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CASE STUDY OF A CLIENT DIAGNOSED WITH MAJOR DEPRESSIVE  
DISORDER

by  
Barbara Ann Marie Allison

A Thesis

Submitted in partial fulfillment of the requirements of the  
Master of Applied Psychology Degree

The Graduate School  
at  
Rowan University  
2005

Approved by:

Date Approved: 7/20/05

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## ABSTRACT

Barbara Ann Marie Allison  
Case Study of Client Diagnosed with Major Depressive Disorder  
2005  
Dr. Janet Cahill  
Applied Psychology Program

The purpose of this study was to determine the best practice for a client diagnosed with major depressive disorder whom was referred for treatment at a community mental health facility. The client was assessed, diagnosed, and a treatment plan was developed. Implemented treatment consisted of combined cognitive behavioral oriented psychotherapy and psychotropic medication. The Beck Depression Inventory (BDI-II) was used to assess changes in depressive symptoms. Results indicated a significant decline in depressive symptoms over the course of treatment. At the onset of treatment, the client's BDI scores were in the clinically depressed range, while at the conclusion of treatment they had decreased to the borderline range. The client self-reported an improvement in mood. A comparison between the client's current treatment and what might be considered "best" treatment is presented. Suggestions for treatment improvements are made, with a particular emphasis on concerns regarding a potential relapse.

## Acknowledgments

I would like to extend my eternal gratitude to Dr. Janet Cahill for her unending patience and optimistic spirit. Her encouragement gave me the fortitude to hang in there until the end. Her medical advice was priceless. Dr. Haugh added his professional insight and gave me advice that was invaluable. Appreciation and love go to my husband, Glenn, for his computer mishap rescues his assistance, and his sacrifices to get me through the past several years of school. Finally, I would like to thank my friend of many years, Jackie Lampe, for her hours of help with margins and page numbering. All your kindness will not be forgotten.

## Table of Contents

Chapter I	Psychosocial	Page	1
Chapter II	Differential Diagnosis	Page	15
Chapter III	Literature Review	Page	20
Chapter IV	Normative Practice/Outcomes	Page	77
References		Page	86

## Chapter I: Psychosocial

### Presenting Problem:

The client is a 29 year old Caucasian female who presented with symptoms of depression. She stated that she had daily crying spells, felt sad “all the time”, had trouble sleeping at night, and was overeating. She reported that her sleeping was disturbed in that it frequently took her several hours to fall asleep, that some nights she could not fall asleep at all, and if she did, she slept for only a few hours. She stated that she spent the time awake “thinking” and “worrying”. She acknowledged that some of her worries included thoughts that she was not a good mom, and she felt that she was a problem to her husband. She reported that she thought about her family of origin and her unsatisfactory relationship with her mother.

She stated that she thought her depression had worsened after the birth of her third child ten months ago. During the initial intake interview, the client noted that she felt “all right, always down”. The “all right” response came out immediately, almost automatically. After a pause, she added “always down”. She revealed that she was constantly thinking and worrying, and that she felt “like everyone is looking at me”. She denied suicidal behavior and ideations. She said it would be nice to run away from her problems, but she added that she knew she could not do that.

Cecilia\* acknowledged that depression was affecting her life in a number of ways. For one, she reported that it was affecting her relationship with her husband and children.

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\* 1. The name of the client and some details has been changed to protect confidentiality.

Secondly, she stated that depression affected her socially because it was keeping her from participating in family events. She reported that she felt unable to work outside her home at this time, therefore, it was having a financial impact. She expressed unhappiness that she was not the person she wanted to be, and she stated that her depression was “wrecking my life”.

#### History of the Complaint:

Cecelia reported that she sought help for post-partum depression six months ago following the birth of her third child, Zeke. She stated that she became depressed when she found out she was pregnant, and the depression continued to worsen after the child’s birth. During the initial months of her pregnancy, she recalled being tired, sad, having no energy, and crying several times a week. She reported that she felt exhausted but could not sleep. She stated that she felt like she “lost control of her life”. She acknowledged that these feelings continued after Zeke’s birth. Her gynecologist prescribed 20 mgs. of Paxil, which she continued to take for a few months. She reported that she discontinued the medication because she did not think it was helping her. She said that it did not work, and she felt no difference in her depression. She also stated that she did not like taking medications. She reported no other periods of depression in her life.

#### Household Composition:

The client lives with her husband, Jerome, 32, her nine year old daughter, Larissa, (from a previous relationship), four year old son, Samuel, and ten month old son, Zeke.

The family owns a home in a residential area.

#### Early Development/Neurological History:

The client did not recall any problems with her birth or prenatal history. She stated that there were no unusual events that occurred during this time. She reported no head injuries or trauma. She acknowledged having no history of neurological problems. She reported no problems with her developmental milestones.

#### Family of Origin:

Cecilia's family of origin includes her younger sister, Margaret, currently 27 years old, her younger brother, Brian, 23, her mother Alice, 52, and father, Roger, 57.

Cecilia recalls having a chaotic childhood characterized by a great deal of stress and instability. She lived with her father, mother, and younger siblings while growing up. She reported that her parents argued frequently, usually over her mother's use of alcohol. At age 11, her mother left the home and the family and was absent for several years. The client stated that her mother was an alcoholic. Her mother would contact the children by phone, but physically did not have contact with them during this time. Her mother later returned to the family when the client was 16 years old, and she is currently living back home with her husband, Roger, and son, Brian.

During the time that her mother was away, Cecilia reported that her father had to raise the children on his own. Cecilia remembered him being very "hurt" when her mother left. She stated that her father was always a quiet man who did not share many of his feelings with his children. She added that he worked long hours, but made sure the children had what they needed. His family helped out by looking in on the children when he worked. When Cecilia was in her teens, she was responsible for getting dinner prepared for her siblings and doing other chores around the house. She remembered



feeling that they all had to pull together during this time. She stated that she did not feel that her father neglected them. He was home every night and made sure they were doing their homework and chores around the house. She rarely recalled getting punished by her father. If she did, it usually involved losing privileges such as sleeping over a friend's house or not being allowed to use the phone. She stated that her father never struck her nor was he physical with her or the other children. Cecilia said that she always felt somewhat "distant" from her father because they never talked much. She said she was afraid to talk to him because she did not want to get angry around him about her mother's absence. She stated that she did not think, "he was strong enough to handle it". She said that he never tried to talk to her or ever asked her how she felt about taking over some of her mother's roles. Instead, she acknowledged that they just did not communicate about the situation. She reported that this was the way the entire family handled the situation, and that it led to emotionally distant relationships. In her opinion, her family seemed to avoid facing and talking about their feelings. She recalled that she and her siblings did talk about their mother, although they did not have the same reactions about her abandonment of them. She stated that Margaret was angry, but Brian always tried to be understanding and not blame his mother for leaving. She remembered that he would defend her actions and make excuses for her, which Cecilia reported as being difficult for her to hear. She acknowledged that she was very angry with her mother when she left, and she is still angry. Overall, Cecilia reported that she did not have adequate communication or high levels of emotional support from her family.

Cecilia expressed that she continued to have strong feelings of anger and resentment toward her mother after her mother returned home to the family. This return

led to significant acting out and impulsive behaviors on Cecilia's part. For example, she became pregnant by a man who was "unstable and irresponsible". He did not continue to be a part of her life during the pregnancy, and he currently has no contact with their child. She broke off the relationship when she was 19, and she chose to keep the baby and raise her on her own. Cecilia remembered having a few serious boyfriends during and after high school. In the past, she stated that she had dated a few young men that she described as "bad". They seemed to be exciting, but she realized they were not really whom she wanted to be with.

With the birth of Cecilia's daughter, she acknowledged that she settled down and became focused and serious. For example, she went on birth control pills to prevent another pregnancy. She also looked for a partner who was responsible and could take care of and love both of them. She said that she found these qualities in her husband, and she married him when she was 23. She stated that her husband is a hard worker and a good provider; she is happy that she married him.

Overall, Cecilia viewed her childhood as emotionally unsupportive and unstable. As a teenager, she assumed the role of a parent, which she resented. She acknowledged that she developed strong unresolved feelings of anger toward her mother, and these feelings continue to surface in their present relationship.

#### Current Family Relationships:

Cecilia lives with her husband of six years and their three children. Her husband adopted her daughter from her previous relationship, and they have two additional children together. Her husband has a small roofing business and puts in many long hours. Cecilia is home with their children all day long.

Cecilia, her husband, and children attend family barbecues, picnics, parties, and other activities together. They also occasionally spend time with other couples and their children. She reported that they rarely spend time alone as a couple. Cecilia states that she would like to do this more often. When they did have time at home together, there were usually friends present, and this posed a problem for her. When friends were around she stated that her husband tended to drink more, and this made her feel anxious. The client described her husband as “wonderful, understanding, puts up with all her problems, could not ask for a better guy”, but they would get into arguments about his drinking. She did not feel that he had a drinking problem since he drank only a few beers and did not become intoxicated, but she would have preferred no drinking at all. She stated that she would tell him this and that he would react negatively back to her. She realized that these reactions to alcohol came from her past experiences with her mother, and she acknowledged that she could not feel comfortable with her husband’s use of it. She stated that she was unable to control her fear that alcohol could ruin their relationship.

Cecilia reported that she becomes frustrated that her husband works so much, and they do not get to spend time alone together as often as she would like. She complained that getting baby-sitters was a problem, and that her mother always made excuses not to baby-sit for her. In addition, her friends that she baby-sat for rarely offered to reciprocate. This caused some angry feelings and feelings of being taken advantage of by them.

Cecilia’s husband recently hurt his back at work and had to miss several weeks of work. As a result, they got behind on their financial obligations. Since his recovery, he

has been working longer hours to catch up with the bills. As a result, he could not help her out with the children as much as she would have liked. She reported that she has the roles of major caretaker and disciplinarian of the children. In terms of discipline, she stated that she utilizes short time out periods and loss of privileges as punishment. She reported that she is usually satisfied with the results. She said that the two older children were not much of a problem. They were “good kids” in comparison to her youngest who was more of a challenge. She related that she was exhausted when she tried to keep up with him. She stated that he was too energetic, and that he was a difficult child from the date of his conception.

Cecilia recalled being sick during her pregnancy with Zeke, which was different from her other pregnancies. She claimed that she was on birth control pills when she became pregnant with him. He was unplanned, and she felt drained and depressed the entire pregnancy. She said that he changed her life from the moment he was conceived. Her relationship with her youngest son is a considerable source of stress for her, although she states that she loves all of her children and that she tries to be a good mother.

Cecilia acknowledged that she puts a great deal of pressure on herself to be everything to everyone. She wants to be a good mother, daughter, sibling, wife, and friend making everyone happy without regard for her own feelings and needs. Cecilia reports that she wants to be a good mom to her children and a better mother than her mom was to her. She stated that she always plans outings with the kids such as trips to the beach, the circus, and various other places of interest. However, she reported that she was going through the motions but was not enjoying any of these activities. She related that because of this, she would have thoughts that she was not being a good mother. She

reported having feelings of guilt. She stated that at the present time she does not feel that she is “emotionally there” for her children due to her current state of depression, and this is causing her to cheat her children out of what they deserve from her.

Cecilia reported that her relationship with her mother is a concern for her, and that she would like it to improve. She stated that her mother drinks socially at the present time; she usually will have one to two drinks at a social function. According to Cecilia, her mother is no longer drinking heavily. It was not known by the client if her mother ever sought help. Although Cecilia stated that alcohol does not seem to be the focus, she and her mother still frequently argue. Cecilia stated that her mother was not there for her as she grew up, and she is not there for her now. She said that her mother was selfish and did not care about her or her grandchildren like she should. Cecilia complained that she did errands for her mother, drove her to work, and did all that was asked of her, but that her mother did not reciprocate. According to Cecilia, her mother made up excuses and did not help her out when asked. She reported feeling resentful and angry, and then afterwards, she stated that she feels guilty.

Cecilia’s family of origin stays in contact with each other, but there are frequent arguments and conflicts that she states are due to the many unresolved issues the family still has. Cecilia’s sister is married and lives in Pennsylvania. They talk weekly and try to see each other monthly. Her brother is currently living with her parents. She stated that she gets along with him, but also becomes angry at him when he does not spend time with his own teenage daughter under his care. Cecilia reported that she likes her niece and takes her shopping and does other activities with her. She realized that she puts herself into the caretaker role with her brother’s child.

Cecilia had two family events that still bothered her and caused her great sadness and guilt. One incident related to her grandmother's death. Instead of visiting her grandmother, she went out on a date, and her grandmother died the next day. In another instance, her father asked her to do something for him, and she refused. He had a heart attack that evening. In both instances, she relates that she felt guilty and blamed herself for the outcomes. She stated that she ends up helping other people out even if she does not want to because she fears that something bad will happen to them. She acknowledges that this reasoning has become a strong motivating force behind many of her decisions.

#### Drugs, Alcohol or Other Addictive Behaviors:

Cecilia recalled going through a period of rebellion during her teens. She related that she experimented with alcohol and drugs (mainly wine coolers and marijuana), but quickly lost interest in them. She recalled drinking on weekends at parties and smoking marijuana once or twice a month at the most. She began smoking cigarettes as a teen, and has continued smoking about ten cigarettes a day. She reported that she does have an occasional drink at a social event. Cecilia denied any other drug use.

Cecilia acknowledged that she does obtain comfort through food, and she had put on 40 pounds while pregnant. The weight was not coming off as fast as she would like. She recognized that she ate when she did not feel hungry, and she tended to eat foods that were high in fat content. She stated that this was not healthy and that she wanted to improve her eating habits to lose weight and feel better about her.

#### Medical and Psychiatric History:

Cecilia reported that she had never sought psychological help prior to now. She did not feel that she was depressed at any other time in her life. Medically, she reported

having heavy menstrual flows lasting as long as nine days. She had been on birth control pills before her unplanned pregnancy. She states that she got pregnant while on the pill. She said that she must be in the “1% group that it doesn’t work for”. She reported no other medical conditions that she was experiencing at this time. When this agency’s psychiatrist evaluated her, she was prescribed 50 mg. of Zoloft for her depression. She stated that she did not like the “cotton mouth” feeling she had from it, but she reported sleeping better since she started on it. She added that she felt better on the medication and thought it had helped decrease her depression.

Some mental health illnesses have genetic components to them and tend to reappear in a family. Therefore, it is pertinent to ascertain a family history. Cecilia remembered an aunt on her mother’s side who was diagnosed with bipolar disorder and another aunt who was “mentally ill”. She could not specify exactly what her diagnosis was. Cecilia recalled that her own mother often seemed “unhappy”. She stated that her mother probably also suffered from some form of depression.

