degrees or experience with providing individual psychotherapy.

The outcome measures for this study included: the Beck Depression Inventory, the Hamilton Rating Scale, Hopkins Symptoms Checklist and the Automatic Thoughts Questionnaire. Results showed that individuals in the professional therapists groups had a greater reduction in depressive symptoms than the paraprofessionals groups in the Cognitive Behavioral Treatment (CBT) condition. Both professionals and paraprofessionals had equal results with the MSG condition. These results suggest that the professionals were more effective at administering CBT. Overall, this study reported that professional therapists administering CBT changed mood more than either professional or paraprofessional with the MSG therapy. This was consistent with all of the measures. The CBT groups led by professionals had a larger number of alleviated symptoms in participants when compared to CBT groups led by paraprofessional therapists,($p=.03$).

Jacobson et al, (1996) conducted a study to examine the efficacy of cognitive-behavioral therapy (CT) for depression. One hundred fifty outpatients diagnosed with major depressive disorder were randomly assigned to one of three treatment conditions. The conditions were behavioral activation (BA) (a component of CT), both BA and the teaching of skills to modify automatic thoughts (AT), and cognitive therapy (CT). The outcome measures used in this study were the Hamilton Rating Scale for Depression (HRSD) and the Beck Depression Inventory (BDI). These were administered before therapy and at termination. In addition they were given at 6, 12, 18, and 24 months post treatment. At posttest, the individuals were given a modified version of the Longitudinal Interval Follow-Up Evaluation II (LIFE). (Jacobson et., at al, 1996, p.306).

No evidence was provided that the clients completing treatment with CT produced better outcomes at the end of treatment. The same was true at the follow-up treatment. When

comparing both BA and AT treatments to CT treatment, the component therapies were just as effective at altering negative thinking as well as dysfunctional attributional styles. In both the short and long term outcomes attributional style was highly predictive in the BA condition, but not in the CT condition. This study concluded that BA and AT treatments are as effective as CT. However, this study stated that CT may prove to be more effective in preventing relapse relative to the component treatments.

McNamara and Horan (1986) conducted a study evaluating cognitive and behavioral treatments for depression. Forty individuals experiencing a depressive episode were included in the study. Subjects were included in this study if they scored greater than an 18 on the Beck Depression Inventory, and had a combined score of 20 on a modified version of the Hamilton Rating Scale for Depression. Subjects were randomly assigned to one of the four treatment conditions: Cognitive Treatment, (CT) Behavioral Treatment, (BT) a combination of both, or a high-demand control group (C). The outcome measures used were Automatic Thoughts Questionnaire (ATQ), Cognitive Scale (CS), Recalled cognitions (RC) exercise, Self-Evaluated Social Skills, Pleasant Events Schedule (PES), Behavioral Scale (BS), Observer-Evaluated Social Skills (OESS), Beck Depression Inventory (BDI), and Hamilton Rating Scale for Depression (HRSD). The results indicated that of cognitive therapy was effective in reducing depressive symptoms. ($F(8,22)=3.77, p<.006$). There were no other significant multivariate interactions or main effects. The results for the behavior therapies were comparatively weak. One possible explanation for these results was that the counselors may have favored CT and did not apply the BT as effectively as they should have.

Beutler et al, (1991) conducted a study focusing on the predictors of differential response to cognitive, experiential, and self-directed psychotherapeutic procedures. The two key variables

used in this study were coping skills and resistance potential. Sixty three individuals diagnosed with major depressive disorder were randomly assigned to one of three groups: group cognitive therapy (CT), a form of experiential therapy (FEP), and supportive, self-directed therapy (S/SD). Each treatment group received treatment in or over the period of 20 weekly sessions. The outcome measures in this study included: The Beck Depression Inventory (BDI), The Brief Symptom Inventory (BSI), The Hamilton Rating Scale for Depression (HRSD), The Barrett-Lennard Relationship Inventory (BLRI), and The Working Alliance Inventory (WAI). The results indicated that the characteristics of the individual can be used differentially to assign the different types of psychotherapy. The behavioral/symptom-focused procedures of CT yielded the strongest effects in patients that control stress poorly, are irritable and impulsive and project blame onto others.

Defined patient characteristics were divided into two dimensions: authority directed versus nondirective and behavioral versus insight-oriented. Individuals that externalized improved more than the individuals that internalize when using the CT techniques. Internalizing individuals improved most with S/SD. High resistant individuals improved more with S/SD than in either CT or FEP. The low defensive individuals improved more in CT than in S/SD. These results of this study suggest that more studies should be conducted to test specific treatments for specific individuals.

Arean, Perri, Nezu, Schein, Christopher, and Thomas (1993) compared the effects of two psychotherapies (reminiscence therapy and problem solving therapy) on older depressed clients. The study consisted of 75 adults over the age of 55 who were diagnosed with major depressive disorder. These individuals were randomly assigned to three groups: problem-solving therapy (PST), reminiscence therapy (RT), or a waiting list control (WLC). The individuals in the PST

and RT were enrolled in twelve weekly group treatment sessions. The outcome measures administered in this study included: The Beck Depression Inventory (BDI), the Geriatric Depression Scale (GDS), the Schedule of Affective Disorders and Schizophrenia (SADS), and Hamilton Rating Scale for Depression (HRDS). The results suggested significant improvements in depressive symptomatology in the individuals that received treatment when compared with those individuals that did not receive any type of treatment. Sixty-four percent of the individuals showed considerable amount of positive change. At posttreatment, SADS was administered to these individuals were either in remission or their symptoms had improved.

