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A SINGLE SUBJECT STUDY ON MAJOR DEPRESSIVE DISORDER, PTSD, AND
MILD MENTAL RETARDATION

by
Jennifer Yvette Rodriguez

A Thesis

Submitted in partial fulfillment of the requirements of the
Master of Arts Degree
Of
The Graduate School
at
Rowan University
December 23, 2002

Approved by _____
Professor

Date Approved 4/30/03

ABSTRACT

Jennifer Rodriguez

A SINGLE SUBJECT STUDY ON MAJOR DEPRESSIVE DISORDER, PTSD, AND
MILD MENTAL RETARDATION

2002/03

Dr. Janet Cahill

Master's of Arts in Applied Psychology in Mental Health Counseling

The purpose of this single subject study was to compare best practice and normative practice in the treatment of Major Depressive Disorder, Posttraumatic Stress Disorder, and Mild Mental Retardation. A client from a community-based agency was used in the study. The client was an African American woman who resided in a low socioeconomic area and whose income was below the poverty line. The client experienced emotional, physical, and psychological abuse and neglect during childhood. She presented with symptoms of depression, post traumatic stress disorder, basic coping skills and parenting skills. Outcome data was obtained through interviewing and observations. The treatment consisted of a minimum of one therapy session per week for duration of six months. A head therapist, co-therapist, and a counselor would visit the woman in her home for weekly sessions. The results suggested that the treatment used in this study was unsuccessful in obtaining significant positive behavioral change.

Acknowledgements

No person achieves success without the help of others. For that reason, I would like to acknowledge those who helped me succeed in my professional training. I would like to first acknowledge my mother, Yvonne E. Rodriguez, EdD who has been my inspiration and a true female role model. She has been there for every step I have ever taken, and I appreciate her sacrifice and her love. To my sister, Marnid, and her husband, Denny, thank you for your encouragement and support. Barbara Sjoström, PhD has also been an important person in my life. She has helped shape my ideas, and aided in my personal and academic growth, as well as being a positive female role model. I would also like to thank Matt Dixon for his support and kindness. I love all of you.

I would like to acknowledge my thesis advisor, Janet Cahill, PhD for her contributions, encouragement, professional advisement, and student advocacy. In addition, I would like to thank Katherine Perez-Rivera, PhD my second thesis advisor for her contributions and her dedication to her students. I would like to thank all of the professors of the Applied Psychology program for being a part of my development and my academic growth. I will never forget you.

Last, but not least, I would like to acknowledge my niece, Marisol, who has been the greatest inspiration to me. Marisol, you make me want to be the best I can be. I love you and wish you the best in life, and I hope this work serves as a model for you on your journey to success.

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Chapter 1

Psychosocial Assessment

Presenting Problem

The client, whose name has been changed to “Betty” to protect client confidentiality, is a 30-year-old African-American woman. Betty resides in a low socioeconomic area, and has an income below the poverty line. Betty is the mother of four children. She presented at intake session feeling overwhelmed and sad. She also reported anger management problems. Betty experienced rages of anger unexpectedly and this anger was not geared towards anyone in particular. She had trouble sleeping; either feeling fatigued all the time, or waking up in the middle of the night for no reason. Three months prior to the initial interview, her electricity and heat were turned off. This caused Betty to experience depressed mood and feel intense fear about the future of her children. Specifically, Betty worried about her children being taken away from her because she could not provide for them. This was evidenced by Betty’s report of her crying in the bathroom alone at night.

Betty has felt depressed the majority of her life. As a child, Betty was severely and emotionally abused by her mother, as evidenced by physical scarring on Betty’s stomach, arms, and legs. Betty continually remembers the physical abuse she suffered as a child from her mother, and often gets angry with her mother. The lack of family structure in Betty’s home of origin has led to emotional instability and inappropriate boundary

issues between Betty and her children. Although Betty has experienced overwhelming sadness most of her life, she claims that when her 3-week-old infant son died of Sudden Infant Death Syndrome 10 years ago, she was diagnosed by a psychiatrist as experiencing a Major Depressive Episode. Betty reports not being able to get out of bed, and not being able to care for her children at that time. As stated by Betty, “This was not the first time I had felt this way, or acted like that.” As a young adult in her early twenties, Betty reported having the same type of emotional impairment as when her son died, which she stated was brought on by the sadness she felt when her significant other had an affair. It is apparent that Betty has a chronic history of depressive symptomatology and history of physical abuse.

Based on Betty’s previous behaviors and those currently observed, Betty does not have the ability to cope with common life demands, such as household planning. Betty is deficient in the care of her children and her self-care. She lacks academic skills, and social and interpersonal skills. Betty does not understand health or safety concerns. She lacks self-direction, and the use of community resources. In addition, Betty has a low IQ score. Betty’s exact IQ score is unknown due to lost documents. However, the previous therapist’s report stated that Betty was below borderline intellectual functioning.

Psychiatric History

Betty was evaluated by a psychiatrist for the first time in 1998 for symptoms of depression. Since that time, she attended an outpatient clinic for treatment. She has taken medication, attended medication monitoring sessions for two years, and was in psychotherapy for one year. The client was unable to give more information in regards to

her therapy because she did not remember the details of her treatment. She was unaware of the therapist's training and credentials, but was aware that the counselor was not her psychiatrist. Betty did not know which interventions were used during counseling. The client did report the cause as to why she stopped going to therapy. She stated that it was not really helping her anymore and that she was doing fairly well by that time. Betty stopped psychotherapy in 1999 after one year of attending bi-weekly sessions. Betty reported having been diagnosed as having Major Depressive Disorder, Generalized Anxiety Disorder, and Attention-Deficit/Hyperactivity Disorder. She was also classified as Learning Disabled with borderline intellectual functioning. She was also diagnosed with a sleep disorder, but was unsure of which type. Betty reports that she is Learning Disabled with deficits and/or low proficiencies in the areas of reading, verbal skills, and memory. In the past, Betty has taken the following medications; Ritalin, Risperdal, and Triazolam. Ritalin is a central nervous system mild stimulant used to treat Attention Deficit/Hyperactivity Disorder, and narcolepsy. Risperdal is an antipsychotic medication often used for treating schizophrenia; however, it may be used for other purposes. Betty could not recall the specific purpose for her taking this medication. Triazolam, also known as Halcion, is in a class of drugs called benzodiazepines, which are used to induce sleep and relaxation. Betty reported that these medications helped during the time she was taking them. However, Betty stopped taking the medications on her own, without consulting a physician, after being on the medications from 1998-2000. Betty reported stopping the use of these medications because she never went back to the psychiatrist for new prescriptions. She reports not being seen by a physician since the spring of 2000. She has reported that weekly therapy was beneficial. Betty's depression has been severe

enough for her to be classified as permanently disabled. She receives SSI benefits for this and her mild mental retardation.

Household composition

Betty lives in a single-family dwelling along with her paramour, Dwain, a 30-year-old African-American male, whose name has been changed to protect confidentiality, and their children. Betty and Dwain have never been married; however, Dwain is the biological father of all four children. The children's names have also been changed to protect their confidentiality. The four children are: 15 year-old Dawn, 13 year-old Rita, 10 year old John, and 8 year-old Amanda.

Family Relations

Betty's partner, Dwain, is unemployed. He was raised in a low socioeconomic family. Dwain was severely physically and emotionally abused as a child by his father and mother. According to Betty, on one occasion, Dwain's father beat him with a baseball bat in the head, which reportedly resulted in neurological damage. Dwain lacks involvement with Betty and the children. Betty explained that Dwain does not participate with the family because he feels the children "pick" on him. For instance, when they play board games and he loses, the children might laugh at him. Betty felt that this was "stupid". However, she understands that he is sensitive about it, so she "lets him be". Upon observing Dwain during a session, it became apparent that he has low self-esteem and attachment issues. While Betty and Dwain have never been married, they have been

together since they were fourteen. They had their first child together when Betty was fifteen. The couple lost a 3-week-old male child to Sudden Infant Death Syndrome ten years ago.