#### Education and Job History:

Cecilia stated that she is a high school graduate. She acknowledged that she has worked at various jobs. The most recent one was at a neighborhood convenience store as a cashier. She reported working full time for four years and then part time until the birth of her last child. She currently is a full time homemaker. Since she is home, Cecilia often baby-sits for her friend, and many times does so for free. She expressed an interest in getting trained in the field of phlebotomy or some other kind of blood work when her children are a bit older, and she stated that she planned to look into this in the future.

#### Other Agency Involvement:

There were no other agencies that the client dealt with. She stated that she had not been in treatment before. She had no involvement with the courts or any other social service agencies.

#### Social Supports and Patterns of Relationships:

Cecilia said her husband recognized that she had some kind of problem, and that he was supportive of her seeking treatment. She stated that he wanted to help her, but he did not know what to do. She added that she talked to him about her depression, but she did not feel that he understood what she was going through. According to her, he did want her to get help and was accepting of her receiving counseling. She reported that he was willing to participate if need be. She stated that she was concerned that her depression may cause problems in their marriage if she does not get “out of it” soon. She said that she worried that he will get tired of her being this way if it continued to last for an extended period of time.

Cecilia stated that her sister was also an advocate for her, as she insisted that other family members reduce their demands on Cecilia.

Cecilia listed her husband, some friends, and her sister as her supports. She reported that she talked to them and shared how she was feeling but only to a certain extent. She acknowledged that they did not know how depressed she really was because she did not disclose everything to them. She attempted to act more upbeat around them than she was feeling. She related that her brother was the reason she sought counseling. He had suggested it since he noticed that she was unhappy and angry especially in



dealings with their mother. She reports that she was resistant to his advice, but eventually accepted that he was right.

#### Situational Stressors:

Cecilia acknowledged that her primary sources of stress are related to her lack of financial resources, long hours spent caring for her children, and difficulty in managing the behavior of her youngest child. Cecilia also stated that her mother continued to be a cause of stress due to her lack of emotional reciprocity.

#### Coping Mechanisms:

Cecilia reported that she relies on five primary techniques to cope with stress. She stated that two of these techniques are negative and she would like to change her reliance on them. The other three coping techniques are viewed as positive and helpful. The first negative coping mechanism Cecilia mentioned was smoking. She stated that she smokes approximately ten cigarettes a day to help her relax. Even though smoking was reported as effective in reducing her stress, Cecilia also stated that she had a desire to stop smoking. The second negative coping mechanism is eating. She admitted food was a way of dealing with stress, but she wanted to work on changing and not resort to eating when she is stressed.

The first positive coping mechanism she relies on is exercise. She stated that she used exercise videotapes that she worked out with for 40 minutes a day. She reported that she felt much better mentally and physically after she exercised. She added that she wanted to lose all the weight she gained with her last pregnancy.

The second positive coping technique she employed was seeking out the support and guidance of friends and family. She stated that she talks to her girlfriends daily and

has been sharing some of her therapy homework assignments with them. She said that some of her friends experienced depression also. She acknowledged that she was getting support from them, and that she liked having other people available with which she can share information. In addition, Cecilia was planning a visit to her cousin's for a weekend in the near future. She stated that this would help her relax and that she would be able to get away from some of the stress and pressure in her life. She reported that it would be a change in her daily routine, which could be beneficial.

The final positive coping method she employed was seeking therapy. Since starting therapy, she reported feeling less depressed. She also stated that coming to therapy and telling a stranger her problems made her feel better.

#### Perception of Self and Motivation Toward Treatment:

Cecilia reported that she had no confidence in herself and that she felt that she was at the mercy of others. She recognized that her self-concept was tied into reactions received from those around her. She acknowledged that she had made her role one of service to others at the cost of herself. She reported dissatisfaction with this and wanted to change. She stated that these realizations and feelings are what prompted her to enter into therapy.

#### Summary:

The client is a 29-year-old Caucasian female who sought treatment for depression. She reported that her depression began with the conception of her third child and has continued for ten months prior to her seeking treatment. Cecilia stated that she has never been in therapy before, but she had taken antidepressants prescribed by her gynecologist.

However, she reported that she stopped taking the medication because she felt it was not helping her.

**Review of Prior Assessments:**

The client reported having no prior evaluations.

## Chapter II: Differential Diagnosis

Axis I: Major Depressive Disorder, Single Episode, Moderate

Axis II: V71.09

Axis III: None

Axis IV: Problems with Primary Support Group; Relationship concerns with her mother and her children

Economic Problems: Financial Concerns

Axis V: GAF = 70 (Current)      Highest GAF (in last year) = 70

According to the DSM-IV-TR, the client is exhibiting characteristics matching that of a Major Depressive Disorder. Loss of interest or pleasure in most activities is evident. Changes in sleep habits. Weight, appetite, and energy level are seen, as well as levels of psychomotor activity. She is experiencing feelings of worthlessness and guilt. She has difficulty trying to think and concentrate, which affects her decision-making ability. Although she states that she has no suicidal ideation, she does wish to disappear to escape her current situation.

These symptoms have continued for most of the day, every day, for at least two weeks in a row. Distress accompanies these symptoms causing deficits in social, occupational, and other areas of functioning. Cecilia states that she feels sad and hopeless. She cries or feels like crying often. Bursts of anger have also occurred. Worrying, anxiety, somatic complaints, and phobias have manifested themselves (DSM-IV-TR, p.349).

In order to assign a diagnosis of Major Depressive Disorder to Cecilia, it must first be established that she meets the criteria for a major depressive episode. Cecilia exhibited at least five of the symptoms necessary for the diagnosis of a major depressive episode, and in addition these symptoms were present for longer than a two week time period.

Cecilia showed evidence of:

1. Depressed mood most of the day, nearly everyday – Cecilia reported having a depressed mood everyday. She felt sad day after day, and she cried often.
2. Diminished interest and pleasure in almost all activities most of the day, everyday – Cecilia was taking no interest or gaining any pleasure out of the activities she was involve in. She felt that she went through “the motions” of interactions with her children, but she was not getting any enjoyment from them. She avoided some social activities that she previously enjoyed. She expressed that there was nothing to look forward to, nothing excited her.
3. Weight gain or weight loss – Cecilia gained weight during her pregnancy and had not been able to lose it. She felt that she was approximately 40 pounds overweight. She also reported overeating and eating a great deal of fatty foods to comfort her.
4. Insomnia – She had difficulty falling asleep. She would go to bed at 2:00 or 3:00 a.m. and sleep restlessly for a few hours.

5. Fatigue and loss of energy every day – Cecilia felt that she had no energy, no motivation, and she was always tired.
6. Feelings of inappropriate guilt and worthlessness nearly every day – She described herself as anxious, worrying all the time, nervous, and plagued with feelings of guilt.
7. Indecisiveness, inability to concentrate nearly every day – She described her thoughts as being jumbled and confused. It took her a long time to make a decision, and then she would change her mind. She had doubts about any decisions she finally did make.

Cecilia met seven of the criteria for a major depressive episode, and therefore Criterion A for Major Depressive Disorder.

Criteria B states that the “symptoms do not meet criteria for a Mixed Episode” (DSM-IV-TR, p.356). Her symptoms do not meet this criterion because she has never reported having a manic or hypomanic depressive episode.

Criteria C states that the “symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” (DSM-IV-TR, p.356). Her symptoms caused her problems socially. She had to force herself to attend social outings. She had no interest in them nor did she receive any enjoyment from them. They were more work than fun for her. She worried about them. Her low self-esteem affected her participation in these kinds of activities. She viewed herself as unattractive, overweight, and with nothing to offer other people.

Cecilia felt overwhelmed at home with her children, especially the youngest. She did not think that she was an adequate mother to them. She feared she was emotionally

distant at times and that this would affect her relationship with them. She also was afraid that her depressive behaviors were pushing her husband away, and that he would eventually tire of helping her deal with her depression.

Criteria D states that the “symptoms are not due to the direct physiological effects of a substance or a general medical condition” (DSM-IV-TR, p.356). This client is in good health otherwise and denies using any substances.

Criteria E states that the “symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation” (DSM-IV-TR, p.356). This client’s symptoms are not due to bereavement. She has reported no deaths or losses in her life at the present time. She is not morbidly preoccupied with feelings of worthlessness. She does not express suicidal ideations. She shows no evidence of psychotic symptoms or psychomotor retardation.

#### Rule Outs:

Dysthymic disorder has been ruled out since the client has not been depressed for two years. Bipolar is ruled out since manic episodes are not exhibited. The postpartum onset specifier is not appropriate since the client began feeling depressed after she discovered she was pregnant. This feeling persisted after the delivery of her son. There is no evidence of a general medical condition contributing to her depression. She denies using any substances that could induce a mood disorder.

Adjustment Disorder has been ruled out for several reasons. It usually begins within three months of the stressor. The stressor in this case may be pregnancy, but the

symptoms last no longer than six months after the stressor or consequences have ceased. The child is now almost one year old, and the depression continues. Adjustment Disorder is frequently associated with suicide attempts, substance abuse, and somatic complaints. These are not evident in this client. For an Adjustment Disorder diagnosis, the stress related disturbance does not meet the criteria for another specific axis disorder. In her case, it does meet the criteria for Major Depressive Episode in Response to a Stressor which is more severe than an Adjustment Disorder. There also is a history of mood disorders in her family. This diagnosis appears to fit this client better. Therefore, Adjustment Disorder does not apply.



### Chapter III: Literature Review

Depression will affect approximately 30 million Americans every year. One in five individuals will be affected by a mood disorder sometime in their life. The peak occurrence time is between 25 – 44 years of age. One third of all depressions will be severe enough to require medical interventions. The precise cause of major depressive illness is not known, but its onset is related to a chemical deficiency of norepinephrine, serotonin, and/or dopamine in the brain. There are some types of depression that have familial patterns, and there is some evidence that individuals can be genetically predisposed for depression. According to the American Psychiatric Association, 80 – 90% of people experiencing depression can be helped. The first step is to get an accurate diagnosis by a doctor or mental health professional. Medical problems should be ruled out (Ross-Flanigan 2003).

There are several different treatment modalities commonly used in the treatment of depression. Some treatment approaches advocate psychotherapy and medication. Others propose that medication or psychotherapy alone can alleviate symptoms. Each of these methods of treatment has some empirical support. The goals of treatment are to end the depression through reduction of symptoms and to prevent recurrences.

This literature review will provide information about medications that have been used to treat depression. Early antidepressants and newer ones will be examined. The two main psychotherapeutic treatments will be discussed. They are cognitive behavior therapy and interpersonal therapy. The review will present evidence to support the use of

pharmacological treatment and psychotherapy to treat depression. Empirical studies will show that each method of treatment is effective, and that both used together can be advantageous. Finally, comparisons between pharmacological and psychotherapeutic treatments will be reviewed showing the treatment that would be considered best practice.

#### Pharmacological Treatment:

Antidepressant medications are commonly used to treat depression. They have a mood elevating action which can take several days to achieve or even several weeks. They can help reduce anxiety, calm a person down, and improve the quality of sleep. These medications do not cure depression, but they may reduce its effects and shorten its duration.

There are two major groups of antidepressant drugs. These two types of medications have different clinical and pharmacological effects (Spiegel, 2003). The first is thymoleptic, which means mood stabilizing. This type of medication affects the mood of a patient in a manic or hypomanic state. It helps regulate the person's mood to achieve a more stable level of functioning. It is usually prescribed for clients who are diagnosed with bipolar disorders. The second is thymoretic, a mood-activating medication that causes the person to be more active. It elevates a client's mood and is primarily used for unipolar depression.

A number of studies have concluded that antidepressant medications are effective in the treatment of depression. For example, one meta-analysis reviewed 300 published studies examining the treatment of affective disorders (Davis, Wang & Janicak, 1993). The medications studied included imipramine, amoxapine, and amitriptyline. The results

showed that these antidepressants are effective and that there are few quantitative distinctions among them. The differences that do exist may involve dosage amounts or the types of side effects reported.

Several types of medications are commonly prescribed to treat depression. These include tricyclics (TCAs), serotonin reuptake inhibitors (SSRIs), monoamine oxidase inhibitors (MAOIs), lithium, and heterocyclic antidepressants. An overview of each of these medications will be given.

Tricyclic antidepressants (TCAs) started being used for the treatment of major depression in the 1960's. They were the first to be studied, and they showed that in meta-analyses of placebo-controlled trials they are significantly and consistently more efficacious than placebo. They are often used for severe depression and are beneficial to patients needing sedation. They have been shown to be 60 – 75% effective in reducing depressive symptoms (Davis & Casper, 1978). They prevent the reuptake of norepinephrine into presynaptic neurons, and they have fewer effects on serotonin reuptake.

There are several side effects associated with this type of medication. TCA's can produce blurred vision, constipation, weight gain, memory disturbances, tachycardia, dry mouth, and urinary hesitancy. They are the number one cause of overdose death due to prescription drugs in the United States. They can be cardiotoxic and have low therapeutic index (Nemeroff & Schatzberg, 1997). Some typical tricyclics used are amitriptyline, clomipramine, desipramine, doxepin, imipramine, nortriptyline, protriptyline, and trimipramine (Ross-Flanagan, 2003).

Morris and Beck (1974) presented evidence that TCA's were superior to placebo in 63 out of 91 controlled studies for the treatment of depression that were conducted from 1958 through 1972. Janicak, Davis, Preskorn and Ayd (1993) performed a meta-analysis of the TCA randomized clinical trials literature and have presented evidence that these antidepressants are overwhelmingly more effective than placebo. Fifty studies were reviewed that compared imipramine with a placebo and showed an aggregate response rate of 68% to imipramine and a 40% response rate of the placebo.

(Nemeroff & Schatzberg, 2002) reported that tricyclics, when used alone, are less effective in treating major depression with psychotic features or atypical features. They were effective in only 35% of cases where psychotic features or atypical features were present in contrast to a 65% response rates for depression without psychotic features. There was evidence that when combined with antipsychotics they have been significantly more effective in the treatment of depression with these added features.

Due to safety concerns and adverse side effects, TCAs have been replaced by Selective Serotonin Reuptake Inhibitors (SSRIs) as the first line of treatment for major depression. SSRIs work by inhibiting reuptake of serotonin in presynaptic neurons without affecting the reuptake of other neurotransmitters. More of the serotonin stays in the synaptic cleft and is available for mood regulation, control of sleep, eating, and arousal, and in regulation of pain.

