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CASE STUDY TO EVALUATE EFFECTIVENESS OF A TREATMENT APPROACH FOR COMORBID ANXIETY AND DEPRESSION

by
Maria Brent

A Thesis

Submitted in partial fulfillment of the requirements of the
Master of Arts Degree
Of
The Graduate School
At
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Approved by_____
Janet Cahill, Ph.D.

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ABSTRACT

Maria Brent
CASE STUDY TO EVALUATE EFFECTIVENESS OF A TREATMENT APPROACH FOR COMORBID ANXIETY AND DEPRESSION
2002
Janet Cahill, Ph.D. and James A Haugh, Ph.D.
Master of Arts in Applied Psychology

This case study evaluates the effectiveness of supportive-expressive therapy combined with aspects of cognitive-behavioral therapy in the treatment of an adult female who has breast cancer and is diagnosed with comorbid Generalized Anxiety Disorder and Major Depressive Disorder. The subject had many psychosocial stressors. The subject voluntarily participated in outpatient individual psychotherapy received in a private counseling facility based on the twelve-step model of Alcoholics Anonymous. She completed various formal assessments of anxiety and depression periodically during the course of treatment, as well as a satisfaction survey following the termination of treatment. The literature review, which explored empirically supported treatments and pharmacological considerations, revealed that assessing styles of anxiety-coping can help in the selection of effective treatment approaches, and that comorbidity generally requires longer treatment. Pharmacotherapy effects and the need for counselor-physician cooperation are described. An overview of the subject's progress is included. Outcome measures were completed, indicating that anxiety and depressive symptoms diminished over the course of treatment. Finally, suggestions for improving treatment are made for future clients who have similar diagnoses.

MINI-ABSTRACT

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This case study evaluates the effectiveness of supportive-expressive therapy combined with aspects of cognitive-behavioral therapy in the treatment of an adult female who has breast cancer and is diagnosed with comorbid Generalized Anxiety Disorder and Major Depressive Disorder. Outcome measures were completed, indicating that anxiety and depression were decreased. Suggestions for improving treatment are made.

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I thank, most of all, my client "Alexa" and her family for allowing me the privilege of working with her for all these months. Their struggles and fortitude have inspired me, and I have learned in every session. Alexa and I have been through a lot together, and neither of us gave up on the other.

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I thank my family and my friends, here or away, living or dead, for loving and encouraging me. I especially thank George, Elisabeth, James, my brother Jim and his wife Charlene, Lindsay, Rose, Aimee, Jason, Urszula, Deanna, Patricia, Mary, David and Barbara, Frances, Maurice, Judi and Rick, Jane and Ed, my sister Helen, and my parents, Theodore and Florine.

And I thank all those generations of people, sitting around the campfires for millennia, telling stories about what it means to be human on this earth of ours---how we get ourselves into emotional trouble and what we have to do to get out of it. I thank the healers who comforted and strengthened the sufferers among us, and taught each subsequent generation the healing ways---the wise old women and shamans, Freud, P. D. Kramer, N. McWilliams, L. Havens, A. Beck, H. Pinsker, I.Yalom, Bowen, H. G. Lerner, Sullivan, Horney, Adler, Young--all the way to the "Can This Marriage Be Saved?" articles that I read as a kid in *The Ladies' Home Journal*. I am thankful to be part of that lineage.

In the depths of winter, I finally learned that within me there lay an invincible summer.

Albert Camus

Table of Contents

List of Tables

Chapter 1

Psychosocial Assessment

Client: Alexa S. (all names changed and identifying information obscured)

Age: 48

Intake Interview: 2001

Source of Information: The client

Identifying Data and Presenting Problems

Depression

Alexa was a 48 year old white woman who stated that she was "having a nervous breakdown" and was "too fatigued" to cope with her clerical job, resulting in her leaving her place of employment in tears the week before, and now being unemployed. Her distress had been increasing over the previous five weeks, she remembered. She described herself as "severely depressed," stating she was not suicidal but that she felt "hopeless" and thought at times she "would be better off dead." Alexa was having difficulty concentrating. Alexa stated, "I can't think straight." Activities that previously were interesting and pleasurable were no longer so. She stated she was not talking to friends as she once had, and that she rarely attended church nowadays even though her Catholic faith was important to her. Caring for her home, once a source of satisfaction, now seemed to be burdensome.

Additionally, she reported difficulty getting to sleep, awakening in the night and being unable to go back to sleep, anger outbursts, mood swings, binge eating, chronic

fatigue, and crying episodes. Alexa related that she spent much of her day secluded in her bedroom, needing to nap or needing to remove herself from distressing family interactions. She also alluded to several areas of her life about which she felt especially guilty: parenting her sons and conflicts with her mother. She stated she felt "overwhelmed" by her family, health, financial, and employment problems.

Anxiety

Alexa also stated that she was "anxious" much of the time, worrying about herself, her mother, and her sons. She noted that she became especially uneasy when away from her home for several hours, feeling that "something might be going wrong there." She was unable to be more explicit about this fear. She denied that she was fearful about herself when away from home, and denied symptoms suggestive of agoraphobia or panic attacks. Although Alexa mentioned having mood swings and being irritable, she denied symptoms suggestive of mania or hypomania.

History of Complaints

Over the past several years, Alexa had suffered stresses and losses: the break up of her marriage, the diagnosis of cancer, and the loss of her best friend, for whom her husband had left her and subsequently married. Additionally, her sons were growing up, beginning to make their way in the adult world, and encountering difficulties brought on by their immature and risk-taking behavior.

Alexa reported that until recently, she considered herself "emotionally very strong," stating that she had at times felt sad in the past, but had never experienced this sense of hopelessness before. Two years previously, her marriage had ended in divorce. One year ago she had been diagnosed as having breast cancer, and had a mastectomy,

chemotherapy, and radiation. She also had reconstructive surgery that seemed to be failing: the surgical site was infected and draining. She felt she "could not put cancer behind her" until she healed and her physical appearance had "returned to normal." Still, she had thought she was physically and emotionally able to return to work even though she still was contending with the draining wound.

However, Alexa found that she could not concentrate on her job duties and that she did not have enough energy to function at work. She reported that her "bad feelings" had become progressively worse over the past month. She had left her job in tears and was no longer employed. She stated she was feeling increasingly hopeless and powerless. Her family doctor had prescribed Prozac and Xanax the week before her intake interview. She felt no improvement in mood, but reported that taking the Xanax decreased her irritability somewhat and relieved some of her anxiety.

A major stressor for Alexa was her relationship with her former husband. Over the past several years, she had assumed that she, her ex-husband, and his new wife could maintain friendly relations and be supportive of each other. His new wife had been her best friend. But now Alexa had begun to feel angry toward her ex-husband and his new wife, resenting that she was struggling financially when they were not. She stated they "looked down" on her and belittled her difficulties. Also, she was growing angrier about receiving little support from her ex-husband in parenting their sons. Even so, she also admitted that she often felt she was still in love with her ex-husband and was lonely for him. And, she felt bereft of the friendship she had enjoyed with the woman whom her ex-husband had married.

Another of Alexa's deep concerns pertained to the emotional well-being and behaviors of her young adult sons. They demonstrated irresponsibility in their work and spending habits. Further, they were angry toward their father for divorcing Alexa and for not being more financially supportive of them, and the animosity they felt for their father concerned Alexa. She felt that she and her former husband had many shortcomings as parents, and that they had not prepared their sons to be self-reliant. Additionally, Alexa described being in conflict with her elderly mother about guiding and disciplining the sons. Further, she was concerned about how her cancer diagnosis had affected them. She worried that they were frightened about her health and that they had difficulty discussing their fears.

Indeed, the habitual interactions of the sons, Alexa, and her mother were conflicted and tumultuous. Later in therapy, Alexa admitted that both sons regularly used illegal substances and that her older son drank to excess and gambled.

In addition to her current feelings of hopelessness, failure and guilt, she recounted life-long tendencies of pleasing others at the expense of herself. This concern about meeting the expectations of others had affected her family relationships, her employment, and her financial stability. She recounted that her ex-husband often spent to excess, but that she could not bring herself to oppose his behavior, fearing his angry response. She related feeling uneasy as a schoolgirl and as a worker, afraid that she could not perform well enough to please her teachers and employers. It seemed that Alexa had a long history of worrying, beginning when she was a child.

Appearance, Sensorium, Affect, and Language

Alexa appeared distraught, sad, fatigued, and tense. She was slightly overweight and her posture was slumped. She fidgeted and plucked at her clothing. She was neat and clean, simply groomed, wearing an oversized shirt that obscured her mastectomy site. Her hair was extremely short, appearing to be the first growth after chemotherapy-induced alopecia. Her face was puffy and pale, and she was not wearing make up or jewelry. Her facial muscles drooped, making her appear older than her actual age. Her manner suggested a desire to please as exemplified by readily responding to the interviewer's questions, and by her apologetic tone and self-blaming statements.

Her speech was fluent and expressive. Its somber content was appropriate to her mood and circumstances. She was self-disclosing, and tended to include extra information in an effort to explain the background, thoughts, and feelings of herself and significant others. She was cooperative, responsive, and volunteered details. Alexa seemed to have a normal fund of knowledge and information, and did not exhibit disordered thought or perceptual processes.

Household Composition

Alexa lived in three-bedroom condominium with her mother, her sons, and their dog, Milly. Her mother Valerie slept in the living room because there was no bedroom for her. She and her mother began living together after Alexa's husband left her, 2 years before. At the time of the initial intake interview, Valerie at age 77 was healthy, energetic, and continued to work sporadically: taking care of the elderly, walking dogs, and helping out at their friends' bowling alley. Alexa stated that she often stayed in her bedroom so as to give her mother some privacy and to seclude herself from family

conflicts. Before the divorce, Alexa had lived in her own house with her husband and their teenaged sons.

Developmental and Early Social Histories

As far as Alexa knew, she was the product of a normal pregnancy. She met the usual infant and childhood developmental milestones. She had been generally healthy and active as a child. Alexa's menarche occurred when she was 10. She had not been told about menstruation, and remembered being alarmed. Her mother then did explain to her what menstruation was.

Alexa remembered being ridiculed by some of her classmates during her elementary school years, and being "self-conscious" about her appearance. She recounted distressful feelings of being unsure if she could meet the expectations he believed that others, especially authority figures, had about her. She attended Catholic school until she graduated. She reported being dutiful and well behaved in school. Alexa stated that she did have friends in school, but school itself was not rewarding. She enjoyed the business classes. Her mother offered to pay for Alexa to go to nursing school, but Alexa chose instead to go to work in an office because she planned to marry. She stated she also doubted her ability to be academically successful in nursing school.

Early Family Life and Relationships

Alexa was born in 1952 in Camden, NJ, to Valerie, a homemaker, and Mike, who had a shoe repair business. She had one brother, John, 4 years older. She described her parents' marriage as happy. Initially, she described Mike, born to Italian parents, as "a wonderful father" who enjoyed his children, was a good listener, the one she would go to with her problems, and easier going than her mother. She stated her personality

was much like her father's, "quiet and patient." Later in therapy, she described her father as "weak," adding that she had never told anyone before she felt this way about him, and that he tended to "pamper himself." When Alexa was 17, her father had a heart attack and became disabled. He died of lung cancer when she was 37. She noted that she identified with her father in terms of her health because of her bout with cancer and her current physical and mental difficulties.

Her mother, Valerie, born in Canada to English parents, went to work fulltime when Alexa was 8. Valerie's father considered her "the boy he never had" and Alexa reported that Valerie had "good feelings" about her father. Valerie's mother also was "strong and energetic." She reported that Valerie is close to her siblings.

Alexa's brother, John, was four years older. When they were children, her brother would tease her for being overweight. When she and her brother would not stop fighting, their father would threaten to take off his belt to hit them, but he rarely did. She stated that their mother waited on John when he was a child as she continued to wait on her grandchildren---laying out their clothes, starting their showers, helping them financially as she was able. Alexa noted, "I was brought up to wait on men." John was actively addicted to heroin from his late teens through his 20s. His parents repeatedly sought treatment for him.

Her mother went to work fulltime when Alexa was 8. She remembered feeling lonely for her mother and uncomfortable around her impatient and quick-tempered paternal grandmother who took care of her and her brother after school. She stated that there was on-going conflict between her mother and her paternal grandmother. After

her father died, her mother and she became estranged from her father's family. She also remembered that her family had to move several times due to financial difficulties.

When asked about any upsetting events during her childhood, she remembered that each evening she would become frightened watching the news about the war in Vietnam. She would cover her head with a pillow to block out the sight and sound of the TV, but she would not leave the room because she wanted to be close to her parents. "I worried that the war would be coming here." In 1964, the year that the fighting escalated and war news was seen nightly on TV, Alexa was 12 years old.

Current Family Relationships: Marriages, Children, and In-Laws

When Alexa was 15, she met Rick, then 17, at school. It was with Rick that she had her first sexual experiences at age 18. They married when she was 21, and divorced two years later because she found out he was having an affair. There were no children. When she was 24, Alexa married Greg. She described their relationship as "fun and exciting" until their sons were born when she was 27 and 30. Then, she reported that Greg appeared to be resentful of the attention she gave their children. He tended to run up debts and to switch jobs frequently. She went back to work when her sons entered elementary school in part because her husband quit his job without warning. She described Greg as temperamental and as tending to blame Alexa whenever there were problems. At times, she said, he would seem very moody and irritable. He tended to compete with his children for attention, and his behavior towards them was erratic---sometimes generous and caring, but often harsh and short-tempered, especially with their younger son, Tom, who had learning disabilities. Greg also consumed alcohol heavily. Later in their marriage, Greg underwent treatment for alcoholism and stopped

drinking. Alexa stated that she tried not to upset her husband and that she tried to compensate emotionally for what their father did not give their sons. Later in therapy, Alexa announced that Greg, at the prompting of his new wife, had sought therapy and was diagnosed as having a bi-polar disorder.