The oldest of the four children is a 15-year-old female, Dawn. Dawn is a good student in school, participates in sports, and helps around the house. However, she has trouble controlling her anger, as indicated by her getting in trouble at school for arguing with teachers and other students. Betty claims that her oldest daughter is her main support system. This indicates that Dawn and Betty have inappropriate boundaries. Betty claims that when she feels depressed, her oldest daughter is the one who reminds her that she needs to get back on her feet.

Dawn and Betty's interactions were observed during a home visit. Betty often tries to act like a friend to Dawn, by allowing her to be a peer rather than her child. Dawn speaks to Betty disrespectfully, constantly putting her down and taking advantage of her. Betty accepts this behavior from Dawn, never calling it to her attention or disciplining her. It is clear that there are inappropriate boundaries between Betty and Dawn.

The second oldest daughter, Rita, is a 13-year-old female who has been experiencing nocturnal urinary incontinence. Betty stated that she has been to the "doctors" in the past, and that she has a physical problem with her bladder being too small. Betty reports that Rita is the most quiet and sweet of all the children. She helps around the house and does fairly well in school.

The next child is a 10-year-old son named John. John has chronic asthma. He collects disability for this condition. He does not attend school given his severe asthma. A tutor comes to the family home after school. Betty reported that she does not like it

when John goes outside to play because he could get sick. She also does not expect him to help around the house for the same reason. John is currently on a new medication which is greatly helping his condition.

The youngest child, Amanda, is an 8-year-old female. Amanda becomes angry and/or violent when she does not get her way. Betty reports that she rarely asks her youngest daughter for anything, other than to stop fighting. Betty reports that she has no responsibilities in the home other than to listen to Betty. However, she does not listen when Betty asks her to stop fighting or to control her anger; fighting occurs on a daily basis, and often causes problems in the home. Usually what happens is Betty will yell at her to stop, but Amanda will not listen. When Betty attempts to send her to her room, she will go for one minute, but immediately comes back into the room, at which time Dwain tells her it is okay.

Betty gave an example of an incident which occurred in the car. Betty had picked up Rita, and Amanda from school, and John was riding with her. She stopped at the store on her way home, and bought John a present there. Amanda got angry with John because he got a present and she did not, and began fighting with her brother in the back seat. When Betty told Amanda to stop by yelling at her, Amanda got mad and continued hitting John, disregarding her mother. Betty said she leaned towards the back seat and pulled Amanda off of John while yelling at her again to stop. Apparently, a man walking by saw the incident and called the police. Amanda continued "messing with John" while they pulled up to another stop. A police man approached Betty. As she explained what happened, she began yelling at the police officer, calling him a racist, and telling him to mind his own business. Amanda stopped "messing with John" only after the police approached

the car. In the end, Betty told Amanda, “look at all the problems you caused because you would not stop messing with John”, and then bought her a gift at the dollar store.

Generally, Betty feels she has a good relationship with her children. She shows little insight regarding how her lack of consistency and limit setting is impacting on the children’s behavior.

Betty has unresolved anger towards Dwain as she is not able to forgive him for cheating on her several years ago. Dwain has been unfaithful to Betty twice, but has always remained in the home. Betty gets mad at Dwain when she feels unsupported in raising the children, or with things around the house, even though he lives in the home. She reports sometimes feeling mad at him for reasons unknown to her. In Betty’s own words, “sometimes I have good days when I like him, but sometimes I can just look at him and hate him for no reason.” However, Betty reports strong feelings of love and commitment for him. Betty rarely spends time alone with Dwain without the children. According to Betty, they do not have money to go out, and when they are home she spends time with the kids, and he often spends time alone. When the children go to bed, she spends time with Dwain, usually having sex daily, which she enjoys. Betty does not currently use any form of birth control. According to her statements, she has had no sexually transmitted diseases.

Betty feels her biggest concern in her relationship with Dwain is that they disagree on child rearing practices. She reports feeling that Dwain is permissive with the children. Betty gave the example that if she tells the children no, they will go ask their father. He will say yes to them instead of asking her first, and the children will get their way, consistently “walking all over” both of them. Betty reports feeling frequently

undermined by Dwain, and that they tend to disagree on the subject frequently. Betty gave the example of the children asking their father for money. Dwain will give the money to the children and never ask what it is for, or check to see if Betty has already given it to them.

Betty reports that Dwain has no responsibilities in the home. Dwain does not work, or help with the household duties, including paying bills, grocery shopping, cooking, cleaning, and caring for the children. During in-home sessions, it was observed that Dwain was not involved in daily routines, household duties, and interactions with the family.

Betty has unresolved grief associated with her son's death of Sudden Infant Death Syndrome. During the time of his death, Betty suffered what appeared to be a Major Depressive Episode, which caused her to stay in bed for months, lose an extreme amount of weight, and lose interest in her children and Dwain. Betty reported feeling guilty about her expectations of her two oldest daughters regarding household responsibilities, and her lack of expectations for her son, which whom she fears will get sick and die if he does anything strenuous. Betty stated that she feels it is unfair that her two oldest daughters help and John does not, but that she fears losing him because "males are weaker" and she only has one son. Betty reported that she associates this fear of losing John with the loss of her other son. The loss of her infant son is what led Betty to seek psychological services in 1998. During the six years between his death and Betty seeking psychological services, she reports feeling "sad". Betty has stated that she often feels sad to this day over her son, and has stated that, "no one can understand what it is like to lose a child".

Family of Origin

Betty did not feel loved or supported as a child by her mother or her father. Betty lived with her mother and her half-sister. Betty had no relationship with her father when she was growing up. He took no interest in the family, and Betty has had no relationship with anyone from his side of the family. However, Betty does know who he is, and that he was an alcoholic. Betty's mother lacked formal education and was an alcoholic. She was physically, mentally, and emotionally abusive towards Betty and her half-sister. Betty and her half-sister suffered abuse and neglect their entire childhoods. For example, Betty stated that her mother would get intoxicated, beat them, and then make them sit in the kitchen completely silent for hours, without giving them food. Her mother often withheld meals from her, would not send her to school, and did not provide the proper clothing, because all her money reportedly went towards buying alcohol. Betty feels her mother was the disciplinarian. Betty was responsible for some household duties, such as cleaning, cooking and caring for her half-sister.

As a child, Betty was not allowed to express herself without getting a "beating" for doing so. Currently, Betty does not talk to her sister because she lives far away. She has not seen her in years. She has never felt close to anyone, other than Dwain. Betty does not allow her mother in her home, nor does she allow her to see the children. Betty wishes to have nothing to do with her mother. Betty has severe issues resulting from the abuse and neglect. These include low social support, poor attachment, and low self-esteem.

Throughout her childhood, Betty lived with her mother and her half-sister. She left her mother's home when she was 15-years-old after her mother beat her stomach. At the

time, Betty was pregnant with her oldest child and feared her mother would harm the baby.

While Betty's mother has several brothers and sisters, only one of Betty's aunts ever took interest in the two girls. This aunt occasionally provided Betty and her half-sister with food after they had been physically abused by their mother, and would sometimes take them to her house. Betty has a deep affection for this aunt. However, she does not communicate with her other aunts and uncles, some of whom have severe drinking and health problems. Betty's grandparents refused to get involved with the family when Betty was a child. She reports only seeing her grandparents on holidays. When Betty was approximately 8-years-old, DYFS became involved with the family when someone reported Betty's mother for chronic abuse and neglect of the two girls. According to Betty, nothing was ever done to improve the situation and the case was closed. Betty moved out of her mother's home when she became pregnant at 15-years-old. She moved in with Dwain and his parents.

Betty is embarrassed by her mother and the things she has done. Betty stated that once she was pregnant she moved in with Dwain and his family because she feared her mother would hurt her unborn child. A few years after Betty moved out of her mother's home, her mother needed a place to live. Dwain's parents allowed her to move into their home temporarily. According to Betty, Dwain's father and her mother ultimately had an affair that lasted approximately two years. She remembers arguments between Dwain's mother and her own mother over the subject. It is for this reason that Betty feels Dwain's mother was always "mean" to her. Betty feels that her mother took away Dwain's father's love, and she took away Dwain's love, leaving Dwain's mother loveless.