One type of SSRI, fluoxetine, was first introduced in the United States in 1988, with three others closely following-paroxetine, sertraline, and fluvoxamine. These compounds which are also known as Prozac, Paxil, Zoloft, and Luvox are newer

medications that are less toxic and have fewer side effects for some clients. There have been some common side effects associated with the use of SSRIs. These include nausea, diarrhea, insomnia, sexual dysfunction, and nervousness, but SSRIs do not cause anticholinergic effects such as dry mouth, urinary problems, or constipation. They do not sedate the client or cause weight gain. Paroxetine is the exception since it does have weak anticholinergic effect and can be mildly sedating to some patients.

SSRIs are the drug of choice for mild to moderate depression since they are safer and better tolerated than tricyclics (Agency for Health Care Policy and Research, 1999). Several studies have concluded that SSRIs are as effective as tricyclics and are superior to placebo. There have been concerns, though, that they may not be as effective as TCAs and venlafaxine for severely depressed patients (Nemeroff & Schatzberg, 2002; Clerc, Ruimy & Verdeau-Pailles, 1994).

Tignol, Stoker, and Dunbar (1992) performed a meta-analysis that reviewed the effectiveness of paroxetine (SSRA) treatment for melancholic depression and severe depression. Melancholic depression, a term not used much today, was characterized by lack of pleasurable responses, lack of motor responses, loss of interest in life, reduced responses to environmental changes, and the occurrence of somatic symptoms. It was viewed as depression originating from a biological base (endogenous) more than a psychological base (exogenous) (Rosenham & Seligman, 1989).

In this meta-analysis, paroxetine treatment was compared with placebo. The study included 178 patients who received paroxetine and 66 who received placebo. The Hamilton Depression Scale was used as an outcome measure. Results indicated that

subjects taking paroxetine had a greater reduction of depressive symptomatology than the placebo group.

Mauri, Fiorentini, Cerveri, Volonteri, Regispani, Malvini, Boscati, LoBaido and Invernizzi (2003) conducted another empirical study showed that sertraline (SSRI) is successful in prevention of recurrent episodes of major depression and relapse. The participants included twenty-three outpatients ranging in age from 18-65. All participants were diagnosed with major depressive disorder. There were 14 males and nine females who were prescribed 25-150 mg. of sertraline for 12 months. They were evaluated at baseline, 15 days, 30 days, six months, and 12 months after treatment began. The Brief Psychiatric Rating Scale, Hamilton Rating Scale for Depression, and the Hamilton Rating Scale for Anxiety were used along with plasma samples that were taken to evaluate the amount of sertraline that was effective for optimal treatment results. A positive relationship was seen between drug plasma levels and dosages of setraline. Lower plasma levels (25-50 mg/ml) were sufficient for clinical maintenance treatment. Sertraline in low dosages was well tolerated and effective for acute and maintenance levels of recurrent depression.

Initial use of SSRIs suggested that they might be more effective with fewer side effects. However, that has not been consistently evident. In a meta-analysis of nine controlled fluoxetine (SSRI) outcome studies (Greenberg, Bornstein, Zborowski, Fisher & Greenberg, 1994) only a modest mean effect size of 0.39 was seen with controls on patient-related measures which is comparable, but not more than, those found in previous meta-analyses of TCAs.

SSRIs and TCAs advantage has been seen as negligible in another study when compared to placebo. Results of overall effect size of 0.25 and 0.31, respectively were found, and when patient-rated outcomes measures were used the TCAs were not more effective than placebo showing effect size of 0.06. SSRIs did not do much better ranging from 0.44 to 0.79 effect sizes that were smaller than earlier meta-analyses of TCAs (Morris & Beck, 1974) thus showing that these medications have no higher success rates than placebo for some clients. They are not always effective in reducing symptoms or producing changes in the client.

Numerous studies have been undertaken to research which of these pharmacotherapy treatments (TCAs) or (SSRIs) is the most efficacious in the treatment of depression. In 1986, a study done by the Danish University Antidepressant Group (DUAG) presented controversial findings of the differences between the effectiveness of TCAs and Selective Serotonin Reuptake Inhibitors (SSRIs). One hundred and fourteen inpatients diagnosed as having endogenous and non-endogenous depression were included in the study. Endogenous depression is similar to major depressive disorder with melancholic features (Spitzer, Endicott & Robins, 1978). The Newcastle II Scale was used as a diagnostic tool to identify endogenous or non-endogenous depression. The participants received placebo for one week. That was followed by patients being randomly assigned to a fixed dose of a TCA which consisted of 150 mg/d of clomipramine treatment group (62%) than the citalopram group (34%) for endogenous depression as measured by the HAMD. A more favorable response to TCAs over SSRIs also occurred for the non-endogenous clients. Between both drugs, there was no difference in the response of partial responders for endogenous or non-endogenous

depression. When the full and partial response rates results were totaled there was no difference in response rates. It was concluded that TCAs were more effective over SSRIs in the treatment of endogenous depression and non-endogenous depression (DUAG, 1986).

Laakmann, Blaschke, Engel and Schwartz (1988) completed a study similar to the DUAG study involving 105 clients with endogenous depression. After clients were given a placebo for seven days, they were then randomly assigned to the TCA, 0-150 mg/d amitriptyline or the SSRI, 20-60 mg/d fluoxetine. In contrast to the study previously mentioned, there was no statistically significant difference noted between amitriptyline (TCA) and fluoxetine (SSRI).

The DUAG repeated their benchmark study in 1990 substituting the SSRI paroxetine for citalopram. Copying the initial study, 120 patients diagnosed with endogenous and non-endogenous depression were randomly assigned to a fixed dose of clomipramine (TCA) 150 mg/d or paroxetine (SSRI) 30 mg/d for six weeks. A complete remission of depressive symptoms was more likely for clients diagnosed with endogenous depression in the clomipramine treated group (56%) as compared to (25%) in the paroxetine group. The partial response rates were similar. Thirty percent had some response in the clomipramine group, 25% for paroxetine. There was a 14% nonresponse rate for clomipramine, and a 50% nonresponse rate for paroxetine. As with the first study (DUAG 1986), the response pattern in this study also favored clomipramine for the treatment of noendogenous depression. The response rates were 60%, 30%, and 10% for complete, partial, and no response rates, respectively. The rates for paroxetine were 12%,



44%, and 44%, respectively. It was concluded that TCAs more effectively treated endogenous and non-endogenous depression than SSRIs (DUAG 1990).

Some recent studies have investigated the effects of different combinations of medications. For instance, Nelson, Mazure, Jatlow, Bowers and Price (2004) studied the effects of combining norepinephrine and serotonin reuptake inhibition mechanisms for the treatment of depression. Thirty-eight inpatients diagnosed with nonpsychotic unipolar major depression were randomly placed in different six-week treatments. They were prescribed either fluoxetine (SSRI) 20 mg/d, desipramine (TCA) adjusted to an adequate plasma level, or the combination of fluoxetine and desipramine. Desipramine blood levels were taken to evaluate the dosage amount to reach a therapeutic level and to predict the enzyme-inhibiting affect of fluoxetine. Scores on the Hamilton Rating Scale for Depression (HRSD) and the Montgomery-Asberg Depression Rating Scale (MADRS), the two most widely used scales for the measurement of the severity of depression, were used as outcome measures. Results showed that the combination of fluoxetine and desipramine was more likely to produce remission indicating that these two types of medications may be more efficacious combined than when used alone (Nelson, Mazure, Jatlow, Bowers & Price, 2004).

Monoamine Oxidase Inhibitors (MAOIs) have been used when a person does not respond to other antidepressants for atypical depression. They have been shown to be effective in the treatment of unipolar depression, biologic endogenous depression, and atypical depression (Nemeroff & Schatzberg, 2002). Some examples of MAOIs are isocarboxazid, phenelzine, and tranylcypromine (Ross-Flanagan 2003). They inhibit serotonin and catecholamine inactivation preventing the breakdown of released and

available catecholamines. They are not considered as first line treatment for depression due to several factors. They are not as popular because of the many side effects such as food and drug interactions, withdrawal symptoms, agitation, convulsions, tremors, and sexual difficulties. They also require taking several doses per day as compared to one time a day as with other antidepressants. The best way to prescribe MAOIs is to measure baseline platelet MAO activity. Treatment can then begin and the platelet MAO is repeated in three to four weeks. Treatment responses should be associated with 80-90% inhibition of platelet MAO activity. Clients vary greatly as to their MAO activity making it impossible to predict what an ideal dose should be for any one patient (Nemeroff & Schatzberg, 2002). MAOIs can bring about a swing from depression to a manic stage in bipolar disorder, and they can activate psychosis in a patient who has schizophrenia. The use of MAOIs should not be stopped suddenly since this can cause the client to quickly return to the previous depressive state (Long & Ryback, 1995).

Several early studies showed that MAOIs were effective in producing a reduction in depressive symptoms. A Swiss psychiatrist named Roland Kuhn used imipramine in 1956 for 300 clients with several different types of mental illnesses. They were treated for a year. Some participants included in the study were diagnosed with endogenous depression. Imipramine was shown to have a strong antidepressant effect on these individuals, and in some cases reduction in symptoms occurred within a few days after treatment started (Kuhn, 1957).

Several years later, J. Schildkraut in 1965 hypothesized that depression was due to an insufficient amount of catecholamines, mainly norepinephrine, at adrenergic receptor sites in the brain. Strong evidence was found in support of this theory, and MAOIs were

shown to have an antidepressant effect because they increase the amount of catecholamines at the synapse (Spiegel, 2003). Sternberg and Jarvik (1976) hypothesized and found evidence that the MAOIs amitriptyline and imipramine not only brought about reduction of depression symptoms, but also produced better memory functioning within four weeks of improvement.

Lithium has been prescribed to treat recurring episodes of depression, but it is mainly used for bipolar disorder. It is effective in preventing recurrences of depression in unipolar depression and is 70% effective in mood stabilization (Adderly, 1999). It has side effects that include loss of appetite, nausea, thirst, tremor, fluid retention, and a metallic taste. It can be toxic; therefore, blood levels must be monitored. Some foods are restricted, and thyroid and kidney functions have to be continuously checked. Lithium takes its toll on the body and should not be used for extended periods of time unless it is absolutely necessary.

Heterocyclics are another class of antidepressants that have been successful in the treatment of unipolar and bipolar disorders (Davis, Wang & Janicak, 1993). Some examples are maprotiline, amoxapine, and trazodone. Maprotiline acts faster than a TCA, but it is very sedating. Amoxapine can cause tardive dyskinesia and symptoms that resemble Parkinson's Disease. It cannot be used for longer than four months. Trazodone is sedating and has had success in the treatment of elderly patients (Long & Ryback, 1995). These antidepressants are more easily tolerated and are less toxic than earlier ones used. This is an advantage that could reduce interruptions in treatment or stopping of treatment. These medications can be important to use for clients with a high risk of

relapse or for those who are suicidal. They are preferred for use in the treatment of elderly clients and outpatients (Rudorfer & Potter, 1989).

Ritalin has been used for long-term treatment of depression in some elderly patients, and Xanax, a benzodiazepine tranquilizer, has shown some success in short-term treatment of minor depression. (Long & Ryback, 1995).

Another drug that has been used for treatment of depression is Venlafaxine (SNRI). It is a selective noradrenaline reuptake inhibitor. This antidepressant promotes dual reuptake inhibition of serotonin and noradrenaline. It has been shown to be equal to other antidepressants in its efficacy and produces less nausea and dizziness. It comes in extended release form which may make compliance easier than other antidepressants (Olver, Burrows & Norman, 2004). A more recent study completed by Guitierrez, Stimmel, and Aiso (2003) have shown it to be useful for remission in depression and treatment-resistant depression. It was shown to be superior to SSRIs for severe major depressive disorder, depressive symptom disorder, and treatment-resistant depression. In the past ten years, no new or adverse effects have been identified with venlafaxine use except the possibility of a fatal overdose (Guitierrez, Stimmel & Aiso, 2003).

Clients experiencing no response or partial response to other antidepressant treatment were involved in an empirical study using venlafaxine. The adult subjects were male and female, ages 18 years and beyond, diagnosed with depression. One third of them was unresponsive or had only partial response to venlafaxine. Treatment at this point usually involves switching to another antidepressant, adding other psychotropic agents, or combining antidepressants. The subjects of this study had already been on at

least two different classes of antidepressants or combination of them for a considerable time. This study evaluated the effect of adding an SSRI (either sertraline, paroxetine, or citalopram) to their venlafaxine treatment. It was concluded that there was improvement in all cases (Gonul, Akdeniz, Donat & Vahip, 2003) indicating that combinations of antidepressants may be necessary to successfully care for treatment resistant clients.

Montes, Ferrando and Saiz-Ruiz (2004) conducted a naturalist six-month follow-up study of 44 unipolar depressed adult outpatients to evaluate the rate of remission obtained with SSRIs and to assess alternative treatments. The Hamilton Rating Scale for Depression was the outcome measurement used. After receiving treatment for six weeks, the patients were categorized as remitted, partial responders, or nonresponders. If a patient was a nonresponder, they were given an antidepressant with noradrenergic action or switched to venlafaxine. At the end of the follow-up 96.2% of the non-responders had experienced remission with the alternative treatment, and 31.8% of the initial sample were remitted with SSRIs. This study showed the benefit of using treatments that have a combined mechanism of action. It also showed that SSRIs have a low remission rate in the long-term treatment of severe and melancholic depression.

Duloxetine, a dual reuptake inhibitor of norepinephrine and serotonin, was evaluated against placebo and paroxetine (SSRI) for treatment of emotional and physical symptoms of major depressive disorder. A randomized double blind design was used involving depressed adult outpatients. Duloxetine was prescribed at 40 mg. twice a day or 20 mg. twice daily. Other participants received either 40 mg. of placebo two times a day or 20 mg/d of paroxetine. The Hamilton Depression Rating Scale, Visual Analog Scales for Pain, Clinical Global Impression of Severity, Patients' Global Impression of

Improvement, and the Quality of Life in Depression Scale were used as outcome measures. Safety was assessed through laboratory tests, discontinuation rates, vital signs, and adverse events rates. Results showed the duloxetine at 80 mg/d and at 40 mg/d was superior to placebo on the Hamilton Depression Rating Scale with a total change of 3.62 points and 2.34 points, respectively. Paroxetine was not. Duloxetine was superior to placebo for most measures and was superior to paroxetine on the 17 – Item Hamilton Depression Rating Scale improvement. The estimated probability of remission for duloxetine was 57%, 34% for paroxetine, and 11% for placebo. The conclusion reached was that duloxetine was efficacious for the treatment of emotional and physical symptoms of depression (Goldstein, Lu, Detke, Wiltse, Mallinckrodt & Demitrack, 2004). These triple uptake inhibitors may be superior first line treatments because they have high rates of response and they produce fewer sexual and gastrointestinal side effects. They also show that psychiatric disturbances occur in more than one neurotransmitter system, or disturbances in more than one neurotransmitter system could produce similar clinical features.

