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Transportability of an Empirically Supported Manual for the Treatment of Depression in Community Mental Health

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Philadelphia College of Osteopathic Medicine

Department of Psychology

The Transportability of an Empirically Supported Manual for the Treatment of
Depression in Community Mental Health

By Marcy A. Shoemaker

Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Psychology

May 2007

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Dissertation Approval

This is to certify that the thesis presented to us by Marcy A. Shoemaker on the 20th day of March, 2007, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

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Abstract

Depressive Disorders impact an estimated 17.6 million Americans a year (National Institute of Mental Health, NIMH, 1999). It has been found, in fact, that major depressive disorders are the predominant illnesses among the population served in the community mental health population (Bailey, 1999; Blendon & Benson, 1998). Due to restrictions in funding in Medicaid and Medicare services, many mental health services have been either restricted or eliminated for the indigent population requiring treatment (Bailey, 1999). Recognizing the need for improved outpatient care for this underserved population, the NIMH increased funding to develop stronger relationships between research and clinical practice. The NIMH also concluded that the use of evidenced-based practices, especially the use of psychotherapy treatment manuals, might be helpful in the dissemination of translational research in community mental health settings (Wilson, 1995; Addis, 2002). However, empirically supported treatment manuals have been resisted in the clinical community due to fear of standardization by clinicians (Wilson, 1995; Addis, 2002).

To better understand the potential advantages and disadvantages of translational research and evidenced-based practices, an empirically supported treatment manual was implemented in a community mental health center for the treatment of major depressive

disorders in a single case study. The findings suggested that the client found the structured approach helpful, especially in applying the new skills to his everyday life. There were some questions pertaining to the success of the outcome of the treatment because of the variability of the data points related to the Beck Depression Inventory –II Scores. Based on anecdotal information gathered from the transcripts and from the therapist’s process notes, the client felt that his depressive symptoms reduced and his quality of life improved. The client also successfully attended all sessions and completed 90% of his assigned homework activities. It is also important to note that the client and therapist maintained a strong therapeutic working relationship, which was measured by the Working Alliance- Short Form. It is proposed by this author and researcher to conduct an empirical study with a larger sample size, three interventions and a greater number of sessions to gain a greater understanding of the benefits of manual interventions in a community mental health center.

Table of Contents

	Page
Chapter 1	
Introduction.....	1
Chapter 2	
Methods	61
Chapter 3	
Case Conceptualization	77
Chapter 4	
Treatment Summary	88
Chapter 5	
Results	95
Chapter 6	
Therapist Reflections	113
Chapter 7	
Discussion.....	118
Chapter 8	
Empirical Proposal.....	143
Appendices	
Appendix A - Informed Consent	171
Appendix B - Outline for Manual	172
Appendix C - Transcripts	180
Appendix D - Flow Chart	270
Appendix E - Process Notes.....	273
Appendix F - Outline for Empirical Proposal Sessions	294
Appendix G - Empirical Proposal Timeline.....	302

Chapter 1

Introduction

Agreement exists about the seriousness and prevalence of major depression. Major depression is a wide spread disorder, exceeded only by alcoholism and phobias. The National Institute of Mental Health has estimated that 17.6 million Americans suffer from depression each year (Emery, 2000). Major depression has a devastating effect on families, employment and social interactions (Emery, 2000). It is recognized that the increase in recorded cases of major depression may also be due to a mandate from managed care companies and government officials to increase outpatient care and reduce the hospitalization of chronically depressed individuals (Bailey, 1999; Blendon & Benson, 1998). It is estimated that the indigent population, who are provided services in community mental health consist of 1.7 million chronically depressed individuals (Emery, 2000). It is clear that the major depressive disorder identified as MDD is a serious problem affecting a large population of Americans, especially those in the community mental health population.

Professionals in the community mental health field have questioned how to address the growing population of individuals suffering with major depressive disorders. They have considered the use of treatment manuals as an effective form of treatment for major

depressive disorders (Chorpita, 2002). It was also necessary for community mental health professionals to consider the use of evidenced-based practices, the integration of best research evidence, due to their growing population of sufferers, to cost-constraints, and budget cuts (Addis & Krasnow, 2000; Shepherd; 1998, Azrin & Goldman, 2005).

At the same time, studies have focused on the recognition of obstacles and variances in treatment between the research and community mental health environment due to different orientations and settings (Addis, 2002; Merrill, Tolbert, & Wade, 2003; Goldfried, Castonguay, Hayes, Drozd, & Shapiro, 1997). Other obstacles included differences in goals and outcomes even when psychotherapy manuals were utilized (Gibbons, Crits-Christoph & Levinsohn, 2002). One concern was that the goals in the treatment of major depression in the community mental health environment may be divergent from treatments developed in the research arena (Shepherd, 1998).

Treatment manuals are not a new phenomenon for the community mental health or research field. Beck, Rush, Shaw & Emery (1979) developed one of the earliest manuals in 1979, which introduced one of the first session-by-session treatments of depression based on the Cognitive Therapy model (CT). In addition, the Cognitive-Behavioral approach (CBT) focused on the existence of a depressogenic cognitive style in the patient and the need to correct the misappraisals underlying depression (Beck et al., 1979). This approach was educational in style and focused on the mastery of adaptive skills, which were helpful in community mental health settings (Bailey, 1999). This approach helped

promote dissemination of evidence-based practices (Addis, 2002).

Despite the obstacles and criticisms, there is a strong need to examine the feasibility of implementing treatment manuals in community mental health settings. The purpose of this study is to evaluate the feasibility of implementing an empirically supported treatment manual to treat an individual with a major depressive disorder in a community mental health setting. The focus of this project is to describe the process of implementing the treatment within a naturalistic environment. Cognitive-behavioral techniques are used as described in the manual, *Overcoming Depression- a Cognitive Behavior Protocol for the Treatment of Depression* (Emery, 2000). This treatment is designed to reduce depressive symptoms and improve the quality of life of a client diagnosed with a major depressive disorder. In order to evaluate the feasibility of implementing this manualized treatment in a community-based mental health center, three sets of assessments are collected: 1) client level, 2) therapist level, and 3) administrative level.

To support the study, empirical practices that could be beneficial in the treatment of major depressive disorder in non-university based settings are reviewed. The goals and values of practitioners in the community mental health field are reviewed to determine if their goals are divergent with professionals in the research field. The belief is that the use of an empirically supported treatment manual can be effective in the treatment of depression with the understanding of possible clinician resistance to manuals and treatment protocols (Persons, 1995). The value and utility of manualized treatments

among community mental health workers are reviewed to determine if empirically supported treatments could be transported from laboratory to field settings. Potential modifications, changes and concerns are addressed, including training methods, staff review of outcome literature, utilization of research findings in clinical settings, and communication to consumers.

Clinical Features and Prevalence

The diagnosis of major depression can be found in the Diagnostic and Statistic Manual of Mental Disorders, DSM-IV, which includes a generally accepted listing of symptoms of depression. A client can be considered as meeting the criteria for major depression when he or she reports at least five of the following symptoms which have been present for at least the last two weeks and represent a change from the client's previous level of functioning (American Psychiatric Association, 2002). Symptoms must initially present in the form of depressed mood or loss of interest in almost all activities. In addition, other symptoms may include significant weight loss or gain of 5% of body weight, insomnia or hypersomnia, psychometric retardation, agitation, fatigue, loss of energy, feelings of worthlessness or excessive inappropriate guilt, diminished ability to think or concentrate and recurrent thoughts of death, suicidal ideation and include a specific plan for suicide (American Psychiatric Association, 2002).

The National Comorbidity Replication Study included nationally representative data

on prevalence and correlates of Major Depressive Disorder, (MDD). Researchers found that the prevalence of MDD was 16.2% or 32.6 million US adults for lifetime and for a 12-month period was 6.6% or 13.1 million US adults. Role impairment was substantial as indicated by 59.3% of 12-month cases with severe or very severe role impairment (Kessler, Beglund, Demler, & Jin, 2003). In addition to the high rate of prevalence, recurrence of depression is also a major concern for the mental health community. Zeiss and Lewinsohn (2000) reviewed data from a large community-based sample, which was originally conducted in 1989. They found that of 1130 individuals who had a first episode, 45% (513) reported a second episode over a 10-year follow-up period. Rush et al. (1995) studied 2433 depressed outpatients, 26% of whom had episodes that lasted at least 2 years.

Prevalence rates may be understated due to a lack of diagnosis of major depression cases in primary care offices. The unfortunate result is that major depression is often not detected in primary care offices. This occurrence may lead to cases that are overlooked, ignored or undetected (Organista, Munoz & Gonzalez, 1994). Cole, Smith, Rabin, & Kaufmann (2004) concluded that depression frequently remains undiagnosed by busy medical practitioners. The likelihood that a primary care physician will detect depression is 50% or lower than detection by mental health professionals. In addition, another probable reason for the low detection and treatment of depression in medical patients is the belief held by many medical providers that depression as a mood disorder is

secondary to chronic medical conditions and is therefore less clinically significant (Organista et al., 1994).

Complications in Diagnosis and Treatment

Diagnosis and treatment may be complicated by the presence of comorbid factors, which are often found in the population of outpatient mental health consumers (Bailey, 1999). Many clients who come to therapy for depression also present with additional problems that can complicate the course or approach of therapy. McCullough (2000) found that over 80 percent of depressed patients experience clinical levels of anxiety. He also found that when dysthymia and major depression are comorbid, the failure to treat both disorders results in the exacerbation of recurring major depressive episodes (McCullough, 2000). The diagnosis of major depression may also be complicated by the presence of chronic illnesses that may trigger or exacerbate the depression (Emery, 2000). One in four people with a severe chronic medical illness may become depressed. About five percent of individuals initially diagnosed as being depressed are found to have a medical illness that triggered the depression (Emery, 2000). Boyles, Delos-Reyes, and Kryszynski (2005) also stated that roughly half the people who experience severe mental illness develop substance use problems at some point in their lives and half of this group currently has substance use problems at the time of diagnoses.

Another important diagnostic concern is determining whether or not an Axis II

personality disorder is present (Markowitz, 1995). McCullough (2000) reported that comorbid personality disorders are present in approximately 50% of chronically depressed outpatients. When a comorbid Axis II disorder is diagnosed in a chronically depressed patient, the treatment becomes even more arduous and successful outcomes are even more difficult to achieve (McCullough, 2000). Obstacles with the implementation of treatment may exist because many manuals do not address the treatment of comorbid disorders especially in the case of Axis I and Axis II disorders (McCullough, 2000).

Complication in Determining Type of Depression

Complications exist in the medical community in correctly diagnosing the type of depression, despite the existence of models and explanations of the etiologies and proposed treatment approaches. These diagnostic complications may exist due to confusion in terminology usage. The DSM-IV uses the term major depressive disorder or MDD to describe depressive episodes that exceed 2 weeks and meet at least 5 stated criteria (American Psychiatric Association, 2002). Recently McCullough (2000) concluded that the term chronic depression should be used as an alternative diagnosis for MDD for patients that present with more difficult medication and treatment challenges.

Treatment Prognosis

The field is slowly recognizing that until very recently, MDD has been grossly

misdiagnosed, understudied and undertreated (Keller & Hanks, 1994; McCullough, 2003). Akiskal (1983) stated that major depression does not respond favorably to treatment. Keller (1990) described MDD as treatment resistant. Judd, Frankish & Moulton (2001) followed originally identified depressed patients for several years and found that little or no sufficient treatment was provided that met current standards for evidence-based practices. Even though the chronically depressed patient is considered to be one of the most difficult outpatients in psychotherapy, improvements have been noted in the use of integrative therapies including CBT, as well as integrative therapies, which include Cognitive Behavioral Analysis and Interpersonal Psychoanalysis (McCullough, 2000; Emery, 2000). Whitethorn (1999) found that psychotherapy is being revisited with newer, more focused time-limited approaches in treating MDD. Therapists and researchers with training in major depression, its diagnosis, treatment and incorporation of evidence-based practices are recently providing a more optimistic outlook to the treatment of these patients. In particular, CT and CBT approaches hold promises for the treatment of major depression (Beck, 1976; Emery, 2000).

Confusion between CT and CBT

Confusion may exist in the professional community concerning the differentiation between CT and CBT, because of their shared techniques and philosophies. Cognitive therapy is an active, directive, time-limited, structured approach used to treat a variety of

psychiatric disorders. It is based on an underlying theoretical rationale that an individual's affect and behavior are largely determined by the way in which he or she structures the world (Beck, 1967, 1976). A variety of cognitive and behavioral strategies are utilized in cognitive therapy; cognitive techniques are aimed at delineating and testing the patient's specific misconceptions and maladaptive assumptions. Cognitive behavioral techniques are used with more severely depressed patients not only to change behavior, but also to elicit cognitions associated with specific behaviors (Beck et al. 1979). The treatment manual for this case study is based on a cognitive-behavior protocol, which is a recommended approach for MDD (Beck, 1976).

Models of Depression

It is beneficial for the practitioner to have an understanding of the various models of depression to gain a greater understanding of etiologies and proposed treatment approaches. Beck's cognitive therapy (1976) and Lewinsohn's (1974) behavioral learning theory are two well-accepted models for treating MDD. The etiology of depression is often discussed according to variations of these models.

Beck (1967 and 1976), who is recognized as the founder of cognitive-behavioral therapy, rejected the psychoanalytic concept of inwardly directed anger or retroflected hostility as important constructs in depression. He did not view the patient's conscious, negative verbalizations as retroflected hostility (Eist, 2002). Beck et al. (1979);

Abramson, Metalsky, and Alloy (1989) suggested that people who become depressed possess a stable depressogenic cognitive style that predisposed them to depressive episodes following the occurrence of negative events. The cognitive school of thought is based on the belief that a patient's symptoms are maintained by his or her thinking. The etiology of a patient's depression is also explained by behaviors of passivity, inactivity, withdrawal from others and avoidance of pleasant activities. The patient's negative emotions or feelings are best explained by distorted thoughts about the client's experiences (Emery, 2000).

Even though the cognitive theory of depression is based on challenging negative beliefs and attributions, behavioral techniques are also utilized for the severely depressed individual. It is often necessary for the therapist to concentrate on restoring the patient's functioning to the premorbid level. The behavioral school of thought includes various explanations for depression based on learned helplessness, an increase in stressful events and a reduction in activity. Seligman et al. (1998) discussed depression using the learned helplessness model of depression, which claimed that a tendency to make internal, stable, and global explanations of life events is a risk factor for depression. The hopelessness theory of depression is a cognitive diathesis-stress theory, proposing that certain inferential styles predispose individuals to hopelessness (Abela, Brozina, & Seligman, 2004).

Lewinsohn (1974) demonstrated in his research, a temporal association between the

onset of pathology and a recent increase in the number of stressful life events.

Lewinsohn, Hoberman & Rosenbaum (1988) also stated that depressed individuals have difficulties in interpersonal interactions. These characteristics contribute to depressive symptoms according to the model. Lewinsohn et al. (1988) found that there was a relationship between the occurrence of aversive life events and depression; these researchers (1988) developed the Unpleasant Event Scale in which the occurrence of aversive events and clinical depression was measured by assessing the rate of occurrence of unpleasant events, the type of aversive event and whether or not depressives differentiated by the rate of occurrence of aversive life events.

Antonuccio, Danton, and DeNelsky (1995) postulated that depression may result from a stressor that disrupts normal behavior patterns, causing a low rate of positive contingent reinforcers. The rate of reinforcement is functionally related to the availability of reinforcing events, personal skills or the impact of certain types of events. If the individual cannot reverse the negative balance of reinforcement, a heightened state of self-awareness will follow that can lead to self-criticism and behavioral withdrawal.