Alexa and her mother were close to Alexa's in-laws, Edith and Gus. She described Edith as "an angel" who was the peacemaker between Gus and Greg. Gus was verbally abusive, and habitually used obscene epithets towards his son.

Despite having frequent emotionally rough times, Alexa expected their marriage to last. However, when she was 45 and the boys were adolescents, her husband left her for her best friend, Diana. Alexa and Greg had been close to Diana and her husband. Subsequent to the breakup, Diana's first husband suddenly died. Alexa and her sons suffered tremendous change and loss. They were close to Diana and her first husband and their children. Suddenly, the constellation of the four adults was rearranged: two divorces, one death, and one remarriage.

Alexa remained emotionally involved with her former husband and his wife. At the time she began therapy they saw each other at least weekly to discuss their sons and household matters. Alexa reported that she bore anger towards Greg and Diana because they were financially much better off than she and tended to treat her as if she were foolish with money. Also, Alexa believed that Diana influenced Greg to become harsher with his sons about finances without becoming more emotional supportive and nurturing. She also felt he was overly critical and sarcastic. Additionally, Alexa often felt she was still in love with Greg and believed that he regretted leaving the marriage.

Alexa maintained her relationships with her former in-laws. She stated they continued to consider her part of their family. When therapy began, Valerie and Alexa visited Alexa's former elderly in-laws daily, providing physical care for Alexa's former mother-in-law who was disabled. Her former father-in-law had recently given Alexa financial help. She stated that she felt obligated to help her former in-laws because she loved them and because they had given her money. Also, she said, her former father-in-law, Gus, was demanding and often verbally abusive, and could not get other caregivers to stay. Alexa said that she felt as if she were "walking on eggs" when in the company of her former father-in-law because of his explosive temper. She noted that Greg and Bob also had explosive tempers, and that being around these men made her "nervous."

Alexa also was concerned about her sons. Neither has graduated from high school. The older son, Bob, 21, had a verbally explosive temper and did not manage his money well. She was worried that he would be fired from his job because of his temper and because of frequent absences. Her conversations with him about his work habits frequently resulted in angry exchanges. She stated that Bob refused to talk about her about having cancer. He did not pay any rent or board. Alexa stated that she would like him to help pay towards his living expenses, but she did not feel she could expect him to. She worried that he may also develop bi-polar disorder and become an alcoholic, as his personality greatly resembled his father's. Bob had not been psychiatrically evaluated, and opposed the suggestion, she said. Alexa stated she spent a lot of time alone in her bedroom, feeling anxious and miserable, avoiding the company of her older son.

Her younger son, Tom, 18, had learning disabilities and was "shy." She said that he was afraid to apply for a fulltime job. At the time of the initial interview he was employed part time by family friends who run a bowling alley. She described Tom as having "an easier personality" than his older brother, and more willing to talk about his feelings. He also did not contribute to the household income.

Both sons, in fact, frequently asked their mother for spending money. She felt that she needed to give them money since, before the divorce, they were regularly given money and presents. Now, she said, their father rarely gave them money or gifts and spoke harshly to them when they ask for financial help. Alexa was concerned that her sons expressed much anger towards their father for the breakup of the marriage and for their financial difficulties. She repeated that she and the boys' father "created monsters" by indulging them materially, and that she felt at fault for her sons' shortcomings.

Later in therapy, Alexa stated that both sons use marijuana regularly and that her older son sometimes used cocaine, drank excessively, and gambled. Alexa stated that she felt it was OK for her sons to use marijuana for the comfort it afforded them because "it is natural, not man-made." She was distressed about her older son's drinking, cocaine use, and gambling.

Alexa's 77-year old mother, Valerie, lived with her. Alexa and Valerie attempted to meet their expenses by pooling their incomes. She described her mother as energetic and supportive, but sometimes controlling. Valerie tended to "overfunction" for her grandsons. She fretted about the boys getting to work on time. Each morning, she would start the shower running for her grandsons, and on cold days, she would start their cars. She gave them extra spending money when she could. She tended to ignore

Alexa's ideas about raising her sons, especially about them taking more responsibility for their own actions and choices. Often Alexa would spend most of the day in her bedroom, retreating from family interactions and providing Valerie and herself some distance from each other. Alexa seemed to love her mother dearly, but also was quite resentful of her undercutting Alexa's attempts to discipline the boys and to expect them to be more responsible for their actions. Additionally, Alexa was distressed when she thought about her mother's health and death, knowing that at age 77, health can easily become precarious.

Alexa had not felt close to her brother John and voiced resentment for the years of difficulty he caused the family when he was using heroin. She described him as "harsh, judgmental, and critical," especially of her sons, and stated his outspokenness resembled her mother's. She noted that, with age, she and her brother were becoming closer in part because they both anticipate the death of their mother. When Valerie dies, Alexa and John will be the only original family left. Her brother contracted hepatitis C, but has responded well to medical therapy. Alexa expressed concern for him even as she remained resentful about the trouble he caused everyone when he was using drugs.

Drugs, Alcohol, or Other Addictive Behaviors

When she began therapy, Alexa used no illegal drugs, alcohol, or cigarettes. However, her family doctor had prescribed Xanax for her anxiety and Vicoden for back and surgical pain. Over time, she reported that she became addicted to the Xanax and Vicoden. She discussed her dependence on these medications. Alexa once became extremely distraught when attempting to talk to her older son and took "six or seven" Xanax tablets at once ("I took whatever fell into my hand. I didn't take all the pills in

the bottle. I didn't want to die---I was just very upset and wanted to feel better"). When informed of her overdose, her physician suddenly stopped her use of both Xanax and Vicoden. At that time she began smoking cigarettes, resuming a habit she had stopped many years before. She remarked that she needed the comfort of cigarettes. Both Alexa and her former husband used marijuana in their late teens and 20s. Her former husband is an alcoholic in recovery. She reported that her parents did not drink to excess or use drugs. She also reported that her brother was addicted to heroin.

Medical and Psychiatric History

A year after the break up of her marriage, Alexa was diagnosed with breast cancer and had a mastectomy followed by chemotherapy and radiation. Adriamycin and Cytoxan, the drugs she received, have multiple debilitating side effects on the body's energy levels and immune system, and cause all body hair to fall out. She had reconstructive surgery that was unsuccessful, resulting in constant drainage from the surgical wound that did not heal. She stated that caring for this wound made her feel as if she would never heal, that she felt disfigured, and that until she had successful reconstructive surgery she cannot "put cancer behind her." She also reported intermittent, chronic back pain, pain at the surgical site, trouble with urinary urgency, and continuing marked fatigue that began during chemotherapy.

Throughout her therapy, Alexa continued to need medical care and testing to determine if cancer was elsewhere in her body. She also had breast reconstructive surgery again. Alexa had a "lat flap" surgical breast reconstruction. In this procedure a back muscle is used to form a new breast. Also, a small implant was required.

Subsequently, the implant became infected, and Alexa again had to have surgery remove it.

Alexa had no psychiatric history and described herself as healthy, albeit anxiety-prone, until her diagnosis of cancer. The rigors of chemotherapy could have contributed to her feelings of pronounced fatigue. She also had urinary difficulties that may have been aggravated by hormonal medication therapy for cancer treatment.

At the time of the initial interview she was prescribed and was taking:

1). Tamoxifen, an anticancer medication that affects estrogen.

2). Ditropan, a urinary bladder antispasmodic.

3). Lipitor, which helps to reduce cholesterol serum levels.

4). Vicodin as needed every 6 hours for chronic back pain and pain related to breast surgery.

5). Prozac, increased to 30 mg. daily two weeks before her initial interview. Prozac is an SSRI antidepressant.

6.) Xanax, 0.50 mg, four times each day. Xanax , a fast-acting benzodiazapine, is prescribed for anxiety

Employment History

Alexa had worked since she was a teenager and continued to work throughout her marriage. She described herself as having been concerned about meeting the approval of others since she was a child, and that she often felt uneasy about whether her employers were satisfied with her work. She stated that she has not enjoyed the clerical jobs she has had, and had hoped to do some other kind of work. Her last job had ended a few weeks before treatment began when she became too distraught to continue

working. Also, she and other family members have worked part time for friends who run a bowling alley.

Other Agency Involvement

Alexa had had no involvement with any other mental health agencies. She had applied for and received municipal welfare. She also had applied for Social Security Disability.

Social Supports

Alexa was supported by her family and ex-family members to varying extents. She also had a few close friends. Alexa had casual involvement in her church. Her family physician and his office have been especially supportive of Alexa. She had not been involved in any therapy before, nor had she joined any support groups for those who have cancer. Over all, she seemed to have a medium level of support.

Situational Stressors

Alexa had many situational stressors:

1) Various health problems, including cancer, a draining wound, disfiguring surgery, chronic back pain, and bladder dysfunction
2) Financial troubles and debt
3) Living in close quarters with her elderly mother who seemed to be controlling and with two sons who seemed to have irresponsible work habits and used illegal substances
4) Transportation difficulties
5) Continued close and conflicted involvement with her ex-husband and his family
6) Unemployment and uncertainty about her job future

Coping Mechanisms

Alexa demonstrated a number of interpersonal strengths. She was compassionate and consistently willing to help others. She was of capable of loving family and friends. She was assertive in getting the help she and her sons have needed, and followed through with tasks and paperwork in a purposeful and organized fashion. She behaved with integrity and generally accepted responsibility for her own behavior and choices. Despite her on-going fatigue, she was active and goal-directed, and demonstrated common sense. She availed herself of medical care and had completed the arduous and lengthy treatment for breast cancer. Alexa wanted to get better and to understand more fully herself and those important to her.

Dysfunctional Coping Mechanisms

Alexa also demonstrated a number of dysfunctional coping mechanisms, including altruism, repression, rationalization, and introjection She tended to be concerned with meeting the needs of others, even at her own expense (altruism). Alexa also tended to underplay the threat to her health that her cancer diagnosis posed. She also described blunted reactions when her husband left her. These reactions connote coping via repression. She tended to employ rationalizations to defend or excuse irresponsible and emotionally abusive the behaviors of those she cares about. She also tended to excuse herself for going along with choices that she herself would not be inclined to make. Alexa habitually attempted and continued to try to ameliorate or forestall the painful consequences of others' behavior, especially of her ex-husband and sons. Alexa also seemed to have introjected the overly critical and unkind attitudes she experienced as a child and consequently tended to blame herself when things would go wrong. She

blamed herself for the failings of others. She seemed to have low self-esteem and deep, pervasive feelings of shame and guilt.

Summary

Alexa was a 48-year-old divorced Caucasian, woman troubled with depression and anxiety. Her depression and anxiety appear to be a result of numerous stressors she was experiencing, including serious health, family, relationship, and financial difficulties. She lived with her mother and two young adult sons. She sought therapy when depression and anxiety so distressed her that she was unable to work. Her history suggested that Alexa had been troubled by anxiety since childhood. Alexa also seemed to have low self-esteem. She tended to blame herself for her own problems as well as for the problems of others. It also seemed that she and her mother tended to overfunction for the men in their family. Alexa seemed to have great difficulty setting and enforcing rules for her two sons. Also, there were patterns of drug and alcohol abuse in her family of origin, her marriage, and her current family.

Chapter 2

Differential Diagnosis

The following diagnoses were made concerning Alexa's emotional difficulties:

Axis I 296.22

Major Depressive Disorder, Single Episode of Moderate Severity

Axis I 300.02

Generalized Anxiety Disorder

Axis II V71.09

No Diagnosis

Axis III General Medical Conditions

1. Breast cancer
2. Antineoplastic chemotherapy: cytotoxins & anti-estrogenic medication
3. Multiple surgeries: mastectomy, failed implant surgery
4. Infected surgical wounds
5. On-going medical diagnostic testing
6. Chronic back pain
7. Deceased urinary bladder control

Axis IV Psychosocial and Environmental Problems

1. Family discord
2. Divorce
3. Parenting Issues

4. Unemployment

5. Poverty

Axis V Global Assessment of Functioning = 52 at intake

Discussion of Diagnoses

The DSM-IV Axis I Disorders of Mood, Anxiety, and Adjustment needed to be considered for Alexa. It was difficult to tease out each of these from the others because anxiety can be one of the symptoms of depression and because depression and anxiety are features of adjustment disorder, and depression can be a feature of anxiety.

Alexa exhibited 7 of the 9 symptoms of Criterion A for Major Depressive Episode. Five or more symptoms must have been present for at least two weeks, there must be a change from previous functioning, and one of these symptoms must be depressed mood or loss of interest or pleasure. She described herself as "severely depressed," "hopeless," having difficulties concentrating, and having insomnia. Alexa also reported being fatigued and having a markedly diminished interest in daily activities. Psychomotor agitation was obvious in the initial interview, as were her frequent references to feelings of excessive and inappropriate guilt. These symptoms began at least 5 weeks prior to seeking therapy. She denied being suicidal, although she stated that sometimes she felt she would be better off dead. It is important to remember that her family physician prescribed Prozac, 30 mg, for Alexa several weeks before she sought therapy. This medication may have moderated the severity of her depressive symptoms.