Betty's family of origin then was characterized by high conflict, a lack of emotional support and chronic abuse and neglect. These factors are major contributors to Betty's current low self-esteem, poor parenting skills and deficits in adaptive behavior.

Situational Stressors

Betty's biggest stressor pertains to managing the household and finances. Betty lacks skills in long-term planning and often falls behind on the bills. Eventually her utilities were cut off leading to the involvement of the Division of Youth and Family Services (DYFS). Betty feels a great deal of stress from raising her children. She worries that she will not be able to provide for them, and that they consequently will be taken away from her.

The disability payments for John's chronic asthma helps bring in family income. Other reported sources of income are food stamps, her disability payments, and welfare for her children. Betty is unaware of the condition for which she collects disability. According to Betty's statements, her previous caseworker at the Department of Health filed her disability paperwork for her after Betty was assessed psychologically and cognitively. Betty reports that Dwain has filed for disability due to a neurological disability incurred during his childhood from the physical abuse of his father. Betty reports that if Dwain is approved for disability and can bring in extra income, she may feel less stressed and less depressed. Overall, Betty often finds herself crying due to financial worries.

The client reported that the family is getting ready to move from a Section 8 apartment to a Section 8 house. Betty reported that she is excited about moving into the

house because there will be more space for the family. The new home has four bedrooms, one for Betty and Dwain, one for John, one for Dawn, and one for Amanda and Rita to share. The new house also has a larger kitchen, dining room, basement and carpeting. The family's current apartment is small; with 3 bedrooms and a small family room. Therefore, the three girls have been sharing a bedroom and one twin-size bed.

Drugs, Alcohol, and Addictive Behavior

Betty and Dwain deny the use of drugs or alcohol. They also deny having ever used substances as a coping mechanism. However, they both smoke cigarettes habitually, and are dependent on this substance.

Betty reported a family history of substance abuse and dependence. She specifically reported that her uncles and aunts have substance abuse and dependence problems. She also reported that her mother is dependent on alcohol. Dwain's parents are not substance abusers, nor are his two sisters.

Education and Job History

Betty completed the eighth grade. According to Betty, her mother was responsible for taking her out of school in eighth grade because her mother did not want the teachers or staff members at Betty's school to notice the physical markings on Betty's body from the abuse. Betty does have deficits in basic skills, such as writing and reading. Betty has always had trouble in school. According to her own statements, she never did well in school because she could not understand the subject matter and was not sure what was expected of her. Her academic functioning was substantially lower than others of her

same age. Betty appears to have an IQ in the educable mentally retarded range, and concurrent impairments in adaptive functioning. Betty's IQ was tested when she was being psychiatrically assessed. Her IQ score provided evidence for eligibility to collect disability payments.

Betty has held only one job. She drove a taxicab for 6-months. Betty would like to go back to school and study cosmetology. It is not clear if this is a realistic goal.

According to Betty, Dwain dropped out of school after a beating from his father when he was 14 years old, which caused him severe memory, motor, and learning problems. Betty stated that because of these deficits, Dwain has never been able to hold a job. His exact literacy proficiencies are unknown.

Early Development/Neurological History

Betty was unable to give information about when her mother was pregnant with her. Betty could not recall being ill as a child. The majority of her memories are filled with abusive episodes. She could not recall any head trauma.

Social Support

According to Betty, she has no social support systems. She does not belong to a church or community group. According to Betty's statements, no one other than the nuclear family is present in the home. However, while visiting for treatment sessions, different people were observed going in and out of the home, often going upstairs, where Dwain was. According to Betty, these people were "friends". Their exact ties to the family are unknown. She stated that she speaks to only one family member, an aunt, who

helped raise her. Neither, Betty or Dwain speaks to their parents because they have not gotten over the abuse they incurred. Betty feels she could benefit from social support systems.

Betty has issues of trust, which are evidenced by her lack of trust for outsiders. Betty reports having only one neighbor with whom she confides, but does not like others to know her business. Betty stated that she loves her aunt and feels supported by her, but does not get to talk or see her often. Betty seems to mostly rely on Dwain for social support. She also inappropriately seeks peer support from her older children.

Medical

Betty has a number of medical concerns. She has problems with her menstrual cycle. She stated being seen several years ago for the same symptoms, but can not recall the source of the problem. At that time, the doctor prescribed birth control pills to help with a hormone imbalance. According to Betty, she knew the prescription would help alleviate the problem, but never had the prescription filled. However, she states it was not important to her to fill the prescription. In addition, Betty has not had a physical examination in five years. Betty is missing all of her teeth, but uses dentures for her upper teeth. She claims that she is planning to see a dentist for the bottom dentures. However, this severe neglect of her own dental needs is symptomatic of Betty's difficulties with basic life skills. Betty reports an upset stomach, and trouble digesting food. She has not seen a doctor about these problems. There is a family history of heart disease, diabetes, and substance abuse and dependency. Betty does not demonstrate an ability to address her own medical needs. She has difficulty in following through on

treatments and has poor insight regarding the importance of these matters. Betty did not report any family psychiatric history.

It is apparent that Betty does not follow through on her own medical care but also on the care of her children. This was evidenced by Amanda's severe case of athlete's foot. According to Betty, Amanda had been experiencing symptoms of athlete's foot for approximately 3-months. When asked if she had taken Amanda to be seen by a physician, Betty answered by saying no. She was planning on using something over the counter, but did not have enough money to purchase the foot cream.

Coping Skills and Strengths

Betty generally has the ability to manipulate people to meet her needs, especially for lower level or immediate survival skills. However, she lacks the appropriate coping skills to deal with stressful situations. In addition, Betty is unable to seek help from community agencies.

Betty does love her children, and wants to provide them with a better life than that which she experienced. She is willing to cooperate with treatment.

Summary

This 30 year old African-American women has a number of serious issues. She has significant deficits in basic life skills including basic household management, medical and dental care, and financial planning. For example, she reported that the family was behind several thousands of dollars in their bills. Betty claims to run out of money within

the first few weeks of the month. She is concerned with her financial situation and her occasional sadness and lack of anger management.

Additionally, she has significant psychiatric problems including depression, difficulties in controlling her anger, unresolved grief over the death of her infant son, attachment concerns. Betty has some level of cognitive impairment and has been previously diagnosed as mentally retarded. She is socially isolated and has very weak coping skills. Her partner also has a low level of adaptive functioning.

The clinical picture is further complicated by Betty's current inability to adequately parent her children and maintain a functioning household. While Betty has not directly abused her children, she is being supervised by DYFS for neglect, primarily because of her difficulties in managing her finances. Of equal importance, however, is Betty's poor parenting skills and her lack of supervision of her children. Betty also has a pattern of not following through on treatment. Based upon her failure to follow through on needed medical treatment for Amanda's athlete's foot and Rita's incontinence, Betty and Dwain are medically neglecting their children.

Clinical Concerns

A major clinical concern for this client is attachment. It is apparent that there are issues of abuse and neglect which are causing symptoms of anger, rage, and low self-esteem. The client has reported previous flashbacks of her abuse as a child which may be a symptom of posttraumatic stress.

We see that Betty has unresolved issues of grief from the loss of her son, which are evidenced by her overprotection of her son, John. Another major area of concern is the

lack of boundaries between Betty and her children. Betty needs to learn appropriate parenting skills and disciplining. Clinically, there is a concern with Betty's level of functioning. Betty may not be able to care for her children properly without additional support due to her limited intellectual functioning. She is still suffering from symptoms of depression, such as crying, sadness, and trouble sleeping. In addition, Betty is suffering from symptoms of anxiety and excessive worry. It is apparent that Betty may need to get back on psychotropic medications.

Chapter 2

Differential Diagnosis

The client's symptomatology met criteria for several differential diagnoses. A specific area that was of clinical concern regarded Betty's cognitive abilities. Initially, it was believed that Betty had a Learning Disorder, due to her low academic functioning when she was in school, her skills deficits in reading, writing, and math, lack of comprehension of tasks, inability to perform well on standardized test, and the interference of these deficits with daily living activities. However, this was ruled out due to Betty's measured intelligence, which was measured during her psychiatric assessment in 1998. Compared to others, Betty is substantially below average in her reading, writing, comprehension, and math skills. The criteria that ruled out this disorder is that Betty's intellectual level, or measured intelligence, is much lower than average. Therefore, she does not have the intellectual capacity to perform such skills. It is currently unknown if the client has Learning Disabilities due to a lack of Learning Disability testing.