Cole, Lazarick and Howard (1987) found that treating depression involved addressing social interaction problems experienced by the patient. Very often depressed patients experience dissatisfaction with family, job, and social relationships (Libet & Lewinsohn, 1973). Depression may result because individuals lack the prerequisite social skills necessary for obtaining maximum positive reinforcement. Depressed individuals often

have negative self-perceptions of their social competence and have a negative impact on those around them (Coyne, 1976). Behavioral skill deficits include a tendency to be less assertive, less positive, have negative facial expressions, poor eye contact, and display less activity in-group interactions (Youngren & Lewinshohn, 1980).

Empirically Supported Treatments for Depression

Cognitive behavioral therapy (CBT) is one of the most frequently used and empirically tested treatments for depression (Castonguay et al. 2004). The CBT therapist will work with the patient in helping him or her to alleviate symptoms through modifying cognitive processes and by using behavioral techniques to reinforce involvement in pleasant activities. CBT has been shown to be effective in randomized, controlled clinical trials conducted in research settings with homogeneous, highly selected samples of patients (Beck et al., 1979).

Despite the overwhelming acceptance of CBT by clinicians, questions remain in clinical settings concerning whether or not these empirically supported treatments can be effectively and equally implemented with similar results in all settings, especially in community mental health centers (Mosher & Burti, 1994). Questions also remain if CBT is superior to other treatment modalities because of resistance and roadblocks by clinicians, patients and administrative staff (Patelis-Siotis, 2005). Critics state that CBT may be ineffective for specific chronic conditions including major depression, psychosis,

bipolar disorder, posttraumatic stress disorder and binge eating. Other critics conclude that CBT may ignore the feelings and individuality of patients and the importance of the therapeutic alliance (Patelis-Siotis, 2005). At the same time, critics conclude that many CBT research studies have yielded low response rates, especially those found in the NIMH Treatment of Depression National Collaborative Research Program (Blatt et al., 1996). A comprehensive review of empirical research findings is essential in understanding the acceptance and criticisms of CBT.

Empirical Review of Research Studies

In intensive pilot studies at the University of Pennsylvania, Rush, Beck, Kovacs and Hollon (1977), assessed the effectiveness of CT for the treatment of depression. In the 1977 study, a combined approach including CT and an antidepressant drug, imipramine, for 44 depressed outpatients was efficacious. Both treatment groups were equivalent with respect to demographics characteristics, histories of illness, treatment and mean severity of depression at the start of treatment. Of 19 patients assigned to cognitive therapy, 18 completed treatment over a mean period of 11 weeks. Of 25 patients assigned to pharmacotherapy, 17 completed treatment over the same mean period of time.

By the end of treatment, both treatment groups showed statistically significant decreases ($p < .001$) in depressive symptomatology according to self-reports, observer evaluations and therapist ratings. By the end of treatment, cognitive therapy resulted in

significantly greater improvement than did pharmacotherapy on self-reports and observer-based clinical ratings of depression ($p < .01$). Of the cognitive therapy patients, 78.9% showed marked improvement or complete remission by the end of therapy, whereas only 20.0% of those who completed pharmacotherapy showed a similar degree of response. Follow-up data at 6 months past termination indicated that treatment gains were maintained for both groups (Rush et al. 1977).

In a follow-up study by Rush et al. (1977), the effect of CT alone was compared with the combination of CT and amitriptyline in which CT was proven more effective in the treatment of depression. In the follow-up study, 33 patients were prescribed randomly to each of the treatment conditions and were treated in individual sessions according to the procedure described in the Rush et al. (1977) study. After cases were eliminated due to breach of research protocol or discontinuation, it was found that 14 patients in the CT alone study showed a reduction in their BDI scores from 31.0 to 8.64 at the termination of treatment. The combined CT and amitriptyline group consisting of 12 patients showed a reduction in scores from 29.9 to 9.83 at the termination of treatment. Thus, both groups showed a highly significant and clinically substantial improvement (Rush et al. 1977)

In an additional study, which was performed to test if cognitive therapy for depression could generalize to routine clinical settings, Persons, Bostrom and Bertagnolli (1999) proved that patients treated with cognitive therapy for depression in private practice responded positively. The patients in the Persons et al. (1999) study were then compared

to a randomized controlled trial conducted by Murphy, Simons, Wetzel and Lustman in 1984. This study was performed because it is a fairly large trial that examined the outcome of CT and CT plus pharmacotherapy. The mean post treatment BDI scores of both samples were then examined.

The main goal of the study was to examine the generalizability to clinical practice of Beck's cognitive therapy for depression as described in Beck et al. (1979). It was found that the Beck et al. (1979) protocol required modification because private practice patients had multiple comorbid difficulties including panic attacks, substance abuse, and diabetes that were not addressed in the standard protocol. It was found that in private practice, the interventions provided more flexibility; therefore the order of administration was often changed. The subjects selected were adult outpatients who were clinically depressed, based on a BDI score of 14 or greater and therapy followed a formulation-driven CT approach for individuals. Forty-five patients met these criteria and were selected for the study. Twenty-seven of these patients received CT and eighteen received CT plus pharmacotherapy. As predicted, patients treated with CT for depression in private practice showed outcomes comparable to those of patients treated in research settings.

More recent research studies of CT and CBT for depression have focused on new issues including sudden gains, critical sessions and rapid response. Tang and DeRubeis (1999) found that many CBT patients experienced sudden gains, sudden and large

symptom improvement during single between session intervals. Patients who experienced sudden gains were significantly less depressed than other patients at the end of treatment, as well as 18 months afterward. Furthermore, patients who recovered after sudden gains showed better long-term outcomes than patients who recovered without sudden gains.

Tang and DeRubeis (1999) analyzed many aspects of the pregain session. They found that the control sessions did not differ significantly on the therapists' adherence to CBT techniques, therapeutic alliance, facilitative conditions, or therapist competence. They did find that the patients explicitly acknowledged many cognitive changes in the pregain sessions but very few cognitive changes in the control sessions. It was suggested that in-session cognitive changes might have contributed to triggering CBT sudden gains.

In a more recent study, Tang, Beberman, DeRubeis and Pham (2005) reexamined these finding in two variations of CBT investigated by Jacobson and Hollon (1996). In that study, Jacobson and Hollon (1996) randomly assigned clinically depressed outpatients to three variations of CBT including behavioral activation, automatic thoughts, (AT), and cognitive therapy (CT). Tang et al., (2005) focused on sudden gains and in-session cognitive changes in two cognitively oriented conditions, AT and CT. To improve the interrater reliability from the 1999 study, the training time allocated for the Patient Cognitive Change Scale (PCCS) was doubled. Data was collected by rating relevant therapy sessions from 26 pregain and control sessions from AT and 26 pregain and control sessions from CT. Tang and DeRubeis' (1999) findings were successfully

replicated and the study found that CBT sudden gains predicted good outcomes and were immediately preceded by substantial in session cognitive changes.

In another study, Hollon et al., (2002) studied whether or not CT had an enduring effect that extended to the prevention of relapse among more severely depressed outpatients. The study also examined the subsequent course following the initial treatment for patients randomized either to CT or to antidepressant medication (ADM). Subjects included patients with moderate to severe unipolar depression aged 18-70 who were recruited from outpatient psychiatric clinics at the University of Pennsylvania and Vanderbilt University.

All patients met criteria for major depressive disorder (MDD) as ascertained by the structured Clinical Interview for DSM-IV Diagnoses. The patients were also required to have scores of 20 or above for two consecutive weeks on the first 17 items of the Hamilton Rating Scale for Depression (HRSD). Two hundred and forty patients met all inclusion and exclusion criteria and were randomly assigned to 16 weeks of acute phase treatment either with CT (n=60) or with ADM (N=120). The remaining 60 patients received 8 weeks of pill placebo. Although responders to CT discontinued treatment at the end of the acute phase, they were allowed up to 3 booster sessions over the 12-month continuation phase. These sessions could be scheduled at any time, with the proviso that they may be scheduled at least one month apart (Hollon et al. 2002).

The findings of the study suggested that CT had an enduring effect that reduced risk

following successful treatment, as indicated by the reduced relapse rates relative to medication withdrawal. The magnitude of the CT effect appeared to be at least as great as that achieved by keeping patients on continuation medication, which is widely regarded as the most effective means of preventing relapse. A total of 40 patients who remained active in ongoing assessments completed the 12-month continuation phase without relapse. Hollon et al. (2002) concluded that there were two ways to prevent relapse effectively, including continuing of ADM or the administration of CT during the acute treatment phase. Hollon et al. (2002) also concluded that these findings needed to be interpreted cautiously because it remained unclear how CT exerted its enduring effect. It was concluded that enduring effects and improvements occurred because of a change in patients' beliefs, which would be expected to reduce the likelihood of becoming distressed in formerly problematic situations. Hollon et al. (2002) questioned whether or not the actual mechanism was a change in the content of patients' beliefs or rather a change in the way that patients react to their thoughts. Although there were indications that CT's enduring effect may extend to the prevention of recurrence, direct comparisons to maintenance medication in larger samples would be required to fully assess its relative value (Hollon et al. 2002). Hollon (2006) proposed that enduring effects may be due to treatment effects that reduce existing problems which would not have gone away on their own or to preventive effects that reduce risk of future problems. He felt that an enduring effect must set in motion causal processes that interrupt the sequence of events leading to

the onset or return of (?) the disorder. Hollon (2006) also explored whether or not psychosocial interventions have enduring effects. He felt that for an effect to have an enduring effect, it must be detected.

Bannan (2005) concluded that cognitive therapy is an effective form of treatment for depression and may be at least as effective as pharmacotherapy in terms of acute symptom relief with a more enduring effect not found with other approaches. Patients diagnosed with acute depressive symptoms benefited in terms of mood, hopelessness, and overall social and occupational functioning; pharmacotherapy alone had failed (Bannan, 2005). Despite this, the evidence is limited for the use of CT specifically in the treatment of resistant depression (DeRubeis, Gelfand & Tang, 1999). Teasdale, Segal and Williams (1995) stated that the mechanism of action of CT in residual depression might be to change coping skills rather than ameliorating all symptoms. Other critics concluded that CBT may ignore the feelings and individuality of patients and the importance of the therapeutic alliance (Patelis-Siotis, 2005). At the same time, critics conclude that many CBT research studies have yielded low response rates especially those found in the National Institute of Mental Health Treatment of Depression National Collaborative Research Program (Blatt, et al., 1996).

This study questioned the superiority of CBT and indicated only modest differences in therapeutic outcome among the various forms of brief treatment for depression evaluated in this study. Few substantial differences in therapeutic change were found

among patients seen in CBT, interpersonal therapy (IPT), imipramine with clinical management (IMI-CM), or placebo with clinic management (PLA-CM). IPT and IMI-CM appeared to be somewhat more effective than CBT, but only with seriously depressed patients (Blatt et al. 1996). Blatt et al., (1996) (also) discussed the fact that significant outcome effects were found in the Treatment of Depression National Collaborative Research Program as a consequence of pretreatment patient characteristics.

Current Research Findings

McGinn (2000) stated that future research studies need to evaluate the effectiveness of CBT for depression outside of clinical research centers. The demonstration of treatment efficacy in controlled research environments is only the first step in treatment research. After a positive therapeutic effect has been conclusively demonstrated, generalizability becomes of paramount importance. Data is not available on the efficacy of CBT for depression when delivered in non-research clinical settings to a diverse group of patients. Caution must be warranted until data are generated specifically on CBT for depression that support the effectiveness of evidence-based treatments outside of controlled research environments (McGinn, 2000)

Recent studies are examining many of the well-accepted fundamental aspects of CBT therapy. Thase and Callan (2006) stated that even though homework is considered a cornerstone of CBT treatment for depression, a relatively small number of studies have quantified the causal relationship between homework completion and symptomatic outcome. Most of these studies have limited power to detect small-to-moderate effect

sizes and rely on retrospective or incomplete measurements of homework that do not distinguish between the quantity and quality of the assigned tasks. Nevertheless, there is relatively consistent evidence from correlation studies to conclude that homework adherence is associated with significantly better outcomes. These findings point to new questions for research.

Therapy for depression

Castonguay et al. (2004) concluded that there is ample evidence that a number of depressed individuals fail to respond adequately to CT. A similar conclusion was reached in the NIMH 1999 Collaborative Study in which the rate of recovery of the clients who completed CT varied from 51% to 65 %, depending on the criteria used for clinical recovery. These concerns have led researchers to question the effectiveness of CT or CBT for depression.

Tang and DeRubeis (1999) studied rapid early response in CBT for Depression. They also noted that most CBT efficacy studies have allowed a maximum of 20 therapy sessions and patients who have received at least 12 sessions have usually been considered completers. The study examined the mechanism of time course data, which was originally studied by Ilardi and Craighead in 1994. It was concluded that the pioneering work of Ilardi and Craighead could be further developed. This included plotting depression severity against the number of sessions received rather than the number of weeks in therapy. It was suggested that a future analysis should extend to individual patient's time courses because individual subject's change over time is the best way to detect underlying causal relationships. It was also recognized that the time course data did not directly support Beck's cognitive hypotheses.

In a study by Castonguay, Goldfried, Wisner, Raue and Hayes (1996), the functional impact of the therapists' focus on the client's intrapersonal functioning was studied. This focus refers to connections or links made by the therapists between different aspects of the client's functioning. Reflecting the central element of the cognitive therapy model, these links include the impact of clients' distorted thoughts on their depressive symptomatology. It was concluded that although the therapeutic alliance was positively related to client change, therapists' focus on intrapersonal issues such as the causal relationship between the clients' thoughts and emotions correlated negatively with outcome. (Castonguay et al. 1996). The working alliance inventory was used to measure agreement on goals, tasks and feelings about the therapeutic bond. The study provided information regarding the predictive ability of common and unique factors in CT. The therapeutic alliance and clients' emotional experiences are assumed to be common to different psychotherapy approaches (Castonguay et al., 1996). Other studies have focused on the therapeutic relationship in CT and concluded that an integration of various therapies would prove beneficial. The results of these studies suggest that the efficacy of CT can be improved (Castonguay et al., 2004). Leading cognitive therapists have also demonstrated the beneficial impact of empathy on the client's symptoms. These findings suggest that the efficacy of CT may be improved by the adoption of more appropriate strategies aimed at repairing alliance problems consistent with the concepts of client-centered therapy (Castonguay, et al., 2004).

McCullough (2000), an ardent critic of CBT as a superior treatment modality for chronic depression and an advocate of the use of his integrative approach to therapy known as the Cognitive Behavioral Analysis System of Psychotherapy (CBASP), conceptualized depression in terms of a person x environment perspective. McCullough (2000) concluded that the patient should be educated regarding his or her stimulus value within his or her living context. The treatment approach also incorporates Piagetian formal operations when teaching social problem-solving and empathetic responses in the conduct of social interaction. Patient transference issues and negative reinforcement methods are utilized as essential motivational strategies in order to modify behavior. CBASP was clinically tested in a combined medication and psychotherapy trial involving 681 individuals with major depression in an outpatient setting. Participants were randomly assigned to 12 weeks of treatment with nefazodone, CBASP, or a combination of both. Among the 519 participants who completed the study, the rate of response for the monotherapy did not significantly differ (nefazodone group, 52% response rate; CBASP group; 52% response rate and the combined group reported response rates of 85%). The degree of superiority of combining CBASP with nefazodone, as compared with monotherapy, suggested that combination treatment for major depression provides a meaningful clinical advantage (McCullough, 2003).

At the same time, Young, Grant and DeRubeis (2003) concluded that the most difficult problem when treating chronically depressed patients is finding a clear-cut

normal baseline functioning. Some patients may not have had a nondepressed period for a significant duration of time; others have simply been depressed for so long that they cannot remember how they thought or coped before the depression began. Young et al. (2003) found that chronic patients frequently present with hopelessness and pessimism as prominent symptoms of their depression; therefore the therapist must label their hopelessness as a belief that that can be examined, challenged, and modified.