In addition to her symptom picture being consistent with a major depressive episode, Alexa also met the remaining criterion for Major Depressive Disorder.

Although Alexa reported mood swings, she appeared to have no symptoms suggestive of hypomania or mania currently or in the past. Therefore, her condition met Criterion B for Major Depressive Disorder because a diagnosis of Mixed Episode could be ruled out. Criterion C was met because Alexa was in significant distress and experienced occupational impairment, impairment in her family interactions, and impairment in maintaining her friendships. She met Criterion D because her symptoms were not due to a direct physiological effect of previous drug usage or medical condition. However, it was possible that she was still suffering from the debilitating effects, especially fatigue, of Adriamycin, Cytoxan, and Taxol, even though chemotherapy had ended months before. And, Alexa's symptoms met Criterion E in that they were not better accounted for by Bereavement. Her marriage had ended 2 years before and although grief and shock can be part of the reaction to a cancer diagnosis, her diagnosis had occurred a year previously.

Alexa's account of her life contains much evidence of on-going anxiety that pre-dated her Major Depressive Episode. Her worries and fears about of the Vietnam War when she was a young teenager are an example. Also, she related that when employed she was constantly preoccupied about the opinions of her bosses, fearing that she couldn't meet their expectations. At the time of seeking therapy, Alexa expressed many worries, some concerning the practicalities of living, and others concerning her interactions with families and neighbors, even being reluctant to say hello to casual acquaintances for fear of what they might think of her.

She met the diagnostic criteria A through F for Generalized Anxiety Disorder (GAD). Social Phobia was ruled out, despite her reluctance to interact with her

neighbors, because Alexa did maintain friendships and was able to venture out for appointments and could interact with officials as needed. She experienced no panic attacks. She was not subject to obsessive thoughts that would indicate Obsessive-Compulsive Disorder. She did not have flashbacks that would suggest PTSD. Yet, her anxieties did affect many aspects of her life and caused her much distress.

Alexa's level of anxiety might have been heightened by the effects of the Xanax prescribed by her family physician just before Alexa sought therapy. This anxiolytic medication is extremely short-acting, and when the effects wear off, the rebounding of anxiety, and the fear of the rebound, can result in higher anxiety levels. On several occasions, Alexa took more Xanax than prescribed in an effort to decrease her anxiety when she was especially upset. It was difficult to know how much of her anxiety was endogenous and how much iatrogenic. However, the diagnosis was given because her history and the severity of her symptoms.

Another diagnostic category review was Adjustment Disorder. Alexa had several identifiable psychosocial stressors: divorce, cancer, and serious financial problems. She also had ongoing concerns about her adult sons' abilities to meet their responsibilities. Yet her emotional difficulties have a chronicity and pervasiveness that seem to be outside of the parameters of this diagnosis.

It could be argued that her identifiable psychosocial stressors were so numerous and strong that her reactions were not in excess of what would be expected. If so, her condition fails to meet Criterion A. But she did meet Criterion B in that her symptoms did significantly impair occupational functioning. The Adjustment Disorder Diagnosis for Alexa seemed to hinge on whether her pattern of symptoms could be entirely

accounted for by her other Axis I diagnoses, Major Depressive Disorder and Generalized Anxiety Disorder. Certainly much of it can.

Still, we must not downplay the effects of the multiple stressors on Alexa, especially since they were chronic and pertained to major parts of her life: health, economic status, employment, family of origin and parenting. These multiple stressors are listed on Axes III and IV. In addition, it is common for a major depressive disorder to have its onset in relation to stressors, especially those related to loss (e.g., breast cancer, maritial break-up, etc.).

Alexa's functioning was assessed at 52 on the Global Assessment of Functioning Scale (Axis V) because of her serious occupational impairment due to her emotional distress. She also was impaired vocationally because of her physical ailments. Overall, she seemed to have moderate to serious impairment and distress related to interpersonal functioning with her family, and in her relationship with herself.

Chapter 3

Literature Review

Literature concerning the treatment modalities for anxiety, depression and their co-morbidity is reviewed. Empirically supported psychotherapy treatments are emphasized. Pharmacological treatments are also reviewed. Adjunctive therapies--relaxation, meditation, and exercise--are also reviewed. A major focus of the literature review is the treatment of emotional distresses related to having cancer. Then, articles are reviewed pertinent to the selection of treatments most likely to be effective for Alexa.

Generalized Anxiety Disorder

Generalized Anxiety Disorder (GAD) has a lifetime prevalence rate estimated at 5% (DSM – IV, 1994, p.434). It may affect 10% of women over the age of 40 (Wittchen and Hoyer, 2001). GAD is chronic, fluctuating disorder, exacerbated by stress. It is often co-morbid with depression, and often as debilitating. GAD adversely affects work, personal relationships, and physical health. Half of those presenting with this condition experienced its onset before adulthood (DSM – IV), and only 1/3 are likely to experience spontaneous complete remission (Wittchen & Hoyer, 2001).

There is evidence that generalized anxiety disorder is trait-stable. Lydiard (2000) noted that anxious patients often report somatic difficulties even when they do not complain about emotional distresses. Borkovic & Costello (1993) described GAD patients as being stuck in a chronic condition of multisystemic interactions, including

physiological, affective, and behavioral, that tend to be inflexible and predispose these individuals habitually to respond defensively and anxiously. These anxious responses tend to become stronger and more frequent with repetition, rendering them more ego-syntonic. Ego-syntonic responses tend to be more difficult to treat than ego-dystonic responses (McWilliams, 1994, p. 26).

Treatment Modalities for GAD: Psychotherapy, Applied Relaxation, and Meditation

The main treatment modalities for GAD are psychotherapy, pharmacotherapy, and related therapies, including relaxation and meditation. Cognitive behavioral approaches as well as others have been somewhat successful. Matheny, Brack, McCarthy, and Penick (1996) reported on a meta-analysis of therapies for stress-related disorders of anxiety and depression, but not specifically for GAD, and concluded that cognitive behavioral therapies and other psychotherapies tend to have similar success rates. Supportive-expressive therapy also has shown some success in treating GAD specifically. For example, in a study of 26 clients diagnosed with GAD, the average Beck Anxiety Inventory score decreased from a mean of 21.5 (SD 7.1) at intake to a mean of 7.4 (SD 8.1) after 26 weeks of treatment (Crits-Christoph. & Connelly, 1996). However, a sizable number are not helped significantly by either CBT or S-E therapies. In a review article, DeRubeis and Crits-Cristoph (1998) noted that in 3 studies of cognitive behavioral therapy, on average, 56% of patients were in the normative range at the end of treatment. Three to 6 months after treatment ended, 59% were in the normative range. The assessment tools were not specified. So, fully 40% of patients participating in these studies were not helped sufficiently by cognitive-behavioral therapy. Crits-Cristoph and Connelly (1996) reported that 79% of patients

(n=26) treated with supportive-expressive therapy improved enough that they no longer qualified for a GAD diagnosis at the termination of a 16-week treatment protocol. Assessment tools included the Beck Anxiety Inventory, The Beck Depression Inventory, The Hamilton Anxiety Rating Scale, The Hamilton Depression Rating Scale, as well as others. Again, at least 20% of those treated still met the criteria for GAD at the conclusion of treatment. This study and others show than supportive-expressive therapy is effective for many who have GAD, but not for everyone. But, of the two, it appears S-E may be more effective.

A meta-analysis of empirically supported therapies for GAD was undertaken by Westen and Morrison (2001). Criteria for inclusion were strict: "a study had to test the efficacy of a specific psychosocial treatment against a waiting-list control condition, an alternative psychotherapy, a pharmacotherapy, or some combination of these." Each study had to meet minimal criteria for randomized controlled trials. At least one assessment had to be done after 12 months. The therapies had to be guided by practice manuals to keep each study condition as pure as possible. Weston and Morrison reported that in the 5 studies done from 1990 and 1998 that met their criteria for inclusion, the percent of subjects who improved ranged from 24 (cognitive-behavioral therapy) to 79 (brief supportive/expressive therapy; see Crits-Christoph and Connelly, 1996). One study (Borkovic & Costello, 1993) included a follow-up assessment at 12 months, but not later. Since no later assessments were done, Westen and Morrison conclude the no mode of therapy has been proved to effective over the long term. (It is of course possible that various therapies would have shown efficacy had long-term follow-up assessements been done.).Durham, Fisher, Treliving, Hau, Richard, and

Stewart (1999), included in Westen and Morrison's meta-analysis, did complete a follow up assessment at 12 months that was not included in the meta-analysis. The 12-month post assessment showed that the clients treated with cognitive therapy (n=16) had less anxiety than those treated with analytic psychotherapy (n=15). Outcome measures included self-report, the Brief Symptom Inventory, and the State-Trait Anxiety Inventory. Fifty percent of subjects treated with cognitive therapy rated their improvement as "very considerable, " but only 36% of those receiving analytic therapy were able to give the same rating. However, there seemed to have been a great difference in the quality of client-therapist alliance between these two groups. Only 3% in the analytic therapy responded that they "got on" with their therapist extremely well. In the cognitive therapy, 11% stated they got on extremely well.

Applied Relaxation

Borkovic and Costello (1993) compared cognitive, applied relaxation, and non-directive therapies in the treatment of GAD using 66 adults meeting their criteria and randomly assigned to each treatment condition. On the Hamilton Anxiety Rating Scale, the nondirective therapy pre-treatment mean was 19.7 (SD 4.3) and the 12-month follow-up mean was 8.9 (SD 7.7); for cognitive behavioral therapy the means were 19.4 (SD 5.4) and 5.2 (SD 4.9), respectively; for applied relaxation the means were 20.8 (SD 4.0) and 7.4 (SD 6.8), respectively. The cognitive and applied relaxation treatment conditions were more effective than the non-directive. Still, the authors noted that only one-third of subjects in the relaxation treatment condition and only about one-half in the cognitive treatment condition demonstrated adequate improvement at the 12-month follow up.

Ost and Breitholtz (2000) also compared applied relaxation and cognitive therapy in the treatment of GAD. In their study, 50-60% in both treatment conditions were clinically improved at the end of treatment and maintained this improvement at the 1-year follow-up. However, the dropout rate was more than double for the applied relaxation group compared to the cognitive group (12% to 5%, respectively). And, 40-50% of subjects were not clinically improved by the use of either method.

Meditation

Meditation has also been used to treat anxiety. Miller, Fletcher, and Kabat-Zinn (1995) treated 22 medical patients who met the DSM-III-R criteria for GAD or Panic Disorder with an 8-week program of stress reduction interventions based on mindfulness meditation. Mindfulness meditation was described as various formal and informal practices including hatha yoga and sitting meditation. Each subject was required to devote 45 minutes each day to doing mindfulness meditation. Post-intervention and 3-month follow-ups showed significant improvement. A 3-year follow-up was also done, showing that the majority of the subjects remained compliant in their meditation practices and that they had even greater reductions in their scores on the Hamilton Rating Scale for Anxiety .The pre-treatment mean was 25.65 (SD 11.19) and the 3-year follow-up mean was 17.24 (SD 9.73). On the Beck Anxiety Inventory, the pre-treatment mean was 21.41 (SD 12.61) and the 3-year follow-up mean was 11.35 (SD 10.3). Improvements were seen in depression scores also: the pre-treatment mean on the Beck Depression Inventory was 15.18 (SD 9.32) and the 3-year follow-up mean was 7.29 (SD 7.47). The standard deviations were quite wide in all the measurements, denoting much variability of scores for individuals, indicating that even though some

subjects realized great improvement, others did not. Also, the demographics of subjects were not included in this article, and there was no control or comparison group. Therefore, the results of this study must be interpreted with caution.

Summary of Treatment Modalities for GAD: Psychotherapy, Applied Relaxation, and Meditation

All three of these modalities have demonstrated some success for treating GAD. Cognitive and supportive-expressive therapies were found to be more efficacious than non-directive therapy. Applied relaxation also resulted in improvements. Even so, many dropped out and good proportions of subjects were not significantly better. The meditation study demonstrated remarkable success with 22 medical students; it remains to be seen, however, if this success can be replicated in other populations. In addition, there is the possibility that various combinations of these treatments may be more effective than any done alone And, more work needs to be done to delineate which individual characteristics of those with GAD might make one treatment more or less successful.

Treatment Modality for GAD: Psychopharmacology

Medications are used in the treatment of anxiety and anxiety disorders, including GAD. Current medications used include the benzodiazepines (e.g., Xanax, Ativan, and Klonopin), buspirone (BuSpar), and some of the selective serotonin reuptake inhibitors (SSRIs). Other medications include the tricyclic antidepressants, barbiturates, antipsychotics, and antihistamines, such as atarax (Vistaril). The tricyclics have demonstrated greater effectiveness than the benzodiazepines, but can have side effects ranging from uncomfortable, such as dry mouth, to intolerable, including cardiac

and blood pressure effects, weight gain, sedation, and agitation (Gitlin, 1996, pp.303-307).

Lydiard, Brawman-Mintzer and Ballenger, (1996), reviewed studies of GAD patients in a double-blind experiments testing the effectiveness of benzodiazepines and tricyclics Both classes drugs were effective anxiolytics, but the tricyclics were superior in decreasing depression, interpersonal sensitivity, and obsessionality. However, subjects taking the tricyclics had unspecified side effects intolerable enough to cause them to drop out.