The results for the WLC group showed little change in depressive symptoms. This data showed that elderly individuals diagnosed with depressive disorders are unlikely to improve without some type of treatment. Individuals in the PST group reported significantly lower depressive symptoms when compared to the individuals in the RT group. These results were measured by the GDS and the HRSD. At posttreatment, 60% of individuals in the RT group remained depressed while only 11% of individuals in the PST group remained depressed. This study found that PST is a superior treatment to RT; however, some type of treatment is better than no treatment at all.

Thompson, Gallagher, and Steinmetz (1987) conducted a study that compared the effectiveness of behavioral, cognitive, brief psychodynamic therapies, and delayed treatment (Six week waiting list) psychotherapy in older adults. These individuals were diagnosed with Major Depressive Disorder, and were treated for 16-20 sessions. The outcome measures included: BDI, HRDS, and GDS. The results found that there were highly significant improvements in depressive symptoms at the posttreatment session. Positive response rates in lowering symptoms occurred in all three treatment groups. Using the SADS-Change interview

to measure improvement the scores indicated the following: the behavioral condition had a 70% decrease in symptoms, the cognitive condition had 80% decrease in depressive symptoms, and the brief psychodynamic condition had a 62% decrease in symptoms. Seventy percent of all clients improved by the posttreatment. In the delayed treatment group, there was very little evidence of spontaneous remission. There was not a significant difference in the treatment modalities used in this study. This study suggested that although elderly clients are less likely to seek psychotherapy, it is recommended that they try some type of psychotherapy rather than none.

Gallagher-Thompson, Hanley-Peterson, and Thompson (1990) conducted a cross-sectional and longitudinal study based on a two year follow up of 91 elderly individuals in the above study. The outcome measures were the same. At the two year follow up 70% of patients that were interviewed were not depressed, 22% were suffering from depression. These individuals had originally been diagnosed with an episode of major depressive disorder. They had been treated with brief cognitive, behavioral, psychodynamic psychotherapy, or delayed treatment (a six week waiting list). They had received 16-20 individual treatment sessions during a four month period. The follow up data was collected at 3, 6, 12, 18, and 24 months after the completion of therapy.

At the completion of the original study there was no significant difference in treatment modalities in terms of diagnostic outcomes. The outcome measures used to collect this data were the SADS-Change interview and the Longitudinal Interval Follow-Up Evaluation (LIFE). Twenty individuals participated in the study. Twelve of the individuals had been diagnosed with a major depressive disorder, and ten had remained in an episode of major depression throughout the entire two year period. Seven had shown improvement and had been free of depressive

symptoms for at least two months at the time of the follow-up. One individual had improved but still had suffered symptoms that were diagnosed as a minor depressive episode. There were no differences reported among the therapies, $\chi^2(2, N=68)=1.36, ns$. This study concluded that the individuals that were free of depressive symptoms at the end of the original study were the individuals that remained free of depressive symptoms at the two year follow-up. Those who were in the cognitive therapy group were the most patients free of depressive symptoms. This indicates that the methods taught in the treatment modalities remained effective for those who continued to use them after treatment was completed.

Psychopharmacology

Rivas-Vasquez and Blais (1997) completed a study on the medications used to treat Major Depressive Disorder. Antidepressants are currently broken down into three classes: Monoamine oxidase inhibitors (MAOIs), Tri- and tetracyclic antidepressants (TCAs), and Selective Serotonin Reuptake Inhibitors (SSRIs).

SSRIs are currently the most popular antidepressants. This is not solely based on the drugs efficacy but is attributed to the lack of side effects. The SSRIs have less severe side effects than other antidepressants. There is a lower risk of overdose and suicide. The most common SSRIs are: Fluoxetine (Prozac), Sertraline (Zoloft), Paroxetine (Paxil), and Fluvoxamine (Luvox).

Monoamine oxidase inhibitors (MAOIs) inhibit enzyme monoamine oxidase. This is the substance that breaks down monoamine neurotransmitters. Some of the MAOIs are: isocarboxazid (Marplan), tranylcypromine (Parnate), and phenelzine (Norpramin).

Tri- and tetracyclic antidepressants (TCAs) inhibit the reuptake of norepinephrine, serotonin, or other neurotransmitters. They increase the amount of these transmitters to the synapse. Some of the TCAs are: amitriptyline (Elavil), clomipramine (Anafranil), desipramine (Norpramin), nortriptyline (Pamelor), and imipramine (Tofranil).

There are several antidepressant medications with an atypical structural or functional property that are currently being used. These atypical antidepressants have been proven to be just as effective as SSRIs and TCAs. These antidepressants are used when a patient does not respond to other antidepressants. The most common of these medications are: Bupropion (Wellbutrin), Nefazodone (Serazone), Venlafaxine (Effexor), and Mirtazapine (Remeron). These drugs have more side effects than SSRIs and TCAs. The most prominent of these side effects are the sedative effects.