Another important aspect of CT is the context of the relationship between the patient's desire to get better and the therapist's expertise in aiding his recovery. At the same time, the primary goals of CT are not to enhance the therapeutic alliance (Young et al. 2003). Burns and Auerbach (1996) felt that the therapeutic alliance was a primary component of CT therapy and developed several techniques to repair alliance ruptures during treatment. These techniques include listening skills, which are focused on paraphrasing the client's criticisms and feelings of anger, frustration or disappointment about the therapist or therapy. Burns and Auerbach (1996) also included self-expression skills called; "I feel" statements and "stroking", during which the client will frequently feel validated and understood. Other influences including the contribution of humanistic and interpersonal therapists have suggested the use of similar therapeutic tools to help cognitive therapists recognize and resolve relationship ruptures (Castonguay et al., 2004).

Pinard (2007) and (Young et al. 2003) examined ways to prevent relapses by helping patients develop a realistic approach to their problems. Relapse prevention involves the

patient's ability to predict, evaluate, and cope with potential problems realistically. The therapist works with the patient using role-playing with with potential problems scenarios. Using Socratic questioning, the therapist helps the patient identify distorted cognitions that might occur in specific situations, as well as suggesting strategies that he or she could use should he or she encounter these problems in the future (Pinard, 2007; Young et al. 2003).

The author has reviewed a number of studies concerning the application of CT and CBT both in research and in clinical practices. At the same time despite new research studies, the CBT field is relying on the original work of Beck developed in the late 1970's and 1980's (McGinn, 2000). Unfortunately the research literature is lacking in the application of such practices to clients diagnosed with major depression (Young et al. 2003). Many of these clients are treated in the community mental health field and are diagnosed with resistant or chronic depression (Markowitz, 1995). An estimated 40-50% of diagnosed clients in this population do not receive appropriate treatment and an estimated 20-30% of patients with major depression do not respond to treatment (Bannan, 2005; Wang, Demler & Kessler, 2002). Despite these statistics and the acknowledgement that CBT treatments may result in lack of sustained treatment and/or relapses during treatment, CBT treatment has shown marked improvements in patients' moods, reduction in depressive symptoms and greater acceptance from patients (Bannan, 2005; Beck et al., 1979).

Reasons to Study MDD in Community Mental Health

The content of this paper has focused on treatment prognosis, etiologies, proposed treatment modalities and clinical features of major depression. It is understood that many of these explanations and approaches are developed in university settings (Torrey & Gorman, 2005). Individuals treated in the community mental health field predominantly receive mental health insurance coverage from Medicaid or Medicare; these do not require empirically supported treatment modalities. The Surgeon General in 1996 concluded that the statistics of mental health sufferers increased to 27 million low-income individuals or 12% of U.S. adults who received Medicaid coverage (Mosher & Burti, 1994).

The forecast for the indigent and Medicaid population serviced in community mental health is poor. A large sector of this population is described as despondent with loss of affect or as chronically depressed (Pratt & Gill, 2005). Kiesler (1982) and Organista et al., (1994) forecast that care for chronic mental patients will, at best, stay the same and that most mental health patients who are deinstitutionalized will remain poor, socially isolated and unhappy due to high unemployment and lack of health care. Most of these patients will be transinstitutionalized not deinstitutionalized (Shadish, 1989).

The increase in the population receiving mental health services in community mental health was well documented. According to Shadish (1989), the main diagnostic groups

receiving care included major depression, mild to moderate depression, substance abuse, schizophrenia and other mental health disorder. The most common primary diagnoses were other mental health disorder (50.7%), mild to moderate depression (25.4%), and major depression (17.1%). Other mental disorders included dual diagnosed patients. As can be seen, the prevalence of depression in community mental health was significant and should be researched in the mental health field (Leslie & Rosenbeck, 1999).

Unfortunately, depression in community mental health is understudied and poorly researched because of insufficient funding (Shore, 1992; Leslie & Rosenbeck, 1999).

Before suggesting or implementing treatment strategies, an understanding of the development, practices and problems in the community mental health field may be necessary to assist the professional in gaining a clearer understanding of the community mental health environment (Mosher & Burti, 1994).

Present Practices in Community Mental Health

Mosher and Burti (1994) stated that the community mental health system was designed to assist in the prompt delivery of consistent care for social, psychological and medical needs of a defined population of individuals who required mental health care in a specified geographical area. Community mental health practices originated from the mandate of the Community Mental Health Act of 1963 to revolutionize the care of the mentally ill in the direction of decentralized, local community treatment as opposed to

institutionalized care for patients. This mandate was well supported by research that documented the detrimental effects of prolonged institutional treatment as well as the beneficial effects of community treatment (Test & Stein, 2000).

The field responded with a variety of programs including community mental health centers, crisis intervention centers, halfway houses, psychosocial rehabilitation groups and boarding facilities. There is criticism, however, that markedly impaired individuals who were treated in mental hospitals experience a large hospital readmission rate and that community programs that rely on outpatient care have been unsuccessful with these individuals (Test & Stein, 2000). The mental health field has reacted to this problem by developing new innovative programs that focus on preventing psychosocial problems. This is accomplished by reducing the incidence and prevalence of new and existing cases, by reaching out to people in crisis and by providing them with immediate guidance to master their difficulties (Caplan & Caplan, 2000).

Community-based health promotion programs often emphasize empowerment, social participation, and collaboration with multidisciplinary teams. Empowerment, in its most general sense, refers to the ability of people to gain understanding and control over personal, social, economic and political forces in order to take action to improve their lives (Judd et al., 2001). Judd et al. (2001) suggested that standards should be set, based on the community's concerns and interests. These standards meet practical issues expressed by the community and are often programs that are realistic, prudent and frugal

(Judd et al. 2001). Programs and standards are designed to lower the rate of mental disorders in the community based on pro-active policy, a crisis approach and prevention of mental health problems in the community (Caplan & Caplan, 2000).

To accomplish this mandate, treatment, primarily focused on the teaching of basic coping skills that are deemed necessary for clients to live autonomously in the community, is often recommended (Caplan & Caplan, 2000). The rationale for treatment guidelines is based on research that suggests that the majority of individuals receiving care in community mental health demonstrate a limited repertoire of problem solving behaviors to meet the demands of life (Test & Stein, 2000). It was also concluded that inadequate social and vocational capabilities contribute greatly to the need for ongoing treatment. It appears that the current problems of the “revolving door syndrome” and the poor quality of life manifested by many patients treated in the community can be explained by the fact that their underlying deficit in coping skills are seldom altered (Test & Stein, 2000).

Social skills training may concentrate on daily living skills, vocational skills, leisure time skills, and interpersonal skills. Clients often lack not only specific work skills, but also job-seeking abilities and good work habits (Dooley, 2003). Test and Stein (2000) stated that treatment of the markedly impaired population should occur in the patient’s natural environment. This recommendation may reduce “no shows”, often a result of passivity, dependence and withdrawal. Wolpe (1969) found that increasing appropriate,

adaptive behaviors in a patient's repertoire often leads to a decrement of inappropriate behaviors.

Staff Requirements

Staff requirements for therapists in community mental health settings vary from other clinical settings. It is recommended that staff in community settings demonstrate specific attributes including comfort in leaving an office setting and ability in making decisions independently in the community (Test & Stein, 2000). Fund restrictions are commonly found in community mental health settings (Chu & Trotter, 1979). At the same time, working in community mental health programs is often regarded as having second-class citizenship because the pay is low, the clientele is notoriously difficult and the working condition is inferior. Staff may also suffer disappointment at their clients' low levels of motivation and chronicity of illness (Mosher & Burti, 1994).

The mental health staff is an essential key to the provision of care. Unfortunately, the Benefits to the staff are few and the requirements are great (Mosher & Burti, 1994). Staff in the community mental health field must be willing to interact with non-mental health professionals, including the representatives from the fields of education, welfare, law, corrections and religion. These additional requirements are best accomplished through collaboration with other professionals (Caplan & Caplan, 2000).

Community mental health patients have diverse needs, including the search for

residential facilities and the needs for crisis intervention, partial day hospital programs and ongoing case management needs (Mosher & Burti, 1994). These diverse needs can be accomplished only with a strong partnership with agencies, professionals and paraprofessionals (Mosher & Burti, 1994). There is an unfortunate lack of interest and knowledge concerning the role and activities of nonprofessionals in the field by many professionals. This is partly due to different ways of working and styles of operation of professionals and nonprofessionals (Caplan & Caplan, 2000).

Advantages in Delivery of Care

A number of positive outcomes have occurred in the delivery of mental health care in community mental health settings. The use of cost containment strategies proved helpful in introducing interventions that aided administrators in demonstrating specific health outcomes (Jackson, Pitkin, & Kington, 1998). Stakeholders had a role in articulating acceptable standards for a given program. This is a major tenet of community mental health (Judd et al., 2001). Nonmedical care systems often involved in community mental health were integrated into the health delivery system and were instrumental in controlling cost and reducing hospitalization. Groups including schools, churches, social and vocational groups and social agencies became an important aspect of the patient's care (Bailey, 1999). Integrated approaches, which are often found in community mental health care, may assist administrators in enhancing care and controlling costs (Shore, 1992).

The Conflicting Role of Managed Care

With the many advantages found in the community mental health system, the presence of managed care provided controls and restrictions of needed services (Farran, 1992). At the same time, many managed care programs are poorly designed to provide care for chronically mentally ill patients because they are focused on limiting the cost of each discrete episode of care, thereby failing to adopt the longitudinal perspective so important to the care of people with chronic mental illness (Bailey, 1999). Capitated managed care systems often encourage caregivers to restrict medical care to the minimum necessary to eliminate overt symptoms (Bailey, 1999).

Problems in Community Mental Health

Many of the problems that have occurred in the community mental health field are results of the development of managed care and reduced federal funding (Mosher & Burti, 1994). The decline in funding and the evolution of managed care began with President Nixon's reduction of federal funding and the transfer of responsibility to the states in the early 1970s. In the 1980's, the Reagan administration rescinded all federal funding which was outlined in the Mental Health Systems Act. Mental health reductions occurred especially during the liberal administrations of the Kennedy and Carter administrations (Shore, 1992).

In addition to federal funding restrictions, other problems existed in the community mental health field. Community mental health never dealt effectively with the severely

mentally ill due to funding restrictions and the underdevelopment of adequate community-based services. Prevention was not well integrated into the community mental health programs despite recommendations from the NIMH and American Psychological Association (Price, Cowen, Lorion & Ramos-McKay, 1988). Problems occurred in the community mental health delivery system due to lack of federal grants, severe local state fiscal problems, limited fee-for-service payments, and lack of sufficient attention to research (Shore, 1992).

Evidence-Based Practices

Because the community mental health movement has achieved significantly less than its original aims due to insufficient research efforts and reduction of government funding, evidence-based practices may be a potential solution (Hausman, 2002). Evidence-based practices are defined as the integration of best research evidence with clinical expertise and patient values (Azrin & Goldman, 2005). Although the concept of evidence-based practice is new to the field of mental health, its impact has already been felt widely through federal, state and local mental health agencies (Bond, Salyers, Rollins, Rapp, & Zippel, 2004). Evidence-based practices, which are often developed in university settings, can be effective in community mental health settings because they are developed, based on mutual values and principles (Mosher & Burti, 1994).

One such concept is the belief in a shared healing context in which the client perceives

the therapist as helping or providing the context in which the client can heal. In both settings the clinician and client should develop a shared definition of how the problem developed and positive expectations for therapy. These goals are achieved in a partnership, which is caring and confiding through various forms of psychotherapy and with specified common features.

Common Features of Evidence-Based Practices

To achieve an effective implementation of evidence-based practices, six evidence-based practices are recommended for adults with severe mental illness. These features include a primary focus on recovery, the facilitation of empowerment and choice, the recognized role of relationships, the importance of in-vivo delivery, utilization of the environment as a resource and a primary focus on teamwork and integration of helping. In addition, assertive community treatment, supported employment, integrated dual-diagnosed treatment; family psychoeducation, illness management and recovery and medication management are also recommended features (Rapp & Goscha, 2005).

Problems with Evidence-Based Practices

Mosher and Burti (1994) acknowledged that problems existed with the integration of evidence-based practices in community mental health due to a lack of acceptance in the community mental health field by professionals and staff. One area of contention is lack of appropriate evidence that may not be viewed by staff as actually fitting the clinic's model. There may also be lack of information on relevant outcomes because researchers

may see one outcome as important and consumers will ignore the evidence if it does not address the intervention that they value (Anderson & Strupp, 1996). Hausman (2002) also concluded that despite the benefits, implementation of evidence-based practice principles is not uniform. Barriers to the adoption of practice guidelines by practitioners existed due to personal beliefs, experience, organizational factors and the lack of relevant research about specific practices. Hausman (2002) also noted that additional barriers include lack of implementation information, conflicting practice goals, and lack of information on funding context.

The criticisms of the evidence-based practice movement have been strong and widespread (Essock, Goldman, Van Tosh, Anthony, & Appell, 2003). There are concerns about whether or not sufficient funding exists for the implementation of evidence-based practices. Jackson et al., (1998) discussed the Rand Study, which demonstrated that private foundations, which fund evidence-based practices, are less oriented to the goals or the concerns of the community. Anthony, Rogers, and Farkas (2003) concluded that that the goals of evidence-based practices might be indifferent or even antithetic to recovery. Azrin and Goldman (2005) expressed concerns about whether or not the appropriate care was used when evidence-based practices were utilized. In a population study by Wang et al. (2002) only 25% of the respondents with a serious mental illness received appropriate treatment consistent with evidence-based practice recommendations or guidelines.

As with any new concept, it has been interpreted in many different ways. Some have

embraced evidence-based practice while others have viewed the movement as a threat. One particular area of criticism is the view that evidence-based practices do not promote recovery-oriented outcomes. Others argued against this viewpoint and also stated that evidence-based practices facilitated consumers in moving out of patient roles toward greater independence through the acquisition of self-management skills (Bond et al., 2004). Despite these divergent views, Mosher and Burti (1994) concluded that evidence-based practices could be successfully integrated in a community mental health environment.

Conflicting Goals

Differences existed between the implementation of evidence-based practices in university and in outpatient settings. One reason may be that empirical guidelines are developed from an epidemiologic perspective that assume decisions are made rationally and in accordance with credible data. At the same time, agencies working to improve community mental health may take a different approach to decisions, relying on flexible proposals and the ability to meet specific community needs (Jackson et al. 1998).

A Reason for Optimism

Bond et al. (2004) stated that the future for evidence-based practices is bright despite conflicting goals and problems in implementation. Other reasons for optimism include the emergence of the evidence-based practice movement. Encouraging factors included emerging knowledge based on how to train and consult effectively with agencies

concerning implementation and support of these practices. At the same time, increased expertise, knowledge and a growing understanding of the critical importance of providing empirically approved mental health practices by integrated teams of providers have also proven beneficial.

National evidence based practice project.

Bond et al., (2004) acknowledged the National Evidence Based Practice Project in promoting the growth of evidence-based practices. This effort is a large-scale effort to study and improve strategies for implementing evidence-based practices. The first phase of this project was to create toolkits, which provided practical, hands-on material to enable agencies to implement evidence-based practices with high quality. The second phase of the project incorporated systematic consultation and technical assistance to help 55 agencies in 8 states to develop environments that would sustain these practices over time. The National Association of Mental Institutes (NAMI) and other organizations offered programs in which consumers and families served as providers of training. Some sites within the National Evidence Based Project involved consumers and family members as trainers and members of leadership teams who aided in the implementation of evidence-based practices. At the same time the integration of supported employment services, illness management and medication management for clients were positive steps in reducing key barriers in community integration (Bond et al. 2004).

National evidence-based practice attitude scale.