Barbiturates have pronounced drawbacks, including troublesome and dangerous side effects. Barbiturates are sedating, addictive, and have a narrow safe range. Overdose readily causes respiratory arrest and death (Gitlin, 1996; Julien, 2001; Loebl, Spratto & Woods, 1994).

Lydiard (2000) cautioned against using the benzodiazepines alone as well as their use in general because of they are addictive and cause physiological dependence. Since GAD tends to be chronic, clients may require medication over a long time. Hoehn-Saric (1998) noted that the specific pharmacologic treatment of GAD depends on the severity of symptoms. He concluded that if benzodiazepines must be resorted to for immediate relief, it is beneficial to use the longer-acting ones, such as clonazepam (Klonopin), rather than those with short half-lives (e.g., Ativan and Xanax). He stated that the benzodiazepines should be reserved for those who do not respond to other medications.

Gorman (2002), in a review article, stated that several studies have shown that the benzodiazepines are effective only in about 60% of patients and that after 4 to 6

weeks of treatment they are no more effective than placebos. Discontinuing benzodiazepines is a lengthy and uncomfortable process during which the client is at risk for seizures and a rebounding of anxiety symptoms (Gitlin, 1996, pp. 364-372).

Lydiard (2002), in an overview of treatments for GAD, wrote that buspirone, in adequate doses (at least 30 to 60 mg/day), has been shown to be as effective as the benzodiazepines, although response to this drug tends to be gradual, occurring over several weeks. Buspirone has few side effects (Gitlin, 1996, p375-376).

The selective serotonin-norepinephrine reuptake inhibitor venlafaxine (Effexor) has been studied for treating GAD. Johnson, Crawford, Naresh, Lydiard, and Villareal (1998) found it to be effective in symptom reduction. But side effects, including gastro-intestinal and sexual dysfunctions, resulted in nearly half of the subjects discontinuing the medication even though side effects tend to subside over time.

Gorman (2002), however, reported that in another study of venlafaxine, only 43 % attained remission of symptoms, although 66% responded positively. Mirtazapine, also affecting both serotonin and norepinephrine availability, seems to have a beneficial effect on anxiety symptoms (Harmann, 1999). Citalopram (Celexa), an SSRI, ameliorated the symptoms of GAD and depression in 13 subjects, some of whom had not responded to other SSRIs (Varia & Rauscher, 2002). Gorman (2002) found that paroxetine (Paxil), also an SSRI, is effective in the treatment of GAD: 43% of subjects achieved remission and 72% responded in some positive fashion. However, caution is called for in the use of paroxetine in those who have breast cancer as it may be associated with a substantial increase in breast cancer risk (and using tricyclics for more

than 2 years may be associated with doubling the breast cancer risk) (Cotterchio, Kreiger, Darlington, & Steingart, 2000).

Summary of Treatment Modality for GAD: Psychopharmacology

It seems that medications for GAD, even the powerful benzodiazepines and the newer neuro-hormone selective reuptake inhibitors, fail with approximately 30% or more of patients. The benzodiazepines have habituation and addiction effects that can cause anxiety to rebound when doses are missed or the medications discontinued. The tricyclics are quite efficacious, but can have uncomfortable and intolerable side effects. Barbiturates are rarely used because of safety and addiction concerns. Buspirone can be effective, but many clients find it not effective enough. Pharmacotherapy, along with psychotherapy, is not yet wholly reliable in the treatment of GAD.

Major Depressive Disorder

The lifetime risk for Major Depressive Disorder (MDD) ranges from 10% to 20% for women, and does not appear to be related to ethnicity, income, or marital status. There is evidence that psychosocial stressors precipitate the first or second episodes. Chronic medical conditions are a risk factor in the persistence of symptoms. The DSM-IV states that a diagnosis of MDD complicates the management of physical illnesses and renders prognoses less favorable. The course of MDD is variable. About 2/3 of those afflicted will recover completely. Of those who have two episodes, however, 70% will have a third; of those who have had 3 episodes, 90% will have a fourth. Of those who have severe MDD, 15% will commit suicide. (DSM-IV (1994, pp. 341-342)

Treatment Modalities for Major Depressive Disorder

Treatment modalities include various psychotherapies, pharmacotherapy, and relaxation and exercise. Two types of psychotherapies predominate: the cognitive or cognitive/behavioral therapies and the interpersonal/psychoanalytic therapies.

Two major studies of depression are the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP) (Elkin et al., 1995) and the Second Sheffield Psychotherapy Project (Shapiro et al., 1995). Both of these studies compared the effectiveness of cognitive-behavioral and interpersonal psychotherapies. The TDCRP also included comparisons of tricyclic antidepressant medication/clinical management and placebo/clinical management. In the TDCRP, 250 patients were randomly assigned to 1 of 4 treatment conditions: cognitive behavioral therapy, interpersonal therapy, imipramine and clinical management, or placebo and clinical management. All treatments were 16 weeks long and ranged from 16 to 20 sessions. Subjects were assessed at the beginning of treatment and periodically during and after treatment. The last assessment took place18 months post treatment. Assessment tools included the Hamilton Rating Scale of Depression, the Beck Depression Inventory, and the Global Assessment Scale.

Results from the TDCRP study indicated that for severely depressed patients, tricyclic antidepressant medication plus clinical management was more effective than cognitive-behavioral therapy. Also, for severely depressed patients, interpersonal therapy was more effective than cognitive-behavioral therapy, but not as effective as medication. Blatt, Zyroff, Bondi, and Sanislow (2002) further analyzed TDCRP data and found that at the 18-month follow-up, patients who received interpersonal therapy

were more satisfied with the therapeutic experience, and that patients in the interpersonal and cognitive-behavioral treatment conditions stated they were better able to establish and maintain interpersonal relationships and to recognize and understand the sources of their depression.

The Second Sheffield Psychotherapy Project (Shapiro, et al., 1995) divided 120 depressed subjects into 4 groups. Each group received either 8 or 16 sessions of cognitive-behavioral therapy or psychodynamic-interpersonal therapy. Also, the severity of depression of each subject was assessed based on Beck Depression Inventory scores. At the one-year follow-up, those who were rated as having low, moderate or high levels of depression and treated with cognitive-behavioral therapy had mean BDI scores ranging from 4.72 to 8.78 (8 sessions) and from 9.67 to 10.88 (16 sessions). Those who were rated as having low, moderate, or high levels of depression and treated with psychodynamic-interpersonal therapy had mean BDI scores ranging from 7.38 to 14.44 (8 sessions) and 2.44 to 7.23 (16 sessions). The standard deviations of all of these means were quite wide, indicating much variability. Other assessment instruments were used as well. Based on all the findings, the authors concluded that the outcomes are equal except for those who received only 8 sessions of psychodynamic-interpersonal therapy. However, some subjects treated with cognitive-behavioral therapy improved significantly more than those in the 16-session psychodynamic-interpersonal therapy group. Another article (Hardy, Shapiro, Stiles, & Barkham, 1998) addressing possible causes for this phenomenon will be reviewed under the topic of treatment effectiveness below.

Exercise

Another hypothesis that has been investigated in the literature is that exercise should be helpful in alleviating depression. However, Lawlor and Hopker (2001) analyzed 14 studies and found that all had methodological weaknesses. They reported that the subjects in most of these studies were community volunteers who were diagnosed by their scores on the Beck Depression Inventory. They concluded that the role of exercise in reducing the symptoms of depression still has not been determined.

In a meta-analysis of manualized therapies for MDD considered to be empirically supported treatments, Westen and Morrison (2001; see above) found 12 studies done since 1990 that met their criteria (their criteria are described earlier in this chapter on page 25). These studies include expressive and interpersonal psychotherapies, cognitive and cognitive behavioral therapies, and pharmacological therapies alone and combined with other therapies. The authors are not sanguine about the outcomes, stating:

"The most positive rendering of the data on depression—namely, the number of patients who improved and remained improved of those who completed the treatments—is in the range of 36% to 38% at both 12—18 months and 2 years. Including patients who began the treatment but did not complete it, however, drops the improvement rate at 2 years to 27%. Thus, roughly one fourth of carefully screened patients with major depression, who are not suicidal and do not abuse alcohol or other drugs, can expect to improve and to remain improved 2 years later if they embark on a brief course of manualized treatment for depression. By any standards, it is difficult to construe these data as evidence for the hypothesis that these treatments show genuine

efficacy for the treatment of depressive *disorders* (which occur with troubling regularity after an index episode) as opposed to depressed *states*"(Westen and Morrison, 2001).

Chronic physical illnesses are stressors that can increase the severity and prolong the episodes of depression. Mohr, Boudewyn, Goodkin, Bostrom, and Epstein (2001) compared the outcomes of moderately depressed multiple sclerosis (MS) patients receiving cognitive-behavioral individual therapy, supportive-expressive group therapy, or the medication sertraline (Zoloft), an SSRI. Subjects were assessed using a modified Beck Depression Inventory (BDI) in which items common to both depression and multiple sclerosis were eliminated, and using the Hamilton Rating Scale for Depression (HRSD). The modified BDI showed that individual cognitive-behavioral therapy and medication were somewhat more effective than the group supportive-expressive therapy on assessments done at weeks 4, 8, 12, and 16. However, at the 6-month follow-up, according to the BDI data, all of the subjects in the study were in the mildly depressed range. However, again, there was greater variability in the scores of those receiving supportive-expressive therapy. The authors noted that the different formats of the psychotherapy treatments---individual cognitive behavioral vs. group supportive-expressive---make it unclear as to whether it is the type of therapy or the format, or some combination, which was responsible for outcome differences measured on the BDI. The HRSD showed no consistent differences between these treatments. The authors pointed out that the HRSD relies heavily on somatic items that could be affected by the disease rather than depression itself. They also noted that the disease process of MS itself can cause a depression related to autoimmune dysfunction. Different physical diseases may have different mechanisms that create mood disorders. Therefore,

interventions effective for mood disorders in those who have a specific disease may not be helpful for those who have another.

Major Depressive Disorder and Psychopharmacology

There is an on-going comparison of the effects of psychotherapy versus the effects of medication in the treatment of depression. Antidepressant medication, specifically the tricyclics, was shown to be more effective than cognitive behavioral therapy for those who are severely depressed in the TDCRP study reviewed above (Elkin et al, 1995). However, Antonuccio, Danton, and DeNelsky (1995) reviewed studies showing that psychotherapy often is as effective as pharmacotherapy.

In an attempt to comprehensively review the literature related to the differential efficacy of medication and psychotherapy, DeRubeis, Gelfand, Tang, and Simons (1999) did a meta-analysis of the effects of 4 randomized trials comparing psychotherapy and medication in the treatment of those who have severe depression and concluded that neither modality is superior to the other. Other researchers have drawn somewhat different conclusions, especially when the depression is severe, from studies that show that combining both modalities is more effective than either alone (Burnand, Andreoli, Kolatte, Venturini, & Rosset, 2002; Frank et al, 2000; de Jonghe, Kool, van Aalst, Dekker, & Peen, 2001; Keller et al, 2000; and Tai-Seale, Croghan, & Obenchain, 2000). Approximately 30% to 50% do not respond to the first antidepressant medication prescribed, but some of those nonresponders may benefit from one of the other antidepressant medications (Thase and Kupfer, 1996).

Tricyclics, the antidepressants evaluated in the TDCRP study (Elkin et al, 1995), have bothersome and dangerous side effects (Gitlin, 1996, p 301-307, Julien, 2001, pp.

283-310). Currently, they tend to be reserved for those patients for whom the newer SSRIs and related antidepressants are ineffective. About 20% to 30% of clinical trials using tricyclics are ended because of their side effects (Thase and Kupfer, 1996).

The SSRIs have negative side effects as well, but these tend to be more annoying than dangerous: nausea, especially when first prescribed, and sexual dysfunction are common. Approximately 10% to 20% stop using the SSRIs because of side effects (Thase and Kupfer, 1996). A serious condition, termed serotonin syndrome, can occur at high doses or in combination with other medications. Symptoms include alterations in cognition and mood such as confusion and hypomania; autonomic nervous system dysfunction, including alteration in body temperature, hypertension, and tachycardia; and abnormal neuromuscular activity, such as spasms and hyperreactive reflexes. The serotonin syndrome usually subsides within 48 hours after the SSRI is discontinued (Julien, p 296).

A serotonin withdrawal syndrome can occur following discontinuation (Julien, p 296). Fluoxetine (Prozac, one of Alexa's medications), because of its long half-life, is less likely to cause this syndrome. Symptoms include disequilibrium, gastrointestinal dysfunction, malaise, paresthesias, sleep disturbances, and psychological symptoms, including depressed mood and anxiety.

Antonuccio, Danton, and DeNelsky (1995) argued that when antidepressants are discontinued, patients often experience a return of their depressive disorder. However, Littrell (1994) proposed that these symptoms of depression recurring after drug discontinuation may be a manifestation of the fairly short-lived serotonin withdrawal syndrome rather than a true relapse into depression.

Mirtazapine (Remeron) belongs to a new class of antidepressants. Its action has both specific serotonergic and noradrenergic effects. It does not act upon the serotonin receptor sites that affect sexual functioning. Also, this drug has few side effects in general, the most common one being sedation. Important to note is that mirtazapine also has been shown to reduce anxiety. It has been successfully used to treatment of mild to severe anxiety (Hartmann, 1999). Alexa was prescribed mirtazapine later in her treatment.

The preponderance of the research supports the use of antidepressant medication for those who are severely depressed. However, psychotherapy and antidepressant medication in tandem seem to be most effective for severe depression. However, even this combined treatment does not insure that depression will be adequately treated (see Weston and Morrison, 2001, above). But for those with mild to moderate depression, adding medication does not seem to improve the outcome. And, still, it seems that a sizeable number who are depressed will derive little benefit from all currently available treatments.