The pharmacological treatment for patients diagnosed with depressive disorders are divided into three phases: acute, continuation and maintenance. Efficacy trials of antidepressants have indicated 30%-50% of depressed patients using the medication will not respond to the antidepressant regardless of which drug is chosen. When this occurs the clinician has several treatment options. The first treatment option would be augmentation. This would be adding another agent to enhance effectiveness. (Lithium, thyroid hormone, or TCA) A second treatment option would be substitution. This would be substituting one medication for another. The third option would be electroconvulsive therapy. It would be used if both option one and two failed.

SSRIs are the most common antidepressant medications used today. This is due to their comparable efficacy, reduced side effects, and decreased fatality risk. It is very important that

psychologists continue their education to increase their knowledge with antidepressant medication with regards to biological, clinical, and practical aspects to ensure proper treatment.

Geddes et al. (2003) conducted a meta-analysis to examine the long term effect of antidepressant drug treatment for depression. The study consisted of 31 randomized controlled trials of 4,410 individuals taking antidepressants. In each trial they examined the long term effects of continuing the drug treatment after the completion of a major depressive episode. The drug treatments were then followed by maintenance periods ranging from 6 to 36 months. The results were compared to results with individuals taking a placebo in the same time frame. The outcome indicated that individuals who continued their antidepressant medication for 6 to 36 months after completion of major depressive episode showed significantly lower relapse rates than those taking a placebo. This study reported that antidepressants reduce the risk of relapse in depressive disorder and the continuation of treatment with antidepressants would be beneficial for individuals with depressive disorders.

Herman et al. (2002) conducted a study predicting drop out or failure to benefit from therapy using exercise therapy (exercising on a daily basis) or medication to treat depression. One hundred fifty-six individuals diagnosed with major depressive disorder were randomly assigned to a 16 week group of aerobic exercise, sertraline medication (Zoloft), or a combination of both. Thirty-two individuals were considered drop outs because they did not complete the program. The outcome measures that were used consisted of: the Diagnostic Interview Schedule (DIS), the Hamilton Rating Scale for Depression (HRDS), and the Beck Depression Inventory (BDI). Fifty-three percent of combination therapy improved their symptoms, when compared to a thirty-two percent decreases in symptoms of patients who were in the medication group only. There was a twenty-one percent decrease in symptoms with the patients who were in the

exercise group alone. Dropout rates tended to be higher with individuals who had lower life satisfaction. This study concluded that factors such as lower life satisfaction, lower self-esteem, and lower social support can cause a higher rate of individuals to drop out of any type of therapy. Overall results indicated that combining antidepressant medication with daily exercise is more effective than medication or exercise alone.

Thase and Kupfer (1996) conducted research on the recent developments in the pharmacotherapy of mood disorders. They focused on the importance of finding the correct medication for the correct patient. In outpatient trials of acute phase treatment, 50%-70% of individuals responded well to antidepressant medication. The major problem with the potential effectiveness of acute phase pharmacotherapy is attrition from treatment before giving the medication adequate time to work. These attrition rates are as high as 30%-40%. These attrition rates are related to the medications side effects but can also be attributed to inadequate psychoeducation, ambivalence about taking medication, and practical roadblocks.

During the continuation phase therapy should be conducted biweekly or monthly. The primary goal is to prevent relapse. Continuation phase therapy reduces the risk of relapse from 40%-60% to 10%-20%. Another goal of continuation therapy is consolidation of response into subsequent recovery and complete remission. Maintenance pharmacotherapy is used to prevent recurrent affective episodes. It is used when patients have a history of three or more depressive episodes, bipolar disorder, or chronic depression. Maintenance treatment is conducted by monthly or quarterly visits that can continue for years.

Although SSRIs are currently the most widely used antidepressants, however, they are the most expensive. Although 20%-30% of TCAs trials end because of side effects there is a

strong rationale for continued use of TCAs because they are relatively inexpensive. However, due to the need for monitoring by the means of blood tests, electrocardiograms, and more visits to the pharmacy TCAs become more expensive to the patient. New antidepressants are being introduced. The newest FDA approved antidepressant is nefazodone. Nefazodone has a unique structure and neurochemical effects. It improves sleep efficiency and has an edge over imipramine in patients with higher levels of agitation or anxiety. Thirty to fifty percent of patients who do not respond to one antidepressant will not respond to another. MAOIs and Bupropion are the important alternatives for SSRIs and TCAs. MAOIs may have lethal hypertensive reactions. There are dietary restrictions that have irreversible effects on both the A and B sub forms of monoamine oxidase. The antidepressants that are newer tend to be safer but no more effective. There is still knowledge to be gathered on the effectiveness of pharmacotherapy with regard to mood disorders. A large number of patients do not comply with their prescribed medication, and withdraw prematurely from treatment. More research needs to be conducted on first line medications, optimal duration of treatment, reduction or relapse risk and improved psychosocial functioning.