In addition to the previously discussed principles and components, a proposed tool may prove helpful in monitoring provider concerns toward the integration of evidence-based practices. This proposed tool, the Evidence-Based Practice Attitude Scale (EBPAS) was designed to measure provider attitudes toward the adoption of evidence-based practices in community based health settings (Aaron, 2004). There remain a number of new practices that require integration into the medical delivery system. These practices may be helpful in reducing resistance to the integration of evidence-based practices. Some of these practices are directed to consumer needs but others are proposed to better serve the practitioner in better providing evidence-based practices. For the consumer, supported housing, family psychoeducation, supported education and employment are proposed as future practices.

There have not been new developments in the National Evidenced Based Project or in the National Evidenced-Based Practice Scale. But according to Barlow (2005), several trends have come together to bring the idea of evidenced-based practice to the “tipping point”. Our knowledge of the nature of various pathologies, both physical and psychological, has advanced rapidly in recent years. This has led to the development of new and more precisely targeted interventions. Clinical research methodology has established the effectiveness of certain interventions, which have been tested in large clinical trials. The mission of the Agency for Healthcare, Research and Quality is to improve the quality, safety, efficiency and effectiveness of health care for all Americans.

Evidence-based practices are a new development that has impacted all health care professionals including clinical psychologist. According to Barlow (2005), the greatest emphasis to date has been on empirically supported treatments. Assessment strategies are an implicit part of any intervention strategy but much work remains to be done.

Unified treatment approaches for the treatment of anxiety and mood disorders which may affect between 55- 75% of clients in their life time may be a diagnostic group with overlap which can be treated with empirically supported treatments and evidence-based assessments (Barlow, 2004).

Training needs.

Weisz, Chu, and Poli (2004) stressed the fact that extensive training and supervision are required to build mastery in the implementation and dissemination of evidence-based practices for practitioners and administrative staff. Weisz et al. (2004) also stated that the divergence of practice and research over the decades has left us with two rather distinct professional tracks, both focused on similar goals of improving adaptation, adjustment and reduction of distress and dysfunction, but unfortunately operating in rather insular fashion despite their common goals. Many decades of practice have helped build skills in clinical care on the front line while decades of research have built a base of tested approaches. A critical challenge for the field is to find ways to link these two traditions to capitalize on their complimentary strengths.

Psychoeducation

Psychoeducation is one of the most effective applications of evidence-based practices that have emerged both in clinical trials and in community settings. Psychoeducation is a professionally delivered treatment modality that integrates and synergizes psychotherapeutic and educational interventions. Psychoeducation reflects a paradigm shift to a more holistic and competence based approach, stressing health, collaboration, coping and empowerment (Lukens & McFarlane, 2004).

Standardized treatment manuals. Another application of evidence-based practices is the use of standardized treatment manuals in clinical settings (Drake et al., 2001). Musser and Drake (2005) stated that the use of treatment manuals should be encouraged as an effective way to implement evidence based practices because they include information to orient clinicians to the nature of the problem as well as to some conceptual foundations of the intervention. Specific guidelines are provided regarding the logistics of the intervention, the identification of consumers for whom the intervention is designed, the curriculum, teaching skills and guidance for handling common problems. Manuals often provide clinical vignettes to illustrate treatment principles and incorporate specific instruments for assessment and monitoring clinical outcomes.

Transportability

Although manual-based treatment manuals are not synonymous with evidence-based practices, they do provide a potentially helpful means to utilize efficacious interventions in real-world clinical settings (Addis et al., 1999). Manual-based treatment manuals may be one of the best choices in facing the reality that evidence-based practices will be required or strongly suggested by insurance providers due to the need of economic and accountability contingencies. The use of treatment manuals has been described as a small revolution in psychotherapy research (Dobson & Shaw, 1988). The earliest treatment manuals were designed for behavioral therapies with the publication of Wolpe's manual in 1969. The development of these treatment manuals reflected several assumptions made by behavior theorists, namely, that therapist variables were much less important than treatment procedures in outcome studies and that treatment variables could be administered and quantified with precision (Dobson & Shaw, 1988). As treatment manuals were developed for other non-behavioral treatments, most authors gave some degree of flexibility in treatment guidelines and provided flexibility and modifications in treatment. One of the most well known treatment manuals was also developed by Beck in 1979 for cognitive-behavioral therapy (Dobson & Shaw, 1988).

Treatment manuals, in addition to focusing on multiple treatment approaches, also yielded other positive factors. They may be a sound choice for clinicians in dealing with

the pressure from outside sources to integrate empirically approved treatments and provide outcome measurements in a cost-effective manner (Addis et al., 1999). Treatment manuals are critical in delineating the rationale and parameters of an intervention. At the same time, a criticism of treatment manuals is clinicians' resistance to the use of evidence-based practices, which may be due to their concern of control from outside parties along with their fears of losing creative control (Henggeler & Schoenwald, 2002).

Clinician Resistance and Concerns with Manual-based Treatment

Clinician's concerns may also include the therapeutic relationship, patient and client needs, competence and job satisfaction, credibility of manual-based treatments, restriction of clinical innovation, and feasibility issues (Addis et al., 1999). One of the main concerns expressed by clinicians is that it will not be possible to develop an effective therapeutic relationship while using a treatment manual. One belief is that implementation of manualized treatments required clinicians to abandon their rapport building skills with patients. Addis et al. (1999) found that 45% of clinicians agreed with the belief that treatment manuals ignored the unique contributions of individual therapists and 33% agreed that using treatment manual detract from the authenticity of the therapeutic interaction.

Physician concerns.

Another concern expressed by clinicians is that treatment manuals will detract from the effectiveness of specific treatments and the effective management of problematic

symptoms. Raue, Goldfried, and Barkham (1997) found that higher ratings of the therapeutic alliance were associated with higher impact sessions of psychodynamic and cognitive behavioral therapies. Moreover, rigid adherence to a protocol under conditions of a strain in the therapeutic alliance is associated with poorer outcomes in cognitive behavioral therapy for depression (Castonguay et al., 1996). Although these studies support the importance of the therapeutic relationship, they do not specifically address the issue of whether or not clinicians in clinic settings can establish effective therapeutic alliances while using manualized treatments. Addis et al., (1999) stated that the common perception is that manualized based treatments turn therapists into technicians. This claim is disputed because therapists bring well developed skills to the context of training; they also focus on developing client expectations, address concerns about specific interventions, assign homework, evaluate treatment outcomes and debrief at the end of each session while eliciting client feedback (Raue, Goldfried, & Barkham (1997)).

Clinicians also express concerns about the effect of manual- based treatment implementation on their job satisfaction and creativity. Beutler (2000) suggested that appropriate training in graduate programs and at clinical sites are important to assuaging the fears of providers' loss of creativity. Beutler (2000) found that there is no evidence to suggest managed care organizations are willing to commit the resources that are required. Norcross and Porchaska (1988) believe that conventional treatment manuals are organized around a single theory, whereas most clinicians adopt an eclectic or

multitheory perspective. These are noteworthy criticisms and concerns.

Patient Concerns

A common concern expressed by patients is that the therapist will not be able to address their individual needs when using a manual intervention. Craske, Meadows & Barlow (1994) concluded that there are no data to suggest that individual clients' needs are unmet in manual-based treatment. In fact, tailoring manualized treatments to individual clients' needs is critically important and occurs in the treatment of panic disorder when utilizing CBT. Kendall (2002) concluded that it is essential for the therapist to provide common examples to the patient of flexibility in therapy while using treatment manuals. Patients may also express concern that the use of a treatment manual for one diagnosis will not address other mental health issues. Wade, Treat and Stuart (1998) found that there is accumulating evidence that the positive effects of manualized treatment for specific disorders generalize to other problem areas. Significant improvement was noted in symptoms of depression, social phobia, blood-injury phobia, and generalized anxiety in patients treated specifically for panic disorder in a community mental health setting. Borkovec, Abel, and Newman (1995) found that successful treatment of generalized anxiety disorder led to the reduction of concurrent anxiety and mood diagnoses. The benefits of cognitive-behavioral treatment for bulimia nervosa also appear to generalize to other areas such as depression, self-esteem, and social functioning (Wade et al., 1998). Another concern expressed by clients is that manual-based

treatments ignore clients' emotions. Phenomenologically, all treatments involve getting to know a client and his or her unique life experiences. Manualized supported treatments are no exception (Addis et al., 1999).

Remaining Concerns among Psychology Professionals

Wilson (1995) concluded that there has been little research on the impact of treatment manuals in clinical practice. According to Scholomskas, Syracuse-Siewert, Rounsaville, Ball and Nuro (2005), there has been little research on clinicians' ability to implement treatment manuals effectively or to impact the clinical environment. Even though treatment manuals have proven effective in research settings, empirically validated treatments are not used widely in clinical practice. Craske et al. (1994) predicted that the second phase of the treatment manual revolution would be the development of self-help manuals. Patients could read the manual in advance of sessions, resort to it after therapy ends and involve family or friends in assignments to aid in a more supportive social context for change. Even though self-help manuals could be used under professional guidance, concerns exist in the research and clinical community concerning their limitations or potential disadvantages (Wilson, 1995). The use of self-administered treatment is a new area of research which is generating concerns in treatment outcomes. Scogin, Floyd, Jamison & Ackerson (1996) performed four studies of self-administered depression treatment. They concurred that severely distressed individuals should not routinely be involved in minimal-contact treatment programs, especially those disorders

that involve long-term disabilities. Young, Grant and DeRubeis (2003) suggested that setting an agenda collaboratively with the patient, identifying topics and taking care to apportion appropriate allotments of time to each is a crucial component when utilizing CT manuals. At the same time, it is important to note that depressed patients usually experience difficulty adhering to agendas. Although it is important that the agenda be set collaboratively, it is the therapist's role to guide the patient in identifying and prioritizing topics (Young et al. 2003).

Concerns in behavioral community.

Concerns have been expressed in the behavioral therapy community, advocating the use of single case experimental designs with the use of a functional analysis (Hayes, Castonguay & Goldfried (1981); Wilson, 1996). Malatesta (1995) stated that treatment manuals advocate a technological approach, which perpetuates the illusion that complex clinical problems can be treated easily and quickly. Wilson (1995) concluded that treatment manuals might be most effective for patients who meet diagnostic criteria for a particular disorder.

The Stage Model for Psychotherapy Manual Development

Carroll and Nuro proposed a stage model of psychotherapy manual development in which a clear distinction is made between the formative stage in the development of a new treatment (stage I), the stage of efficacy research (stage II) and the stage of

implementation and effectiveness research (stage III). They argued that manuals need to evolve, as therapists make progress through the incremental stages of development and as treatment manuals undergo evolutionary progress (Dobson & Hamilton, 2002).

Dobson and Hamilton (2002) discussed the specifics of the various stages of Carroll and Nuro's model. The proposed model reviews the disconnect between the academic research and clinical application of manual development. In the first stage, known as manual development, creativity, innovation, and experimentation with the model is recommended. This stage of manual development requires a broad focus. Patient feedback is required during the first phase of the model. Stages II and Stage III of the proposed model highlight the critical distinctions between efficacy research and effectiveness research. Efficacy research (Stage II) addressed the issue of whether or not an intervention is beneficial under standardized conditions. By contrast (Stage III) addresses the question of whether or not an intervention is beneficial in applied settings. Dobson and Hamilton (2002) expressed concern about the implementation process in Stage III because outcome research is fueled by national funding agencies and academic publications standards.

Dobson and Hamilton (2002) acknowledged the importance of this model in the implementation of empirically supported treatment manuals in clinical settings but recognized the need for therapist adherence, therapist competence and the paramount need to balance psychotherapy protocol with clinical flexibility. The Carroll and Nuro

model served as a sound general template for conducting the necessary development of treatment manuals and is worthy of study (Dobson & Hamilton, 2002). Dobson and Hamilton (2002) also acknowledged the long-standing disconnect between research and practice. They also stressed the need for the development of adherence and competency rating scales, based on stage III manuals to test the adequacy of training and supervision of implementation. Dobson and Hamilton (2002) offer a warning that there will continue to exist a long-standing disconnect between research and practice which is a threat to clinical practice in this era of increasing cost containment without collaboration between the two parties.

Research Studies

This disconnect can be illustrated in many research studies which reflect contradictory conclusions concerning the implementation and effectiveness of manualized-treatment. The opinions of prominent researchers vary greatly concerning the role of treatment manuals in therapy. At the Center for Behavioral Health (CBH), a community mental health center in Bloomington, Indiana, client ratings of the therapeutic relationship for programs utilizing only manualized treatments were superior to ratings of other programs which provided treatment as usual (Addis et al., 1999). In a study by Schulte, Kunzel, Pepping and Schulte-Bahrenberg (1992), in which therapists were able to select either a cognitive or a behavioral technique, standardized treatment was found to be superior

because of the therapists' consistent use of a standardized, empirically validated technique. Wilson (1995) stated that treatment manuals are effective when therapists can choose from treatment modules.

In a study of marital therapy, Jacobson and Hollon (1996) compared a standardized treatment consisting of six modules, administered in a fixed order, with an individualized treatment. The treatments were equally effective at posttreatment, but at 6 months follow-up, the individualized treatment was superior. Persons (1995) argued that manual-based treatment derived from outcome research assumed that all patients with a given set of presenting problems have the same etiology leading to their disorders. In response to Person's criticism, Wilson (1999) concluded that most clinical disorders are heterogeneous with different maintaining variables if not different causes.

At the same time, Wilson (1999) concluded that manual-based treatment does not necessarily mean that therapy is not individualized. Rather the issue may be to what degree and in what manner do particular treatment manuals allow for individualization. Heimberg (1998) supported Wilson's arguments and proposed that manuals may be productively employed in clinical settings with proper implementation. This implementation requires experience with the disorder and a strong background in theories of psychopathology and therapy techniques. Heimberg (1998) concluded that the use of manual-based treatments will probably continue to be a controversial topic because it reaches the heart of therapists' desires for freedom and self-determination. Manuals can

be successfully integrated in therapy if viewed as a potentially useful tool in the clinicians' armamentarium. Kendall (2002) discussed the need for ongoing supervision as one of the many factors in overcoming the misperceptions of manual-based treatments. The extent to which a therapist misperceives a treatment manual as a required cookie cutter approach will no doubt reduce his or her enthusiasm and interest. Kendall (2002) suggested that future research funds should be allocated to developing better training programs to bring empirically supported treatments to clinicians. It is crucial to gain an understanding of researchers' and clinicians' goals as new, empirically approved programs are developed. Kendall and Southam-Gerow (1995) concluded that researchers and practitioners must be encouraged to collaborate in order to accomplish the transport of programs across contexts. Kendall emphasized (2002) the importance of a profitable partnership between practitioner and scientist that is required in advancing the field. Training, collaboration and partnerships are important new areas of research that need further investigation.

Future Areas of Research- Translational Efforts

Efforts have been made by the National Institute of Mental Health (NIMH) in 1999 to support translational research and programs that interface between research and clinical areas with the publication of the NIMH's report entitled, *Translating Behavioral Science into Action*. Translational research addressed how basic behavioral processes inform the

diagnosis, prevention, treatment and delivery of services for mental illness, and conversely, how knowledge of mental illness increases the understanding of basic behavioral processes (NIMH, 1999). Translational research has been defined by the National Institutes of Health's funding agencies as research that seeks to translate advances from the bench or animal laboratory into clinical applications (Nunes, Carroll and Bickel, 2002).

National Advisory Mental Health Council

The NIMH report addressed the focus of the National Advisory Mental Health Council Behavioral Science Workgroup, including improved communication and collaboration between basic scientists, clinicians and researchers. Other areas included engagement by the scientific community for translational research, identified as important by consumers, family members, providers and payers. The major priorities addressed in the report included basic behavioral processes in mental illness including the development of reliable and valid methods for assessing clinical diagnosis. Other areas included the evaluation of indicators of risk for the development or exacerbation of mental illness (NIMH, 1999). The report also focused on the need to understand how mental illnesses and their treatments affect the abilities of individuals to function in diverse settings in social or other environmental contexts, which influence the etiology, prevention and treatment of patients (NIMH, 1999).