Comorbid Anxiety and Depression

Many of those diagnosed with GAD also have a major depressive episode or have been diagnoses with MDD. The estimates of comorbidity range from 39% to 60%. In most cases, the anxiety disorder predates the depression, and GAD is likely to be a risk factor in the development of depression (Stein, 2001). This comorbidity has been associated with more severe depression, more greatly impaired psychosocial function, and poorer treatment outcomes (Stein, 2001). In addition, there is greater likelihood of premature termination of treatment. For example, in a study done by Brown,

Schulberg, Madona, Shear and Houck (1996), comparing interpersonal psychotherapy and tricyclic antidepressant pharmacotherapy, those with comorbid anxiety and depression needed treatment twice as long to achieve the same recovery rates as those who had depression alone (8 months vs. 4 months of treatment). The percentages of those in the comorbid group that dropped out were greater in both the psychotherapy and psychopharmacology treatment conditions than those who had depression alone: 48% and 40% (comorbid diagnosis) compared to 31% and 29% (depression alone), respectively. Of the 52 comorbid subjects selected for the psychotherapy treatment group, 25 dropped out early in the study, and only 23 (44%) completed the entire study. Only 55% of those diagnosed with depression completed the entire psychotherapy treatment in the study. Of the 52 original comorbid subjects, only 11 (21%) achieved full recovery after 8 months of treatment. The pharmacotherapy treatment group had similar results.

Stein (2001) also found in studies he reviewed that longer treatment times tend to be more effective. Also, his opinion is that the newer medications, the SSRIs and the serotonergic/noradrenergic effectors (e.g. venlaxifene and mirtazapine), having both antidepressant and anxiolytic actions, may result in increased functioning and a decrease of symptoms.

The outcome studies of the various treatments of anxiety, depression, or their comorbidity demonstrate that much remains unknown and much remains unproven.

The Psychological Impact of Cancer and its Treatment

Being diagnosed and treated for breast cancer is associated with anxiety and depression (Epping-Jordan et al. 1999). Intrusive thoughts are common, especially of

past traumas and losses, as well as intrusive thoughts about possible future threatening developments (Brewin, Watson, McCarthy, Hyman, & Dayson, 1998). About 25% of women diagnosed with breast cancer experience levels of distress severe enough to meet the DSM-IV criteria for diagnoses of anxiety and depression (Ronson & Razavi, 1999), and many more experience lesser but significant levels of distress during this crisis (Carver et al, 1993). In addition, Cordova estimated that 5% to 10 % of these women meet the diagnostic criteria for Posttraumatic Stress Disorder in the DSM-IV (Andrykowski, Cordova, Studts, & Miller, 1998). And, women diagnosed with breast cancer tend to use cognitive avoidance as a coping strategy; cognitive avoidance has been shown to increase distress (Stanton & Snyder, 1993).

The effects of various types of therapies in moderating the distress of those diagnosed with breast cancer, other cancers and other diseases, and the benefits of these efforts have been investigated (Anderson, 1992; Bader, Peretz, & De-Nour, 1997; Bloch & Kissane, 2000; De Branander & Gerits, 1998; Edelman, Bell, & Kidman, 1999; Edelman & Kidman, 1999; Edelman, Lemon, Bell, & Kidman, 1999; Fobair, 1997; Harman, 1991; Hegelson & Cohen, 1996; Hegelson, Cohen, Schulz, & Yasko, 2000; Kidman & Edelman, 1997; Meyer & Mark, 1995; Presberg & Kibel, 1994; Simonton & Sherman, 2000; Spencer, 1999; Spiegel, et al., 1999; Stanton, 1993; Stevens & Duttlinger, 1998).

A controlled comparison study of cognitive behavioral stress management group therapy for this population showed decreased plasma cortisol levels and enhanced benefit finding as measured by the Benefit Finding Scale (BFS; Cruess et al., 2000). In this study, a subset of a larger one done by Antoni et al. (2001), cognitive behavioral

stress management did not reduce emotional distress levels as measured by a version of the Profile of Mood States (POMS; McNair, Lorr, & Drappelman, 1971), yielding a composite score of distress comprised of measurements of anxious, depressed, and angry moods developed by Carver, et al (1993), but other measures of distress, the Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977) and the Impact of Events Scale (IES; Zilberg, Weiss, & Horowitz, 1982), showed significant decreases. In the larger controlled comparison study of cognitive behavioral stress management therapy and breast cancer (Antoni et al, 2001), in addition to the increase in benefit finding, there was a decrease in thought intrusion and avoidance, a decrease in depressive symptoms, and an increase in optimism. The interventions used were a combination of cognitive, behavioral, informational, and supportive techniques; the authors pointed out the difficulty in determining which approaches had the greater effects.

Relaxation and visual imagery approaches also have been effective in decreasing elevated cortisol levels. In a controlled comparison study of healthy adults, cortisol levels were lowered by using guided imagery and music therapy (McKinney, Antoni, Kumar, Tims, & McCabe, 1997); depression and fatigue were also decreased. In healthy women at risk for unemployment, a randomized study showed that relaxation exercises had a beneficial effect on cortisol and other stress-related hormones (Toivanen et al., 1996).

Spiegel, et al (1999) did a major study (n=115) of the effects of supportive-expressive group therapy for women with early stage cancer; the groups of 8-12 women met over 12 weeks, 1 and ½ hours each week. A goal of this kind of therapy is to help

women confront their fears and to find ways to cope with them through the group process. Distress-related scores significantly decreased on the POMS, the IES, and the Hospital Anxiety and Depression Scale.

Choosing Treatments: What Works for Whom?

There is a continuing effort to determine which types of therapy are more likely to be effective in the treatment of various psychological problems (DeRubeis & Crits-Christoph, 1998). Most studies focus on the outcomes of homogeneous groups. Great efforts are made to winnow out any confounds so that significant outcome differences are more likely to the result of a specific and repeatable treatment. But Jones, Cumming, and Horowitz (1988) pointed out that outcomes in psychotherapy cannot be measured precisely, and that it remains difficult to compare the outcomes of individuals. Additionally, they noted, "In many respects it is unsurprising that patients treated by one therapy or another do not show impressive differences; the differential effects of two therapies would need to be robust indeed to override the limitations imposed by the general nature of assessment devices, the brief duration of treatments, and the small sample sizes." And, we have seen that many who suffer emotionally often have comorbid conditions. Yet, having a comorbid condition is more likely than not to cause that individual to be excluded from a study. Therefore, the generalizability of many findings is more limited than might be generally thought.

Many studies have been done comparing the effects of various therapies vis a vis specific diagnoses to determine which therapies have empirical support. Many have focused on comparing the effects of cognitive behavioral therapy and various insight-based psychodynamic therapies in the treatment of depression and anxiety.

There is much support for cognitive-behavioral therapy. Yet cognitive behavioral therapy does not work for everyone. It does not seem that any therapy--psychotherapy, pharmacotherapy, relaxation, meditation, or exercise—is wholly efficacious. There are many factors to consider in choosing treatment for an individual. One paramount factor is the creation and maintenance of client-therapist relationship. Other factors are the complexity and severity of the dysfunction, presence of comorbidity, social/cultural beliefs and habits, and client characteristics. What follows is a review of literature concerning the effects of the client-therapist relationship and the effects of the interplay of client characteristics and therapeutic approaches.

The importance of the therapist-client alliance in the success or failure of therapy has been well documented (Luborsky, McMellan, Woody, O'Brian, & Auerbach, 1985; Horvath & Luborsky, 1993). Hardy (1998) and fellow researchers observed that cognitive-behavioral and psychodynamic therapists may tend to modify their approaches to fit their clients' interpersonal styles in order to strengthen the therapeutic alliance. In the second Sheffield Psychotherapy Project (Hardy, Stiles, Barkham, & Startup, 1998), it was found that both of these types of therapy were effective in treating depression, but that the therapists of both orientations tended to use affective and relationship-oriented interventions with overinvolved (anxious-ambivalent) clients and cognitive-behavioral interventions with underinvolved (avoidant) clients. The conclusion seems to be that effective therapists are likely to respond to their clients' interpersonal styles by modifying their treatments to maintain the therapeutic alliance. And Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) found that some cognitive therapy practices ran the risk of damaging the therapeutic

alliance and were correlated with negative outcomes, especially when the cognitive approach paid insufficient attention to distressing life events and the related strong emotions of the client. The authors suggested that cognitive therapy is better used flexibly: there are events that must be processed emotionally (e.g.death, illness, infidelity, tragedy) before utilizing cognitive approaches. Too pure a form of cognitive therapy may damage the therapeutic alliance, and clients may finish treatment more depressed than they began.

In addition to the therapeutic alliance, the interaction between patient characteristics and therapeutic practices can affect the outcome. Jones, Cumming, and Horowitz (1988), after exploring which factors constitute effective therapy, concluded that effective therapists employ different techniques based on their assessments of their clients emotional and characterological weaknesses and strengths. Hardy, Shapiro, Stiles, and Barkham (1998) were interested in why cognitive therapy was more effective than interpersonal therapy with some subjects even though the overall outcomes of these two were about equal in The Second Sheffield Psychotherapy Project. They discovered that subjects who were better able to describe their difficulties and describe the meanings of their problems at the beginning of therapy tended to progress more readily with cognitive therapy. Those whose difficulties tended to be work-related profited as well from cognitive therapy. But those who had more difficulty defining their problems and elucidating the meanings of those problems were better helped by interpersonal therapy.

Beutler et al (1991) approached the problem of determining effective therapy by comparing the treatment effects of cognitive, expressive, and supportive

psychotherapies in depressed patients who had different styles of coping with anxiety. Also, their levels of defensiveness, or resistance, were taken into account. The expressive therapy used in this study was "focused expressive therapy." This therapy assumes that depression is the result of unresolved anger. Its approach is directive and authoritative. The styles of coping included externalization, characterized by irritability, poor impulse control, acting out and projection; and nonexternalization (internalization), characterized by worry, self-blame, or unwarranted guilt. It was found that patients who tended to externalize were more likely to benefit from cognitive therapy and those who tended to internalize (or nonexternalize) were better helped by the supportive and expressive therapies.

In Beutler's study, the degrees of defensiveness, or resistance, also affected the efficacies of these three types of therapy. Patients who were less defensive tended to profit from cognitive therapy. Those who were more defensive fared better with supportive therapy.

Barber and Muenz (1996) also found that there is significant interaction between types of treatment and patient personality characteristics. Those who tended to be characterologically avoidant had better outcomes when treated with cognitive-behavioral therapy, and those who tended to be obsessive compulsive were more effectively helped by insight-oriented therapy. Barber and Muenz believed that obsessive-compulsive characteristics, being self-punishing, also fall into the realm of internalizing in an effort to cope with anxiety (see Beutler, 1991, above). They were less sure that avoidant characteristics are congruent with externalizing to cope with anxiety.

Age is another factor that may need to be taken into account. Barkham, Firth-cozens, and Shapiro (1989) found that depressed, anxious, or manic clients between ages 27 and 44 years receiving cognitive therapy had a significantly better outcome than those who received exploratory therapy. However, depressed clients between ages 47 and 62 years seemed to have greater improvement with the use of exploratory therapy.

Implications of this Literature Review

The treatment of comorbid anxiety and depression is likely to be lengthy and probably is best done by combining psychotherapy and medication. Although some studies show one or another therapy to be more efficacious, overall it seems that cognitive, cognitive-behavioral, supportive-expressive, or interpersonal therapies have generally equal outcomes. The cognitive-behavioral therapies generally seem to lead to improvement sooner than the others. Both cognitive-behavioral therapy and supportive-expressive therapy show efficacy in decreasing dysphoria in women who have breast cancer. Relaxation and meditation have been useful in decreasing anxiety in GAD and in mood states associated with breast cancer.

Certain factors are being identified that perhaps can help in choosing therapies that are more likely to be effective for an individual. Those who tend to externalize when stressed, who can more readily define their difficulties and speak about their causes, and are less defensive, may profit especially by the use of cognitive therapy. Those who tend to internalize when stressed, who seem less clear about the nature of their difficulties, and are more defensive, may be better treated with a therapy less directly focused on cognition, such as supportive-expressive or interpersonal. Perhaps for some clients, depending on their characteristics, best practice would be supportive-

expressive or interpersonal therapy followed by cognitive therapy when they can begin to discuss their difficulties with some objectivity.

In any event, it seems that creating and maintaining a solid therapeutic alliance is basic to all varieties of psychotherapy. The client must be able to trust the therapist enough to tolerate the anxiety of revealing inadequacies ("the ghastly inadequacies," James Baldwin wrote) to find out if this other person can find any value in one so flawed. Without that trust, the hard work of therapy may be skirted, and the client could feel more inadequate and experience more despair.

Medication is probably helpful for the severely depressed, and may be helpful for the mild and moderately depressed. Many studies show that for mild or moderate depression psychotherapy is as effective as medication. In the case of mild or moderate depression, it seems justifiable to withhold antidepressant medication until it is clear that psychotherapy is ineffective since medications can have negative effects.

The SSRIs and the newer serotonergic/adrenergic antidepressants have fewer side effects than the tricyclics, and some of the SSRIs and the newer serotonergic/adrenergic antidepressants are also effective anxiolytics. Benzodiazepines, used to relieve anxiety, can cause physiological dependence and lose effectiveness over time. They are quite difficult to discontinue because decreasing doses can cause an uncomfortable upsurge of anxiety and increase the risk of seizure.