Another study that evaluated combining different categories of medications to see what their effects would be on depression tested Olanzapine, an antipsychotic and fluoxetine, and SSRI. They were combined in a 76-week open-label study involving 560 adults diagnosed with major depressive disorder with or without treatment-resistant depression. The study examined long-term use safety and efficacy of the drug combination. The Montgomery-Asberg Depression Rating Scale (MADRS) was the measure used. By ½ week of treatment, MADRS mean total scores decreased by seven points (31.6[N=552]). Eleven point reductions were seen in one week and 18 points in

eight weeks. A mean decrease of 22 points in 76 weeks was maintained. Remission and response rates were 56% and 62% respectively for the total sample. The relapse rate was a low 15%. Response, remission, and relapse rates for treatment-resistant depression were 53%, 44%, and 25% respectively indicating that combining an anti-psychotic medication and an SSRI may be a favorable treatment for some clients (Corya, Anderson, Detke, Kelly, Sanger, Williamson & Dube, 2003).

The Agency for Health Care and Policy Research (AHCPR, 1999) investigated 29 newer antidepressants (SSRIs) and three herbal supplements used for treatment of depressive disorders in children and adults to evaluate their advantages and adverse effects. Twenty-four specific questions were formulated by an expert multidisciplinary panel based on two key principles: the ability to summarize new information that has not been dealt with in past literature synthesis and the relevance to practitioners and policymakers in making treatment decisions and creating guidelines. The questions were concerned with the effectiveness of newer pharmacotherapies for the most frequently occurring types of depression and for clients with refractory or recurrent depression. Some questions addressed the effectiveness of newer medications as compared to psychosocial therapies and herbal treatment. These questions were formulated so answers could be found for them through the research process. Data was taken from literature that related to the specific topics.

Rating scales or clinical diagnosis, total dropouts, and dropouts due to adverse side effects were used to measure primary outcomes. Secondary outcomes were functional status, health-related quality of life, and suicides. Specific populations (e.g., adolescents and children) were focused on along with specific settings (e.g., primary

care). Combination treatments with other psychotropics, psychosocial therapies, and other agents were evaluated. Long-term efficacy was studied through relapse prevention studies. English and non-English literature was selected for a registry of 8,451 clinical trial articles along with references from meta-analyses and experts. Trials dealing with depression came from a variety of sources including electronic databases, biological abstracts, the Codhrane Library, 69 psychiatry-related journals, and 30 pharmaceutical companies. The search extended from 1980 to 1998 focusing on literature related to newly released antidepressants.

Randomized controlled trials lasted for at least six weeks, and compared a newer antidepressant to another (newer or older) one, placebo, or psychosocial intervention. Patients with depressive disorders were included in the study and clinical outcomes were measured. Three hundred fifteen trials were reviewed by two or more independent reviewers. Data was synthesized descriptively and analyzed quantitatively using an empirical Bayes random-effects estimator method. Primary outcomes were symptomatic response rate, discontinuation rates due to adverse events, and total discontinuation rates (dropouts). Response rates were assessed at a 50% or more improvement in symptoms ascertained by a depression symptom rating scale or a rating of very much improved or much improved by a global assessment method. Over 300 randomized trials studied newer pharmacotherapies for depression, the majority (90%) for major depression. The largest number of comparisons were between older and newer antidepressants (n=206). More than 100 of the studies compared the newer antidepressants' efficacy to placebo. Over 90% of the trials were short duration (6-8 weeks), and a double-blind methodology was employed. A great deal of information was synthesized at the conclusion of this



comprehensive study. Over 80 studies showed that the newer antidepressant drugs were more efficacious than placebo for treating major depression in adults with response rates being 50% for treatment and 32% for placebo. The newer antidepressants were also shown to be equally efficacious as first and second generation tricyclic antidepressants, and for patients who continued treatment with newer antidepressants for at least six months after their recovery their risk of relapse was decreased by 70%. Two SSRIs (fluoxetine, sertraline) and amisulpride were shown to be efficacious for treatment of dysthymia in adults with response rates being 59% as compared to 37% for placebo. There was not enough evidence to ascertain whether or not newer antidepressants were effective for mixed anxiety depression or for minor depression.

It was noted that patients stopped treatment at similar rates for newer and older antidepressants because of lack of effect, side effects, or other reasons. Fewer patients taking SSRIs or reversible inhibitors of monoamine oxidase stopped treatment because of adverse effects as compared to individuals taking first generation tricyclics with the rate differences being 4% and 5% respectively. SSRIs had higher rates of diarrhea, nausea, insomnia, and headache when compared to first generation tricyclics. Some uncommon serious adverse affects were also associated with SSRIs such as bleeding, seizures, hyponatremia, bradycardia (slowing down of the heart), hepatotoxicity (damage to the liver), extrapyramidal effects (i.e. shuffling gait, involuntary motor reactions, Parkinson-like tremors), serotonin syndrome, granulocytopenia (a fatal blood disorder), and mania in unipolar depression. TCAs had high rates of dry mouth, constipation, dizziness, blurred vision, and tremors.

This study also evaluated alternative forms of treatment. It was concluded that the herbal supplement, St. John's Wort, was shown to be effective for some clients for short-term treatment of mild to moderately severe depressive disorders over placebo. Less adverse side effects were noted when compared to first generation TCAs (National Center for Complementary and Alternative Medicine, 2002). There have been some concerns about the safety of this herb due to adverse interactions with other drugs such as indinavir and cyclosporine. Earlier studies have also shown it to be ineffective in the treatment of major depression of moderate severity (National Institute of Mental Health, 2001).

In addition, the ACHCPR (1999) study also presented evidence that newer antidepressants are effective for the treatment of major depression and dysthymia in mental health and primary care settings. They have similar efficacy and total dropout rates when compared to older antidepressant medications and because of this both should be considered when making decisions for treatment (Agency for Health Care Policy and Research Publication Number 99-EO13, 1999).

One side effect that has contributed to noncompliance of antidepressants is the impact these medications have on sexual functioning. Solutions to this problem are being researched to encourage clients' compliance. One study examined this issue through 30 clients who experienced sexual problems from the use of SSRIs. Dosages of medication were stopped for the week on Thursday morning and started again on Sunday evening. Sexual functioning improved significantly during the drug-free time for those individuals taking Paxil and Zoloft but not for Prozac. Depressive symptoms did not worsen during this brief "drug holiday". Another attempt to resolve this side effect was to switch clients

to a structurally different medication like Serzone. Eighty men and women at four medical centers were treated with Zoloft for six weeks. They were switched to Serzone with both men and women reporting an improvement in sexual interest lasting for 36 weeks. Both medications were considered highly effective in treating depression for 64% of the patients (Brody, 1996).

A second study examined 75 clients experiencing sexual dysfunctions while on Paxil. Clients underwent a two-week drug free period to restore sexual functioning. They were then randomly assigned to either Serzone or Zoloft for eight weeks. No difference was shown in antidepressant affects, but sexual problems occurred more than two and ½ times as often in the patients taking Zoloft (Brody, 1996). Continued research in this area may help alleviate some of the sexual concerns that either prevent people from using antidepressants or cause them to stop using them.

#### Summary of Pharmacological Treatments:

Pharmacological treatments have been empirically shown to be efficacious. With the pharmacological treatments currently available to use, depressed clients can expect to achieve partial symptom relief in two-four weeks after receiving the standard therapeutic doses. After four-six weeks of treatment, when it is successful, full response as in 50% or more improvement in scores on the Hamilton Rating Scale for Depression can be attained. The newer dual action antidepressants seem to have advantages over SSRIs for remission of depression, and combined with dual-reuptake inhibitors may offer better efficacy with less side effects (Kennedy, 2003). TCAs are beneficial in the treatment of

severe depression and psychotic episodes. They are 60-75% effective in treating major endogenous depressive illness and severe reactive depression (Long & Ryback, 1995).

SSRIs do not seem to be as effective for severe depression or depression with melancholic features. They better treat mild to moderate depressive symptoms or depressive reactions that are prolonged. There is no data supporting the superiority of one SSRI over another, but there are differences in side effects and costs (Paton, 2000). The newer SSRIs such as Paxil, Prozac, and Zoloft are being looked upon as the panacea for depression treatment, but they are not without problems. They still have side effects, and these effects can be physical as well as psychological. Clients have reported having problems with empathy, sociability, creativity, and irritability while on these antidepressants. Some patients may have an increased risk of suicide (Bolling, 2004). An increase in the use of these medications for adolescents and younger children has been noted. The short-term and long-term effects on these two populations have not been fully studied at the present time. There is some risk of overdosing on SSRIs, but the chances of death are slim (Kapur & Mann, 1992). In addition, they can cause serious problems if combined with other medications due to their pharmacokinetic and pharmacodynamic properties (Settle, 1992). They can also cause fatal reactions if combined with a MAOI. Both TCAs and SSRIs are efficacious for treatment of major depressive disorder and dysthymia.

MAOIs seem best for unipolar and atypical depressions. They are considered after periods of inadequate response to TCAs and SSRIs. They bring about remission in unipolar depression, severe depression, and treatment resistant depression. Cyclical depression seems to respond to combinations of antidepressants and lithium.

A major area of concern for clients and clinicians is that clinical trials indicate that more than 50% of patients having depression have inadequate responses to antidepressant therapy (Kennedy & Lam, 2003). Secondly, research shows that 30% of patients do not respond to the first antidepressant prescribed, while 5-10% are still depressed after several different therapeutic interventions (Paton, 2000). In addition, adherence to antidepressant medication is low. A third concern is that antidepressants are looked upon as addictive (van Schaik, Klijn, van Hout, van Marwijk, Beekman, de Haan & van Dyck, 2004). Fourth, they have to be used with caution due to their side effects and interactions with other drugs. A fifth concern is that they initially can cause drowsiness, and they usually take a period of trial and error before the right dosage is achieved. This can make taking antidepressants frustrating and discouraging. A sixth concern, noncompliance, is the main reason clients stop pharmacological treatment.

With noncompliance being a major reason for the discontinuation of medication, newer recommendations will be even more of a deterrent for some clients. The American Psychiatric Association (APA) published a Practice Guideline for the Treatment of Patients with Major Depressive Disorders (2000) and recommended that medication usage should be extended beyond the time when the client starts to feel improvement. The APA is advocating for continuance of medication for four-five months after depressive symptoms have been reduced. The British Association for Psychopharmacology Evidence Based Guidelines for Treating Depressive Disorders with Antidepressants (2000) advocated continuing antidepressants for six months and up to five years for those individuals who have had more than three major depressive episodes in the past five years or if other factors such as social or personality may bring about a

recurrence or relapse. This may be discouraging news for those taking antidepressants and wanting to get off of them quickly. It may be difficult convincing clients to continue taking them for such an extended period once they begin to feel better.

#### Psychotherapy:

There are many different kinds of therapy to choose from, and certain therapies seem to successfully treat specific problems. Psychotherapy has been shown to be an effective method to treat depression. For example, Steinbrueck, Maxwell, and Howard (1983) conducted a meta-analysis of 56 controlled outcome studies to show the effectiveness of both drug therapy and psychotherapy in the treatment of unipolar depression in adults. Behavioral therapy, social learning, interpersonal, cognitive, marital, and a combination of cognitive, social learning and behavioral therapies were examined. Thirty-five varieties of drug therapies were also evaluated with imipramine and amitriptyline being prescribed most often. Results indicated that psychotherapy has a significantly stronger impact on unipolar depression. It was shown to be superior to drug therapy with a mean size effect of 1.22 as compared to .61, respectively.

One important advantage of psychotherapy over medication relates to client preferences (van Schaik et al., 2004). In a study of preferences in the treatment of depression, it was concluded that the majority of patients preferred psychotherapy. Psychotherapy was viewed as the way to solve the causes of depression. More patients received treatment that was preferable to them because they were able to discuss their feelings and get support. The clients' preferred method of treatment is important in research and clinical practice as their preferences may affect outcomes in clinical trials.

There are two major forms of therapy used in the treatment of major depressive disorders. The first major form of therapy is cognitive behavior therapy (CBT). CBT focuses on correcting the behavioral and cognitive causes that keep a person in depression. Negative thoughts and dysfunctional beliefs are identified and evaluated. With this new awareness, emphasis is placed on learning to control internal thoughts, motivations, and feelings. Cognitive change may affect depression management. Effective behavior and cognitive interventions can help clients to think differently. Future possibilities can be separated from past negative experiences. In CBT, a client's problem is defined and moved from being general to more specific. This can help change behavior from the dysfunctional to functional (Rees, Hardy, Barkham, Elliot, Smith & Reynolds, 2001). CBT helps develop self-management skills in the form of journal keeping, specific behavior assignments, contracts, and environmental changes. Relaxation techniques, exposure, and management of anxiety are also included. Cognitive restructuring begins when systematic rational restructuring, realistic goal setting, using controls, and making changes of unrealistic characteristics of failure and success take place.

CBT includes skills training to teach the client methods for testing how valid their beliefs are. Clients learn strategies that can be applied to many situations. Learning occurs in therapy, and practice is done through the homework assignments. Homework can initiate behavioral and cognitive changes necessary to change the underlying belief structure. Those who completed the homework assignments had 64% reduction in their Beck Depression Inventory scores. They improved three times as much as those who did not (Detweiler & Whisman, 1999).

CBT trials showed that cognitive changes are associated with good outcomes for people dealing with depression (Elkin, Shea, Watkins & Imber, 1989). Cognitive changes can have an effect on the management of depression. Behavioral and cognitive interventions can help clients think differently and ultimately help them change dysfunctional behaviors to functional ones (Rees, Hardy, Barkham, Elliott, Smith & Reynolds, 2001).

The Agency for Health Care and Policy Research (AHCPR, 1999) recognizes cognitive behavioral therapy as a first-line treatment for depression. It is effective, comparable, may even be superior to medication, and has lower rates of relapse (McGinn, 2000).