An important area of the report is the action plan, which included recommendations

to establish and publicize translational behavioral science research, stimulate NIMH funding and develop training programs for researchers. The benefits of translational research have been identified; these include the collaboration between scientists and clinicians, the development of measurement techniques and hypotheses about how interventions may work (Strauman & Merrill, 2004).

Translational research is applicable not only to treatment development but also to studies of treatment process and outcome. Outcome research examined whether or not therapy-based skill acquisition leads to changes in fundamental cognitive processes and whether or not such changes moderate clinical improvement. Questions concerning symptom relief and treatment, predicting outcomes and preventing relapses are also important areas in improving efficacy (Strauman & Merrill, 2004).

Obstacles and Opportunities for Translational Research

Despite the support of the NIMH (1999) in fostering the growth of translational research, outstanding issues exist for the therapist in community mental health settings. One major area of concern was the lack of examples and lack of clinical experience in applying these methods successfully. According to Yin (1994), the case study approach may be the most feasible in respect to time and financial constraints but was criticized for being limited in the clinician's ability to generalize the findings. Yin (1994) later supported the case study approach by stating that it was best defined as analytical generalization. Both Yin (1994) and Eisenhardt (1989) support the use of the case study

approach when little is known about a new and emergent field or phenomenon.

The clinician who is interested in pursuing translational research may be faced with the need to explore case study approaches from other disciplines because little work presently existed in the psychology research field. Dunbar (2005) concluded that in many ways psychological research is no different from research in other disciplines because it adheres to standards of quality but points out clear concerns including the existence of empirical, quantitative research in psychology but a lack of qualitative research studies in psychology. Tellis (1997) stated that the field of sociology is associated most strongly with case study research but verified the lack of case studies in other fields especially psychology. There are a number of diverse case study approaches that may aid the psychologist including the work of Alan Peshkin and Margaret Mead. Even though these individuals come from vastly different disciplines and time periods, their approaches and their experiences gained from the case study approach may prove beneficial to an individual developing a case study in the psychology field.

In his ethnographies, Peshkin (1985) stated that his analysis and discussion were affected by his social relationship to the people he studied. Wolfskill (2002) criticized Margaret Mead's preconceived ideas about the Samoan adolescent girl and also felt that her work reflected other ethnographers' collaborative efforts between the United States government and academic research departments. Feagin, Orum & Sjoberg (1991) concluded that case study researchers can discover ways to help them address conceptual

or practical problems from reading other case studies and should not concentrate on the barriers and limitations of the findings.

Efficacy and Effectiveness

Clinicians can use case studies to implement translational research results from clinical trials (Wells, 1999). Clinical trials, however, provided information on treatment efficacy under best-practice conditions. An understanding of the design, analysis, and conventions both of efficacy and of effectiveness studies can lead to research that better informs clinical and societal questions. Clinical trials, which evaluate efficacy, may be defined as whether or not a given treatment improves relative to a control or comparison condition. Achieving this goal often requires testing treatments under ideal or best-practice conditions. This represents an important step toward determining the desirability of implementing a treatment in practice (Wells, 1999). In particular, patients and providers are especially interested in effects of treatments as delivered in the community, outside of rigorous clinical trials. Wells (1999) suggested that a broad research agenda should include efficacy, effectiveness and hybrid studies that use features of both.

Efficacy studies examined whether or not treatments improve outcomes under controlled conditions. Effectiveness studies evaluated effects of treatments on health outcomes under conditions approximating usual care. Effectiveness studies are usually more heterogeneous in design than are clinical trials (Wells, 1999; Leff, 2005).

Fidelity Measures

Leff (2005) proposed the development of fidelity measures to demonstrate that practices are implemented properly. Fidelity measurements refer to measuring the degree to which interventions are implemented and sustained as specified by practice experts, in manuals, or in other materials. Valid studies or measures should implement fidelity measures to provide evidence that the intervention was delivered as defined. These measures should include measures of how contextual factors, including administrative and financing issues were addressed. Ideally, studies should use fidelity scales designed specifically to assess the implemented practice (Leff, 2005).

Challenges in Implementation of Translational Research

Translational research is viewed as a potential solution to the integration of research findings into practice and policy. There are a number of challenges in the implementation of translational research including the integration of diverse fields, the need for researchers who understand the real needs of patients and the continued development of incentives by the NIMH (Fenton, Stover, Cuthbert, Heinsen & Rosenfeld, 2002).

Translational research can provide a new model to address the long-standing gap between research and practice. Research is necessary to achieve greater understanding but it cannot by itself put new knowledge to useful application. The bridge between the worlds

of research, practice, and policy is difficult to build but it is one that is necessary.

Without this bridge between research and practice, the depth of the value of the work of researchers and clinicians will not be realized (Hudgins & Allen-Meares, 2000).

Summary

In the movement from a macro level discussion of applying evidence-based techniques in the form of a treatment manual to a micro level application in a single patient in a community based mental health setting it is helpful to review the key concepts and issues presented to date. It is clear that depression identified as MDD is a serious problem affecting a large population of Americans, especially those in the community mental health population. The NIMH recognizes the need for improved outpatient care to encourage a stronger alliance between researchers and practitioners. Evidence-based techniques have been suggested as a feasible way of implementing empirically supported treatments for depression, especially the use of CBT. Even though treatment manuals may not be synonymous with evidence-based practices, they may provide potential interventions for applying empirically supported treatments in out-patient clinical environments (Addis et al. 1999).

However, a number of obstacles exist in the transportability and implementation of manualized treatments in community mental health centers. It is recognized that resistance exists in the professional community regarding the implementation of

empirically supported treatment manuals due to therapists' perception of the potential loss of creativity and freedom in the treatment of their patients (Addis et al. 1999). New areas of research in the form of empirically supported experiments may concentrate on techniques for internal training of clinicians on treatment manuals and on the use of measurement tools to ascertain and measure clinician resistance or acceptance. Other areas of research may focus on gaining a better understanding of the patient's perception of the differentiating factors in treatment technique and the relationship between therapy-as-usual and the use of an empirically supported treatment manual (Musser & Drake, 2005). At the same, it is fully recognized that there is a great need for the implementation of empirically supported methods and approaches in the treatment and management of major depression (Azrin & Goldman, 2005). The use of evidenced-based practices in the form of manualized treatments are an alternative approach for therapists in community mental health that may help control costs, implement state of the art research and offer assistance for patients who are not responding to conventional forms of treatment (Azrin & Goldman, 2005).

Therefore this study is designed to evaluate the feasibility of implementing an empirically supported treatment manual to treat an individual with major depressive disorder in a community mental health center. A case study will be utilized while implementing this process in a naturalistic setting. The manual, *Overcoming Depression- A Cognitive –Behavioral Protocol for the Treatment of Depression* (Emery, 2000) will be

utilized by the therapist with the goal of reducing depressive symptoms and improving the quality of life for the client. The hypotheses are separated into three areas: client level, therapist level, and administrative level.

Research Questions and Hypotheses

Client Level Hypotheses

1. *Reduction in Symptoms.* Will the use of an empirically supported treatment manual based on cognitive behavioral principles implemented in a community mental health center improve the quality of life for the client and reduce depressive symptoms? It is hypothesized that there will be an increase in quality of life (QOLI scores) over the course of treatment and a decrease in depressive symptoms (BDI-II scores).
2. *Client Satisfaction.* Will the client report high satisfaction with the current manualized treatment as measured by the Patient Satisfaction Questionnaire (PSQ)? Will the client feel satisfied with the structured format of a manualized treatment as compared with his previous treatment? It is hypothesized that the client will report greater satisfaction according to session transcripts with the current treatment as compared to previous treatments.
3. *Adherence.* Will the client complete the treatment and engage in the activities as prescribed? It is hypothesized that the client will complete the treatment and engage in the activities prescribed as monitored by homework completion, session attendance and

therapist process notes.

4. *Therapeutic Alliance.* Will the client experience a strong therapeutic alliance throughout the course of this treatment? It is hypothesized that the client will report consistently high scores on the Working Alliance Inventory- Short Form (WAI-S).

Therapist Level Hypotheses

5. *Benefits to Therapist.* What benefit(s) will the therapist glean from utilizing this manualized approach to treatment? It is hypothesized that the therapist will realize specific benefits (e.g. the opportunity to utilize and introduce an evidence--based treatment to the community mental health center, utilizing evidence-based practices in treating other diagnoses such as anxiety disorders and helping create a community of clinicians who employ evidence-based practices.

6. *Difficulties for Therapist.* What difficulties with the manual will the therapist experience while utilizing this approach? It is hypothesized that the therapist will not encounter difficulties, such as a loss of creativity, pressure from colleagues, and/or a lack of training, while utilizing the manualized approach. Information concerning the therapist's experience can be found in the process notes.

Administrative Level Hypotheses

7. *Administrative Support.* Will the administration provide the necessary support to implement this manualized treatment? It is hypothesized that the administration will approve the client for this case study but is not likely to provide any other support such as

training, funding or supervision.

8. *Administrative Outcomes.* Will the therapist encounter any obstacles from the administration in implementing the manualized approach? It is hypothesized that the therapist will not encounter difficulties in implementing the manualized approach such as a delay in the approval of the case study and an inability to present case study updates at staff meetings. At the same time, the administration will not promote the use of evidence-practices.

Chapter 2

Method

Purpose of Study

The purpose of the study was to evaluate the feasibility of implementing an empirically supported treatment manual to treat an individual with major depressive disorder in a community mental health center. The particular focus of this project was to describe the process of implementing this treatment within the naturalistic environment. Cognitive-behavioral techniques were used as described in the manual, *Overcoming Depression – A Cognitive-Behavior Protocol for the Treatment of Depression* (Emery, 2000). This treatment is designed to reduce symptoms of depression and improve the quality of life in a client with Major Depressive Disorder. In order to evaluate the feasibility of implementing this manualized treatment in a community-based mental health center, three sets of assessments were collected: (1) client level, (2) therapist level, and 3) administrative level. It is hoped that this type of translational research, describing the implementation of an evidence-based manualized treatment in a community mental health center, will provide critical information needed to improve the quality of mental health care services in these types of settings.

Design

A single subject descriptive case study with repeated measures of outcomes was

adopted for this investigation. A case study was chosen because it was a cost-effective way to begin investigating the feasibility of a treatment in a community mental health environment that had no additional funding.

Inclusion Criteria

In order to be included in this study, the client must be 18 years of age or older and have received a diagnosis of a major depressive disorder based on the criteria stated in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)-Fourth Edition. In order to receive services at the community mental health agency, the client must complete an initial intake and a psychiatric intake.

Exclusion Criteria

Exclusion criteria included an Axis II disorder, mental retardation, and active participation in an alcohol and/or drug rehabilitation program. A client would not be excluded from the study if he/she was presently taking medication or prescribed medication by the staff psychiatrist. Finally, a client would not be excluded for a preexisting medical condition(s).

Participants

Identified Client

Three potential clients were identified. The term client will be used throughout the duration of the case study because it is the consistent nomenclature used in the community mental health center. The first did not appear to have the intellectual ability to

participate in a manual intervention. The second client was not interested in participating in weekly homework assignments and participated in therapy as usually administered by the mental health care agency. The third client appeared appropriate for the study. He had suffered from his disorder since high school. He received previous, but unsuccessful treatment for his depression. The client was highly interested in participating in the manualized treatment. He agreed to complete homework assignments and was highly interested in participating in a CBT program. He stated that he had heard of CBT programs while listening to advertisements on the radio and informed the therapist that he had participated in a CBT program at the University of Pennsylvania. It was determined to select this client for the current study.

The client, a 47-year-old Caucasian male, completed an initial intake for the mental health care center during which a multi-axial assessment and a diagnosis were completed. The center's psychiatrist subsequently confirmed the diagnosis and prescribed an anti-depressant, Wellbutrin, and an antipsychotic, Zyprexa.

Upon entering this treatment, the client was underemployed and had severe economic difficulties. He was unable to pay his bills on a timely basis and had been denied social security benefits. Mr. M. expressed dissatisfaction in all areas of his life including his job, his family relationships and his relationship with his girlfriend upon whom he relied to pay his bills. He stated that he suffered from a shy bladder problem, which was a source of great embarrassment. Most information regarding the client's unemployment and economic situation was based on his self-report

Therapist

The therapist had been employed at a community mental health center since

September 2000. She is a senior level therapist at the community mental health center and a doctoral student at the Philadelphia College of Osteopathic Medicine (PCOM). The average number of clients treated by the therapist during the data collection phase of this study was 16 per week but this varied based on client attendance. The average time per session was 50 minutes. The staff respected the therapist because she worked effectively in an interdisciplinary manner when planning her clients' treatments. Integration of client care is an essential ingredient to staff acceptance in community mental health (Shadish, 1989).

Administration

The administration consisted of the director of outpatient services, the supervisor of outpatient therapists, the supervisor of case management and the supervisor of clerical responsibilities. This department included 5 clerical and 5 salaried employees.

Setting

The setting was an outpatient mental health clinic in suburban Philadelphia. When a client entered the reception area, he or she often observed a crowded waiting room. Familiar faces often greeted the client because many individuals were born and raised in the same geographic area as the clinic. Many clients felt uncomfortable due to a lack of privacy and confidentiality in the reception area. The reception area was filled with chronically ill individuals, whose hygiene was often poor. Therapists were diligent in protecting their clients' privacy by individually greeting each client instead of having the receptionist announce their names.

CBT Treatment

The CBT treatment manual, *Overcoming Depression - A cognitive protocol for the*

treatment of depression (Emery, 2000) was implemented as the therapeutic approach for this client. The treatment manual and worksheets were tested and validated by respected clinicians in the field of depression. (See Appendix xx for outline of the topics covered in the manual).

The manual prescribed that the therapist addressed the following components in each session: agenda-setting, homework review, psychoeducation, and homework assignment. Agenda-setting involved the therapist's setting expectations of each session. Homework was prescribed in each session of the manual and involved the skill learned in the sessions. The psychoeducation session was the educational component of the session during which the therapist instructed the client concerning new skills and concepts, which were instrumental in monitoring his depressive symptoms. In the sessions, the therapist presented essential information concerning depression and CBT concepts.

The therapist strictly observed the ten outlined sessions in the manual. In Session 1, client goals, current symptoms, history of the client's disorder and treatment history; a brief review of the CBT model of depression was also introduced. In Session 2 and 3, the nature of negativity was reviewed, awareness of symptoms was discussed, and the action schedule was introduced. Understanding avoidant actions and tips for taking and choosing actions was introduced in session 4. The concept of automatic thoughts and the thought record was introduced in session 5. In session 6, the topic of changing circumstances instead of choosing a different outlook was discussed. The connection between thoughts and feelings was reviewed in Session 7. Emotional, cognitive and physical symptoms were also discussed in session 7. The importance of early learning and core beliefs was explored in session 8. The therapist worked with the client in session

9 on preparing for the completion of therapy by reviewing the concepts discussed in the previous sessions. In Session 10, the client was asked to evaluate his progress and the therapist discussed ways to minimize relapses.

Homework was a critical component to the success of brief, structured therapy. The manual contained homework assignments for each of the ten sessions; it also contained an action schedule, a form used by the client to record events accomplished during the week; another feature found in the manual was a thought record, a form used by the client to record and challenge dysfunctional thoughts. Many of the homework assignments consisted of reviewing the previous chapter and concepts presented in the session. Each homework assignment also included an exercise in which the subject would apply the new skills learned in the session to his every day activities. For example, in Session 2, the homework assignment was to complete the action schedule and rate each activity for mastery or for pleasure using a scale of (1-5). In Session 4, the client was assigned to pick a task, break it down into smaller steps and complete the action schedule. In Session 5, the client was asked to record one thought record a day and then record the thinking error.