Chapter 4

Normative Practice and Outcomes

Alexa was referred to the agency for psychotherapy by her family doctor a few weeks after her anxiety and depression were not decreased by medication. The agency is private and non-profit. Most of the therapists offer a sliding scale for fees, and no one is denied counseling because of inability to pay. Alexa required a sliding scale to be able to afford therapy. Her intake interview took place 3 days after she first contacted the agency, and she began therapy 8 days later.

After a Consent for Treatment Agreement was obtained, Alexa began attending individual sessions weekly. She has been in therapy for 19 months. Sessions have been missed because time conflicts with social service or physician appointments, and because of health problems, surgeries, family emergencies, a condominium fire, lack of money for gas, and transportation problems. Currently she has sessions every two or three weeks. Each session lasts approximately one hour. She has attended 53 sessions over the last year and half.

Treatment Planning

In developing a treatment plan for this client, it was important to take into account her personality and the complexity of her difficulties. Planning began with the premise that supportive-expressive therapy was the default treatment of choice because of its established use for women who have breast cancer, because of its flexibility in

addressing a range of client functioning levels and needs, and because its supportive element is basic to most therapies.

Additionally, Alexa tended to internalize in an effort to cope with her anxieties, indicating that an insight-oriented approach would be useful. Also, her high degree of her distress dictated that rapid relief of suffering was paramount; the supportive elements are helpful in shoring up self-esteem and thereby easing emotional pain.

Supportive-expressive therapy does not forbid inclusion of cognitive-behavioral interventions (Pinsker, 1997; Spiegel & Claussen, 2000), and Alexa would benefit from these as well. Beutler and Williams (1998) offered a method for selecting amongst various therapies by assessing the client's characteristics in 5 domains: Severity and Functionality, Patient and Problem Complexity, Distress, Resistance Potential, and Coping Style. The scores in these domains are then weighted. Alexa's assessment indicated chronicity and acuteness. Beutler and Williams therefore suggested that the immediate goal of therapy should be symptom removal, and the second goal should be long-term behavioral management, and that she would benefit by exploring the "intrapersonal dynamics and interpersonal problems" that prevent long-lasting resolution of her symptoms. Since Alexa's family experiences on-going conflict, they also suggested that family therapy would be desirable. Unfortunately, her sons would not agree to family therapy, and Alexa was doubtful that her mother would participate. However, family therapy is an option for future treatment.

A Description of Supportive-Expressive Therapy

This description of support-expressive therapy is based on Pinsker (1997, pp. 2-3) Supportive-expressive therapy focuses on self-esteem, ego function, and adaptive

skills. Also there is a focus on relationships. The therapist's main supportive focus is supporting self-esteem, and so tends to minimize practices that would provoke anxiety and frustration. Attention is given to the creation and maintenance of a strong, durable therapeutic alliance. The main focus of the expressive aspects is the exploration and reexamination of patterns of behavior, attitudes, and habits of thought that were once adaptive, in an effort to discover if they remain adaptive, or if they have become dysfunctional. Various techniques can then be used to help the client become more adept at developing more effective ways of coping.

Supportive-expressive therapy therefore allows a variety of interventions from which to select in addressing the client's needs, functioning level, and distress level.

The Treatment Plan

I. The client's goal: "relief from depression and anxiety"

II. The counselor's goals and objectives:

A. Assess and address danger to self or others

B. Create and maintain a strong therapeutic alliance

C. Promote compliance with medications and assess their effectiveness and side effects

D. Decrease emotional suffering

1. Increase self-esteem and self-efficacy

2. Cognitive restructuring related to overly high expectations of herself and overly low expectations of others, especially of family and ex-family members

3. Help client to improve boundary setting and maintenance

4. Help client to learn and practice behaviors to manage anxiety

5. Explore and resolve issues of grief and loss

6. Explore issues related to cancer diagnosis and treatment and provide support

7. Encourage client to develop more social supports, to be more involved in activities with others

E. Explore intrapersonal and interpersonal dynamics that affect her current functioning

1. Determine if there is a generational pattern of dysfunctional behavior and, if so, what the effects have been on Alexa and her family
2. Determine areas of competence Alexa has demonstrated

F. Facilitate the adoption of new behaviors and effective problem-solving strategies

1. Help Alexa define her approaches to problem-solving and to evaluate their effectiveness.
2. Help her develop other approaches to problem-solving, implement them as she sees fit, and evaluate the results.

III. Interventions: Supportive-expressive therapy including elements of cognitive-behavioral therapy and stress management techniques and practices, including meditation and physical exercise (although the literature review turned up no conclusive evidence about the efficacy of exercise on mood, exercise was encouraged to help her regain physical strength and improve physical health)

IV. Timing of Sessions and Duration of Therapy: it was anticipated that Alexa would benefit from sessions once or twice weekly, as needed, depending on her level of distress, and that therapy would continue for at least 6 months, or until she had achieved adequate symptom reduction and had increased self-esteem. Therapy was likely to be prolonged because of her on-going, serious health problems and her co-morbid Axis I diagnoses of Generalized Anxiety Disorder and Major Depressive Disorder.

V. Other Special Concerns: physician/counselor cooperation and teamwork

Assessment of Increasing Depression and Suicide Risk

Early in her therapy, Alexa was questioned about any thoughts of suicide or of harming herself during each session. As she became more stable and hopeful, this assessment became more informal. During periods when she was in greater distress, she was questioned directly as part of this assessment. Also, she was asked about the presence and severity of somatic depressive symptoms (sleep, appetite, energy level, weight changes). Twice during therapy Alexa called her therapist in great distress and was directed to notify her family doctor and then to be driven to the local hospital emergency department. Alexa complied. The first time, Alexa said she had swallowed "a handful of Xanax to make the pain stop" after a fight with her older son about his substance abuse. The second time was a week later, after her family doctor abruptly discontinued her Xanax and Vicoden medications. Each time, she was examined and released the same day.

Medication Monitoring and Teaching

Her family doctor had prescribed Xanax and Prozac for Alexa before she began coming to the Starting Point. She felt that Prozac did help to relieve depression. She

took the Xanax daily, and stated she could feel the anxiety surge up after each dose had worn off. She would attempt to delay taking the next dose until the anxious feelings were quite strong. She admitted to taking double doses at times in an effort to quell her discomfort quickly. The addictive nature of Xanax was explained to Alexa, and the effects of delaying doses and the resulting rebounding of anxiety explained as well. Medical management by a psychiatrist was urged. Alexa had Medicaid. Few psychiatrists in the area accepted Medicaid, and Alexa could not afford the cost. And she was loathe to add yet another physician to her already large list. She also trusted and respected her family doctor. It was suggested that she discuss with him switching to Klonopin. But this switch was not made. Her dependence on Xanax grew.

Early in Therapy: Information, Self-Esteem, Anxiety, Socialization, and Grief

When therapy first began, the focus was on decreasing shame and anxiety and increasing self-esteem. Supportive and behavioral techniques were used. Information also helped to lessen shame and to increase self-esteem. Reframing of past events revealed to Alexa areas of competence for which she had not given herself credit. Alexa's self-esteem grew, her depression lifted, and her anxiety declined somewhat. Then, her attention turned to many losses she not yet accepted. She found she had much to grieve for.

The supportive elements used early in therapy were reflective listening and encouraging communication, including "venting" as a way of discharging tension. Also supportive is demonstrating interest in the ways the client experiences life, and giving the client feedback so the client can further clarify her experience and beliefs. Empathy, reframing, communicating respect, and praising specific client behaviors are basic to

supportive therapy. Behavioral approaches were applied relaxation and the use of "reminder cards." Examples of these therapeutic applications are in these following paragraphs.

Alexa perceived herself as weak and inadequate because she remained fatigued even though her cancer treatments had ended six months before. Having such pronounced tiredness was normalized for her when she was reassured that post cancer treatment fatigue commonly lasts at least as many months as the treatment does, and often 2 or 3 times as long (Weiss & Weiss, 1997). She was reminded that surgery and on-going infection tax the body's reserve. She learned that her need for extra sleep and rest periods during the day were par for the course and not signs of having a weak character. At the same time, Alexa was encouraged to walk her dog each day so that she was outside in nature and to help restore her physical strength. She found she was able to walk the dog most days. This accomplishment gave her hope that would get stronger in time.

Relief of anxiety was an early and major goal. In her home, Alexa was on guard, afraid of antagonizing her older son and at the same time afraid of conflict with her mother. In session, she was free to say whatever she wanted. She reported that having a safe place to discuss her fears, worries, and anger was helpful. Being able to discuss them without fear in the therapy sessions afforded some relief. The therapist used reflective listening, gave feedback to demonstrate interest and understanding, and asked for clarification as needed to encourage Alexa to say all that she wanted to communicate.

Alexa agreed to practice applied relaxation and breathing exercises that the therapist was familiar with, and that can be found in Davis, Eshelman and McKay (2000; chapters 4 & 5). Instructions and practice were done during early sessions. She described these as helpful, and was diligent in practicing 2 or 3 times each day when the anxiety was more acute. In times of lesser turmoil she was less diligent.

Another technique she found helpful was creating "reminder cards" which are index cards of her own meaningful phrases. She read aloud these cards at least 3 times each day and whenever she noted an increase in anxiety. Written on the cards were: "Nothing that happens today is more important than my well-being"; "I am able to cope and I will be able to cope with these problems;" and "This is earth, not heaven. I don't have to be perfect."

These practices helped her to begin to cope more effectively with anxiety, but did not decrease her anxiety sufficiently. It seemed that Alexa was extremely anxious about the anger and resentment she felt towards her former husband. At the same time, she believed she loved him and wanted their marriage to be restored. Whenever she talked about him, she would pluck at her clothing and looked distressed even while describing the warm friendship she believed her ex-husband, his new wife, and she shared. She relayed how they would joke about her poor money management skills. When asked if being with them was comfortable for her, she admitted that she was not at all comfortable, but felt she was supposed to be. Finally she was able to say that she was angry about the break up of her marriage and the belittling way she was treated. It was suggested that she write a letter to Greg, detailing her thoughts and writing down how she perceived what had happened, and then destroy the letter. At the following

session, Alexa was visibly more relaxed. Instead of writing the letter, she called Greg on the phone, telling him what she thought about the wrongs he had done to her and their children. She was surprised that he quietly agreed with her and accepted her statements. Alexa had voiced her opinions clearly and had them respected. She stated she felt powerful and that she realized just how powerless she had felt for a long time. However, this tendency of Alexa's to act (calling Greg) when experiencing heightened emotions without considering the consequences did cause her much difficulty later in therapy.

Alexa also felt she had no friends. She had not been going to church or keeping in touch with old friends. She did not want to participate in cancer support groups. She did promise to leave her home at least once each week to visit a friend.

Leaving her home to visit a friend was a big step for her. Alexa only left her home when it was necessary because she felt uneasy being away from home, having the sense that something would go wrong at the house concerning her family. She was unclear about the source of this foreboding. She had not experienced feelings like these as an adult until after her cancer diagnosis. This anxiety over having to be away from home and family reminded Alexa of herself as a child, frightened by the Vietnam war news. As therapy proceeded and Alexa began more regularly to honor her perspectives, trust her judgments, and act as she thought best, her uneasiness about being away from home faded.

Alexa began to talk about her marriages and her children, and began to grieve the breakups and the marriage experience itself. She began to remember important events as a wife and mother when she did not respect her own views and had not

protested her ex-husband's irresponsible extravagances. Alexa spoke about some of the effects her husband's drinking had on the family, and her sense of helplessness at the time. She saw that she and Greg had not prepared their sons for living responsibly ("we created monsters"). Alexa discussed at length how her ex-husband's erratic responses and outbursts of temper affected their sons and her. She was able to admit that sometimes she was angry toward her older son for the trouble he caused. She spoke of her disappointments and sorrows, and of her fears about her future and her sons as well. The therapist supported her in this retrospection by listening, encouraging, pointing out when Alexa had done things worthy of praise for her family, and reframing to help Alexa see where she had done the best she could. It was during this time that Alexa learned her ex-husband was diagnosed with a bi-polar disorder. She stated that his new wife refused to tolerate Greg's bad behavior and that she had, and wondered why.

Middle of Therapy: Expressive Approach, Boundaries, Family Communications, Increased Socialization & Problem-Solving Skills

Expressive therapy (and cognitive therapy as well) aims to uncover mistaken assumptions that lie outside a individual's everyday awareness but exert a powerful influence on the individual's perceptions and behaviors. These mistaken assumptions tend to be protective against assaults to the self, usually the self when a child, and help to keep anxiety bearable. Actions based on these assumptions tend to be maladaptive. Therapeutic ways of uncovering these assumptions include bringing to the client's attention patterns of behaviors and beliefs that are at odds with reality. The client is confronted with discrepancies.

About four weeks after therapy began, Alexa had stopped plucking at her clothes unless she was greatly distressed and having difficulty tolerating the anxiety of speaking as she truly felt. She continued to walk daily, and to do the relaxation and breathing exercises. Alexa was more relaxed, had better posture, and was more animated. She still needed extra rest throughout the day, and still escaped to her bedroom to avoid conflict. She stated she felt much less depressed and was hopeful about recovering physically and receiving job training in work she would find rewarding. She had begun to look into various vocational programs. Anxious feelings had decreased somewhat, but in she still frequently experienced distress related to anxiety. Also, Alexa had begun to have greater expectations of her sons. She felt they should contribute part of their paychecks towards the rent. She no longer wanted to feel intimidated by her older son. Her greater expectations led to more conflict with her mother.