In summary, SSRI's seem to be the best practice treatment with regards to pharmacotherapy. There are fewer side effects and patients tend to find these medications more tolerable than TCA's or MAOI's. SSRI's have been proven as effective as TCA's or MAOI's in both short term and long term therapies. When SSRI's are not effective treatment for a patient then the treatment that should be used are TCA's or MAOI's.

Psychopharmacology and Psychotherapy

DeRubeis, Evans, Hollon, Garvey, Grove, and Tuason (1990) conducted a study on 112 individuals who were diagnosed with major depressive disorder. The focus of this study was to

evaluate the effectiveness of cognitive therapy alone, imipramine pharmacotherapy alone, and the combination of cognitive therapy with imipramine. These individuals were randomly assigned to each group. These individuals met a therapist using one of the three techniques mentioned above, between sixteen and twenty times over a twelve week treatment period. Sessions were forty-five to sixty minutes in length. The individuals had two sessions in the first four weeks, followed by one to two sessions from week five through week eight, and one session in each of the last four weeks. The individuals were then assessed by outcomes on three measures of depression: The Hamilton Rating Scale for Depression, the Raskin Depression Scale, and the Beck Depression Inventory.

During treatment the individuals were also given the Automatic Thoughts Questionnaire (ATQ), the Hopelessness Scale (HS) and the Dysfunctional Attitudes Scale, Form A (DAS). The ATQ is a 30 item, self report questionnaire. It assesses the frequency of when individuals experience 30 depressotypic self statements, i.e. "I am never going to make it." (Hollon, Kendall, & Lumry 1986). The HS is a 20 item, true/false, self report test that tests general pessimism. High scores support evidence of high pessimism. The DAS is a series of forty statements written to depict depressotypic assumptions.

The findings showed that the combined treatment of psychotherapy and pharmacotherapy was more effective than any treatment used alone.

Elkin, Shea, Walkins, Imber, Sotsky, and Collins (1989) conducted a study of effectiveness of Cognitive-Behavioral Therapy (CBT), Interpersonal Therapy (IPT), imipramine plus clinical management (IMI-CM), or placebo plus clinical management (PLA-CM). This study consisted of 239 individuals who were randomly assigned to the four treatment groups. All individuals had been diagnosed with major depressive disorder. The treatment groups were

conducted over a sixteen week period. Results indicated that all treatment options were effective in reducing depressive symptoms. Differences between the treatment groups did emerge. For subjects with more depressive symptoms, the IMI-CM and IPT treatments were more effective than the PLA-CM group. The CBT group did not have a significantly different outcome from the PLA-CM group. There was no significant difference in the efficacy between CBT and IPT treatments. These results have shown that individuals with less severity in depressive symptoms will benefit more with CBT and IPT treatments. More severe symptomatology seems to benefit more from IPT and imipramine.

Elkin, Gibbons, Shea, Sotsky, Watkins, and Pilkonis (1995) conducted a follow up study where random regression models (RRMs) were used to investigate the role of initial severity in the outcome of four treatment groups. These four treatment groups were: cognitive-behavioral therapy (CBT), interpersonal psychotherapy (IPT), imipramine plus clinical management (IMI-CM), and placebo plus clinical management (PLA-CM). The individuals that participated in this study were diagnosed with major depressive disorder. This follow up study focused on the question of whether there was a difference in the effectiveness of the treatments in the Treatment of Depression Collaborative Research Program (TDCRP) that was conditional on the initial severity of the patient's illness. The study used random regression analyses based on the full range scores on the Hamilton Rating Scale of Depression (HRSD) or Global Assessment Scale (GAS) to assess the initial severity.

Another analysis to assess initial severity was conducting using the BDI. The results supported the importance of the initial severity of the depressive symptoms as a predictor at the termination of treatment. There was no significant difference reported for compared to whom in less-severely ill individuals. However, IMI-CM was more effective in individuals with severe

symptoms. This study concluded that IMI-CM was the most effective treatment for individuals with severe depression. IMI-CM had significantly superior improvement ($p < .03$) on the HRSD as compared with PLA-CM and CBT but not when compared to IPT. IPT was superior to both PLA-CM and CBT but only at a trend level ($p < .08$) on the HRSD. On the GAS the scores showed significant improvement, IMI-CM relative to PLA-CM, $p < .0003$, and IMI-CM relative to PSY, $p < .002$. However, Not for IPT relative to CBT, $p < .54$. CBT did not differ significantly from PLA-CM.

Blackburn, Bishop, Glen, Whalley, and Christie (1981) examined the relative effectiveness of cognitive therapy, pharmacotherapy (amitriptyline or clomipramine, in doses up to 150 mg/day) or a combination of the two. The treatment was conducted over a twenty week period. The results indicated the combination of cognitive therapy and pharmacotherapy was superior to cognitive therapy alone or pharmacotherapy alone. The treatment outcome was measured by the Beck Depression Inventory (BDI). Seventy-nine percent of the combined therapy treatment group showed significant improvement by the end of treatment. The cognitive therapy group measured 48% improvement, and 59% of the pharmacotherapy group measured improvement on the BDI by the end of treatment. There was no evidence that the severity of depression had an impact on the outcome of the two treatment modalities.