Research conducted by the National Institute of Mental Health (NIMH) has shown that certain types of psychotherapy, mainly cognitive-behavioral therapy and interpersonal therapy, can relieve depression. Cognitive behavioral therapy or interpersonal psychotherapy should be considered the treatment of first choice for depression due to superior long-term outcome and fewer medical risks. Fifty to 80% of patients will respond to specific psychotherapeutic strategies in 8-16 weeks without drugs (Antonuccio, Danton & DeNelsky, 1995).

CBT has been compared to no treatment and to behavioral treatment. Cognitive and behavioral interventions for the treatment of depression were found to be equally effective (Wilson, Goldin & Charbonneau-Powis, 1983) in a research study involving 25 depressed 20-60 year olds. They were assigned to one of three options-behavioral treatment, no-treatment, or cognitive treatment for eight weeks. Symptoms of depression



were evaluated before treatment, at four weeks, eight weeks, and at a five-month follow-up. The Hamilton Rating Scale for Depression, the Beck Depression Inventory, Irrational Beliefs Test, Pleasant Events Schedule, a cognition schedule, and a mood rating form were all utilized as outcome measures. Significant improvement was found in both treatment groups but not in the no-treatment group. Behavioral treatment and cognitive treatment were shown to be equally effective in reducing depression symptoms and their effects were maintained during follow-up.

In contrast, another study (LaPointe & Rimm, 1980) comparing cognitive therapy, assertive therapy, and insight-oriented therapy presented in group therapy form, cognitive treatment did not appear to be as efficacious as the other therapies. Thirty-three women exhibiting depression that was situationally related participated in a six-week program of therapy. The BDI, Rathus Assertiveness Schedule, Personality Data Form, and four tape-recorded scenes were used as outcome measures. Clients were evaluated after six weeks and at a two-month follow-up. All groups showed significant improvement in depression, assertiveness, and rationality. The insight and assertive groups improved significantly more in rationality than the cognitive group. At the two-month follow-up none of the assertive group had requested further treatment. These participants exhibited more rationality in relationship to their self-worth and frustrating life events. Both the assertive and insight groups were shown to have made more significant gains than the cognitive group.

Another study has given evidence that CBT leads to faster reduction of symptoms as compared to nondirective counseling or general practitioner care in patients with moderately severe depression. Ward, King, Lloyd, Bower, Sibbald, Farrelly, Gabbay,

Tarrier and Addington-Hall (2000) conducted a prospective, controlled trial with randomized and patient preference allocation choices to compare the effectiveness of general practitioner care and two general based psychological therapies (non-directive counseling based on Carl Rogers and CBT) for clients diagnosed with depression. Participants included 464 individuals with depression or mixed anxiety and depression. The Beck Depression Inventory, social functioning, satisfaction with treatment at baseline, four months, and 12 months, and other psychiatric symptoms were used as the main outcome measures. One hundred thirty-seven clients chose their treatment. One hundred ninety-seven were randomly assigned, and 130 were randomized between the two psychological therapy methods. Those under the care of a general practitioner acted as the control group. Patients in the control group received care based on the treatment that was normally provided by a general practitioner, which included a combination of therapy strategies.

Results of the study indicated that all three of the different groups showed some improvement over time. Individuals in non-directive counseling and CBT improved more on the BDI than the control group at four months. Their mean scores were 12.9 and 14.3, respectively. Those randomized to usual general practitioner care had mean scores of 18.3. No significant differences were noted between the two therapies. At the end of 12 months, there were no significant differences between the three treatment groups. BDI scores were 11.8, 11.4, and 12.1 for non-directive counseling, CBT, and general practitioner care. The conclusion reached at the end of this study was that short-term psychological therapy reduces depressive symptoms more effectively in a short period of time when compared to usual general practitioner care, but after 12 months the outcomes

were similar. This is beneficial information indicating that if symptoms can be quickly reduced through psychotherapy, and the client can begin to feel relief, the use of medication may not be necessary.

A study (Wierzbicki & Bartlett, 1987) was designed to compare the efficacy of individual cognitive therapy and group cognitive therapy in the treatment of mild depression. Nine individuals were assigned to group therapy and nine to individual therapy for a six-week time period. The BDI, the Brief Symptom Inventory, the D30 Depression Scale, the Tennessee Self Concept Scale, and the State-Trait Anxiety Inventory were used for assessment before and after the treatment or waiting period. Those who were assigned to individual therapy showed more improvement over those in group therapy and waiting list. Differences between group therapy and waiting list were insignificant, but group therapy participants had greater improvement than the control group in follow-up. The study gave evidence that for mild depression individual CBT brought about the most improvement, and group CBT had more effect than delayed treatment conditions.

#### Cognitive Behavioral Therapy versus Medication:

Some studies have found CBT to be more effective than medication in the treatment of depression. The major studies will be discussed.

Studies such as the landmark study conducted by Rush and colleagues in the 1970s have shown the effectiveness of CBT in the treatment of depression. CBT was found to be superior to imipramine tricyclic pharmacotherapy. Relapse rates are lower for those receiving CBT, 39% as compared to those taking antidepressants, 65%. CBT

was shown to effectively treat depression, is comparable, and may even be superior to medications. CBT reduces relapse and recurrence in depression for outpatients having major depression. Results showed less subsequent relapse or the need for additional treatment over recovered patients who used pharmacotherapeutic methods. This study demonstrated that cognitive therapy was more effective than antidepressant therapy in treating clinical depression (Rush, Beck, Kovas & Hollon, 1977). Rush, Beck and Kovacs (1979) again showed that psychosocial treatment was superior to medication in the treatment of depression.

Another study concluded that cognitive behavior therapy was superior in the treatment of clinical depression over behavior therapy and drug treatment (Dobson, 1989). Twenty-eight studies were reviewed to compare results of CBT and other treatments. Ten studies comparing CBT to wait-list control or no-treatment showed that the CBT clients scored better than 98% of those in the control group using the Beck Depression Inventory as an outcome measure. Nine studies compared CBT to behavior therapy with outcomes that showed that CBT participants scored 67% better than those in behavior therapy. Seven studies compared CBT to other psychotherapies with CBT users having better results. In the eight studies comparing CBT to pharmacotherapy, CBT clients did better than 70% of those using drug therapy. CBT was also shown to have rapid effects since most of the studies lasted on average 14.9 weeks.

A study conducted by Murphy, Simons, Wetzel and Lustman (1984) randomly assigned 87 moderately to severely depressed psychiatric outpatients to 12 weeks of cognitive therapy, nortriptyline, cognitive therapy plus nortriptyline, or cognitive therapy and an active placebo. The results showed that cognitive behavior therapy was as

effective as nortriptyline. After a year follow-up those who received CBT were less likely to relapse. Those who received nortriptyline alone or with therapy were more likely to relapse. Medication treatment may make relapse more likely and may interfere with long-term successfulness of cognitive therapy.

CBT reduced depressive symptoms of outpatients with atypical features in a study that included 25 patients 20-58 years old diagnosed with major depression, major depression superimposed on a dysthymic disorder, or dysthymic disorder. They received CBT, and antidepressant medication was prescribed for any nonresponders. Fourteen responded to CBT by itself. Nine out of 13 maintained treatment gains in a six-month follow-up. Seven out of 11 nonresponders had positive outcomes using antidepressant medication. For treatment of acute phase and atypical depression, CBT is more effective than waiting list controls, does not differ significantly from antidepressant medications, and may not differ when used in combination with pharmacotherapy. When 20 sessions took place two times a week for ten weeks, there were no significant differences between CBT and phenelzine (Mercier, Stewart & Quitkin, 1992).

CBT can improve clients' skills and competence to avoid and reduce relapse and recurrence and increase time between episodes when the learned skills are used (Jarrett & Kraft, 1997). This takes place during the continuous/maintenance phase of cognitive therapy. These findings are from research on the outcomes of case studies of clients diagnosed with major depressive disorder over a ten year span. Randomized, clinical trials were conducted at a Southwestern Medical School in a major metropolitan area to test the hypothesis that continuation/maintenance phase cognitive therapy decreases the chance of relapse. Depression was described to the patients, and they underwent

extensive evaluations involving structured interviewing, clinician-rating scales, surveys, medical consultations, and laboratory screenings. They could then choose the treatment preference they wanted, either short-term psychotherapy or antidepressant pharmacotherapy. The DSM-IV was used for diagnostic purposes. The Hamilton Rating Scale, Inventory of Depressive Symptoms-Clinician Rating and Self-Report Versions (IDS-C and IDS-SR), and the Beck Depression Inventory were employed as outcome measures.

The clients that chose CBT were given 8-12 sessions of acute phase therapy with a clinician who worked with them to respond to treatment and to strive for partial remission. The purpose of acute phase therapy is to decrease symptoms of depression. At 20 sessions complete remission was the goal. When the client achieved this stage sessions were reduced and the continuation phase has begun. The outcomes of relapse prevention and full remission were aimed for. Recovery occurs when the patient is no longer having symptoms of depression, and he or she is at their non-depressed baseline state. This is when maintenance therapy begins. The therapist at this point decides how often to see the client. Many of the participants were depression free after 20 sessions of acute phase cognitive therapy, but they relapsed at high rates during the six-eight months after treatment termination. It was evident that CBT was effective in reducing depressive symptoms, but it was concluded that it was terminated too soon. Continuing treatment for a longer period of time to change dysfunctional attitudes seemed necessary to reduce relapse and to insure complete recovery.

Therapy that builds the clients' self-confidence and belief in their own abilities produces the most powerful behavior changes. Cognitive reactivity to mood changes in

patients who had previously been depressed was studied (Segal, Gemar & Williams, 1999). Twenty-five patients who received CBT and 29 treated with pharmacotherapy filled out self-reported ratings of their dysfunctional attitudes before and after an incident were presented to produce a sad mood. The patients receiving medication displayed increases in dysfunctional cognitions compared to the CBT group. Follow-up studies on 30 clients several years later showed that their reactions to the mood induction activity were predictive of depressive relapses. Those trained with CBT experienced fewer relapses.

In a study spanning 18 months Shea, Elkin, Imber and Sotsky, (1992) concluded that the psychotherapies outperformed imipramine on almost every measure of outcome. Cognitive therapy was ranked best on 11 out of 13 outcome measures reported, and there was reduced risk for relapse. Clients receiving CBT showed the highest rates of recovery. This group had the highest percent of clients that recovered without a subsequent major depressive relapse, and the highest percent of clients recovered without major depressive relapse or seeking of treatment.

One hundred sixty-two clients indicated no significant differences among the treatments in ratings of current clinical condition or in symptom reduction, but differences were seen in the patients' ratings of the effects of treatment on their life adjustment. Clients using IPT and CBT stated that the use of these therapies gave them control of their negative self-thoughts. They were able to have more understanding of the effects of unbending self-attitudes and of interpersonal relationships that were contributing to their depression. Clients in both psychotherapy groups felt more in control of their lives. They understood the sources of their depression more so than did

clients in the imipramine clinical management group or the placebo group. They reported having more adaptive methods of coping and were better able to deal with their depression (Blatt, Zuroff, Bondi & Sanislow, 2000). Shea, Elkin, Imber and Sotsky (1992) had similar findings in an earlier follow-up study using the Longitudinal Interval Follow-up Evaluation. CBT and IPT helped clients develop better coping mechanisms and enabled them to more effectively manage their lives and their depressive symptoms.

McLean and Hakstian (1979) conducted a study with 178 participants who completed ten weeks of drug therapy, relaxation therapy, behavior therapy, or insight-oriented therapy. Fifty-five non-depressed people were included for comparison purposes, but they were not part of the data analyses. The Depression Adjective CheckList, The Eysenck Personality Questionnaire, and the Beck Depression Inventory were used as outcome measures. Behavior therapy was superior on nine out of ten measures at conclusion of treatment. At three-month follow-up, it was marginally superior. On outcome measures drug therapy and relaxation therapy had no significant differences. Psychotherapy had the poorest outcomes at every evaluation time period. In a 27 month follow-up behavior therapy ranked best on six out of seven outcome measures. It led to better results in areas of personal activity, mood, and social skills. Twice as many behavior therapy participants fell within one standard deviation of the nondepressed control group.

In 1990, a follow-up study was conducted similar to the one mentioned in the last study (McLean & Hakstian, 1990). Treatments that included behavior therapy, pharmacotherapy, relaxation therapy, or nondirective therapy were assigned to 121 unipolar depressed outpatient clients. A control group of nondepressed individuals was



also included in the study. Clients were evaluated at six different time periods on 28 measures. Again, it was found that behavior therapy was associated with improved mood, social activity, and personal productivity.

Dobson (1989) reviewed eight randomized studies that compared Beck's cognitive therapy to tricyclic medication for the treatment of depression. Comparisons were made between cognitive therapy, pharmacotherapy, behavior therapy, waiting list or no-treatment control, and other psychotherapies. Cognitive behavior was found to be superior to drug treatment according to the results obtained on the Beck Depression Inventory. The cognitive therapy users did better than 70% of those on medication. There was an average differential effect size of 0.53 favoring cognitive therapy. The amount of change did not seem to be related to the length of the therapy or the proportion of women in the studies.

Blackburn, Eunson and Bishop (1986) performed a two year follow-up of 41 depressed patients treated with either cognitive therapy (n=15), pharmacotherapy (n=10), or the two treatments combined (n=16). The age ranges for the patients were 39-47 years. At six months, there were significantly more relapses for those in the pharmacotherapy group as compared with the therapy and the combined treatment groups. Over the next two years the number who continued to relapse was significantly higher in the pharmacotherapy group than in the other two showing possible prophylactic potential of cognitive therapy.

Kovacs, Rush, Beck and Hollon (1981) used a controlled, clinical-trial format with 44 nonbipolar, nonpsychotic depressed outpatients 19-60 years old. The Hamilton

Rating Scale for Depression and the Beck Depression Inventory were used to determine the types and degrees of depression. Patients were treated over a 12-week time period with cognitive therapy or imipramine hydrochloride. Both groups showed reductions in depression symptoms, but the cognitive therapy group showed greater improvement and a higher completion of treatment rate. Thirty-five people in both groups in the one-year follow-up were still doing well. On self-ratings the symptoms for those who completed cognitive therapy were significantly lower than those treated pharmacologically.