The client has symptoms of Borderline Intellectual Functioning. However, it is apparent that there are more severe issues involved. The client scored below the Borderline Intellectual Functioning range of 71-84 on her IQ test as evidenced by speaking to her previous caseworker, who was present when Betty was undergoing treatment and testing at the outpatient clinic. She has symptoms that indicate a lower level of functional skills in her daily routine, hygiene, and social behavior. The client's

problems in functioning extend beyond the academic realm. Therefore, Borderline Intellectual Functioning has been ruled out as an Axis II diagnosis.

Amnesic Disorder due to a General Medical Condition was a possible diagnosis considered. Betty exhibits an inability to recall previously learned information and difficulty retaining new information learned. Due to the fact that Betty was severely physically abused and neglected as a child, there was a possibility that the physical abuse caused the impairment during a traumatic physical event. If this were the case, her memory and level of learning would have been higher prior to the traumatic event. Betty has never been examined physically for neurological impairments, nor could Betty isolate a specific episode of her abuse that would cause such brain damage, since the abuse was chronic. There is evidence to show that Betty has always had deficits in learning, memory, comprehension, and retention, based on her level of functioning, and her grades from school. Betty reported that her teachers were always concerned with her lack of ability. It is clear that Betty does not have any courses of delirium, or dementia. Therefore, based on the differentiating factor that Betty has never functioned at a higher level, Amnesic Disorder has been ruled out as a possible diagnosis.

The client was previously diagnosed by her psychiatrist as Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive subtype. However, some of the symptoms of ADHD, specifically symptoms of inattention, are similar to symptoms of individuals with low IQ or Mental Retardation. While the client does display symptoms of inattention, the symptoms are appropriate for her intellectual capacity. The client has a low IQ score and low adaptive functioning skills. Yet, she has been able to

follow the directions of the therapist, for example, showing bills, keeping the receipts for bills/food/expenses, and keeping a journal. This supports her being able to pay attention to tasks, her ability to listen, and follow through on directions. The client is not completely organized. However, she was able to organize the receipts to show the therapist how the family income was spent. Considering the client has limited intellectual and cognitive capacities, she does not fit specific criteria for a diagnosis of Attention-Deficit/Hyperactivity Disorder. Therefore, further testing would need to be conducted to determine a condition of Attention-Deficit/Hyperactivity Disorder.

Dysthymic Disorder was considered because of her depressed mood. Occasionally, Betty does feel overwhelmed and sad. However, Betty does not presently have depressed mood for most of the day, for more days than not, for 2 years or more. Therefore, this disorder was ruled out.

While assessing the client, it was also believed there could be a possibility that Betty had Bipolar Disorder. It is possible that the prior reports of manic behavior were, in fact, undiagnosed symptoms of mania. However, Betty reported never experiencing a period of abnormal and persistent elevated, expansive, or irritable mood. In addition, she reports no incidents of inflated-self esteem, decreased need for sleep, pressured speech or talkativeness, racing thoughts, increase in goal-directed activity, or excessive involvement in pleasurable activities with a high potential for severe consequences. Therefore, Betty does not fit the criteria for mania and the diagnosis of Bipolar Disorder was ruled out.

Axis V Diagnosis

| | | |
|----------|--------|--|
| Axis I | 296.35 | Major Depressive Disorder, In Partial Remission, With Melancholic Features |
| | 309.81 | Posttraumatic Stress Disorder, Chronic, With Delayed Onset |
| Axis II | 317 | Mild Mental Retardation |
| Axis III | | Irregular menstrual cycle Overall poor health Obese Severe dental problems Poor hygiene |
| Axis IV | | Victim of child neglect and chronic physical abuse Completed up to eighth grade Lack of social systems |
| Axis V | | GAF= 50 |

A diagnosis of Major Depressive Disorder, in partial remission, with melancholic features was given to the client based on the fact that she has suffered from several depressive episodes. During her depressive episodes, the client experienced melancholy symptoms, such as loss of interest and pleasure in usually pleasurable activities, lack of response to usually pleasurable stimuli, severe weight loss without intent to lose weight, not wanting to wake up in the mornings, excessive feelings of guilt, and unwarranted sadness. For instance, the client reported lying in bed while visitors would come in to see her, including her children, and she would not want to say hello. The client reports not eating for a week at a time, and when she would eat she would only take a few bites of something. Betty stated not being interested in her children or spending time with them during her depressive episodes. She recalls feeling “unable to enjoy anything”. Presently, Betty has some symptoms of mild depression, such as depressed mood.

However, her symptoms do not meet criteria for a Major Depressive Episode, and therefore, her Major Depressive Disorder is clinically in partial remission.

Betty's condition of Posttraumatic Stress Disorder is due to her exposure to traumatic abuse as a child. Betty endured chronic and severe physical and psychological abuse daily. She was neglected by her mother, who did not provide adequate food, clothing, or housing for Betty. This abuse and neglect caused Betty to experience threats to her, and her sister's, physical integrity. In addition, she experienced and witnessed serious injury frequently due to the nature of the abuse and its severity. In addition, Betty had an intense fear of her mother and for her survival.

Due to the physical abuse, Betty has intense psychological distress when internal or external stimuli symbolize or resemble the abuse. She has recurring and intrusive recollections of the events. When something either internal or external reminds Betty of the abuse, she becomes enraged; physiologically, her heart begins to race, she gets angry and aggressive, either towards others, or in her present task.

The client demonstrates several avoidant behaviors typical of the PTSD victim. Betty avoids contact with her mother. While Betty will occasionally discuss issues surrounding her abuse as a child, she tries to avoid specific thoughts or details of the abuse. The client exhibits feelings of detachment towards her mother, and is estranged from her. According to Betty's own statements, "my mother is not my mother and I do not want her in my life". Betty no longer feels her mother is a part of her life. In addition, Betty has a significant loss of interest in activities she once enjoyed, such as playing games.

The abuse and trauma have caused the client to have symptoms of increased arousal, specifically, aggression. Betty becomes irritable with outbursts of anger and aggression,

and has difficulty sleeping. She also displays some hyper-vigilant behaviors, such as extreme mistrust of others. Betty has exhibited all of these symptoms for the past 15 years, beginning shortly after she moved out of her mother's home. The symptoms have greatly interfered with her life. Betty is unable to maintain interpersonal relationships due to her aggressive behavior and mistrust for others. She does not know how to express herself appropriately.

Betty meets criteria for Mild Mental Retardation. She has significant subaverage intellectual functioning and she reports this condition since childhood. Her IQ score is reported as being lower than 70 by a previous caseworker. Betty has some very basic communication and social skills, similar to those of a young child. Her academic skills are below average; she can barely read or write as observed by this writer. Betty is unable to support herself financially due to her condition. Therefore, she collects disability. Coping with the daily demands of life is difficult for Betty because she has low adaptive functioning in the following areas: 1) communication; 2) self-care; 3) social/interpersonal skills; 4) utilization of community resources; 5) self-direction; 6) functional academic skills; 7) health; and 8) safety.

In order to have a diagnosis of Mental Retardation, one must have an IQ score below 70, the onset must be prior to 18, and the adaptive functioning must be deficient in at least two areas. However, Betty's adaptive functioning is deficient in several areas. Thus, Betty meets all criteria for Mild Mental Retardation.

The GAF score given to the client was 50 because she has symptoms of depressive mood, social difficulties, occupational difficulties, medical concerns, and conflicts with the children's school.

Overall, the client has Major Depressive Disorder in partial remission with melancholic features. She had her first depressive episode when she was 17-years-old, and has experienced two depressive episodes in the last ten years. Betty also has Posttraumatic Stress Disorder, which causes her psychological distress. Betty has Mild Mental Retardation, making it difficult for her to meet her daily needs. Betty has no diagnosed medical conditions. However, she does have irregular menstrual cycles and poor general health. There is clinical concern because she has not been examined by a physician since 1998.