Roth, Fonagy, Parry, Target, and Woods (2005) reviewed research on the treatments for depression. They concluded that psychotherapy was not superior to pharmacotherapy with regard to efficacy. In rare instances, pharmacotherapy had a clear advantage over psychotherapy. The authors then concluded that both therapies are equally efficient treatments for patients diagnosed with depression. In this review of studies, it was suggested that the combination of both pharmacotherapy and psychotherapy could not be demonstrated to be the

best practice treatment. This was due to methodological issues. This book suggested that due to this information mentioned above, recent trials are better designed. This is alleviating the problems with misinterpretation of the results. IPT in combination with pharmacotherapy have been shown to be more effective than IPT or pharmacotherapy alone.

CBT, IPT, and pharmacotherapy are effective when offered together and separate with regards to booster sessions. Booster sessions involve the client returning to therapy anywhere from six months to a year to “boost” their knowledge of the skills they retained during their treatment. The booster sessions help to ensure that the client is continuing to utilize accurately and effectively the knowledge they learned in therapy. Although these authors did not have a specific view on which therapy is superior to others, the authors feel that it is necessary to have both treatments ready for all patients. Those who respond to psychotherapy better without medication will either not take the medication or be taken off medication. Those who respond better to medication may only take medication. There will also be patients that respond better to a combination treatment. It will depend on the severity of the depressive symptoms and how the patient responds. It is important the patients are being monitored. There will be some patients that are under medicated, overmedicated, or not receiving the appropriate psychotherapy. The patient’s treatments may need to be adjusted throughout treatment period. It is also imperative that the patient is made aware of relapse. About 50% of patients diagnosed with depression will relapse. The patient has to be made aware of these possibilities and prepared for their booster sessions. This study also suggested that a better way for classifying depression may need to be created in the future. The way the different people react, the path of the disorder and personalities should be considered when creating this classification.

Young, Weinberg, and Beck (2001) suggested that each client's preference should be considered when treatment is determined. When reviewing research they found that most patients would choose psychotherapy over medication. Most patients have had a negative event or experience that initiated their depressive symptoms. Therefore, discussing them in therapy may be more beneficial to the patient. Cognitive therapy and medication have been found equally effective in the patients diagnosed with severe depression. There has not been enough research to determine which therapy is most effective. There needs to be more research conducted to test which treatment is more effective for which patient. There are too many different types of depression with patients responding to treatment in different ways. These factors need to be considered when conducting research in the future to determine which treatment is best practice.

Based on the literature review, combination therapy is helpful in patients with more severe depressive symptoms. Especially when IPT and pharmacotherapy are combined. CBT and pharmacotherapy combined are not as effective because they have been found equally efficient when used alone.

In summary, there is good empirical evidence that MDD responds to a number of treatments. Treatment for depression is better than no treatment at all. It seems that individuals with less severe depressive symptoms benefit more from cognitive-behavioral therapy or interpersonal therapy alone. Individuals with more severe depressive symptoms benefit more from antidepressant medication in combination with interpersonal therapy. There are too many contradictions in the studies comparing psychotherapy and pharmacotherapy combination therapies to make a conclusion that this treatment is best practice. More research needs to be conducted to come to definite conclusion.

Chapter 4

Normative Practice and Outcomes

Lorie's treatment took place at a community based clinic. Lorie came to treatment once a week for twenty-two sessions. During her initial intake Lorie seemed motivated for therapy. She was eager to begin as soon as possible and stated she would "do whatever it took" to be "happy again". During her first session Lorie was told that her therapist was an intern and would be at the agency for eight months. In the event that Lorie was still seeking treatment in eight months she would be reassigned to a new therapist. Over the twenty-four weeks of treatment, Lorie attended twenty-two individual sessions, and seven group therapy sessions. Lorie missed only one session during her twenty-four week treatment due to an illness.

Treatment Planning

Before the treatment planning phase could begin, a therapeutic alliance was established. This was established through empathy, respect, acceptance, and active listening. Based upon Lorie's active involvement in the therapeutic process, it appeared that an effective therapeutic alliance was established.

Treatment Plan

I. Treatment long and short term goals.

1. Client will report a reduction in depressive symptoms.
 - a) Client will discuss at least three occasions during the week when the feelings of sadness, irritability, or decreased energy were experienced.
 - b) Client will identify at least three alternative ways of coping with negative emotions that offer more opportunity for positive outcomes.

- c) Client will identify and modify core beliefs and automatic thoughts that are maintaining her depressive symptoms.
 - d) Client will explore her feelings regarding her divorce and emotional suffering associated with her divorce.
 - e) Client will attend a women's group for divorced women twice a month.
2. Client will increase her positive self image
- a) Client will discuss in therapy each week her efforts to resolve negative self image.
 - b) Client will discuss each week in therapy her thoughts about resolving the negative self image.
 - c) Client will reframe faulty cognitions about negative self images to positive self image.
 - d) Client will say out loud five times a week, "I am beautiful inside and out." Client will keep a logbook of when she says this and how she feels.
3. Client will show a decrease in interpersonal conflict.
- a) Client will identify each week in therapy feelings about guilt about not being able to stop her husbands drinking or the affair.
 - b) Client will discuss poor self esteem issues once a week in therapy.
 - c) Client will discuss in therapy once a week interactions with her ex-husband.
Techniques for establishing connections and confrontation techniques will be used.
 - d) Client will discuss each week in therapy, while using the technique, "empty chair" to speak with her ex-husband