Standardized Client Measures

Beck Depression Inventory-II

The Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996) is a 21- item self-report instrument designed to assess the severity of depressive feelings in people 13 years of age and older. The BDI-II differs from its predecessor the BDI-IA and the BDI because response items now correspond to the criteria listed in the DSM-IV. The BDI-II

also differs from the earlier versions of the instrument in item content rather than design format (Beck et al., 1996). Specifically, items addressing body image, somatic preoccupation, and work difficulty were replaced with items that explore levels of agitation, worthlessness, concentration difficulty, and loss of energy. In addition, items addressing appetite and sleep patterns were revised to allow for reporting of increases as well as decreases in symptoms. The BD-II requires about 5 to 10 minutes to complete, making it less time consuming than most other self-report depression instruments.

Item statements are rated on a 4-point scale, from 0 to 3, in ascending levels of severity. Interpretation of severity is based on the following cutoff scores: a total score of 0-13 indicates minimal depression and such scores are typical on nonpsychiatric normals; a score of 14-19 suggests mild depression; scores of 20-28 are indicative of moderate depression; and scores from 29 to 63 are indicative of severe depression (Beck et al., 1996). High scores are thought to be predictive of suicidal risk.

The BDI-II has been the subject of extensive psychometric evaluation. Beck et al, (1996) reported internal consistency of .92 for psychiatric outpatients and .93 for college students. Test- retest stability over a one-week interval was high at .93 among a sample of 26 outpatients. According to Beck et al., (1996), construct validity was measured by correlation with the Beck Hopelessness Scale (.68) and the Beck Scale for Suicide Ideation (.37).

Quality of Life Inventory (QOLI)

The Quality of Life Inventory (QOLI; Frisch, 1993) consists of 17 items. It is based on an empirically validated, linear and additive model of life satisfaction that assumes that an individual's overall life satisfaction consist largely of the sum of satisfactions in

particular areas of life deemed important (Frisch, Cornwell, Villanueva, & Retzlaff, 1992). An additive model is one in which the combined effect of several factors is the sum of the effects of the products of each factor (Frisch et al., 1992). Each of the 17 areas of life deemed potentially relevant to overall life satisfaction is rated by respondents in terms of its importance to their overall happiness and satisfaction (0=not at all important, 1=important, 2= extremely important) and in terms of their satisfaction with the area (-3= very dissatisfied to 3= very satisfied). The inventory's scoring scheme reflects particular areas of life that were weighted by their relative importance to the individual.

According to Frisch et al. (1992), the psychometric soundness of the QOLI exceeds that of most related measures of life satisfaction because of its extensive evaluation of reliability, internal consistency, criterion reliability and construct validity. The moderate negative correlation of the QOLI with measures of psychological distress, depression and anxiety was expected, suggesting that all of these constructs are related yet distinct because most of the variance in distress measures is accounted for by factors other than subjective well-being (Frisch et al., 1992). Test retest coefficients for the QOLI ranged from .80 to .91, and internal consistency coefficients ranged from .77 to .89 across 3 clinical and 3 non-clinical samples (Frisch et al., 1992).

Patient Satisfaction Questionnaire (PSQ)

The Patient Satisfaction Questionnaire (PSQ; Emery, 2000), contained in the treatment manual, was developed to ascertain the client's satisfaction with the treatment including the homework assignments, quality of treatment, format of sessions and content of therapy. It is a measure helpful in understanding the client's feelings and helpful in

garnering qualitative feedback at the end of the treatment in order to refine the manual process.

The Working Alliance Inventory – Short Form (WAI-S)

The Working Alliance Inventory defines alliance as consisting of three-related components: 1) client and therapist agreement on goals of treatment (Goals), 2) client and therapist agreement on how to achieve the goals (Tasks) and 3) the development of a personal bond between the therapist and client (Bond, Horvath & Greenberg, 1989). The Working Alliance Inventory- Short Form (WAI-S, Horvath and Greenberg 1989) was developed as an abbreviated measure of the Working Alliance Inventory.

The reliability of the WAI is adequate with reliability estimates from .85 for the bond scale to .92 for the task scale (Horvath & Greenberg, 1989). There is strong association between the WAI and other inventories designed to measure similar traits (Busseri & Tyler, 2003).

According to Mahrer and Nadler (1986), there is evidence supporting the convergent validity of the WAI scales. There is also evidence supporting the discriminant validity of the goal scales, but there is limited support for the task scale. There are indications that the WAI performs as well as similar measures. These results seem to support the predictive validity of the instrument (Horvath & Greenberg, 1989).

It has been found that the Working Alliance (WAI) and the Working Alliance Short Form (WAI-S) are interchangeable (Busseri & Tyler, 2003). However there is little psychometric information about the short-form (Tracy, Glidden, & Kokotic, 1989). No studies have directly compared the equivalence of the full-scale and short-form versions. In most reports, the assumption was that the interchangeability of the two measures had

been established (Busseri & Tyler, 2003). According to Tracey, Glidden and Kokotic (1989), the results indicated that the factor structure of the short form is similar to that of the WAI.

Descriptive Client Measures

Process Note

This form requires the therapist to record information at the completion of each session regarding attendance, completion of homework, fidelity barriers and any resistance with the administration. (See Appendix B)

Homework

Weekly homework assignments were collected at the beginning of each session and pertained to each session. The homework assignments are pertinent to the concepts discussed in each session.

Transcripts

All sessions are audio taped and typed with previous consent of the client. The transcripts are reviewed for content, themes, problems and treatment patterns (See Appendix D)

Therapist and Administrative Measures

Process Notes

The process notes are not a formal assessment tool but were developed to record thoughts, feelings, events, observations and reflections of the therapists and client after each session. The questions include feelings about providing therapy based on a

structured manualized treatment. Other recorded information includes: specific obstacles, fidelity issues, concerns expressed by the client, tasks accomplished, areas not addressed, and changes needed. The therapist is required to complete the form, which has 18 questions, after each session. The final question requests the therapist to comment on any areas not addressed (See Appendix B). In addition to the process notes, the therapist recorded the client, therapist and administration's completion of measures at each session (see table- 1)

Transcripts

All sessions were audio taped and typed after the session. Both the audiotapes and the transcripts are important records for the therapist. Because the therapist did not receive comprehensive supervision due to budgetary and time constraints, the audiotapes and transcripts were utilized by the therapist to evaluate her pacing, her relationship with the client, in order to review the client's responses.

Table 1-
Assessment Measures for Client, Therapist, and Administration

Session	Measure				Process Notes
	BDI	QOLI	WAIS	PSQ	
Si	C	C	C	—	T
S1	C	—	C	—	T
S2	C	—	—	—	T
S3	C	—	C	—	T
S4	C	—	—	—	T
S5	C	—	C	—	T
S6	C	—	—	—	T
S7	C	—	C	—	T
S8	C	—	—	—	T
S9	C	—	C	C	T
S10	C	—	—	—	T
SPT	C	C	C	—	T

S = Session, i = Intake, C = Client, T = Therapist, PT= Posttreatment

Client Procedures

Initial Intake

The intake coordinator at the community mental health center conducted the initial one-hour intake session. At this session, background information, mental health and developmental history were recorded. Questions were asked about previous medications and allergies and a diagnosis was determined. The client requested to work with a case manager who was a staff member at the outpatient clinic for additional services, including housing and financial assistance.

Psychiatric Intake

At the one-hour psychiatric intake, the staff psychiatrist prescribed medications and the diagnosis was confirmed.

Session Intake

At the intake session, the client completed the informed consent forms, the BDI-II, the QOLI, and the WAI-S. These assessments were completed during the intake session. The first treatment session was then scheduled with the therapist. The client subsequently attended 10 sessions. The therapist restated that all sessions would be audio taped and then transcribed.

Administration of Assessments/Surveys and Homework

The BDI-II was administered during each session. The QOLI was administered during intake and post-treatment sessions. The WAI-S was administered during sessions 1, 3, 7, and 10. The measures were also scored and recorded in the results section. Homework was assigned in each session based on suggestions in the CBT treatment manual. During

session 9, the PSQ was administered.

Post-Treatment

At the post-treatment session, the client was able to ask questions concerning his treatment. The therapist expressed the need for the client to practice the skills learned and to monitor his depressive symptoms. She also urged the client to seek therapeutic help if his depressive symptoms increased or if he experienced difficulties utilizing the CBT skills in his life. The BDI-II, the QOLI and the WAI-S were administered.

Therapist Procedures

Training

Preparation time at the mental health agency was minimal, because there was a lack in the availability of the supervisor and because the therapist was generally scheduled each hour unless a client cancelled his or her scheduled appointment. The therapist therefore allocated time at home to preparation for implementing the case study. Initially, the therapist needed to spend three hours to read the entire manual carefully. Prior to each session, she reviewed the key concepts, the previous week's homework assignment, the subsequent week's homework assignment and the psychoeducation section. This preparation required two hours of time. An additional part of preparation was to read the new section thoroughly and to grade the survey forms.

The therapist was responsible to meet with her supervisor and her colleagues at monthly staff meetings during which she provided five-minute updates concerning the case study. The update included a brief discussion of the psychoeducation topic, any obstacles incurred and an observation of the client's reaction to the structured format. The supervision and training were limited but adhered to a naturalistic environment,

which is often found in community mental health centers.

Administrative Procedures

Administrative Level Issues

The agency approved the administration of the manual based intervention. Because there were no additional requests for supervision, training and/or funding, there were no complaints or obstacles raised by the administration.

Chapter 3

Case Conceptualization (Based on Person's Case model – 1989)

Identifying Information

Mr. M, a 47-year-old Caucasian male, was a factory worker at manufacturing plant where he had been employed part time for 4 years. Mr. M. was greatly dissatisfied with his job and had experienced ongoing economic hardships because he lacked a high school degree, had limited computer skills and had difficulty urinating in public places due to fear of urinating in public places. Mr. M. had interest in and prior employment in medical and automotive sales but feared applying for new jobs in these fields because he had been fired from such jobs in the past. Mr. M. received no satisfaction from his current employment and felt that his job was meaningless and demeaning. Because his salary did not cover his expenses, he was working with a case manager to apply for food stamps and cash assistance. He was also unhappy with his lack of an advanced educational degree because the norm in his family was to attend graduate school. Even though the client believed that his economic difficulties were the root cause of his depression, he resisted assistance from outside sources to aid in his job advancement.

The client had unsuccessfully worked with job coaches in the past and found them to

be unhelpful. Mr. M. was angry when it was recommended by one of his job coaches that he take a GED course. He was also recommended that he take a computer course, which had no associated costs. His job coach terminated their working relationship; she felt frustrated because he would not follow any suggestions.

Mr. M. had been involved in a 4-year relationship with a woman and cohabitated with her in an apartment in Lansdale. Although he called the woman his girlfriend, he also described the relationship as non-romantic. He expressed the idea that his girlfriend was unattractive, boring and depressed but continued the relationship because he was financially dependent upon her. His girlfriend wanted to get married and he avoided discussing any future plans. The client was not interested in involving his girlfriend in his therapy or in previous therapies.

Mr. M. also had a very strained relationship with his siblings, two sisters and two brothers all of whom were over achievers. His siblings continually refused his requests for loans, which deeply hurt him. His mother is residing in a nursing home after receiving a diagnosis of Alzheimer's disease. Mr. M. was the sole caretaker for his mother prior to her residing in the nursing home. His siblings initiated a lawsuit to remove him from any decisions concerning his mother's care. The client showed no insight concerning his siblings' initiation of the lawsuit and the removal of all decision making power with regard to his mother.

Chief Complaints

C.M. had been diagnosed with Major Depressive Disorder. During session 1 with the therapist, the client expressed the idea that he would like to experience a decrease in his depressive symptoms and an increase in his enjoyment of life. The client did not engage in any enjoyable or pleasurable activities. He stated that he had a low level of energy; sleep problems, a low level of activity, little pleasure in his daily life, concentration problems, and daily fatigue.

Problem List

Mr. M's problem list included hopelessness, anhedonia, economic problems, a poor self-image, avoidance, underemployment, lack of a high school and college education, a shy bladder disorder, social anxiety, and an inability to maintain relationships.

DSM-IV Diagnosis

Mr. received a multi axial diagnosis at the initial intake, which was performed by the intake coordinator. The staff psychiatrist confirmed the diagnosis. The multi axial diagnosis follows:

Axis I 296.32 depression recurrent (moderate).

Axis II 301.20 schizoid personality disorder (r/o)

Axis III shy bladder

Axis V GAF 60

Axis IV primary, social, occupational

Hypothesized mechanism of client

“Since I am unloved, always fail, and have no skills then I will always be unhappy in my life.”

According to Beck et al., (1979), the cognitive triad consists of three major cognitive patterns that induce the patient to regard himself, his future, and his experiences in a negative manner. The first component of the triad revolves around the patient’s negative view of himself. The second component of the cognitive triad consists of the depressed persons’s tendency to interpret his ongoing experiences in a negative way. The third component of the cognitive triad consists of a negative view of the future (Beck et al., 1979).

Regarding the first component, Mr. M. viewed himself as defective and inadequate. He viewed himself as undesirable and worthless and believed that he lacked the skills that were essential to survive in his world. He also tended to believe that he lacked the attributes needed to attain happiness in his life.

The second component related to Mr. M.’s life because he interpreted his experiences in a negative way. Mr. M. believed that society, especially his family, made exorbitant demands on him and presented obstacles that were unattainable. This feeling was often expressed when the client discussed the insurmountable goals he wished to achieve in his desired profession. He also misinterpreted situations when alternative interpretations were available.

He interpreted a lack of immediate response from a job coach as lack of interest and viewed himself as an unqualified and unworthy candidate. Despite alternative theories that the therapist offered, the client could not consider these explanations.

The third component of the cognitive triad applied to the client's life because he had a negative view of the future. Mr. M. characterized his future filled with hardships, struggles, frustrations and deprivation. Mr. M. expected to fail not only at any task that he attempted, but also with all relationships. This was clearly illustrated when he discussed career goals, job interviews and when he spoke about his girlfriend and his siblings.

The client also engaged in faulty thinking, which reinforced his hypothesized mechanism. An important theme that appeared in session one was the presence of *dichotomous thinking*, which is the tendency to place all experiences in one to two opposite categories (Beck et al., 1979). Mr. M. felt that he lost his sales job; therefore he could never succeed in another full time job for the duration of his life. The client also used *magnification*, which is defined as evaluating the significance or magnitude of an event as to constitute a distortion (Beck et al., 1979). Mr. M. stated that his girlfriend was the reason that he did not have any fun in his life. There was also the use of *selective abstraction*, which is defined as taking a detail out of context and ignoring other more salient features of the situation (Beck, 1979). The client stated that his siblings mistreated him in regard to his mother. He could only conclude that his constant requests for money and loans were the reason for their court trial and refusal to allow him to make

financial decisions concerning his mother.

Relation of mechanism to problems

The client's problems included anhedonia, a poor self-image, avoidance, economic problems, underemployment, lack of a high school and a college education, a shy bladder problem, social anxiety, and an inability to maintain relationships. Mr. M.'s prepotent idiosyncratic schemas have led to his negative interpretations. He is completely preoccupied with pervasive negative thoughts and has found it difficult to concentrate on external stimuli.