Betty is a victim of child abuse. She was physically and emotionally abused and neglected by her mother. Betty's symptoms include intermittent depressed mood, aggression, conflict with others, and a lack of social and interpersonal skills. Her GAF score is a 50.

Chapter 3

Literature Review

A review of the literature focused on the etiology and efficacious treatments of three specific areas: major depression, posttraumatic stress disorder, and mild mental retardation.

Major Depression

A defining feature of major depression is loss of pleasure, which is often accompanied by grief and guilt (Sapolsky, 1994). Depression is an illness which needs to be taken seriously. Depression is one of the most common disorders known to mental health professionals (Young, Weinberger, & Beck, 2001). It can change an individual's thoughts, moods, feelings, behaviors, and physical health. If depression remains untreated, it can cause long term disability and possibly lead to death. Depression is categorized by symptoms like loss of interest in normal activities, depressed mood, sleep disturbance, impaired thinking or concentration, significant weight loss or gain, agitation or slowing of body movements, fatigue, low self-esteem, less interest in sex, and thoughts of death (American Psychological Association, 2000). Studies show that 66%-90% of depressed episodes are due to a severe event, such as loss, which usually occur within six months of the onset of the episode (Brown, 1996).

According to Schuyler and Katz, 12% of the adult population will require treatment for a depressive episode (Schuyler and Katz, 1973, as cited in Beck, Rush, Shaw, and

Emery, 1979). In addition, 75% of all psychiatric hospitalization among adults is for the treatment of depression (Secunda, Katz, Friedman, & Schuyler, 1973, as cited in Beck, Rush, Shaw, and Emery, 1979). Unfortunately, the majority of people suffering from depression will never seek professional treatment (Frank & Thase, 1999; Jarrett, 1995). Those who seek professional services for depression often receive inadequate care (Keller & Boland, 1998). Morbidity and mortality commonly accompany depression. According to research conducted by the Mayo Clinic, 9 out of 10 suicides involved one or more mental illnesses, including depression (Mayo Clinic, 2002). Suicide is a concern within the depressed population, especially depressed psychiatric patients, who are between 5 to nearly 500 times more likely to commit suicide than the general population (Hirschfeld, 1989).

The literature reveals that the biochemistry of depressed individuals is different than that of non-depressed individuals. Sapolsky stated, "The best neurochemical evidence suggests that depression involves abnormal levels of one or both of a pair of neurotransmitters, norepinephrine and serotonin (Sapolsky, 1994). Due to the growth in the field of neurochemistry and the study of pharmacological treatments of depression, greater understandings of the biological features of depression have been identified (Clark, Friedman, & Gershon, 1992). Therefore, medications are available for the treatment of depression.

Posttraumatic Stress Disorder

Many individuals have both Posttraumatic Stress Disorder and Major Depression (Carmen, 1984). Untreated Posttraumatic Stress Disorder can lead to clinical depression

due to the losses experienced during traumatic events and decreases of serotonin (Flannery, 1992). Many victims of traumatic physical, emotional or psychological abuse become depressed as a result of losses to their physical integrity, self-worth, and personal significance. These individuals have not been able to grieve, and therefore may not recognize depressive symptoms because the symptoms have become a normal part of their functioning (Carmen, Reiker, & Mills, 1984).

The DSM-IV-TR specifies that a person must have experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others (American Psychological Association, 2000). The person's response involves intense fear, helplessness, or horror in order to be diagnosed as having Posttraumatic Stress Disorder (American Psychological Association, 2000). Some traumatic events that individuals experience directly and could cause PTSD include, but are not limited to, military combat, violent personal assault, being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war, being in a concentration camp, natural or manmade disasters, and severe automobile accidents (American Psychological Association, 1994). Traumatic events overwhelm an individual and may take away his/her adaptive capacities, devastating the individual so he/she no longer understands the world and/or his/her self (Herman, 1992; Horowitz, 1986).

The study of PTSD has mostly focused on Vietnam Veterans (Kulka, Schlenger, and Fairbank, 1990). However, combat soldiers are not the only individuals who suffer from PTSD. In fact, it is one of the most common psychiatric disorders (Kolk, Hart, and Burbridge, 2002). It is also common within the general population. It is estimated that

1.3 percent to 9 percent of the general population has PTSD (Helzer, Robins, and McEvoy, 1987; Breslau, Davis, and Andreski, 1991). In addition, studies show that 15% of psychiatric inpatients suffer from PTSD (Saxe et al., 1993).

Research has found that the majority of psychiatric conditions, including PTSD, are biologically and psychologically intertwined. PTSD is not merely an abnormal reaction to an extreme trauma. Instead the trauma itself alters the individual's neurophysiology which may cause the syndrome to manifest and maintain itself over time (Heim et al., 1997; Hockings et al., 1993; Kosten et al., 1987). There is also evidence which supports neurophysiological differences among those with PTSD. This assertion is further supported by evidence that specifies a genetic predisposition to PTSD (True et al., 1993).

Neurobiological findings connect several neurotransmitters, neuronal mechanism, and neuroendocrine systems in the pathophysiology of PTSD (Albucher, etten-Lee, & Liberzon, 1999). There are several neurotransmitter abnormalities found in individuals with PTSD. These include serotonin, endogenous opioids, gamma-aminobutyric acid and cholecystinin, and dopamine (Arora et al., 1993; Davis et al., 1997; van der Kolk, 1994; Hockings et al., 1993; Pitman et al., 1990; van der Kolk et al., 1989; Adamec, 1997; Adamec, Shalloe, & Budgell, 1997; Friedman et al., 1995; & Yehuda et al., 1992).

Mild Mental Retardation

Another disorder which is relevant to this case is mild mental retardation, often called familial retardation. Mental retardation can be defined as an individual's failure to demonstrate age-, cultural-, and situational-appropriate skills (Baumeister & Baumeister, 2000). The DSM-IV-TR states:

“As a group, people in this level of Mental Retardation typically develop social and communication skills during preschool years (0-5), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. During their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings” (American Psychological Association, 2000).

A diagnosis of mental retardation is given when an individual has significantly subaverage intellectual functioning; an IQ of 70 or below. The individual must have concurrent deficits or impairments in present adaptive functioning in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety. In addition, the onset of the disorder must have occurred before the individual becomes 18 years of age (American Psychological Association, 2000).

The estimated percentage of mildly mentally retarded people in the total population ranges from 1% to 3% (Mayo Clinic, 2002). Social class is a contributing factor of mild mental retardation (Merk Manual, 2002). It is more difficult to provide services for mild mental retardation than severe retardation because service systems question the eligibility of such individuals (Durkin & Stein, 1996). This adds an additional strain for individuals

with mild or familial mental retardation. According to the U.S. Department of Education, there has been a dramatic decrease in the prevalence of mild mental retardation among school children. However, during this same time there has been an increase in learning disabilities (Smith, Young, Bae, Choy, & Alsalam, 1997).

Low intelligence is the most defining feature of mental retardation. Intelligence is measured with an assessment called the Intelligence Quotient. The IQ is the best known predictor of performance and is used to predict academic achievement, adaptive behavior, job success, income, social status, mental health and more (Gottfredson, 1997; Lubinski & Humphreys, 1997).

There are genetic/biological and environmental factors which cause mental retardation. Most individuals with mild mental retardation show fewer physical characteristics than severe mental retardation, come from lower socioeconomic backgrounds, and have relatives who score in the range of subaverage intelligence on IQ tests. Mild mental retardation or familial retardation is often used when there is no evidence of biological causation (Baumeister, Kupstas, & Woodley-Zanthos, 1993). Some environmental causes of mild mental retardation include the mother's prenatal care, maternal and child nutrition, family size, the spacing of births within a family, disease, and health risks from environmental toxins; such as lead (Fraser, 1995; Herrnstein, & Murray, 1994).