- e) Client will learn relaxation skills to reduce stress from interpersonal conflict. Client will learn breathing exercises to reduce stress and use these techniques at home.
4. Client will show an increase in social skills
- a) Client will discuss each week in therapy how isolation has made her feel inside.
 - b) Client will learn about communication skills, each week in therapy.
 - c) Client will identify each week in therapy, when thoughts of being alone occur. Client will keep a logbook of these times while not in therapy.
 - d) Client will discuss each week in therapy, activities that interest her. With assistance from her therapist, she will devise a plan to sign up for an activity outside of her home.
 - e) Client will discuss her relationship with her family and why they are the only people she talks to aside from her therapist.
 - f) Client will discuss feelings about making new friends.
5. Client will show a decrease in unresolved feelings of guilt.
- a) Client will discuss each week in therapy, at least one occasion during the week when the overwhelming sense of guilt affected her daily life routine.
 - b) Client will be able to identify each week in therapy feelings of guilt that prevent her from partaking in everyday life activities. Client will keep a daily logbook about the guilt that she experiences during the week. Client will have to share this logbook with her therapist the following week in therapy.
 - c) Client will identify each week in therapy, with assistance from her therapist, at least two other ways of coping with her divorce.

Outcome Measures

Lorie's progress was monitored utilizing a variety of methods. She was administered the Beck Depression Inventory-II on the third session and then again on the 7th, 11th, 15th, and 19th, session. This instrument contains 21 items that assess self-reported depressive symptoms. Response options range from zero to 3. A higher score indicates higher levels of depressive symptoms. A score range of 0-13 would indicate minimal depression, 14-19 mild depression, 20-28 moderate depression, and 29-63 severe depression. Clinical observation and a client satisfaction survey were used.

Description of Therapeutic Process

From a cognitive-behavioral perspective, Lorie was experiencing depressive symptoms due to her negative automatic thoughts. The Cognitive Behavioral technique of challenging and replacing negative automatic thoughts was used. Lorie had negative automatic thoughts such as: "I feel frumpy and unattractive", "I am worthless", "I am a failure", "I failed as a wife and a woman", "I failed as a caretaker and a lover", "I should have been able to stop Ed's drinking problem myself", "I abandoned Ed when he needed me to stand by him, even if his was drinking excessively and having an affair", "I will not be an adequate lover for a new boyfriend", "I will not be able to comfort another person in their time of need", and "I do not want to disappoint anyone else". All of these thoughts led Lorie to feel badly about herself. Lorie felt like a failure as a wife, woman, caretaker, and lover because she "could not keep her husband happy, sexually satisfied, or sober." This became a major cause of her depressive symptoms.

A major focus of the therapeutic process was to identify these schemas and then discuss the evidence to support the schema. For example, Lorie could not provide sufficient evidence that she had failed as a woman, wife, lover, and caretaker. She could only provide a response of

“I am a failure because I am now divorced.” When Lorie was provided with the current findings that nearly fifty percent of marriages fail throughout the United States, and was asked if all of those women/men were failures she responded with “no.” She replied feeling like less of a failure knowing she was not alone. When asked if Lorie’s husband was a failure because their marriage did not last, she responded with, “Well, I never thought if it that way, yes he is a failure.” Lorie began to realize that some of her thoughts of failure and guilt were extreme. She replaced her negative thoughts of being a failure with, “My marriage may have failed but I am not a failure”. Lorie came to the conclusion that she had done all that she could to help her marriage and when things did not work it did not mean that she had failed as a person. Lorie also realized that just because her husband had an affair did not mean that she was not sexually satisfying. When asked for evidence to support that she was a bad lover Lorie could not give an answer other than “because he had an affair.” Lorie’s interpretation of her husband’s affair was negative because of her poor self image at the time. She replaced this negative thought with, “My ex-husband may have had an affair but not because I was a poor lover.” Lorie replaced “I failed as a caretaker” with “I am not supposed to be my husbands mother, I am supposed to be his wife, I did what I thought was right and now I know I could not have done anything else”. When asked to give supporting evidence about how she was supposed to keep her husband sober, she had no answer to give. Lorie replaced her negative thought with “I am not a doctor, I cannot cure diseases. Ed had a disease, he was an alcoholic. I provided the support for Ed, but he needed to want to be helped.” Lorie could not provide sufficient evidence that she would not be able to support others in the future because she realized that she had been supportive of Ed and that she could continue to be supportive of others. Lorie reported that she would not be able to be an adequate lover for a new boyfriend. There was no evidence to support this statement.

Lorie replaced this statement with, "I will be a good lover and companion in future relationships." Lorie was asked by her therapist, "And if this does happen, if you are in a relationship that ends, what will happen?" Lorie replied, "I will keep my head up, and know that the relationship was not meant to be. Lorie and her therapist discussed that she may want to seek treatment if any of her symptoms returned at that time. Also, keep a journal of her thoughts and feelings. In addition, Lorie stated that she would look at things in a positive context rather than negative. She was asked to provide a short list of people that she disappointed. Her statement was "I do not want to be a disappointment to anyone else." Lorie said that she believed she disappointed her parents and herself. Lorie could not provide evidence that she had disappointed her parents. In fact, she recalled her parents telling her that they supported her one hundred percent and that there was nothing she could have done to prevent Ed's drinking or his affair.