His relationship problems are complex due to an inability to maintain and develop relationships. This may be due to his core beliefs of being unlovable, undesirable and of viewing people as objects. His relationship problems also accompanied a negative belief about himself and a fear of failure in relationships. His irrational belief that he should attain a professional career led him to procrastinate continually in enrolling in GED courses, to obtaining a full time position or to working with a job coach. His work problems resulted from irrational beliefs about his abilities and from the unrealistic goal that he must attain a comparable job to his siblings. He also avoided applying for jobs because of his previous job failures, which he blamed on others. He remained in a vicious cycle during which he searched for jobs that he could not attain and therefore increased his feelings of failure. These feelings also led to depressive symptoms, anhedonia and

economic problems. At the same time, the client had self diagnosed himself with a shy bladder problem. This problem was not evident during the therapy sessions. The shy bladder problem appeared to be an additional form of procrastination in applying for jobs and in avoiding relationship commitments.

Precipitants of current problem

Many of the precipitants to his current problems were his loss of the role of caretaker to his mother, his current health problems, his inability to pay his bills, and his failure to hold previous full time professional positions. Mr. M. felt that the expectations imposed by his family, the workforce and society were unfair and unrealistic. He concluded that he would always fail in all relationships and in all roles of responsibility. Mr. M. felt that he was being punished by his siblings for being a caring son who sacrificed two years of his life to be the sole caretaker of his mother. His interpretations of the above listed stressors were perceived as a confirmation of his negative beliefs for example "I will never succeed in society and I will always be punished."

Origins of the central problem

It is likely that many of Mr. M.'s problems originated in his childhood. This is only a form of conjecture because there was limited information about his past. It is known that the client's father deserted the family and had no financial or emotional involvement with

the family. This may have contributed to Mr. M.'s belief that he was unlovable and that his environment would not remain stable. The departure of his father and the associated effect on his mother is unknown. His mother's availability in parenting may have been reduced due to economic stressors and her sole parenting responsibility to 5 children. The possible existence of schizotypal personality traits has been explained due to the lack of role models or to ineffective parenting practices (Patterson, DeBaryshe & Ramsey, 1989).

Another explanation for the origin of the problem is the lack of pleasant events and few social skills in the client's life. This can be explained by two theories developed by Lewinsohn, Sullivan and Grosscup (1980) and Libet and Lewinshon (1973). According to Lewinsohn et al. (1980), the relationship between depression and reinforcement is central to the existence of depressive symptoms in an individual. Lewinsohn et al., (1980) discussed the existence of depressive symptoms due to a low rate of response contingent reinforcements, which constituted a critical antecedent for the occurrence for depression. The suggested goal of treatment for depressed individuals is to increase pleasurable activities, which accompany reinforcements. Mr. M. expressed the notion, in his first session, that he experienced little pleasure throughout his life. He spoke about the fact that he previously enjoyed playing the guitar and stated that his girlfriend and family never noticed that he even played a musical instrument.

According to Libet and Lewinsohn (1973), depressed people, as groups, are less socially skilled than non-depressed individuals. Social skills were defined as the complex

ability both to emit behaviors that are positively reinforced and not to emit behaviors that are punished by others. It was observed that Mr. M. had extensive relationship and social problems throughout his life.

Treatment Plan

The treatment plan was designed to address Mr. M.'s problem list, consisting of anhedonia, low self-esteem, avoidance, economic problems, underemployment, lack of a high school and college education, a shy bladder problem, and an inability to maintain relationships. In Session 4, the client was encouraged to increase his activities and record these activities on the activity schedule. This approach was helpful in treating the client's identified problems of anhedonia and avoidance. Activity scheduling was also used to address the client's self image problems, distract the client from his depressive thoughts and to view positive responses of significant others. In session 5, the thought record was an important treatment component because the client was asked to record his thoughts, feelings, automatic thoughts and thinking errors. This was a helpful tool in approaching his relationship difficulties. The task was included because the client could also discuss his avoidance of specific social situations, his associated thoughts, feelings of fear and/or self-doubt. The shy bladder problem, which was a self-diagnosed problem, was not directly addressed in the treatment plan due to time constraints. The therapist hoped that the shy bladder problem was a form of avoidance and would be addressed

when the client felt more self confident while achieving success through the treatment.

An important treatment goal was to minimize relapses. The therapist instructed the client concerning ways to recognize symptoms of relapses and emphasized the importance of practicing the skills learned during therapy. Sessions 9, 10 and the post-treatment session were dedicated to the importance of monitoring depressive symptoms and avoiding relapse. The therapist encouraged the client as part of his relapse prevention program to use the *activity schedule* and the *thought record* in his daily life. A support group was recommended as a way to practice the skills learned. Another form of recommendation was to use a journal to record thoughts. The therapist stressed the fact that depressive symptoms may return at different times during the client's life. The therapist stated to the client that it was crucial to seek additional help if symptoms persisted.

Predicted Obstacles to Treatment

The predicted obstacles to treatment included poor client attendance and failure to complete homework, surveys and assessments. These obstacles did not occur because of a strong working relationship between the therapist and the client. The client also expressed strong interest in participating in the program, which he maintained throughout the sessions despite health concerns and life issues.

Chapter 4

Treatment Summary

It is helpful to review the transcript by initially reviewing the client's faulty information processing, which is presented as systematic errors in thinking. There will then be an examination of specific progress and regression to negative thinking patterns during treatment, which are illustrated with the client's quotes from the transcript and comments from the therapist.

Beck's model is clearly illustrated throughout the transcript. The client had a negative view of himself, his future, and his experiences (Beck et al., 1979). Mr. M. saw himself as defective and at the same time felt that the world placed unfair demands on him. As the transcript progressed, it can be observed that the client was able to apply the new skills to his everyday life. The transformation from a client who felt overwhelmed with his everyday life to a client who was able to witness his early improvement was noticed in Session 3. The client stated, "You remember, I thought that I did nothing but go to my part time job and visit my mother." The client also demonstrated a great deal of insight as the sessions progressed when he was able to recognize depressive symptoms in others and recommended that the manual treatment could benefit people in his life.

In Session 4, the client was introduced to the concept of *avoidance*. He felt that this was an important concept for him to learn in obtaining a full time job. At the same time,

it was understandable and expected that he often returned to his old patterns of *avoidance* when he spoke about unrelated topics. During the session he stated, “A nurse at the nursing home burned to death while driving to work.” The therapist quickly acknowledged his progress from the previous week and redirected him. He was able to accept the positive statements and return to the topic of the session, which was avoidance, an area of discomfort for him. When asked why he avoided specific activities, he answered by saying, “Why bother doing things? I avoid going to bathrooms in public. I avoid getting a full time job because I am afraid of going to the bathroom.” He clearly used the fear of public bathrooms as a form of avoidance for other activities. It is interesting to note that the client used the bathroom at the community mental health center and at other public places. He stated many times that he was fearful that he would need to leave interviews or jobs due to his need to urinate often.

Often in sessions during which the client was distracted, there were positive aspects when the client could be refocused by the therapist and could then acknowledge his hard work in therapy. In session 4, when redirected, he was asked to focus on his progress and he stated, “I am a good person who is motivated. I’m someone who gets the job done and enjoys accomplishments.” It is important to note that the client’s gains were often short term and often he would immediately return to his negative thinking patterns. As an example, in session 4 he stated that he was “taking the easiest steps by going to work and just doing what they want me to do.” He was clearly indecisive and quickly returned to

his old patterns. The therapist immediately shifted the discussion to the topic of *graded task assignments*, which would be the homework assignment for session 4. The therapist felt that the client was feeling overwhelmed and hoped that by discussing the structured task of looking for a job and breaking it down into smaller tasks may help him feel less overwhelmed. The therapist explained the concept and then told the client that the goal was to achieve greater self-esteem when tasks were smaller and achievable. The client appeared less overwhelmed and less anxious. He agreed to work on this assignment for therapy.

In Session 5, the client forgot that he was assigned a homework assignment and felt overwhelmed with his health problems. This was viewed as a positive moment by the therapist because the client did not avoid the session and did not follow old behavioral patterns. He was honest with the therapist and was able to engage in the session despite his fear of retributions. The client began session 6 with negative comments about himself. When the therapist challenged him, he was quickly able to recognize that his *negative thoughts* were not accurate and was able to recognize that he had performed well, especially when applying his new skills in his every day life. The client was able to see that he did not need to change his job before being able to see an improvement in his depressive symptoms. This was very helpful for the client who previously felt that without changing to a professional sales position that he would always be depressed and unhappy in his life.

In session 7, the therapist emphasized to the client that changes in depressive disorders occurred slowly. This was important to state because the client said, “He wasn’t doing bad or great but somewhere in the middle”. It was important for the client to understand that this was not an unusual response in the progression of depressive disorders. The client continued to have health concerns but was able to use his skills and applied them to his life. He was also able to see when others in his life used faulty thinking. The client continued to discuss the fact that he was able to use his skills in making decisions without having his old guilt feelings. This session ended positively with clear signs of progress.

In session 8, the client refused to accept the fact that any of his *negative thoughts* could be distortions. He stated, “ I have a lot of negative thoughts. They are not *distortions*. I can’t come up with any positive thoughts.” A *role-playing* exercise was introduced during which the therapist challenged the client’s progress. An excerpt follows.

Therapist- I think that you can’t do anything.

Client- I wouldn’t say that I couldn’t do anything.

Therapist – Name one thing that you can do.

Client- I can visit my mother.

Therapist- But you can’t do things that are important

Client- it is very important to visit my mother....

Therapist-. You can't do anything that is important

Client- I don't agree with you

Therapist- What do you mean by that?

Client- It is important to care for my mother.

Therapist- You are a total failure.

Client- Maybe I am not as successful as my brothers and sisters but I am not a total failure.

Therapist- You don't have a full time job.

Client- That's right. But I do a needed job and my boss has recognized me.

This was a clear example of the progress of the client. He was able to handle an uncomfortable situation and support his positive qualities and beliefs. The client was asked to give himself a grade for the way that he answered and challenged his negative thoughts. He gave himself a "B" which is a very good grade for an individual with low self-esteem.

As in many sessions, the client regressed to his negative thinking. He was, however, easily redirected and was able to learn about the concepts of *core beliefs*. After the concept was discussed, the client stated, "I believe that I am a loser because my sisters and brothers are successful. I believe that I can never be happy." The therapist explained that he was representing one of his core beliefs. The therapists also explained that some of his other core beliefs included feeling unintelligent, undesirable and unlovable as

compared to his siblings. The therapist and client then worked on challenging these core beliefs. There was clear progress in this session, based specifically on his performance in the role- playing exercise and on his ability to learn new skills.

In session 9, the client recognized that the therapy had been helpful because he acquired new skills that were applicable to his life. In session 10, the client continued to do his homework despite his doctor's appointments and health concerns. When the therapist challenged the client about his girlfriend's possible concerns about his health, he became angry and immediately changed the subject. This may support the argument that he may have schizotypal personality traits. He was unable to recognize another individual's feelings.

A discussion about ways to avoid relapses also occurred. The therapist offered alternative therapeutic alternatives to the client; these included joining support groups, continuing with a new therapist, stressing the need to practice his skills and reading the manual. The client thanked the therapist for her time and the therapist discussed meeting for the post treatment session.

At the post treatment session, the client discussed the loss of the therapeutic relationship. He valued this relationship, which was illustrated throughout the transcripts; this was an important relationship for him because it was validating and non-confrontational. The client expressed his thanks for the therapy. The therapist felt that the end of therapy would be a loss for the client because it was the one area of his life where

he felt special. The therapist feared that it would be difficult for him to develop a relationship in which he felt validated. The therapist wished him continued success and hoped that he was able to apply his new skills in reducing his depressive symptoms and in improving the overall quality of his life.

Chapter 5

Results

In this section the results of this study's eight hypotheses are presented. The hypotheses are separated into three levels: client, therapist and administration.

Client Level Hypotheses

1. *Reductions in Symptoms.* Will the use of an empirically supported treatment manual, based on cognitive behavioral principles, implemented in a community mental health center improve the quality of life and reduce depressive symptoms for the client? It is hypothesized that there will an increase in quality of life (QOLI scores) and a decrease in depressive symptoms (BDI-II scores) over the course of treatment.

Hypothesis #1 was partially supported, based on an analysis of the changes in the client's QOLI scores from intake to post-treatment and his BDI-II scores from intake to post-treatment (See Figures 2-3).

His QOLI scores showed improvement as hypothesized due to an increase from a t-score of 22 at intake to a t-score of 38 at post treatment. These scores indicate that his assessment of his quality of life as compared to other adults in the general population began in the 2nd percentile pretreatment and increased to the 12th percentile post treatment.

Because there are various ways to analyze the data points, different conclusions can be reached concerning the outcome of the implementation of the manual intervention in

regards to the client's reduction of depressive symptoms. In one analysis if only the BDI-II scores at intake and post-treatment were analyzed, it could then be concluded that the client benefited from the treatment because his depressive symptoms decreased. The BDI-II scores decreased from a score of 35 at intake, which is considered in the severe range of depression according to Beck et al., (1996) to a score of 17, which falls in the moderate-severe range at post treatment (Beck et al., 1996). However an analysis of the BDI-II scores over the 10 sessions, in addition to the intake and post-treatment sessions, revealed significant variability in Mr. M.'s scores. As a result it could not be concluded that the client benefited from the treatment due to the variability in data points. However, the hypothesis can be only partially proven because one post – treatment data point is inclusive to assess whether or not the client's reduction would have remained stable over time. The inclusion of additional sessions would have been helpful in reaching a clearer conclusion concerning changes in the client's depressive symptoms.

Rationale. Hollon, Amsterdam, and Shelton (2002) concluded that CBT can be as effective as medication in reducing depressive symptoms even among severely depressed outpatients when provided by experienced CBT therapists. Wade, Treat, and Stuart (1998) found that there is accumulating evidence that the positive effects of manualized treatment for specific disorders generalize to other problem areas.