The therapeutic approach became more expressive. Through examining her family of origin interactions, Alexa discovered that she had certain unspoken assumptions pertaining to roles and relationships that interfered with how she wanted to behave now, and interfered with what she wanted to do now Alexa and her therapist created a genogram that included what was salient psychologically about various family members and their relationships. She discovered that, in general, the females (she, her mother and maternal grandmother) were overly responsible caregivers, planners, and directors. The males were characterized as easily frustrated, prone to temper tantrums, and as having work-related failings. Some, like her brother, had addictions. Alexa's perceived her father, who had been good-tempered and caring, as "weak" and as

needing to depend on his wife to provide structure and to get things done. She felt her "peace-keeper" ways resembled her father's ways. She saw that she was quiet like her father, but was "a rescuer" like her mother.

Alexa compared at herself at age 20 with her sons, and noted that she had many responsibilities which she was able to meet, and they had few responsibilities which they had difficulty meeting. Being confronted with this discrepancy was an epiphany for Alexa. She began to see that family dynamics over several generations had played a large role in creating the conflicts and dysfunction she and her family were facing now.

Alexa had justified indulging her sons as a way of making up what they had lost when the marriage ended. Before the divorce, she had justified not disciplining the boys because their father was not supportive. She realized that in fact she and her mother "overfunctioned" in relation to the males (who were expected to "underfunction") because this way of relating was the family norm over generations.

Alexa attempted to set boundaries for her sons and to allow them to make their own decisions. She vacillated at times between not doing enough and doing too much. Her mother put pressure on her to continue to give Bob money for gas and food ("how will he eat lunch?") even though Bob was out of funds due to gambling and drinking. Alexa at times seemed to need therapy sessions to vent and to think through how she was going to approach these difficulties with her mother and her sons. She remained anxious but was determined. She practiced not lecturing her sons and not giving them money. Her attempts to enlist her mother's cooperation were effective for a brief time, but then her mother would take up the old behaviors of fretting about them and then overdoing.

Alexa also became involved in a cancer support group. She found the activities rewarding. She made friends, and was chosen to be the group's "ambassador" to a national meeting to take place in the future. She spent more time out of the house, socializing with friends.

About a year after Alexa began therapy, she was awarded Social Security Disability. Her financial situation improved. Also, she would receive Medicare benefits about 6 months in the future. Then she could afford to see a psychiatrist. Although Prozac and therapy abated her depression, she was still troubled greatly at times by anxiety. At other times, she reported that the anxious feelings had lessened considerably. Again the therapist urged her to discuss altering her anxiolytic medication (Xanax) with her family physician. Again no change was made. She had reconstructive surgery again, involving repositioning of a back muscle and a small implant. She was not able to attend therapy sessions for a month. When she returned she reported that she was doing well. It seemed that Alexa was coping pretty well with difficulties and family conflicts. She stated she was better at letting minor things go. Alexa stated also that it seemed her mother would continue to "baby the boys," and that she, Alexa, may just have to accept it. She began attending sessions bi-weekly. It seemed that Alexa's need for therapy was coming to an end.

Later Therapy: Increasing Family Conflicts, Substance Abuse, Fire, and Xanax Overdose

Alexa's reconstructive surgery again was a partial failure. Although the back muscle repositioning surgery had healed, the implant again became infected. Alexa was discouraged, and decided not to have more surgery.

Several weeks later, Alexa learned that her older son, Bob, was using cocaine. Although she was uneasy about his weekend drinking and "casual" marijuana use, she felt she could not tolerate his using cocaine: "I've given him 2 weeks to move out unless he stops using. I'm not going to bail him out financially. I'm going to be 50 soon. I pacified the boys after their father left, but that's over." Alexa decided that even if Bob stopped using cocaine, she would insist that he get therapy if he were to continue to live at home. Her plan was that she and the boys' father would present a united front, and make it impossible got Bob to refuse treatment. This plan did not work. Her ex-husband would not cooperate and insisted that she "had ruined the boys" by herself, and he would do nothing. She could not face turning her son out. She chose to believe him when he said he was no longer using cocaine, even though she had discussed with the therapist how addictive cocaine is, and that people who crave drugs cannot be relied on to tell the truth.

Alexa's anxiety increased, and she was very angry at her ex-husband and her older son. She spoke of feeling bitter and hating her ex-husband, of feeling frustrated, inferior, helpless, and powerless, and shamed. Her anxiety had returned full force. Again, it was suggested that she discuss medication with her physician or see a psychiatrist. Again, nothing changed.

For the next 6 weeks, Alexa mulled over what to do about Bob. It was discovered that Alexa had complicated feelings about drug use. She revealed for the first time that Bob and Tom used marijuana daily. Her mother was aware of their addiction as well, but neither adult was willing to address this issue. Alexa believed that the boys were in so much emotional pain that they needed marijuana as she needed

Xanax. In fact, she considered marijuana harmless because "it is a natural product, and not addictive." In her view, heroin was addictive, but not marijuana; heroin was dangerous, but marijuana wasn't. Further, one of her son's friends was taking her family out to dinner on her birthday. This celebration would be paid for by drug profits. When asked if Bob thought she truly meant that he would not be allowed to live at home if he used cocaine, knowing that she was planning to attend an illegal-drug funded party, Alexa stated that she liked this young man, had known him since he was small, his mother as well would be there, and she didn't want to hurt anyone feelings. She decided as long as Bob did not use cocaine in their home, she would have to accept his use of the drug---she could not control him or stop him. Alexa was given educational materials about the effects of marijuana and cocaine, and given meeting schedules for Marijuana Anonymous, Narcotics Anonymous, and Alanon, and information about drug rehabilitation/counseling programs.

Then the apartment next door caught fire. No one was injured. Alexa's family's belongings were ruined by smoke and water damage. Her younger son had been at home when the fire broke out, and he was shaken by the event, as was Alexa. The trauma of the fire, however, seemed to bring the family together. She felt that all of them had put aside their differences. Bob told her he would never use cocaine again. Tom was cutting down on his daily marijuana use.

Over the next few weeks, Alexa was subdued and stated she felt sad. She stated she expected more trouble to come since the fire. Alexa stated she felt guilty because she had not been at home when the fire broke out. She was remembering when she was a child and her mother went to work, leaving her with her unloving grandmother,

feeling lonely and frightened. (It was at this time that Alexa agreed to be the subject of the therapist's case study.)

One day soon after, Alexa called the therapist. She said she had "done an awful thing." In the midst of a verbal fight with her older son, she had swallowed "a handful" of Xanax. She had found cocaine in his room, and she become extremely angry and anxious, and took the Xanax, she said, "to stop the pain." Later, she said she took the Xanax because she was very angry at her former husband because he "was not a patient and helpful father." She denied being suicidal, citing as evidence that she had not taken all the Xanax. The therapist believed that Alexa also may have wanted to inflict pain on Bob by having him witness this act, but the therapist did not voice her intuitions. Instead, she told Alexa that she must get someone to drive her to the emergency department of a specific hospital having a behavioral health unit. Alexa's speech became slurred during the phone conversation. The therapist then called the hospital to alert the emergency room staff.

Alexa was discharged later that day into the care of her family physician. He stopped the Xanax and the Vicoden. He continued the Prozac, and added Vistaril (a drug with several actions, including mild anxiolysis and mild anti-seizure), Benedryl (for its sedative effects), Remeron, the antidepressant with anti-anxiety action, and BuSpar, the anxiolytic.

Alexa was confused and conflicted, and still very angry at her former husband. At times, she was in agreement with her doctor's actions, but at other times she was sure that she needed Xanax very much, that she could not function without it. Her anxiety level was high as she was experiencing the severe rebound anxiety that occurs

when Xanax is abruptly withdrawn. The therapist was concerned about Alexa's anxiety as well as the possibility of seizure. With Alexa's permission, the therapist called her family physician, suggesting that she be prescribed Klonopin and perhaps Tegretol, an anti-epileptic that is used sometimes when Xanax is stopped. Although cordial, the family physician did not want to prescribe these medications, stating that he believed Vistaril would be sufficient. Later that day, Alexa went to her doctor. After examination, he did prescribe Klonopin. Alexa also began smoking cigarettes because she felt doing so helped her to be calm.

On Mother's Day, six days after the Xanax overdose and 2 days after she had begun the Klonopin, the therapist again received an emergency call from Alexa. She had had a fight with her mother over the sons' behavior, and felt extremely jittery, Her voice was tremulous and she was crying. She was frightened by the extreme anxiety she was experiencing. Again, the therapist urged her to go to the hospital emergency department. Again, the therapist contacted the hospital staff to give recent history. She was transported by one of her sons. While awaiting care in the emergency department, Alexa began to feel better, and decided she could safely return home. In session, she and the therapist discussed why that day had been especially provoking. Alexa noted it was Mother's Day, and she was fighting with her mother. Also her upstairs neighbor had been diagnosed with breast cancer and was facing surgery.

She reported that while she waited in the emergency department, she began to think more clearly about her life and what she wanted to do with her life. It seemed that Alexa had begun to imagine a future less cumbered by her sons' needs and more fulfilling of her own

The therapist strongly urged Alexa to seek psychiatric care. She did not yet receive Medicare insurance, and decided that she would wait until she was eligible--about 5 weeks hence. She stated she did not have the funds to afford psychiatric care. The therapist pointed out that if her sons had helped to defray household expenses, she would have had the funds. Alexa agreed, but did not seem stable enough to withstand the stress of attempting to make this change.

This period of Xanax withdrawal continued to be a difficult time for Alexa. She vacillated between agreeing that Xanax had to be stopped and pleading with the therapist to tell her family physician that Alexa needed Xanax to function. Therapy now was strictly supportive. Sessions were held twice each week until Alexa was able to see a psychiatrist. Also, she was encouraged to attend a CODA support group. She did attempt this, but due to a schedule change, the CODA meeting was not held. She then decided that she did not want to attend these meetings at this time.

One day she came to therapy in a depressed mood and was unable to state how this mood had come about. The therapist used a cognitive questioning approach in an attempt to discover the chain of events that lead to this depressed mood. It seemed Alexa had been pressured to go on a bus trip to Altantic City by friends of her mother's. She had not wanted to go, and had not wanted to spend her money or her time in the casinos. Cognitive questioning techniques helped Alexa to realize that when she let herself be pressured to do things against her better judgment, she tended to feel depressed. Over time, she became more practiced at identifying triggers to depression ("I get depressed when I give up my power"). She found it easier to decline activities she did not want to do without feeling guilty.

Over several months, her craving for Xanax diminished. She began receiving psychiatric care when Medicare was activated. Alexa was able to give herself credit for kicking the Xanax habit. She became less tolerant of her sons' drug usage. Still, she believed that she could do little to get them to quit. However, she did make clear to her sons that she would not subsidize their budgets. For the most part, she has been able to refrain from giving them money despite her mother's fretting and disapproval. It seems that Alexa had created a different relationship with them, stating that they have to learn their own lessons in their own way. She feared her older son may be addicted and have bi-polar disorder, and wished he would seek treatment, but no longer felt that he was incapable of helping himself.

Current Therapy

After she was stabilized on her new medication regime, Alexa again began to exercise and keep up with her cancer support group. She also decided to once more to attempt reconstructive surgery, and gave up cigarettes at the surgeon's insistence. She again gave herself credit for stopping this habit, and again noted that her sons' drug use was their problem, and that she was powerless to get them to stop. She no longer gave them any money and no longer did their laundry, etc. She was able, much of the time, politely to ignore her mother's fretting over the boys. She decided that she and her mother deserved a small vacation after all that they had endured over the past months, and spent a week at the shore. She made plans to begin vocational training after she recovers from breast reconstructive surgery. Her anxiety level goes up and down, but she reports that she is able to calm herself by using the relaxation exercises and reading the index cards (she has created other reminder cards, including one listing the stressors

over the last 3 years that she has coped with), and by taking walks. She does not feel depressed, she says, but feels hopeful. She also states she spends more times with her own friends, and less time worrying about her sons. She rarely has contact with her former husband. She no longer feels she must "walk on eggshells" when around the men in her family.

Alexa's therapy was fairly eclectic. The therapist attempted to be responsive to Alexa's difficulties by using supportive, expressive, cognitive, and behavioral therapies. Formal cognitive therapy was used the least. At one point the therapist and Alexa attempted the use Beck's (1979) "Daily Record of Dysfunctional Thoughts" sheets. Alexa found them to be frustrating even though she and the therapist worked on them together. Although formal cognitive therapy was used the least, the cognitive strategy of testing assumptions was useful throughout therapy. Alexa found that at times she jumped to mistaken conclusions about others' views of her. She learned that when she believed others were criticizing her she needed more information, and that situations are not always as they seem. For example, one of her friends "shushed" her when they were in the swimming pool. Alexa believed that her friend was criticizing her for being "too loud" a person, and her feelings were hurt. Then, Alexa asked her friend why she had "shushed" her, and learned that her friend was attempting to warn her that strangers were able to hear what she was saying. Alexa realized her friend was not criticizing but protecting her.

Therapy sessions these past two months have become more infrequent, and now take place every 2 or 3 weeks. They have become Alexa's time to think aloud in a safe place, to consider how to approach problems less impulsively and more purposefully.

Therapy has returned to being mostly supportive. The therapist and Alexa plan to continue therapy sporadically as needed. It is anticipated that if stressors accumulate, she may need therapy more regularly.