Empirically Supported Treatment Approaches

Major Depression

There are several well researched treatments for major depression. Cognitive therapy or cognitive-behavioral therapy, interpersonal psychotherapy, psychopharmacological treatment, and psychopharmacological treatment combined with psychotherapy are the most researched treatments for depression (Young, Weinberger, Beck, 2001; Gillies, 2001; Markowitz, & Swartz, 1997; Clark, Freidman, & Gershon, 1992). Depression is a disorder characterized by biological, physical, and psychological symptoms. That is why it is necessary to assess the client's individual needs prior to choosing a theory oriented treatment approach (Young, Weinberger, & Beck, 2000).

Cognitive therapy was developed by Aaron T. Beck (Beck, Rush, Shaw, & Emery, 1979), and has received extensive professional recognition due to its use of testable hypotheses and clinical protocols (Hollon, 1998; McGinn & Young, 1996; Rehm, 1990). In comparison to other cognitive-behavioral treatments for depression, Beck's cognitive-behavioral approach has been the greatest source of empirical study, validation, and clinical application (Barlow & Hofmann, 1997; de Oliveira, 1998; Dobson & Pusch, 1993; Hollon, 1998; Rehm, 1990; Roberts & Hartlage, 1996; Scott, 1996).

The focus of cognitive therapy is on the cognitive disturbances that coincide with depression. Examining the information processes of depressed individuals should be a focus in the treatment of depression (Ingram, & Holle, 1992). It is typical for depressed individuals to have a negative view of themselves, their environment, and of their future. This is often referred to as the "cognitive triad of depression" (Beck, Rush, Shaw, & Emery, 1979).

The literature reveals that outcome research has determined cognitive therapy to be as effective, as tricyclic antidepressants in the treatment of outpatients with non-bipolar

depression at termination of treatment (Beck, et al., 1979; Blackburn & Bishop, 1979, 1980; McLean & Hakstain, 1979; Rush, Beck, Kovacs, & Hollon, 1977). Gloaguen, Cottraux, Cucherat, & Blackburn (1998) found that cognitive therapy was more effective than antidepressants and a set of unspecified psychotherapies. However, cognitive-behavioral therapy was found to be equally effective to behavioral therapy (Gloaguen, Cottraux, Cucherat, & Blackburn, 1998, as cited in Young, Weinberger, & Beck, 2001). Another study found that cognitive-behavioral therapy, or CBT, is a better alternative to standard antidepressant medication for the treatment of depression (Hautzinger & de Jong-Meyer, 1996).

Cognitive-behavioral therapy derives from cognitive therapy (Persons, & Tompkins, 1997). CBT combines characteristics of structural assessment, the causes of behavior, and functional assessment, the function of behavior (Nelson & Hayes, 1986). Similar to cognitive therapy, CBT also focuses on the cognitive diathesis-stress theories of depression while changing unwanted behavior. There are strong outcome data that support the efficacy of cognitive-behavioral treatment, and showing its strength as a treatment approach for depression (Giles, 1993).

There are some precautions necessary when considering the use of cognitive or cognitive-behavioral treatment approaches for clients with depression. Due to its intense focus on cognition and how cognition influences behavior, cognitive-behavioral therapy is not suitable for clients who do not have a particular behavioral issue, whose goals for therapy are to gain insight of their past, or who are not willing to take an active role in the treatment process. In addition, clients who are severely psychotic or are cognitively impaired may be inappropriate for a cognitive-behavioral intervention because their

cognitions are not intact and this could interfere with accomplishing treatment goals (Enright, 1997; Goisman, 1997; Greenberger, & Padesky, 1995).

Behavior therapy is an empirical approach geared at understanding normal and abnormal human behavior. It is based on a set of empirical guidelines which prove behavior can change (Nezu, Maguth-Nezu, Friedman, & Haynes, 1997). Behavior therapy has been defined as the application of modern learning theories (Hersen, Eisler, & Miller, 1975). Clinical application of behavior therapy was founded on operant, or classical, conditioning paradigms. In the past 20 years, behavior therapy has grown to include new approaches for treatment (O'Donohue & Krasner, 1995). Similar to the cognitive-behaviorist clinicians, behavior theorists have made great advancements empirically based assessment protocols for depression and other disorders (Hersen & Bellack, 1996).

Another effective, well supported treatment for depression is interpersonal psychotherapy, or IPT (Klerman, Weissman, Rounsaville, & Chevron, 1984; Weissman, Markowitz, & Klerman, 2000). The theories behind the IPT approach are founded in the interpersonal school of Sullivan, and are based on the idea that life events have an effect on mood (Klerman et al. 1984). The main focus of IPT is on the idea that the psychosocial environment effects mood. Therefore, when painful events occur, mood worsens and depression could result (Markowitz and Swartz, 1997). IPT is proposed as a "treatment for symptom removal, prevention of relapse and recurrence, correction of casual psychological problems for secondary resolution, and correction of secondary consequences of depression" (Weissman & Markowitz, 1994). IPT is a straightforward, functional, and well established time-limited approach for the treatment of outpatients

with depression (Markowitz and Swartz, 1997; Elkin et al., 1989; Weissman et al., 1981; American Psychological Association, 1995).

Often underlying depressive symptomatology is caused by neuroendocrine dysfunction, neurotransmitter systems, and biological rhythms (Burke & Puig-Antich, 1990; Kalat, 1992; Shelton, Hollon, Purdon, & Lossen, 1991). Psychopharmacology has revolutionized psychiatry by its development of treatments over the past 35 years.

Pharmacological treatments for depression have dramatically improved since the early 90's, and are highly effective in treating depression (Clark, Friedman, & Gershon, 1992).

Antidepressant medications are categorized into one of four types; tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs), selective serotonin reuptake inhibitors (SSRIs), and other antidepressant medications (McLeer & Willis, 2000). Tricyclic antidepressants block the reuptake of norepinephrine and serotonin. TCA antidepressants have more extensive side effects than new antidepressants, such as SSRIs. MAOIs increase synaptic monoamine levels by inhibiting neurotransmitter breakdown and metabolism. While MAOIs are highly effective in the treatment of depression and anxiety disorders, their use is limited because clients are required to follow a low-tyramine diet. SSRIs are the latest antidepressants available and are effective with many psychiatric disorders. These medications are as effective as TCAs and MAOIs in treating depressive disorders, but have minimal side effects (Albucher, R., Etten-Lee, M. V., & Liberzon, I, 2002). Therefore, in the treatment of depression it is best to try SSRIs with the client prior to TCAs and MAOIs.

Posttraumatic Stress Disorder

Empirically supported treatment approaches for Posttraumatic Stress Disorder include: exposure therapy, cognitive therapy, stress inoculation training, psychopharmacological treatment, and cognitive-behavioral therapy (Resick & Calhoun, 2001; Williams & Sommer, 1999). There is evidence that suggests psychotherapy and pharmacological treatment can have an effect on physiology, and increase mental functioning in the treatment of PTSD (Baxter et al., 1992).

Exposure therapy began to be researched as a treatment for PTSD in the early 80's. Systematic desensitization, a technique of exposure therapy, has demonstrated its efficacy in the treatment of PTSD in several case study reports and controlled studies. However, it has not been adopted as a preferred treatment approach for the treatment of PTSD (Bowen & Lambert, 1986; Brom, Kleber, & Defares, 1989; Frank et al., 1988; Frank & Stewart, 1983, 1984; Schindler, 1980; Shalev, Orr, & Pitman, 1992; Turner, 1979). This may be due to the fact that clients with PTSD often avoid trauma-related stimuli, making it difficult to follow systematic desensitization protocols (Resick, P. A., & Calhoun, K. S., 2001). A variant of exposure therapy, eye movement desensitization and reprocessing, is controversial, and its efficacy is unclear (Shapiro, 1989, 1995; Tolin, Montgomery, Kleinknecht, & Lohr, 1996). This is a controversial technique because it was not developed based on a theory, but instead from a personal observation made by Shapiro. Shapiro argues that lateral eye movements facilitate cognitive processing of trauma (Shapiro, 1995).