Simons, Murphy, Levine and Wetzel (1986) performed a follow-up study of 70 clients having nonbipolar affective disorders who were treated with cognitive therapy or nortriptyline for 12 weeks. The participants ranged in age from 18-60 years old. They were assigned to cognitive therapy, nortriptyline, cognitive therapy with active placebo, or a combination of cognitive therapy and nortriptyline. Clients were evaluated at one month, six months, and one year after completion of treatment. Measures including the Beck Depression Inventory and depressive symptoms were used to assess their functioning. Sixteen relapsed and had to reenter treatment. Twenty-eight were doing well. Those with significant depressive symptoms were more likely to relapse than those with less severe levels. Those who relapsed had higher levels of dysfunctional attitudes at the end of treatment. More importantly, those in the cognitive therapy groups with or without nortriptyline were less likely to relapse as compared with those who received only pharmacotherapy.

Two studies conducted to evaluate the impact of continuing medication ended up showing that treating depression with brief cognitive behavioral therapy is a more cost effective treatment over long term drug therapy (Evans et al., 1992; Hollon et al., 1992).

In Evans et al., (1992) the relapse rate for 50 nonpsychotic, nonbipolar depressed outpatients were calculated over a two-year period. The clients had undergone a 12-week treatment program that consisted of pharmacotherapy and cognitive therapy. The Hamilton Rating Scale for Depression and the Beck Depression Inventory were used to establish whether the client relapsed by measuring their depressive symptoms. Outcomes showed that cognitive behavioral therapy prevented relapse when used alone or with medication. It was as effective as the continuation of medication to prevent relapse without the expense.

A study that was originally done by Rush, Beck, Kovacs, and Hollon (1977) was replicated by Hollon, DeRubeis, Evans, Wiemer, Garvey, Grove & Tuason (1992). They compared imipramine tricyclic pharmacotherapy to cognitive behavior therapy. Research was conducted on the subset of 64 depressed outpatients who completed the 12-week protocol of treatment and 107 depressed outpatients initially assigned to the treatment. Results from the earlier study showed cognitive therapy to be superior to the imipramine tricyclic therapy. This study showed little difference between the two treatments and no difference in overall response. Using combined treatment was no better than either treatment alone, but there was a potential modest advantage with cognitive therapy that needed further exploration.

Another study that has shown CBT to be more effective than antidepressant medications was presented by Blackburn, Bishop, Glen, Whalley and Christie (1981). They completed a study that involved 49 outpatient clients diagnosed with mild to moderately severe depression and 39 clients receiving care from general practice providers. Out of 88 clients, 64 finished the study. Fifty were women and 14 were men.

Research Diagnostic Criteria and self-rating scales were used as selection instruments. Clients received either cognitive therapy for two hours per week for three weeks, 150 mg/day of amitriptyline or clomipramine, or cognitive therapy and medication. The outcome showed that cognitive therapy was successful in the treatment of mild to moderately severe depression and that medication treatment for clients with depression due to life situations was not the most efficacious treatment. Drug therapy by itself was the least successful treatment for both the outpatient and general practice groups. For the general practice clients, cognitive therapy was significantly better than medication.

Other studies have found CBT to be as effective, but not more effective than medications. Some of those studies will be presented. These studies have concluded that CBT and medication are effectively the same in terms of treatment success.

Antonuccio, Danton and DeNelsky (1995) concluded that antidepressants are the most popular treatment for unipolar depression, but cognitive behavior therapy is at least as effective as medication even for severe depression. This treatment is effective for vegetative and social adjustment symptoms, especially when the outcome is assessed by patient rated outcome measures and when a long-term follow-up is included (Beck, Hollon, Young, Bedrosian & Budenz, 1985; Murphy, Simons, Wetzel & Lustman, 1984; Wexler & Cicchetti, 1992).

Hollon, Shelton and Loosen (1991) did a review of nine randomized controlled studies comparing CBT and tricyclic medications in treating nonbipolar depressed outpatients. It was concluded that cognitive therapy is comparable to medication in the treatment of the acute episode, combined cognitive therapy and drug treatment does not

appear to be clearly superior to either modality alone, and treatment with cognitive therapy with or without drugs during the acute episode appears to reduce the risk of relapse after termination.

Rush, Beck, Kovacs and Hollon (1977) conducted a study of 64 depressed outpatients in 12 weeks of treatment and the original 107 depressed outpatients assigned to the treatment in the study. There was very little difference between cognitive therapy and imipramine tricyclic pharmacotherapy. There were no differences found in overall response rates. In addition, there was no evidence that combined treatment was superior to either treatment alone.

Elkin et al., (1992) studied two hundred fifty unipolar clients who were randomly assigned to one of four different groups. The participants were provided cognitive therapy, interpersonal therapy, tricyclic antidepressants, or placebo. The patients, 70% women and 30% men, were moderately to severely depressed. They received 16 weeks of treatment and were evaluated using tests and interviews. Over 50% of the patients in the two psychotherapy groups and medication group remitted. Only 29% of the placebo group recovered. The medication group improved quickly, but the two therapy groups caught up by the end of the 16 weeks. The results indicated that although medication may reduce symptoms faster, psychotherapy can achieve the same results without the side effects and problems that medication can produce. Other follow-up studies have indicated that cognitive therapy and interpersonal therapy patients learned skills to cope with depression that the medication group does not have, thus, lowering their relapse results (Blatt, Zuroff, Bondi & Sanislow, 2000).

In another study, it was concluded that there were no major differences in the effectiveness of psychotherapy versus medication. DuRubeis, Gelfand, Tang and Simons (1999) researched the results from four randomized clinical trials included in the Treatment of Depression Collaboration Research Program and three other studies that compared cognitive behavior with antidepressant medication. There was no treatment found to be superior over the other. Antidepressants and CBT did not differ significantly in their effectiveness in the treatment of severely depressed outpatients according to results on the Hamilton Depression Scale and the Beck Depression Inventory. These instruments were used as outcome measures.

Herson, Bellack, Himmelhoch and Thase, (1984) conducted a study that included female unipolar outpatients that were not psychotic. Four treatment options were examined: social skills training and amitriptyline, social skills training and placebo, amitriptyline alone, and psychotherapy and placebo. Treatment was for 12 weeks with six months of maintenance treatment. The BDI was used at baseline, six weeks, 12 weeks, three months, and at the end of maintenance treatment. There was significant improvement in depressive symptoms in all groups, but no one treatment was shown to be superior over the others.

The premise that psychotherapy or medication can be equally effective in the treatment of depression was also supported by Chilvers et al., (2001). Generic counseling seems to be as effective for treating mild to moderate depression as antidepressants in a study conducted with 220 clients ages 18-70. Patients were mild to moderately depressed. One hundred three clients were randomized and two hundred twenty clients were assigned to their treatment preference. Outcome measures included the Beck

Depression Inventory, remission time, research diagnostic criteria, and global outcome as assessed by a psychiatrist. At 12 months, there was no difference between the Beck scores in the randomized areas. Patients who chose counseling did better than those randomized to it. Eighty-three percent of the patients with a known outcome had a remission. Time to remission was shorter in the group that was randomized to antidepressants. Those receiving antidepressants recovered quicker than participants who had counseling, but at a 12 month follow-up counseling and antidepressants were seen as equally effective with those having mild to moderate depression. Medication worked faster in the beginning, but therapy was as effective by the 12-month follow-up.

Robinson, Berman and Neimeyer (1990) performed a meta-analysis study of the controlled outcome research on depression. Psychotherapy was compared with no treatment or treatment with medication. It was shown that depressed clients gain substantial benefits from psychotherapy, and these gains compare with those from pharmacotherapy. Psychotherapy had a statistically significant mean effect size that was 0.113 larger than that for drug therapy. No advantage was found for combined treatment over psychotherapy.

Both CBT and phenelzine effectively treat moderate mood disorders and atypical features. The effects of both were comparable on all outcome measures (Jarrett, Schaffer, McIntire, Witt-Browder, Kraft & Rosser, 1999). One hundred forty-two outpatients diagnosed with MDD and atypical features participated in this study. Thirty-six clients were randomized to each treatment protocol, which consisted of cognitive therapy, phenelzine, or placebo for ten weeks in a double blind, controlled trial. The Hamilton Rating Scale was used as an outcome measure. Findings indicated that phenelzine and

cognitive therapy reduced symptoms significantly more than placebo. Response rates on the Hamilton Rating Scale showed significant improvements for both treatments over placebo, 58%, 58%, and 28%, respectively. The two treatments also gave evidence of significantly reduced symptoms. The scores between these two treatments were not significantly different showing that both treatments were equally efficacious.

Another study carried out in Philadelphia by Beck, Hollon, Young, Bedrosian, and Budenz, (1985) showed CBT to be as effective as antidepressant medication. Cognitive therapy was compared to amitriptyline. Nine men and 24 women outpatients with mild to moderately severe depression were included in the study. Eighteen of the 33 received two hours of cognitive therapy over a 12 week time period. Fifteen received 50-200 mg/day of amitriptyline along with the cognitive therapy. According to outcome measures, there were no significant differences between the groups.

#### Combined Treatment-Psychotherapy and Medication:

Empirical evidence indicates that both medication alone and psychotherapy alone can reduce depressive symptoms and decrease the chances of relapsing, but numerous studies have been conducted to evaluate the effects of using medication and psychotherapy in combination to treat depression to see if symptoms can be alleviated quicker and the period of wellness extended longer. The National Institute of Mental Health advocates using antidepressants and therapy together in treatment (National Institute of Mental Health, 2003).

A study conducted by Wexler and Cicchetti (1992) showed that combined treatment offered no advantage over treatment with psychotherapy alone and only a slight



advantage over treatment with pharmacotherapy alone. This was a meta-analysis of treatment success rates, failure rates, and treatment dropout rates reviewed in eight well-controlled studies of outpatients with major depression. Psychotherapy alone and with medication was compared with an additional condition of combined medication and psychotherapy. The meta-analyses involving multiple studies that included thousands of patients was very consistent in showing that psychotherapy is at least as effective as medication in the treatment of depression. Combined treatment was not recommended since it increased the risk of side effects and was an additional expense. For these reasons, psychotherapy alone was advocated as the choice for initial treatment.

Depressive symptoms can be reduced with a combination of medication and psychotherapy (Miranda, Chung, Green, Krupnick, Siddique, Revicki & Belin, 2003) according to research with women in minority populations. The 276 women were at high risk for depression and received county health and welfare services. They had been exposed to high levels of trauma, which included rape, domestic violence, and child abuse. One hundred seventeen black, 134 Hispanic, and 16 white women were randomized in the trial. The median age was 29.3 years. Women in the study who took medication (n=88), were treated with paroxetine or bupropion for six months. Those that were assigned psychotherapy (n=90) saw a psychotherapist for eight weekly sessions which included cognitive-behavioral therapy. They were taught to manage their moods, involve themselves in pleasant activities, refute thinking that kept them depressed, change self-defeating beliefs, and get support from others. The third group was referred to the community mental health program for services. Every month for six months the women underwent a version of a standard psychiatric measuring tool to show functioning

scores and to compare depression symptoms. Clinical outcomes were calculated according to a mixed-effects repeated-measures analysis that compared mean depression symptom and functioning scores across treatment groups over successive time intervals. The groups receiving medication or CBT showed reduced depression symptoms and that these treatments were more effective than no treatment. It was shown that the women benefited from treatment when it included outreach support and encouragement to support the interventions attempted. Outreach support included transportation, spending time with the client, and childcare. After six months, those who received medication reported improvements at work, at home, involvement in social activities, and getting along with others. The group, who was given therapy, reported a decrease in their symptoms of depression and improvements in their relationships with others. Medication and CBT were individually better than no treatment, but even better outcomes were reported for those clients receiving combined treatment. Medication improved role functioning and the combination of medication and CBT led to improvements in social functioning.

Simon, Katon, Von Korff, Unutzer, Lin, Walker, Bush, Rutter and Ludman (2001) conducted a study providing collaborative care for clients who have been diagnosed with persistent major depression or with significant depressive symptoms. The individuals in the study were given education, a consultation visit with a psychiatrist and a period of shared care that lasted two to four months. A psychiatrist and primary care physician offered this care. Follow-up visits and monitoring compliance with medication were also part of the program. These were performed at one month, three months, and six months. After six months, the collaborative care program was associated with a mean

of 16.7 depression-free days more than a program with the usual primary care showing that these interventions can be advantageous without being very expensive. The mean incremental cost of the treatment was \$357. The incremental cost-effectiveness was \$21.44 per depression-free day. A stepped collaborative care program showed increases in treatment effectiveness and a moderate increase in cost (Nemeroff, 2001).

Bowers (1990) analyzed three different treatments for depressed inpatients. Thirty adults were included in the study comparing nortriptyline alone, cognitive therapy plus nortriptyline, and relaxation therapy plus nortriptyline. Twelve therapy sessions were set up with depression symptoms being checked at sessions one, six, twelve, and at discharge from the hospital. Outcome measures included the Beck Depression Inventory and the Dysfunctional Attitude Scale. All groups showed improvement. The groups using cognitive therapy and nortriptyline and relaxation and nortriptyline showed significantly reduced symptoms of depression and negative cognitions at the time of discharge as compared to the nortriptyline group. The number of patients considered depressed at the time of discharge was lower for the cognitive therapy plus nortriptyline group over the other two groups. Combined treatment was shown to be more efficacious, and cognitive therapy seemed to be a consistent factor in attaining cognitive and behavioral changes in depression treatment.

Miller, Norman & Keitner (1989) performed a six and 12-month follow-up of 45 depressed inpatients that had been randomly assigned to one of three groups. One group received standard treatment. Standard treatment involved hospital milieu therapy, clinical management sessions, and pharmacotherapy. Another group was offered cognitive therapy and standard treatment. The third group was given social skills training

plus standard treatment. All of the treatments started in the hospital setting and continued for 20 weeks after the patients were discharged. All participants received medication, but those who received additional cognitive behavior therapy or social skills training showed less relapse during the one-year follow-up, thus indicating that the combination of medication and CBT or social skills training can offer better treatment outcomes.