Although Lorie was disappointed about not having children, she knew she had not failed at being a mother. "I just have not had the chance to be a mother yet, and if I do become a mother I know I will not be a failure." This process is called challenging. Lorie's automatic thoughts and replacing them with more positive ones was an effective approach for her. Lorie noted that if nothing else she learned about herself throughout this process. Lorie stated, "I am not worthless or unattractive, I am beautiful inside and out."

Weekly homework assignments were also used. Lorie would have weekly homework assignments asking her to write down the negative thoughts she was having. She would then write down supporting evidence for this statement and a positive statement to replace the negative statement. This journal was reviewed in therapy sessions.

Lorie was also introduced to the Gestalt technique of the "empty chair." This is a tool of self-exploration. The therapist asks you to hold a conversation with someone or something

imaginary in the chair. It emphasizes on the here and now, individual freedom and responsibility, and is insight oriented. It allows the client to have a “safe” confrontation with the someone or something imaginary that they are speaking to. Lorie would speak to an empty chair as if her ex-husband were sitting in it. Lorie found great pleasure in this technique. She felt that she had said things that she always wanted to say and never could. She reported feeling relief. This technique was chosen because Lorie reported having minimal conversations with her husband. In the initial sessions, it was evident that Lorie had things she had wanted to say to Ed that she never had the chance to say. It appears that withholding emotion and anger this contributed to Lorie’s depressive symptoms. Being permitted to relieve the hostility and pain she held inside allowed her to lessen some of her depressive symptoms.

At the onset of therapy, Lorie reported being socially isolated. She did not have friends and was only receiving some social support from her family. This low level of social support was a significant contributor to Lorie’s depressive symptoms. To address this, it was recommended that Lorie join a women’s divorce group. She thoroughly enjoyed going to group. She liked being around other women that were going through the same ordeal. Lorie reported feeling comfortable in her group. She shared with the group every time they met. By self-report, Lorie’s depressive symptoms lessened after attending the group. Lorie gained insight into the reasoning for her divorce. She realized she was not alone, that other people suffer heartache and betrayal. Lorie realized that she could “pick up and go on from here”. She felt good about herself and her decision to seek treatment.

Treatment Outcomes

The BDI-II was administered for the second time during her seventh session. Her score was 40 putting her in the severe range of depressive symptoms. In addition to lower the BDI

score; (Going from an initial score of 59 to a score of 40) Lorie reported fewer depressive symptoms. For example, Lorie began to sleeping better and not crying as much; that is, she was no longer crying every day. Lorie also reported doing chores because of a slightly higher energy level. The BDI-II was administered again in the eleventh session. Lorie had a score of 49, placing her in the severe range of depressive symptoms. This was an increase from the prior score. The increase in depressive symptoms coincided with the anniversary of Lorie's wedding. This event brought some of her negative thinking and feelings of failure and guilt.

Subsequent sessions focused on working with Lorie to help her gain insight into the role her husband played in the failed marriage; her role in the marriage; and her self-imposed restrictions on pleasurable activities (i.e. being in the company of her friends) throughout her marriage; methods she could use to develop new social supports. Lorie was administered the BDI-II during her fifteenth session. Lorie had a score of 22, placing her in the moderate range for depressive symptoms. This was a significant decrease from her prior scores.

Lorie was administered the BDI-II for the last time during the nineteenth session. Her score was 9, placing her in the mild range for depressive symptoms. Again, this was a significant decrease from her prior score. Lorie reported feeling "much better" than in previous weeks and even years. She made a number of healthy behavioral changes. For example, she signed up for a yoga class and joined a gym. Lorie was making friends in both places and had increased her social activities with female friends. Lorie also began to show an interest in dating a man she had met at the gym. Lorie also reported a number of cognitive changes. For example, she no longer perceived herself as unattractive. She no longer viewed herself as a failure. Lorie no longer felt worthless or felt like a disappointment to herself or anyone else. At this point, planning for termination was initiated.

Treatment Termination

Lorie was given information regarding relapse prevention. Lorie was educated about staying engaged in treatment even after relapse, for example, continuing her journals. She was also informed that lifestyle modification was important in relapse prevention, for example, continuing her yoga classes. Lorie was also encouraged to continue to use the technique of replacing negative thoughts with positive thoughts. She was given phone numbers for emergencies and an option to come back for a “booster session” (a therapy session to go over the techniques previously learned in treatment) in six to eight months. Lorie also was reminded to use her coping skills (exercising, talking to her family, and breathing exercises). In addition, she was going to finish attending her group therapy (an additional four sessions).

Lorie had shown improvement throughout treatment. Her BDI score had gone from an initial score of 57 points to 9 points. It was observed that Lorie appeared less depressed in terms of affect and reported fewer depressive thoughts. Lorie’s self report had gone from “terrible” to “great.” Lorie had gone back to working outside of the home more than inside in the home. Her appearance had also changed. Lorie was styling her hair, wearing make-up, and dressing more carefully.