The greatest studies of psychosocial treatment for PTSD have employed cognitive-behavioral techniques (Foa & Meadows, 1997). Cognitive therapy was originally used to treat traumatized victims of sexual assault (Resick, 1992; Resick & Schnicke, 1992,

1993). Known as cognitive processing therapy, this model incorporates cognitive restructuring and exposure therapy. Cognitive processing therapy is based on the theory that systematic exposure to a traumatic memory in a safe environment may restructure the feared memory (Foa, Steketee, & Rothbaum, 1989; Foa & Meadows, 1997). Studies have shown that individuals in group therapy supplemented by imaginal exposure therapy improved on self-reported psychological functioning more than the control group (Boudewyns & Hyer, 1990; Boudewyns et al., 1990). The cognitive-behavioral approach, or CBT, has proven itself in studies to be highly effective in the treatment of PTSD (Resick & Schnicke, 1992, 1993; Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998).

In recent years, the biological framework of several disorders, including PTSD, has shown the effectiveness of psychopharmacological interventions (Davidson, 1997; Friedman, Charney, and Deutch, 1995; Grillon, Southwick, and Charney, 1996). Pharmacology has furthered the advancements of psychology and neuroscience by adjusting physiological abnormalities in individuals with PTSD. There are several effective medications used to alleviate the symptoms of PTSD. The most effective medications used in pharmacotherapy are antidepressants (Albucher, Etten-Lee, & Liberzon, 1999). Therefore, the use of antidepressant medications as a treatment for PTSD is supported by the literature.

Mild Mental Retardation

There are two approaches most frequently used in the treatment of functional impairments associated with mental retardation; behavior modification and psychotropic

(pharmacological) treatment (Baumeister & Baumeister, 2000). Functional impairments may be in the areas of communication, home living, self-care, social skills, community use, health and safety, functional academics, leisure and work.

Behavior modification has been used in the treatment of many behaviors, such as school refusal, classroom disruptive behavior, cursing, tantrums and aggression, social skills deficits and mild mental retardation (Derby et al., 1992; Frea & Hughes, 1997; Iwata, Dorsey, Slifer, Bauman, & Richman, 1994; Pace, Ivancic, & Jefferson, 1994; Taylor & Romanczyk, 1994 as cited in LeBlanc, Le, & Carpenter). The motivating factors to change the unwanted behavior are positive and negative reinforcement. However, behavior modification may not be as efficacious in treating mental retardation as published research indicates. Research findings suggest that approximately 40%-50% of published studies on behavior modification demonstrated that the interventions had been ineffective or had questionable effectiveness (Scotti, Evans, Meyers & Walker, 1991).

Psychotropic drugs are used to control abnormal behaviors of the mentally retarded. As many as 55% of mentally retarded persons who reside in institutions, and 40 % of those residing in community settings, receive psychotropic medications, such as antipsychotics, antidepressants, and anticonvulsants. Unfortunately, while these medications appear to be effective in the treatment of mental retardation, these drugs suppress all behaviors, including adaptive behaviors (Baumeister, Todd, & Sevin, 1993). Thus, pharmacological treatment may not be suitable for all individuals with mild mental retardation.

Conclusion

According to the literature, the most efficacious treatment for a client with major depression, posttraumatic stress disorder, and mild mental retardation is pharmacological therapy in conjunction with some cognitive-behavioral techniques. The first line of medications to explore with this client would be antidepressants, particularly selective serotonin reuptake inhibitors or SSRIs. Unfortunately, Betty does not have the intellectual capacity required for cognitive or cognitive behavioral treatments, which, according to the literature, have the highest efficacy in treating both major depression and posttraumatic stress disorder. Therefore, the treatment will have to be modified for the specific needs of the client.

Chapter 4

Normative Practice

The Agency

The treatment for the client in this single-subject study took place at a community based agency. This agency offers several programs focusing on family preservation and child welfare issues. Clients in the program are referred to the agency by the Division of Youth and Family Services (DYFS). Treatment consists of a minimum of an hour long home session per week. However, sessions generally last anywhere from 1-4 hours, and take place either in the home or a public setting, including restaurants, parks, stores or other service agencies. Individual or family sessions are provided depending on the individual needs and goals of the family. Treatment lasts approximately six months. A master's level therapist and a counselor with out a bachelor's degree provide the intervention for the families Both are present during sessions.

Participation in the program is voluntary for families. Prior to treatment, families sign a treatment contract stating they are willing to participate in treatment. DYFS provides the agency with specific problem areas or issues that a family is currently having. Attainable behavioral goals are established in order to empower the client and help resolve the family's issues. Recommendations by the therapists are provided to DYFS to aid their agency in deciding whether to remove children from their families or not.

While the orientation of the agency is a family systems orientation, it does not appear to be theory or concept driven. Most of the therapeutic interventions focused on case

management, and not on behavioral change. Treatment teams visit the families' homes, making sure they have food, heat, etc., and discuss any crisis that occurred during the week. Clients are connected to other community agencies for service needs, such as food, heat, medical care, clothing, furniture, child care or legal counsel. Often, clients are taught how to access these agencies once treatment has terminated. Clients may be taught home economics to help them keep a clean home, manage their money, and pay their bills. Some other services offered include: 1) finding homes for families; 2) helping families fill out paperwork such as, disability papers; 3) providing clients with transportation; and 4) providing clients with goods such as car seats.

Observations of the Primary Therapist

Nine family sessions were observed. While other agency therapists focus on family preservation, this particular therapist primary orientation was case management. The team would visit the homes of the families weekly. During sessions, counseling was reactive in nature. The team would react to clients' immediate needs without the use of a specific theoretical framework. The therapists provided emotional support for the clients, but no cohesive therapeutic approaches were carried out. Therefore, the clients were likely to be empowered. For example, the therapist would listen to the clients, but would not use counseling techniques to motivate clients to change. The therapist mostly provided information on where to find needed services or would resolve the problem for the client. A primary example would be the counseling team arriving at the client's home to find there had been a crisis, such as a family member being removed from the home. The therapist would listen to the client's perspective of what occurred, and then take the

family member out to breakfast. At that time, nothing was further discussed regarding the situation or how to avoid similar events from occurring in the future.

It was typical for the therapist to ask the clients questions, but not to employ counseling techniques to encourage rapport during the exploration stage of treatment. Another example that illustrates the therapist's lack of higher level counseling techniques was an inability to provide insight to the clients so they could begin to understand why changing their behavior was necessary for the family. Clients often believed that there is nothing wrong with them; they believed instead that the problem was with others, such as DYFS, their families, the system, and/or the world. The therapist was unable to make the connection for clients about their behaviors and the consequences of those behaviors, so they could understand their problems, where they came from, or work towards a solution. In addition, a lack of counseling techniques and interviewing skills on the part of the therapist caused for an ineffective intervention. The therapist did not use motivational counseling techniques, such as challenging the clients, use of interpretation, immediacy, or providing insight. A specific example would be a client who is lacking parenting skills reporting that they have tried everything to make their child behave, but nothing works with their child. The therapist never asked the client specific questions, such as: what has worked in the past?, what have you done in the past?, I hear you saying ___ but your behavior indicates ____, do you think it could be because ____?, or I am feeling frustrated that we do not seem to be getting anywhere?.

Specific Treatment Goals

DYFS referred the client, Betty, to this agency because her children were considered to be at risk for placement outside the home as the client's heat and electricity had been cut off. It is important to note that the client's heat and electricity were cut off during the month of February. The client had not paid the heat/gas and electric bills. She had also not paid her rent. DYFS recommended treatment for budgeting/finance and home management.

After an initial interview with Betty, specific goals were established. In order to help achieve each of these goals, objectives were established. Listed below are the goals and objectives for treatment:

1. The client will learn to budget her finances.
 - a) Identify monthly expenses.
 - b) Identify financial priorities.
 - c) Familiarize herself with agencies that will assist her with spending.
 - d) The client will complete weekly expense tracking forms.
 - e) The client will learn to keep her spending within her budget.
2. The client will learn to cope with the loss from the death of her son.
 - a) Identify feelings of loss, sadness, and hopelessness.
 - b) Identify appropriate coping skills to deal with depression.
 - c) The client will keep a weekly journal to help express her emotions and thoughts.
3. The client will learn to communicate and express emotions to her significant other in a positive manner.
 - a) The client will learn "I" statements to express emotions.

- b) The client will learn alternative ways to cope with anger.
- c) The client will set aside time weekly to communicate effectively with her significant other.