A meta-analysis study was conducted to determine whether combined psychotherapy and pharmacotherapy were superior to each treatment alone for outpatients diagnosed with unipolar depression. Seventeen controlled studies between 1974 and 1984 were reviewed that involved outpatients aged 18-65 years old. The combined psychotherapy and pharmacotherapy condition was shown to be more effective than psychotherapy alone, psychotherapy plus placebo, pharmacotherapy alone, pharmacotherapy plus minimal contact or minimal contact plus placebo. Combined active treatment using drugs and psychotherapy was moderately superior to pharmacotherapy alone (Conte, Plutchik, Wild & Karasu, 1986).

deJonghe, Hendriksen, van Aalst, Kool, Peen, Van, van den Eijnden & Dekker (2004) investigated if combined therapy had advantages over psychotherapy alone in a six month randomized clinical trial. Short psychodynamic supportive psychotherapy (n=106) was compared with combined therapy (n=85) in patients diagnosed with mild or moderate depression who were ambulatory. Venlafaxine, SSRI, nortriptyline and nortriptyline plus lithium were prescribed according to a procedure providing four steps in case of intolerance or inefficacy. The 17-item Hamilton Rating Scale for Depression, the Clinical Global Impression of Severity and of Improvement, and the depression subscale of the Symptom Checklist were used as outcome measures. Contrary to other

findings, results did not show that it was advantageous to combine antidepressants with psychotherapy.

Conflicting results come from a study done to evaluate the relationship between adherence to use of and efficacy of antidepressants plus psychological treatment vs. drug treatment (Pampallona, Bollini, Tibalbi, Kkupelnick & Munizza, 2004). Antidepressant treatment in combination with a psychological intervention was compared to antidepressant treatment alone in randomized clinical trials. Sixteen trials met the inclusion criteria, which included 932 patients randomized to pharmacotherapy alone and 910 to combined treatment. Results showed that patients receiving combined treatment improved significantly over those in drug treatment alone. Treatment programs that lasted longer than 12 weeks showed significant advantages of combined treatment and a significant reduction in dropouts.

#### Interpersonal Therapy:

The second major form of psychotherapy is interpersonal therapy (ITP) which is a form of psychodynamic therapy based on the belief that depression occurs in interpersonal contexts. ITP helps work through the disturbed personal relationships that may have contributed to the depression. Clarification of internal emotional states along with better emotional communication can help a client work through their depression (Rosenhan & Seligman, 1989). Psychodynamic therapies have not been given the same amount of attention as cognitive therapies, but a large-scale psychotherapy study undertaken in 1986 gave evidence that they are as effective as cognitive therapies (Elkin, Shea, Imber, Pilkonis, Sotsky, Glass, Watkins, Leber & Collins, 1986).

A study was conducted to investigate the maintenance phase of treatment for MDD and the prevention of future occurrences. This study wanted to clarify the prophylactic benefits of Maintenance Interpersonal Psychotherapy (IPT-M). The study examined survival time without a new occurrence of depression, elements unique to this treatment, and the influence of specific treatment techniques. Included in the study were 60 therapists/client dyads whose audiotaped maintenance psychotherapy sessions were rated according to the Therapy Rating Scale. Using survival analyses, the study examined the relationship between time without depressive symptoms and treatment specifically, the influence of frequency of IPT-M, and the patients' clinical characteristics. The main hypothesis of the study was that the better the treatment adhered to certain guidelines, the more positive the results. Adherence to interpersonal therapy techniques within the therapist/client dyads would increase survival time without a new depressive episode. Results did not support this hypothesis, but the overall low rate of recurrence (22%) for subjects showed the benefits of maintenance treatment. The data showed support for the use of IPT and the therapeutic relationship to increase remission rates and to be conducive for continued functioning without depressive symptoms for people diagnosed with MDD, especially those who choose not to or cannot receive psychopharmacotherapy (Maccarelli, 2002).

#### Interpersonal Therapy versus Medication:

In a study of 239 outpatients diagnosed with major depressive disorder in a NIMH 16-week multi-center clinical trial, participants were assigned to interpersonal therapy, CBT, imipramine with clinical management, or placebo with clinical management. One hundred sixty-two patients completed the trial. Their age span ranged from 21-60.

Evidence was gained with results that showed six traits or characteristics that predicted treatment outcome across all treatments. They included cognitive dysfunction, expectation of improvement, endogenous depression, double depression, duration of the current episode, and social dysfunction. Those patients who were less socially dysfunctional fared better using ITP (Sotsky et. al., 1991) showing that this type of treatment works more efficaciously for certain types of clients.

The superior efficacy of combined drug treatment and psychotherapy was addressed in the Pittsburgh studies on long-term treatment of recurrent unipolar major depression. ITP was used to test its efficacy alone and in combination with medication. Two control conditions were employed, no-pill condition and placebo condition. All clients received ITP. The main findings from this study were that there was a high rate of recurrence within one year for untreated control groups. Another conclusion reached was that clinically meaningful and statistically significant prevention of relapse and recurrence is possible with the use of imipramine hydrochloride and IPT. It was concluded that combined treatment is valuable, and pharmacotherapy can be strengthened by using high-dose imipramine hydrochloride and blood level determinations. The use of high levels of imipramine hydrochloride (over 200mgs) and IPT indicated prevention of relapse and reduced reoccurrence of unipolar depression. Sixty percent of the clients did not relapse in one year and 84% of those who combined imipramine and IPT had no recurrence of depression in one year. Maintenance therapy lasted from one year or longer with ITP being given one hour per month to prevent recurrence. Maintenance long-term treatment is necessary for clients with recurrent unipolar depression and

therapy used together with medication showed better results than each alone (Klerman, 1990).

Analyses of data from the National Institute of Mental Health sponsored Treatment for Depression Collaborative Research Program (TDCRP, 1986) presented evidence on the short and long term effects of medication and psychotherapy in the treatment of depression. The study investigated the efficacy of cognitive behavior therapy and interpersonal therapy in comparison to imipramine hydrochloride plus clinical management (IMP-CM) and pill placebo plus clinical management (CM). The 239 outpatients were diagnosed with major depressive disorder and were assigned to one out of four 16-week treatment conditions. The Hamilton Rating Scale for Depression, the SCL-90, and a measure of general functioning were used for outcome measures. ITP and CBT appeared to be equally effective when compared with imipramine and clinical management. Use of imipramine showed significant reduction of depressive symptoms at the eight-week mark in comparison to placebo, CBT, and IPT, but at termination this medication advantage decreased (Elkin, Gibbons, Shea & Shaw, 1996). There was evidence of superiority of IPT and CBT over IMP-CM and placebo-CM in recovery analysis. Twenty-four percent in CBT and 23% of patients in IPT were viewed as “fully recovered” as compared to 16% in IMI and placebo showing a better outcome for using psychotherapy (Shea, Elkin, Imber & Sotsky, 1992). Interpersonal therapy outperformed drug treatment on adjustment measures which included mood, apathy, work, interest, and suicidal ideation, but drug treatment was better if vegetative symptoms were present. In addition medications were not found to be significantly better than either of the psychotherapies with severely depressed patients.



A matched-case-control study was conducted comparing eight-week outcomes between a group of 16 depressed women receiving brief interpersonal therapy (ITP) and a group of 16 who received sertraline, an SSRI. The women met the criteria for MDD according to the DSM-IV and had scores above 15 on the Hamilton Rating Scale for Depression. To compare the two groups' linear mixed-effect regression, models were used on measures of symptoms and functioning. Both groups showed significant improvement with large effect sizes, but an unexpected outcome occurred with the women in psychotherapy improving more quickly than those who were using sertraline (Swartz, Frank, Shear, Thase, Fleming & Scott, 2004).

#### ITP and Medications Combined:

ITP was compared to amitriptyline in a randomized, controlled study of 81 ambulatory, nonbipolar, nonpsychotic depressive adults (DiMascio, 1979). Short term interpersonal therapy, 100-200mg. amitriptyline hydrochloride, both treatments combined, or a nonscheduled treatment control group was the conditions. The clients with the most symptom reductions were in the combined group. Amitriptyline and ITP were both shown to be equal in effectiveness, and combined treatment had an additive effect. ITP had an impact on suicidal ideation, work, interests, and mood, but these effects did not occur until four-eight weeks of treatment. Amitriptyline affected appetite and sleep disturbances, and this occurred shortly after treatment began (one week). The researcher hypothesized that amitriptyline and ITP together can have greater success in the treatment of depression because of the differential effects of each treatment.

In a study where IPT and medication were combined, it was concluded that they were more effective together than either condition alone. IPT combined with antidepressants for MDD was shown to be a favorable treatment. Use of imipramine hydrochloride and IPT showed statistically significant prevention of relapse and recurrence. Untreated control groups had high levels of recurrence with one year. Using high levels of imipramine hydrochloride (over 200mg/d) for enhanced effects monitored by blood level determinators led to high rates of relapse prevention. Sixty percent of the participants had no recurrence in one year, and 84% using imipramine and IPT had no recurrence at all (Craighead, Craighead & Ilardi, 2002).

A study conducted by Frank et al., (1990) evaluated the efficacy of five maintenance treatment strategies in preventing or delaying a recurrence of unipolar depression in a population with a high probability of recurrence. The five treatments offered were IPT-M (maintenance) alone, IPT-M with active imipramine therapy at active treatment doses, IPT-M with placebo, medication clinic visits with imipramine therapy, and medication clinic visits with placebo. One hundred twenty-eight patients were included in the randomized three-year maintenance study. It was shown that imipramine prevented recurrence of depressive episodes more than any other treatment. Fifty percent of those on medications and clinical IPT-M and imipramine had no recurrence. Interpersonal psychotherapy which was offered monthly increased the time period between depressive episodes for those not on medication. Patients using IPT-M alone went an average of 54 weeks and those with IPT-M placebo 74 weeks. It was concluded that imipramine prescribed at an average dose of 200mg. is effective in preventing recurrences of depression and monthly IPT lengthens the time between

episodes of a patient not taking medication. ITP was shown to have a significant effect in both medication and nonmedication conditions. (Frank, Kupfer, Perel, Cornes, Jarrett, Mallinger, Thase, McEachran & Grochocinski, 1990).

One recent NIMH funded study of older adults having recurrent major depression showed that ITP and antidepressants combined together over a three-year period led to reduced recurrences as compared to those using only drugs or only therapy. The study showed that medications and psychotherapy were significantly more effective in showing a decrease in symptoms of depression when compared with a control group that received no treatment. Both medications and psychotherapy were more effective than no treatment at six months in reducing depressive symptoms and improving relationships with others (National Institute of Mental Health, 2003).

#### Cognitive Behavior Therapy versus Interpersonal Therapy:

A study to determine if there was any difference between clients who received CBT or ITP for depression in the maintenance of gains over one year was conducted (Shapiro, Rees, Barkham, Hardy, Reynolds & Startup, 1995). One hundred twenty clients were included in this study in three ranges of depression severity-low, moderate, and high. A scheduled number of treatment sessions of either eight or 16 sessions were completed. Sessions were in one-hour durations twice weekly. The Beck Depression Inventory and the depression subscale of the Symptom Check List-90-Revised were used as outcome measures. General symptomology was measured on the Global Severity Index of the SCL-90-R. One hundred seventeen clients completed treatment. Post treatment assessments were performed at two weeks after the final treatment session,

three months, and one year later. One hundred four were included in the one year follow-up. Thirteen did not complete it and were found to be significantly worse than those who did complete treatment. Fifty-four participants were asymptomatic according to BDI scores, 22 were partially symptomatic, and 28 were fully symptomatic. At three-month follow-up, their scores were 54, 22, 27, respectively. During the one-year follow-up, 69 were asymptomatic. Thirteen were partially symptomatic and 22 fully symptomatic. Maintenance of gains was good for the group as a whole. To explain why some clients maintained gains, it was found that the clients had made adaptations in their functioning according to the treatment approach used. Clients used skills learned from CBT or IPT to make changes in their lives. Case-categorization methods indicated that 16 sessions of CBT was slightly more effective than IPT during the three month follow-up. Clients having 16 sessions were exhibiting fewer symptoms than those having the briefer eight sessions. These results were for individuals diagnosed with severe depression. After the one-year follow-up CBT and IPT had comparable results. This study showed that eight sessions of treatment is not enough to bring about lasting psychological change, and it pointed out the importance of follow-up in the evaluation of psychotherapy treatments used for depression.

In a study to compare group cognitive behavior counseling to individual cognitive behavior and interpersonal group therapy, group CBT was found to be as effective as individual CBT and showed the same amount of change in dependent measures as IPT (Shaffer, Shapiro, Sank & Coghlan, 1981). Participants were diagnosed with adjustment disorder with depressed or anxious mood and were deemed appropriate for brief therapy. Forty-four people ranging in ages 21-40 who were enrolled in a health maintenance

organization participated in the study. They were randomly assigned to one of three treatment groups. The individual therapy clients met for one hour for ten weeks. Those in group therapy met for one and ½ hours for ten weeks. Group and individual CBT sessions included cognitive restructuring, relaxation, and assertiveness training. Those in ITP also were instructed in cognitive restructuring. Seventy-eight percent of the clients in individual counseling were instructed in assertiveness training and 14% in progressive relaxation. The Beck Depression Scale and the State-Trait Anxiety Inventory were used as outcome measures. Group and individual CBT were shown to be equally effective in reducing symptoms of depression and anxiety and to increase assertiveness. ITP and CBT were equal in bringing about significant positive changes in dependent measures. CBT, behavior therapy (BT), and ITP are effective treatments for clients having major depressive disorders. All three methods produced reduced scores on the Beck Depression Inventory and the Hamilton Rating Scale for Depression. There were decreases in the number of clients meeting the major depression disorder criteria after treatment and a significant maintenance of effect after treatment. Initial clinical trials by Lewinsohn (1977) and then continued by Bellach, Hersen, Himmelhoch (1981, 1983) and Hersen, Bellach, Himmelhoch and Thase (1984) showed that BT was as effective in reducing depression as using amitriptyline in a 12 week treatment period of 21-60 year old female unipolar depressed outpatients. Twenty-five normal women were included in the study to examine validity of the dependent measures and treatment changes produced. Four treatments were contrasted. Social skills training and amitriptyline, social skills training and placebo, amitriptyline, and psychotherapy plus placebo were the different options for the 81 patients. The Beck Depression Inventory and the Hamilton Rating Scale for

Depression were administered as outcome measures. Twenty-seven months later the participants exposed to BT were more productive and socially active over any other participants in all other treatments. The women who received social skills training and placebo were the most improved and had the lowest drop out rate. In the follow-up study in 1984, some of the results contradicted the initial study. It was found that after six weeks, 12 weeks, three months, and at the conclusion of maintenance treatment each of the four groups showed reductions in symptoms and that no differences could be seen in the effectiveness of each of them.

#### Summary:

There are empirical research findings that show evidence that CBT, ITP, or medication can successfully treat the symptoms of depression. Each of these methods can successfully reduce symptoms. According to the AHCPR (1999) guidelines, moderate to severe depression is appropriately treated with medication even if formal psychotherapy is used or not. Mild to moderate major depression may be treated by psychotherapy alone if the patient wishes. According to the APA the best treatment is antidepressants and psychotherapeutic management or psychotherapy. Mild to moderate depression may be treated with psychotherapy or psychotherapeutic management alone.