Lorie’s responses on the client satisfaction survey also supported the conclusion that she had found the therapeutic process to be effective. Lorie’s response to her depressive symptoms had “much improved,” and that because of her therapy, she understood her problems well enough to manage them in then the future. She reported that her therapist had been very helpful and would definitely feel comfortable calling this therapist in the future if she needed help. She stated that she would definitely recommend her therapist to others that needed help. She felt that

the interest shown for her by her therapist was “very satisfactory” in helping her to solve her problems.

At the onset of treatment, Lorie was very melancholy and teary. Towards the end of treatment her facial expressions improved, she would smile and even giggle. Her posture was no longer slumped, it was appropriate. She had an elevation in mood; she no longer came to treatment full of sadness but full of happiness and hope. As evidenced by, her positive outlook and happiness about her future. Lorie no longer looked at her future as “dark” but as a positive experience. She left treatment having a positive perception about herself and her future.

Suggested Improvements to the Therapeutic Process

Lorie’s symptoms decreased while in therapy. Although she had a positive reaction to her treatment there are certain aspects that could have been improved throughout her treatment.

Lorie has had a past history of poor interpersonal relationships. She has had a similar pattern when choosing men to date. More time should have been spent with this issue. More details should have been discussed regarding dating men in the future to prevent her from repeating the same pattern. By the client’s self-report, “I will never let a man control me again,” is a good indication that she will be more cautious. However, the therapist should have had another discussion at the time of the last session.

Chapter 5

Normative Versus Best Practice

After completion of the psychosocial assessment, a review of empirically validated treatments was completed to find this client the preeminent types of treatments for this client. After completion of the literature review, it was evident that there were a few treatments that would best suit Lorie's symptoms.

The literature stated that both psychotherapy and pharmacotherapy were the best treatments to help with Lorie's major depressive disorder. In addition, some reviews suggested that Cognitive-Behavioral treatment alone would be an efficient technique to help lower Lorie's depressive symptoms. It was evident that in all studies medication alone was not an effective way to lessen the experience of depressive symptoms.

The treatment approach used with Lorie integrated a number of techniques, including supportive/expressive components and some element of CBT. While not reflecting true best practice, the treatment did prove to be effective.

Specifically, Lorie had a reduction in depressive symptoms, she was able to attend social functions, and she felt better about her self-image. This was indicated by the Beck Depression Inventory II scores that had been administered to Lorie, as well as her self-report. Lorie became more positive about her future. Lorie also began to change "back to her old self," by cleaning up her outer appearance. She was no longer disheveled, her hair was brushed, she wore make-up, and she was dressed in different clothing. Lorie also changed her negative thoughts and beliefs to positive thoughts and beliefs.

Lorie's symptoms had improved a great deal at the time of termination. Although Lorie terminated her individual sessions, she continued to participate in four more sessions of group

therapy. Lorie was given information on relapse prevention. She was also given emergency contact numbers, should she need them in the future.

When discussing the effectiveness of Lorie's treatment, there were some issues that could have increased her benefits from treatment. These issues included: interruption of sessions, temperature in building, lack of experience in applying cognitive-behavioral techniques, and lack of knowledge about the effective self-help self-esteem books.

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Appendix A Client Satisfaction Survey

Client Satisfaction Survey

1. To problems, feelings, or situations that brought me to the therapist are:
 much improved
 improved
 about the same
 worse
 much worse

2. Because of therapy, I understand the problems well enough to manage them in the future:
 strongly agree
 agree
 not certain
 disagree
 strongly disagree

3. My therapist was:
 very helpful
 somewhat helpful
 neither helpful nor unhelpful
 somewhat unhelpful
 very unhelpful

4. If I needed help in the future, I would feel comfortable calling this therapist:
 definitely yes
 probably yes
 maybe
 probably not
 definitely not

5. I would recommend this therapist to others that need help:
 definitely
 probably yes
 maybe
 probably not
 definitely not

6. The interest shown to me by my therapist in helping me to solve my problems was:
 very satisfactory
 satisfactory

- neither satisfactory nor unsatisfactory
- unsatisfactory
- very unsatisfactory

7. How long has it been since your last visit?

- less than one month
- one or two months
- three or five months
- six months or more (how many?) _____

8. Treatment ended with this therapist because:

the concerns that brought me to therapist were worked out to my satisfaction
 most of the significant concerns which brought me to seek therapy were worked out satisfactorily. There are some minor problems which I can now handle.

We reached the number of sessions set by the therapist at the beginning of treatment. Significant problems remained that were not dealt with adequately.

I felt that more treatment would not be helpful to me at this time, even though significant problems remained.

the therapist felt that more treatment would not be helpful at this time, even though significant problems remained.

there was a change in a work or school schedule that made it impossible to arrange further appointments.

9. After you received counseling with this therapist, have you or any members of your family received any counseling elsewhere for the same problems you came here for?

- yes no

10. Additional Comments:

THANK YOU FOR YOUR TIME

Signature (optional)

Date