During the initial interview, an agency assessment called *Life Domains* was conducted. The intake assessment tool consists of six categories: education, employment, home/family, medical, cultural/spiritual, and special interest/activities. *Life Domains* is a questionnaire that is administered verbally by the therapist. The therapist checks off one of four columns: strength, need, yes/no, or non-applicable. There is an additional column for comments. Because this is a limited assessment tool and does not cover all the areas of a psychosocial assessment, information necessary for diagnosis and selection of intervention approaches was not obtained until two months into treatment. For example, the therapist later learned that the client was persistently re-experiencing her trauma, and that the client was cognitively limited. Unfortunately, due to agency policy, it was too late to change the treatment goals and objectives which were established during the intake interview and *Life Domains* assessment. The results of the *Life Domains* assessment revealed the client's need for budgeting and planning skills, some symptoms of depression, lack of social support, lack of communication skills, and lack of parenting skills. After the initial interview and intake process Betty was given a Global Assessment of Functioning (GAF) score of 50 based on her psychological, social, and occupational functioning. Treatment consisted of no specific theoretical treatment approach. Nonetheless, some cognitive-behavioral techniques were utilized, including establishing goals and treatment objectives.

The client's main purpose in therapy was to work on her financial issues and connect her to community agencies that could provide services if she found herself in the predicament of being unable to pay her bills in the future. The therapist first outlined the client's estimated cost of living expenses, including rent, gas/heat, electric, television, food, clothing, and household goods. The therapist also inquired about income; what are the sources of income, and how much money is received each month. The client was asked to obtain receipts for anything that required her to spend money, including utilities. For example, if she bought a cup of coffee to ask for a receipt. The client did collect some receipts. However, she often forgot and did not provide receipts for new items. Therefore, the therapist never understood where the client's money was being spent. The therapist offered suggestions to the client, such as planning her spending, shopping at different stores, spacing out purchases, and buying needed items only.

Due to the client's lack of social support, the client needed an outlet for her emotions, especially her anger and grief. Therefore, the client was asked to keep a journal of feelings and thoughts. The journal was private, and would not be read by anyone, including the therapist. The client did cooperate in keeping a journal. She expressed to the therapist that the journal helped her from getting upset with her children and significant other. The client did share the journal with the therapist as evidence that she was writing regularly in it, and to show the difference in her hand writing when she was angry, sad, and happy. The journal was an effective tool for Betty. She was able to experience her emotions in a safe and positive manner.

The therapist attempted to work on Betty's relationship with her significant other, Dwain. For example, the therapist gave the client a homework assignment which

consisted of sitting down with Dwain, alone, once a week for an hour and spending enjoyable time together. This could include telling jokes and laughing, talking about nice events, sitting and holding hands, smoking a cigarette together, etc. However, the client would not commit to spending the time alone with Dwain. Another example of the therapist's attempt to work with the client on her relationship with Dwain is the therapist would ask if Dwain could be present during sessions. Dwain did not participate in any sessions, even those which focused on parenting issues. Therefore, the couple never addressed their relationship issues.

Information about the client's progress throughout treatment was obtained from clinical progress notes and observations. Clinical progress notes included assessment reports, progress reports, session notes, and a termination report. The two therapists and the counselor kept individual session notes; therefore, progress was observed and noted by three individuals. Outcomes of treatment were based on observations by the two therapists, and the counselor. There was no testing measure employed to determine the outcomes or progress of treatment. At termination, Betty was given a GAF score of 55 for mild improvement, but more overall functioning. Therefore, due to Betty's inability to complete goals and objectives, improve relationships, employ parenting skills, and care for herself and her family, the treatment was unsuccessful.

Chapter 5

Comparison of Best Practice and Normative Practice

The literature review focused on major depressive disorder, posttraumatic stress disorder, and mild mental retardation because the client met the DSMIV-TR criteria for each of these. According to the literature, the treatment most important for this client is pharmacological treatment; specifically, antidepressants or selective serotonin reuptake inhibitors (Clark, Friedman, & Gershon, 1992; Davidson, 1997; Friedman, Charney, and Deutch, 1995; Grillon, Southwick, and Charney, 1996). Due to limited services provided by this agency, pharmacological treatment was not provided for the client as the literature recommends in treating depression and posttraumatic stress disorder. However, the therapist encouraged the client throughout treatment to be examined by a physician or psychiatrist because antidepressant medications had been an effective treatment for depression in the past for the client.

The literature revealed cognitive-behavioral treatment as an efficacious treatment for depression and posttraumatic stress disorder (Foa, Steketee, & Rothbaum, 1989; Foa & Meadows, 1997; Resick & Schnicke, 1992, 1993; Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998; Beck, et al., 1979; Blackburn & Bishop, 1979, 1980; McLean & Hakstain, 1979; Rush, Beck, Kovacs, & Hollon, 1977). While cognitive-behavioral therapy is a well-structured approach with set criteria, the treatment used for this case was not. Some cognitive-behavioral techniques were used, such as setting goals, homework assignments, and self-monitoring. However, a clear agenda was not

established during each session, and sessions often focused on the immediate needs of the client rather than the specified problem areas. In addition, there were no clear, identifiable measures used during this treatment as required for cognitive-behavioral treatment.

The literature also supported behavior modification with people who had limited intellectual capacity, cultural/familial mental retardation, or mild mental retardation (Derby et al., 1992; Frea & Hughes, 1997; Iwata, Dorsey, Slifer, Bauman, & Richman, 1994; Pace, Ivancic, & Jefferson, 1994; Taylor & Romanczyk, 1994). Unfortunately, no specific behavioral case formulation was established for this client. Once again, techniques may have been derived from the behavioral model, but the model did not serve as the treatment approach for the intervention.

Conclusion

There were no specific measured outcome results. Observations and self-reported statements by the client were used to determine the effectiveness of treatment. Generally, the treatment for this client was substantially ineffective. While the client did learn some techniques to better manage her financial situation, she was not able to meet her goal of learning to budget her finances or the objectives associated with doing so. It would have been more effective to use specific behavioral techniques to modify the clients over spending. The client reported depressive symptom relief at the termination of treatment. The workers additionally observed this. However, the symptom relief likely came from the social support the client received from the therapists, rather than from the treatment itself. A more effective treatment for this client would be for her to take antidepressant

medications in conjunction with psychotherapy, not case management services. Furthermore, the client was never empowered to care for her family and herself, and thus never took responsibility for the problems in her life. For example, based on her previous records, the therapist recommended a psychiatric evaluation for medication or a visit to her physician for antidepressant medication. The client agreed that she needed medications and that they had worked in the past. However, while the therapist did try to facilitate Betty being seen by a physician, Betty did not pursue it, and therefore, she was never seen by a physician or a psychiatrist. In addition, the client did not complete her goals of coping with the loss of her son, and communicating or expressing emotions with her significant other. She also did not achieve the objectives associated with these goals. The client would have benefited greatly from grief counseling. Unfortunately, due to her limited capacity, cognitive-behavioral treatment may not have been effective. At termination of treatment, the client was given a GAF score of 55 because the client made little overall improvement. In fact, the only improvements were evidenced by depressive symptom reduction. Overall, this treatment was seemingly ineffective and could have been better structured if it had employed pharmacological treatment and cognitive-behavioral treatment.

Results of the Study

The results of this single subject study indicate that the treatments used within this study for Major Depressive Disorder, Posttraumatic Stress Disorder and Mild Mental Retardation were ineffective interventions and did not lead to changes in the client's behavior. This indicates that specific methodology and counseling techniques are needed

in order to be successful in the treatment of Major Depressive Disorder, Posttraumatic Stress Disorder and Mild Mental Retardation. The study may have been more effective had the client been stabilized on antidepressant medications and followed a structured treatment approach, such as cognitive-behavioral treatment. While providing social support and case management are important aspects in the treatment of a client with Major Depressive Disorder, Posttraumatic Stress Disorder and Mild Mental Retardation, they are not treatment interventions that will change the client's behavior. Therefore, therapists should follow empirically supported treatment approaches when treating these disorders, using treatment manuals, and specific counseling techniques.

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