Short-term trials of medication therapy and psychotherapy for 16-20 weeks are fairly standard in the treatment of acute symptoms of depression. Tricyclic antidepressants are the standard treatment for acute symptoms of depression. They can be used initially for short-term treatment, but 30-40% of patients do not respond and 60-70% experience remission. Fluoxetine and paroxetine, 20 mg. doses, were most often

prescribed in the treatment of depression. Five to ten percent were still depressed after various medical interventions were used.

Problems with medications persist when less than one half of the individuals diagnosed with major depression who are treated with the newer antidepressants achieve remission. Drug treatment results in poorer compliance than psychotherapy. It has a higher dropout rate, and has as high as a 60% nonresponse rate with some client populations. Some clients will continue to exhibit depressive symptoms after six to eight weeks of antidepressant use (Nemeroff, 2001). Medications have numerous side effects that can scare clients away from using them or cause noncompliance. Even the newer SSRIs have about the same risks as some of the tricyclics. There can be overdoses, interaction with other drugs, and there are many side effects. Agitation, nausea, sexual problems, and sleep disturbances are common. There is also a risk of suicide, mania, extrapyramidal effects, and akathisia.

Many clients and practitioners choose to use drug therapy only for quick relief or due to constraints set upon them by insurance companies. If medication only is used to treat depression and not psychotherapy, the client is not receiving the optimal care that is available to them. Psychotherapy should be an integral part of treatment for depression. Medication and psychotherapy should at times be used together to enhance the effectiveness of treatment and to reduce chances of relapse especially if the depression is severe or has psychotic features. Immediate reduction of symptoms in these cases is warranted and necessary. When combined, medication can quickly reduce depressive symptoms, and therapy can educate and change cognitions so remission is possible.

Psychotherapy alone, though, can be the safest most cost effective treatment for outpatient depression (Antonuccio, Danton & DeNelsky, 1995). Statistically, it has been shown to reduce depressive symptoms and prevent relapse even if the depression is severe. Clients seem to favor therapy over medications, and positive reactions occur quickly, usually within a few weeks. The individual needs and desires of the client should be taken into consideration. Some people want the quickest relief possible. Using medication may provide that, but therapy seems to be instrumental in reducing depressive symptoms for a longer period of time. Psychotherapy that emphasizes changing cognitions and changing behaviors seems to insure that there will be fewer relapses back into the depressive state.

Even with as little as four weeks of sessions using CBT, depression symptoms had a 60-70% improvement rate. Enough techniques can be learned in that time period for some relief to be seen. Reduction in depressive symptoms can begin to take place even before cognitive restructuring techniques are formally introduced (Ilardi & Craighead, 1994). There is evidence that psychotherapy is successful in reducing mild, moderate, and even severe depressive symptoms and in restoring individuals back to functioning states. Modifying cognitions would appear to be the best way to make long-lasting effects and changes in a person's life, more so than just taking medication. The client's involvement is an integral part of treatment and recovery in CBT and ITP. The client is empowered so that he or she can take control of their depression by learning the warning signs of its onset and being able to implement procedures to lift themselves out of it.



Both ITP and CBT are easily accessible in manual forms, and can be readily used by any therapist. Instructions are given in step by step formats that even novice therapist can successfully follow. Workbooks are also available for clients to use on their own if they so desire. Psychotherapy is a much safer alternative to medication since it has few health risks and side effects, and according to a significant amount of research it works.

#### Chapter IV: Normative Practice/Outcomes

The agency that served Cecilia Beckett utilized cognitive behavioral treatment for outpatient Major Depressive Disorder. Cognitive behavior therapy was used for this client because it has been shown to be effective for individuals with presenting complaints similar to this client's, with results occurring relatively quickly once negative thinking is confronted and modified.

After the initial session when intake information was gained, a treatment plan was written up that focused on reducing the client's depressive symptoms. The client had five specific goals for treatment. Her first goal was that she wanted to be able to enjoy activities again with her children and husband. Secondly, she wanted to feel happy and reduce her crying spells. A third goal was to be able to sleep for longer periods during the night. She also wanted to be able to say "no" to requests from family members and friends without all the accompanying guilt that she was presently feeling. Additionally, she wished to reduce her tendencies to worry about a variety of topics.

Therapy sessions began with an overview of depression to put the client at ease. She was describing herself as "crazy", and she was feeling that something was wrong with her. By telling her that depression is a treatable illness experienced by many people encouraged her to understand herself and her situation with more acceptance and compassion. Methods of treating depression were discussed and then cognitive

behavioral therapy was explained. A workbook called “Overcoming Depression” was used that provided cognitive behavioral activities to help combat her depressive symptoms.

Once cognitive behavioral treatment was explained to the client, she then began filling in worksheets called Action Schedules. These were used to show what she accomplished during the day so she could see if she was setting goals and achieving them. She could evaluate whether these goals were worthwhile or overwhelming to her. She had to rate if they were pleasurable or if she did them for mastery. The purpose of this activity was to help the client counteract the inclination to discount the accomplishments she made. She could actually see what activities she had done for the day and take some pleasure in the fact that she used her time well. She had been feeling unmotivated and downplayed any successes she did have, even if they were small. One of her core beliefs was that she was not a worthwhile mother. Through all the chores that she did each day, she was made aware of the good things she was doing for her children. She would complete these worksheets for homework and bring them into the next therapy session.

Next, she filled in a Weekly Practice Record in order to schedule specific activities for specific days. She was able to set goals that she wished to accomplish for the coming week. This was helpful in keeping her focused and on target. She also could decide if her expectations were realistic or if she needed to make adjustments to the goals she wanted to achieve.

By using the Action Schedules and the Weekly Practice Record different behavioral symptoms and thought processes were identified. From them her thoughts and feelings were identified. The relationship between what she thought about and how her thoughts were related to her feelings was pointed out.

A technique was then implemented where the client was introduced to different types of cognitive distortions. She used a Thought Record to record situations that occurred, her automatic thoughts related to the situation, and the feelings that followed the thoughts. After that, she had to identify the cognitive distortions that she recognized in her own actions and behaviors. These distortions were discussed during her sessions. Negative thoughts were also identified and targeted.

An Extended Thought Record worksheet was assigned which required Cecilia to list her actions and her thoughts. She had to identify what she was feeling at different times. She had to give evidence to show that her thoughts and feelings were realistic for the situation that occurred. Next, she had to look for any distortions in her thinking. Once she recognized any distortions, she had to identify the type of thinking errors she used, and she had to also supply alternative explanations that could account for the actions or behaviors she listed especially if these actions were coming from other people. She was encouraged to look at her thoughts and feelings and decide if they were on target. If her perceptions were correct she was instructed to evaluate the consequences to see how bad they really could be. Finally, Cecilia wrote down different courses of action she could take to constructively handle a problem or solutions that would make her feel better about the situation. She would then try to use these new responses, and if she did so, write any changes in her emotional reactions. Lessening the impact of negative

feelings through correction of faulty thinking was the specific purpose of this activity. The client becomes more aware of automatic negative thoughts, tries to stop them, and reduces the bad feelings they incur.

Correcting faulty beliefs was the next task of therapy. She had to become aware of her beliefs, especially dysfunctional ones, in order to question and clarify them. During her third session, Thought Records were completed and some anger issues surfaced that the client had not dealt with in treatment. The therapist confronted her with some events that occurred in her past that had caused her to react with feelings of hurt and resentment. Some questionnaires were completed that identified areas of anger for her. She also learned that she used a passive interactive style to deal with her feelings of anger. This style was not working well for her because she did not confront the people or situations that caused her to feel angry, and this eventually caused her much stress. Ideas to deal with the anger and to relieve stress were discussed and the client implemented a few. For example, she kept an anger diary to record events that made her angry, and she recorded how long the angry feelings lasted. The purpose was for her to become more aware of her anger and what triggered it. Reactions to the angry situations were discussed and brainstorming of different solutions acceptable to the client took place. Cecilia chose some activities that she could employ to reduce her anger such as going for a walk, exercising along with a tape, or doing some relaxation exercises.

Cecilia also had other people rate her on an anger temperament scale so she could see how close her score matched theirs. This showed her how accurate her self-assessment was. She discovered that her friends viewed her as an angry person, which surprised her because she thought she hid it from them. She attempted to begin using “I”

messages in her interactions with other people to identify how she was feeling instead of pointing the finger at them with “you made me angry”. She was taking ownership of her anger and recognizing that it was coming from her thoughts and perceptions. Eventually, this could lead to a more active role on her part to talk about it and confront it instead of ignoring the anger and letting it grow and fester.

At the end of the fifth session, the client decided to once again try medication. She thought that this might further reduce her depressive symptoms and work quicker than therapy. She had talked to friends who praised medication and decided it was worth a try. An appointment with the psychiatrist was set up. She was evaluated and agreed to take 50 mg. of Zoloft daily. She was not happy with the side effects, which included “cotton mouth,” but she said she would try it for at least two weeks to see if she noticed any positive changes. She immediately reported being able to sleep for a longer period during the night.

During this sixth session, the client was informed that her therapist would be leaving the agency. She was asked if she would like to continue with a different therapist, and she stated that she did not wish to do so. She decided that she was feeling better, and that it would be difficult to continue therapy anyway once her children started school again. At this point, Cecilia had participated in treatment for three months. She attended six sessions, called and canceled two, rescheduled them, and came in for one psychiatric evaluation appointment to determine if medication could help her. She indicated that she would stay on Zoloft and would come in periodically for medication monitoring only. An appointment was set up for her to come in for that reason in two weeks, but she did not keep the appointment. The appointment was rescheduled twice,

and she again missed them. She ran out of medication during this time, and could not get a new prescription until she came in to the office. A letter was sent to notify her that she would be discharged unless she responded. She did respond stating that she wanted and would keep the next appointment. She failed to attend, and a letter was sent informing her that she was discharged from this agency's care.

#### Outcomes of Treatment:

The Beck Depression Inventory was used during the client's second session to determine her level of depression. She scored a 33 out of 63, which indicated a score in the severe range. During her fifth session, she was given the BDI again and scored an 18. This score was in the borderline range. The Beck Depression Inventory was used because it is a quick, reliable indicator of a person's level of depression. It is easy to administer and score. Results can be immediately shared with the client.

Questionnaires from a book dealing with anger were used to identify events that caused her stress, what were anger triggers, and her style of dealing with anger. This workbook was chosen because it was easy to use and to score. It also had practical advice and activities that were easily completed. The anger scale assessment was developed by Dr. Raymond Novaco at the University of California. Her anger score was 67 out of 80. Any score over 51 was considered high and rated as toxic anger, which is more frequent, more intense, and lasts longer than a normal occurrence of anger.

During her time in therapy, the client reported that she felt better. According to Cecilia "talking to a stranger" about her problems was an outlet for her that reduced her depression. She was fairly consistent in completing the homework assignments. She

also shared the worksheets with her friends and found this helpful because she was not going through her depression all alone. Others could relate to and identify with her. She gained information about herself by completing activities that helped her better understand the ways her friends perceived her. Overall, this young woman put significant effort into her treatment and worked to improve how she felt about herself and her life.

#### Comparison of Best and Normative Practice:

Current literature indicates that the best treatments for major depressive disorder advocated psychotherapy. Some studies have found that used alone it can be more effective than medication with longer lasting positive effects. Cognitive behavior therapy and interpersonal therapy are advocated as the best types of therapy to employ. The counseling agency chosen by the client advocated CBT as the psychotherapy of choice for the treatment of depression. Medication is also endorsed if the client indicates the need or desire for it. Evaluations by the agency's psychiatrists are usually set up within a few weeks of the request.

The agency that provided treatment followed the guidelines for best practice. Sessions that offered cognitive behavior therapy were put in place and medication was available to Cecilia. She became noncompliant with psychotherapy after trying Zoloft, and she did not return to the agency. The literature review indicated that many clients are unwilling to continue to take antidepressant medications and may become noncompliant. It is also possible that the client's mood was improved enough that she did not feel the need for further medication or psychotherapy.



## Summary and Conclusions:

The client was offered cognitive behavioral therapy and medication that would meet the provisions of best practice for the treatment of Major Depressive Disorder according to current literature. She showed improvement within a few sessions as indicated on her Beck Depression Inventory scores and her self-reports. More specifically, she reported feeling better, being more active, having more energy, sleeping better, and making decisions she was happier with. Although she discontinued treatment after starting antidepressant medications, she indicated that she felt that therapy was successful. This optimistic reaction could be helpful in the future if she feels the need to return to psychotherapy. She will view it as something beneficial and worthwhile. In short, therapy seemed to be a positive experience for her.

Cecilia initially had a negative reaction to taking medication for depression dating back to the antidepressants prescribed by her gynecologist. This and the mild dry mouth side-effect she was experiencing may result in a build up of even more resistance to using medications as an effective intervention in the future.

This client, if able to continue in therapy using CBT, would probably be very successful. She seemed to understand the effects her negative thought patterns were having on her emotional state. She was also confronting her thoughts and identifying the cognitive distortions that were present. She was proud of her insights and her motivation to make changes in how she was feeling. Initially she saw herself as a victim having no control over her life or her depression. She learned that she had a great deal of control over what happened to her. She demonstrated how negative thoughts can be changed and

can change feelings. She held the belief that people who were taking advantage of her would see the error of their ways and treat her better. She was confronted with the reality that this had not happened and probably would not. The person who had to change was she. She became that person. She also became aware of the problems she encountered when she suppressed her anger. The feelings and the anger did not go away. They resurfaced continuously. Cecilia made some valuable insights about herself. She was an appropriate candidate for this type of therapy. Unfortunately, she left treatment before she was totally ready. Part of this reason may be because her therapist was leaving the agency. If someone was able to continue working with her whether she was taking medication or not, she would have had time to progress even more so. She did not wish to continue with a new therapist, and she used her children's school schedules as an excuse. If someone at the agency could have reassured her and continued to talk to her offering her understanding and support, she may have been willing to come back. She would benefit from a therapist who did not strongly advocate medication since she is reluctant to taking it. If the psychiatrist would have been able to still see her and offer other alternatives, this too, may have contributed to her willingness to continue receiving treatment. Follow-up phone calls to see how she was doing would have been a way to stay in contact with her and keep the door open for a possible return to therapy.

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