Her psychiatric care continues. She believes the psychiatrist plans to discontinue the Klonopin in time, and she believes she will be able to cope when that time comes.

Assessments and Outcomes

Due to unforeseen circumstances, Alexa was not given standard, validated formal assessments early in therapy. She did complete the Mistaken Beliefs Questionnaire found in Bourne's The Anxiety & Phobia Workbook (2000) two weeks after beginning therapy. The questionnaire consists of 57 statements of "unconstructive beliefs." The subject rates how strongly each statement influences her feelings and behavior: Not at All = 1; Somewhat/Sometimes = 2; Strongly/Frequently = 3; and Very Strongly = 4. The 57 statements are divided into 6 subscales. Each subscale has a criterion value; scores over this value reflect a basic mistaken belief. The subscales and criterion values are: powerlessness (15), self-worth dependent upon feeling loved (15), self-worth dependent upon others' approval (15), self-worth dependent upon external achievements (20), the untrustworthiness of others (15), and perfectionism (25). A search for information about the validity and reliability of this questionnaire was done, but no articles could be found.

Shortly after she began therapy she rated her belief in these statements as very strong (4):

I don't have the money to do what I really want.

Life is very difficult---it's a struggle.

What others think of me is important.

I feel personally threatened when criticized.

It's important to please others.

To fail is terrible.

I should always be very generous and unselfish.

I should always be efficient.

I should always be competent.

If I didn't have my safe person (or safe place) I'm afraid I couldn't cope.

If I stop worrying, I'm afraid something bad will happen.

I should be the perfect:

Employee

Parent

Professional

Son/Daughter

Alexa again did this questionnaire 16 months later, just before she discovered her older son was using cocaine. She also completed this questionnaire recently, 18 months after beginning therapy. The three sets of subscores are listed in this table along with their criterion values:

Bourne's Mistaken Beliefs Questionnaire	Initial Subscores	Subscores at 16 Months	Subscores at 18 Months
Powerlessness (>15)	27	10	12
Self-worth dependent upon feeling loved (>15)	43	21	19
Self-worth dependent upon others' approval (>15)	61	8	9
Self-worth dependent upon external achievements (>20)	101	21	18
Untrustworthiness of others (>15)	12	7	7
Self-worth dependent upon being perfect (>15)	19	15	14

Alexa's initial subscale scores show that her mistaken beliefs were greatest in the areas of self-worth being dependent upon feeling loved, the approval of others, and upon external achievements. Her subscore reflecting her feelings of trust was below Bourne's criterion. Over the course of therapy, her scores improved. Her score reflecting self-worth being dependent upon feeling loved remained above the criterion value.

Alexa also completed the Beck Anxiety Inventory (BAI), and the Beck Depression Inventory (BDI). She did each of these retrospectively 15 months after beginning therapy, attempting to remember what she was experiencing when she began therapy. She also completed these questionnaires at 17 months, 18 months, and 19 months. The BDI and the BAI are well-known measures against which others are validated.

This table shows Alexa's Beck Anxiety Inventory scores:

DATES	BAI SCORES
Retrospective to the beginning of therapy	46
At 17 months (one week after Xanax was discontinued)	42
At 18 months	25
At 19 months	22

Her BAI scores decreased over the course of therapy, showing that the over time her anxiety decreased. It is unfortunate that no BAI scores were obtained periodically all through her therapy. If these scores existed, they could be compared to her scores after the Xanax was discontinued. Even so, it can be concluded that the decrease in Alexa's scores is significant.

Alexa's Beck Depression Inventory scores:

DATES	BDI SCORES
Retrospective to the beginning of therapy	34
At 17 months (one week after Xanax was discontinued	18
At 18 months	12
At 19 months	12

Again, her scores show a decrease in depression, as measured on the BDI, over the course of therapy. None of Alexa's scores, however, fall below 9. A score of 9 is generally considered to be the upper end of the asymptomatic range for depression.

Summary

Alexa has had 53 sessions over 19 months of supportive-expressive therapy including elements of cognitive and behavioral therapies. Major problems had to do with her health, including breast cancer, and with family interactions, expectations, and with the substance abuse of her two sons, the older son possibly suffering from bi-polar disease and the younger having learning disabilities. The choice of the therapeutic approach was guided by the client's characteristics and circumstances. A main focus was the creation and maintenance of a strong therapeutic alliance. Important themes were power and powerlessness and dysfunctional roles of males and females in the family. There were difficulties related to the use of Xanax (alprazolam), a benzodiazepine anxiolytic. The client came to therapy having experienced many stressors, and other major stressors occurred during therapy. Over time, her levels of anxiety and depression have diminished as she has developed insight and has put into practice new ways of relating to her family. Alexa's role as a parent and the substance abuse of her sons remains a major on-going concern.

Chapter 5

Normative Versus Best Practice

One major area that could have been improved is the provision of psychiatric care. Alexa endured suffering and a possibly a prolongation of treatment because she was prescribed alprazolam (Xanax) over a long period of time (approximately 18 months), which was then abruptly withdrawn. Prescription and discontinuation of a short-acting benzodiazepine are best managed by a physician expert in psychopharmacology. It is reasonable to consider that best practice is that psychotropic medications be managed, prescribed, and evaluated by psychiatrists or psychiatric pharmacologists. The therapist's role is to do everything possible to insure that her clients receive expert pharmacological care.

Several factors made this difficult. One is the reluctance of some clients to be seen by a psychiatrist. Another is the paucity of psychiatrists who accept Medicaid. In the area where Alexa lives, there is a public mental health agency that is underfunded. The therapist has had experience with other clients using this agency. They experienced long waits for appointments. Also, the quality of care seems to be erratic. The therapist cannot in good conscience recommend this agency unless the client has no other access to psychiatric medications. There is one private psychiatrist in the area who accepts Medicaid. The therapist interviewed him and formed the opinion that his knowledge of the newer medications may not be adequate. Subsequent to Alexa's medication difficulties, the therapist investigated hospital-run clinics in Philadelphia. She now refers clients to the psychiatric clinic at Jefferson Hospital, which offers a sliding scale.

Intake appointments are available within a week. The waiting time before treatment begins is variable. Clients in greater need are seen more rapidly.

Alexa and her therapist had difficulty using cognitive therapy systematically. The therapist hopes to receive training in this method. Also, she has since found a workbook (Greenberger & Padesky, 1995) with a clinician's guide (Padesky & Greenberger, 1995) that presents the concepts and application of cognitive therapy in incremental steps. Each step is followed by guided practice. The therapist has now adopted this way of using cognitive therapy with clients.

More emphasis on the importance of self-help groups, especially Al-Anon, might have provided Alexa with knowledge and support to better cope with her sons' substance abuse. As Alexa's need for regularly scheduled therapy sessions seems to be decreasing, she will be encouraged to go to Al-Anon meetings (Miller, Meyers, & Tonigan, 1999).

Alexa's treatment may have been improved, or at least been more readily tracked, if formal assessment tools had been used at the beginning and throughout her treatment. The therapist now employs several assessment instruments, and is looking for others that assess clients with diagnoses other than depression and anxiety. She uses the BAI, the BDI, the Clinical Outcomes in Routine Evaluation—Outcome Measure (CORE-OM) (Barkham et al., 2001), and the Depression Anxiety Stress Scale (DASS) (Lovibond, 1998; Antony, Bieling, Cox, Enns, & Swinson, 1998).

Chapter 6

Summary and Conclusions

This case study reviewed 19 months of treatment of a 48 year-old Caucasian woman diagnosed with co-morbid Major Depressive Disorder and Generalized Anxiety Disorder. The client was experiencing multiple stressors related to health, family relationships, loss, vocation, and economics. She had recently been diagnosed and treated for breast cancer, had a chronic pain disorder and other health problems, had been divorced, had financial and vocational difficulties, had two young adult sons troubled with substance abuse and displays of immaturity, and was living with a supportive but controlling elderly mother. Her history also indicated that she had experienced a marked level of anxiety since she was school-aged. The client was referred for psychotherapy by her family physician when her depression and anxiety did not respond to medication, specifically Prozac and Xanax.

A review of the literature revealed that comorbid Axis I disorders, specifically MDD and GAD, are more difficult to treat than either disorder alone, and generally require longer treatment time. Two major studies, the TRCDP and the Second Sheffield Psychotherapy Project, were reviewed. Effective treatments included supportive-expressive or interpersonal therapies and cognitive-behavioral therapies. The efficacy of supportive-expressive therapy in helping women emotionally distressed by cancer and its treatment, and the client's characteristic of internalizing to cope with anxiety indicated that an emphasis on supportive-expressive therapy would be useful.

It is probable that antidepressant medication is useful for those who have moderate depression. Some antidepressant medications have anxiolytic effects. The usefulness and risks of various anxiolytic medications for treatment of GAD were reviewed. The shorter-acting benzodiazepines (e.g. Xanax) are likely to be addicting and tend to cause a rebounding of anxiety symptoms. The client did become addicted to Xanax and did overdose.

The difficulty of obtaining adequate psychiatric care was described. When the client was finally able to be treated by a psychiatrist who managed her medication regime, her symptoms were diminished and her overall functioning was improved.

The client continued to experience major stressors during therapy. She had unsuccessful breast reconstruction surgery twice. Her apartment was badly damaged by fire. She discovered that her older son was using cocaine. Both sons have habitually and regularly practiced drug abuse with the tacit consent of the family adults. These events, circumstances, and the Axis I comorbidity have required a lengthy therapy.

The client treatment plan focused on supportive-expressive therapy and included elements of cognitive and behavioral therapy. There were also attempts at using formal cognitive therapy tools. These were not especially helpful, probably because of the therapist's inexperience. The use of alternative tools for inducing cognitive change seemed to be effective. The therapeutic emphases were aiding the client to value herself, examining useful and dysfunctional behaviors, setting stronger boundaries, grieving losses, and managing anger. Attention was paid to creating and maintaining a durable therapeutic alliance.

Various assessment tools were used. The client demonstrated a decrease in depression as measured by the Beck Depression Inventory, and a decrease in anxiety as measured by the Beck Anxiety Inventory. Also, she showed a decrease in mistaken beliefs as measured by the Mistaken Beliefs Questionnaire.

Also, behavioral changes illustrate the client's improvement. She and her mother experience less conflict. She is sleeping much better, has increased energy, is able to exercise, and has increased social activity. She has gathered information about job training and has formed a plan. She states she is hopeful about the future.

A major area of stress remains concerning her sons. The client reports that they continue to abuse substances and demonstrate other irresponsible behaviors. Although the client has increased her ability to set limits with them, issues surrounding her sons have not been satisfactorily resolved. Strategies she has employed have not appreciably improved this situation. The client has been given information about Al-Anon and has been urged to seek support there as well as to continue counseling.

The client responded well to a treatment plan based on supportive-expressive therapy and including elements of behavioral therapy. Overall, the client demonstrates greatly decreased symptoms of depression. She continues to demonstrate signs of anxiety, but these are less marked than when she began therapy. The therapeutic plan has been efficacious.

Several factors that could have improved her therapy include earlier medical management by a psychiatrist, early and on-going formal assessments, and greater use of cognitive interventions. Interpersonal therapy may have been useful. Also, a greater

emphasis on participating in Al-Anon, a 12-Step group for families of those who abuse drugs and alcohol, may have helped the client with her relationship with her sons.

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Appendices

Consent Form

Client Satisfaction Assessment Form

Consent Form

I agree to participate in a case study that is being conducted by Maria Brent under the supervision of Dr. Janet Cahill of the Psychology Department at Rowan University. The purpose of this study is to help evaluate the effectiveness of the treatment being provided by The Starting Point, a cooperating agency. The outcome measures will be used to help evaluate treatment effectiveness.

I understand that this study will not effect my treatment in any way. I will be asked to fill out some additional tests or measures in order to better evaluate my treatment. These measures will not effect my treatment time. The results of the assessments will be shared with me by my clinician.

I understand that these measures will not leave the clinic. The Starting Point's rules of confidentially will be applied to these measures. I agree that any information obtained from this study may be used in any way thought best for publication or education provided that I am in no way identified and that my name is not used.

I understand that there are no physical or psychological risks involved in this study and that I am free to withdraw my participation at any time without penalty.

I understand that my participation or refusal to participate does not affect any of the services I receive from The Starting Point.

If I have any questions or problems concerning my participation in this study, I may contact Maria Brent's supervisor, Kimberly O'Connor Sparks, at 856 854-3155, ext. 142, or Dr. Janet Cahill at 856 256-4500, ext. 3520.

Signature of Participant_____ Date_____

Signature of Investigator_____

Signature of Faculty Advisor_____

Client Satisfaction Assessment Form

Name: Date:

Please rate these aspects of your therapy/counseling experience and comment as you wish:

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree	Comments
I have been treated with courtesy and respect.						
I have felt I can trust my counselor.						
I have been given hope that my suffering would be relieved.						
My confidentiality is maintained.						
I feel that my counselor understands my life.						
I see myself more clearly as a result of counseling.						
Counseling has helped me to more fully understand why I behave in certain ways.						
Counseling has helped me to have more choices in how I behave with others.						
Counseling has helped me to have more flexibility in problem solving.						
Counseling has helped me to be less concerned about the opinions of others.						
Counseling has helped me to tolerate situations I cannot control.						
Counseling has helped me to feel less depressed.						
Counseling has helped me to feel less anxious.						
Counseling has helped me to feel more in charge of my own life.						