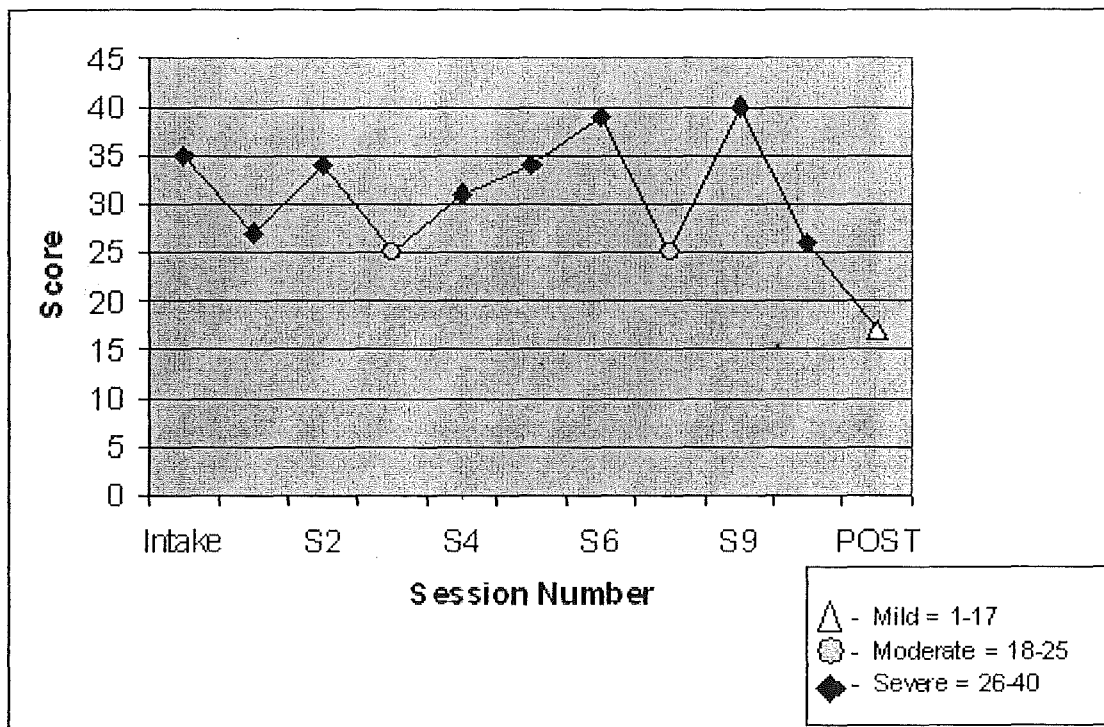


Figure 2. The relationship between Session Number, Severity Level and Beck Depression Inventory Score II (Beck, Steer, & Brown, 1996)

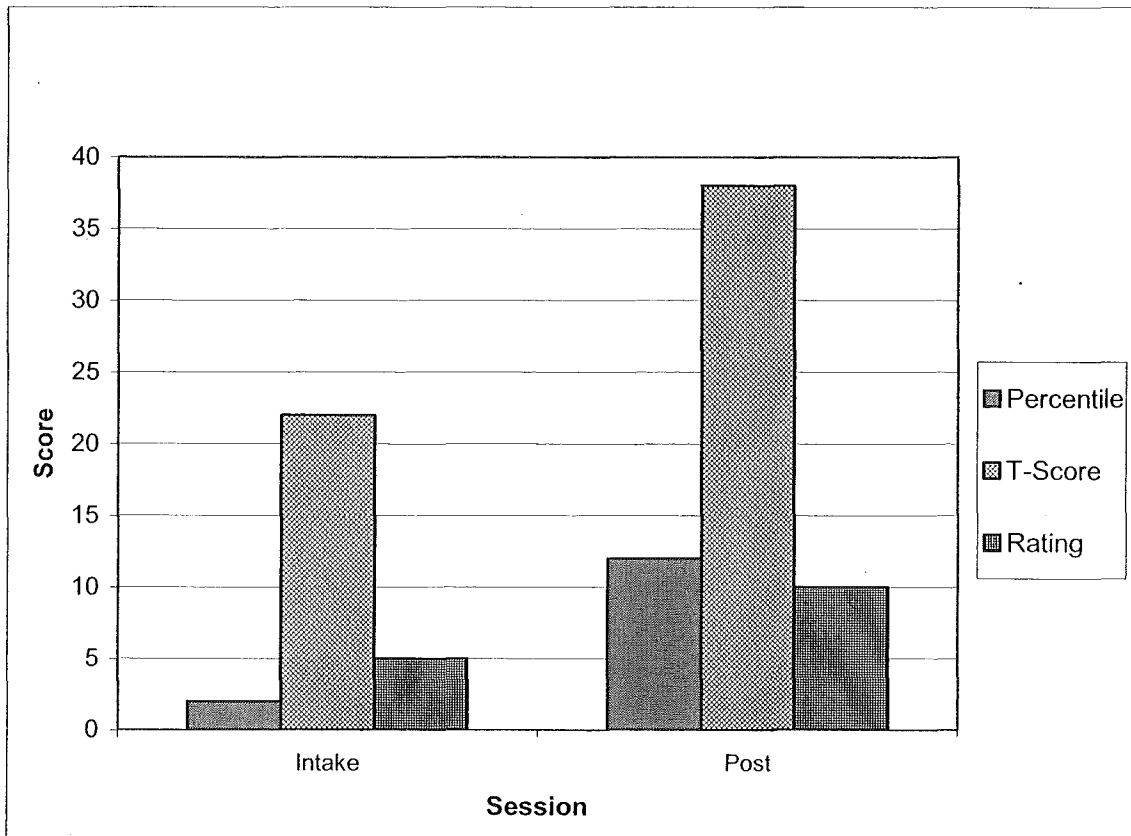


Figure 3. The relationship between Session Number, Percentile, T-Score and Quality of Life Inventory rating

2. *Client Satisfaction.* Will the client report high satisfaction with the current manualized treatment as measured by the Patient Satisfaction Questionnaire (PSQ)? Will the client feel satisfied with the structured format of a manualized treatment as compared with his previous treatment? It is hypothesized that the client will report greater satisfaction according to session transcripts with the current treatment, as compared with previous treatments.

Hypothesis #2 was supported by analyzing the results of the PSQ (Emery, 2000) and the transcripts (See Appendix D). An analysis of the results of the PSQ responses support hypothesis #2. The client's responses on the PSQ revealed that he was satisfied with the structured format of the manual. In question #3, the client responded that he found the skills learned in therapy extremely useful for coping with his problems. In question #5, the client responded that the program would be extremely useful to someone else with a similar problem. Regarding the response in question #6, Mr. M. stated that he would definitely make the same decision again regarding participation in this form of therapy. In question #7, Mr. M. felt that he was moderately successful in meeting his therapeutic goals. In question #8, he responded that his symptoms were improved. Mr. M.'s comments based on his PSQ responses indicated a satisfaction with the structured format of the manualized treatment and a preference for this form of therapy as compared to his previous therapy.

The client's satisfaction with the manual treatment is also reflected in the comments he made in the sessions; these are included in the transcripts. The client expressed

satisfaction with a number of key CBT concepts and components of the manualized treatment, including: activity scheduling and the cognitive approach of the manual. In Session 2, the client stated, “That sounds like a plan that I can accomplish. I think that the negativity discussion was helpful in understanding my depression.” This statement demonstrated the fact that the client felt that he could accomplish the assigned task which would subsequently be helpful to his understanding of his depressive symptoms. In Session 3, the client stated, I was surprised with my level of activity. You remember I thought that I did nothing but go to my part time job and visit my mother. I also feel less depressed when I exercise. Sometimes I don’t want stop.” In Session 9, the client’s endorsement of the manual and the concepts involved are reinforced when he stated, “I think that the book is excellent. I wish that other people would use these skills.”

Mr. M.’s comments from the initial session indicated his satisfaction and his preference with the structured format as compared with his previous therapy. The client stated, “ I never completed the previous therapy or any therapy. I didn’t like my therapist. He didn’t respect my feelings. He didn’t understand my problems or me. He just talked to me.” In Session 7, the client stated, “I think that a lot of other people would benefit too. I know a lot of people who are suffering from depression and suicidal thoughts and they are not getting the help that they need. If they were getting the help like I am getting now it would do them the world of good.”

Rationale. There are no data to suggest that individual client's needs are unmet in manual-based-treatments. In fact individual client's needs are critically important. Cognitive-behavioral needs are often tailored to address the individual’s thoughts perceptions and beliefs, which is unlike many other forms of therapy (Addis et al. 1999).

3. *Adherence.* Will the client complete the treatment and engage in the activities as prescribed? It is hypothesized that the client will complete the treatment and engage in activities prescribed as monitored by homework completion, session attendance, and therapist process notes. (See Table 4)

The hypothesis was supported by the client's engagement in the treatment and completion of all activities with the exception of one homework assignment. The therapist recorded the client's session attendance, adherence to activities and homework assignments weekly in the process notes, which can be found in (Table 4 and Appendix E). The client attended 100% of all sessions and completed 90% of all assignments.

Rationale. Researchers have stated that the people who enter treatment more willing and able to complete the homework may be more likely to improve. The hypothesized reason for greater adherence is the quality of the relationship between therapist and client (Detweiler & Shisman, 1999).

Table-4
Homework Completed Across Sessions

Sessions	Client Attended	Homework Completed	Homework Not Completed
Si	X	X	
S1	X	X	
S2	X	X	
S3	X	X	
S4	X	X	
S5	X		X
S6	X	X	
S7	X	X	
S8	X	X	
S9	X	X	
S10	X	X	
SPT	X	X	

Note. S equals Session. i equals intake. PT equals Post-Treatment

4. *Therapeutic Alliance.* Will the client experience a strong therapeutic alliance throughout the course of this treatment? It is hypothesized that the client will report consistently high scores on the Working Alliance Inventory-Short Form (WAI-S). (See Figures 5-7)

The client's high scores on the individual scales (task, goal and bond) of the Working Alliance Inventory-Short Form supported the hypothesis. Task is defined as the client and therapist's mutual agreement on how to achieve the goals of therapy. Goal is defined as the client and therapist's mutual agreement on the outcome of therapy. Bond is defined as the client and therapist's mutual respect for one another (Horvath & Greenberg, 1986)

The client ratings reflected the fact that he and the therapist agreed on the tasks and goals of therapy between very often (6) and always (7) in all sessions, which indicated high agreement.

The scores for bond from intake to post-treatment remained at "7", indicating that the client felt that he and the therapist had a strong relationship and mutually respected each other across all rated sessions.

Rationale. In manualized treatment a strong alliance may facilitate client involvement

and investment in the treatment, enhancing the likelihood that specific techniques or interventions are effective. Data from a study at the Center for Behavioral Health (CBH) in Bloomington, Indiana, suggested that clients and therapists who engaged in manualized treatments in clinical practice formed strong alliances (Addis et al. 1999).

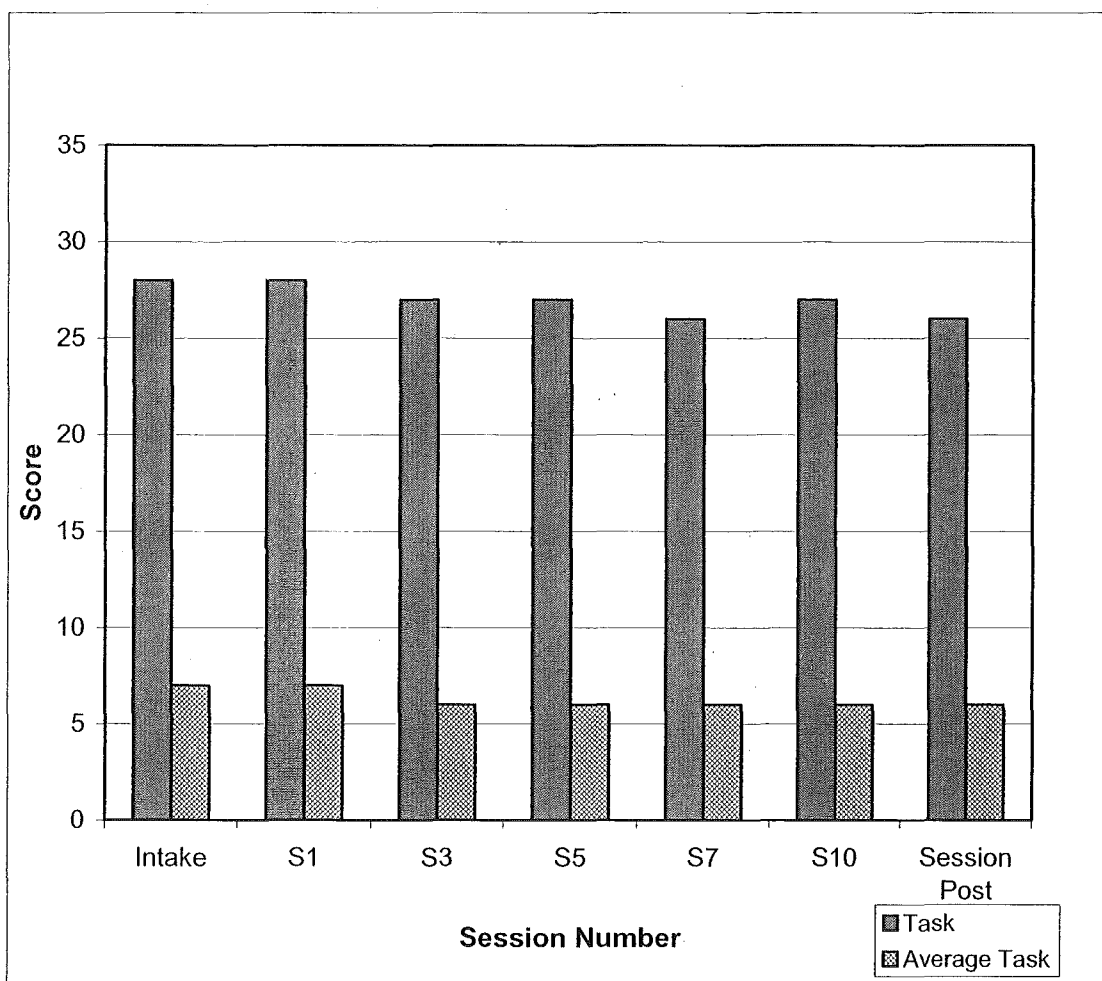


Figure 5. The relationship between Session Number, Task, and Average Task Score.

Task is defined as the client / therapists' agreement on how to achieve the goals of therapy.

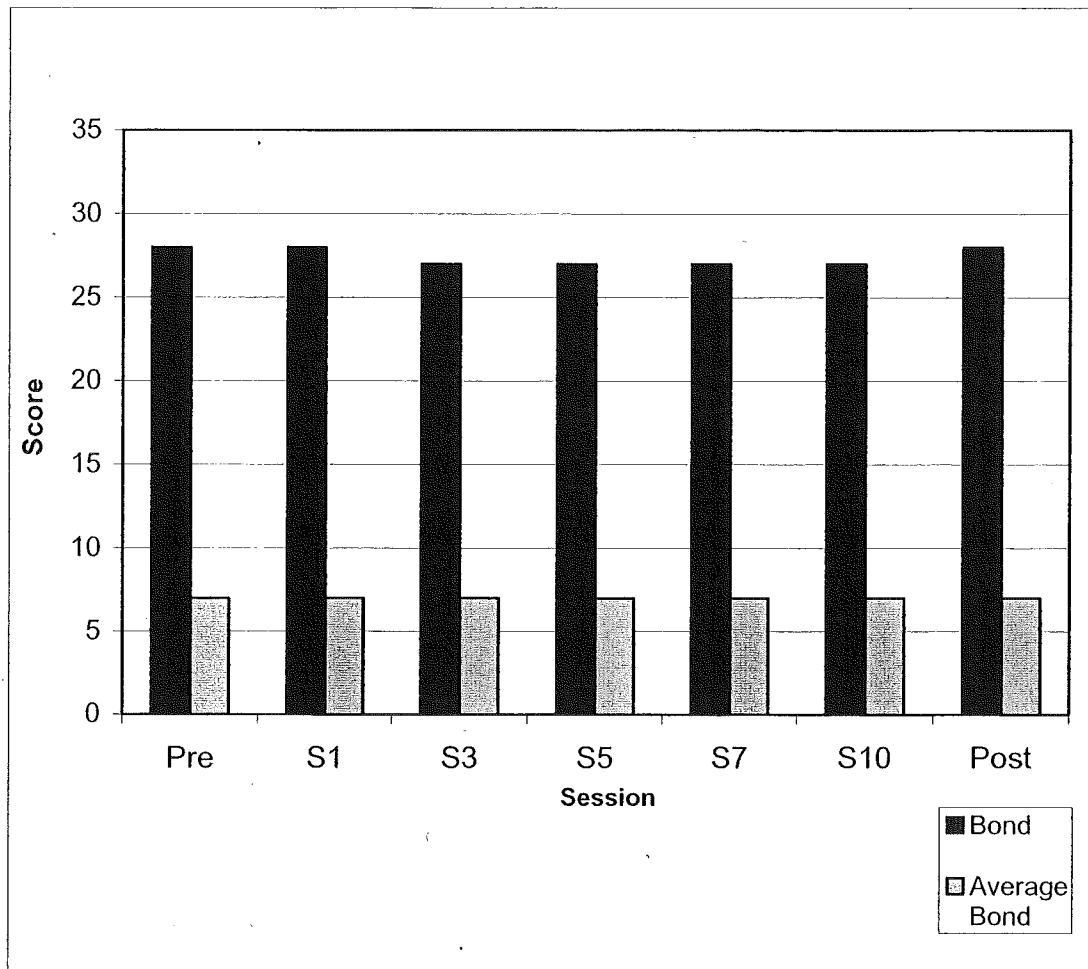


Figure 6. The relationship between Session Number, Bond Score and Average Bond Score. Bond Is defined as the relationship between the therapist and the client.

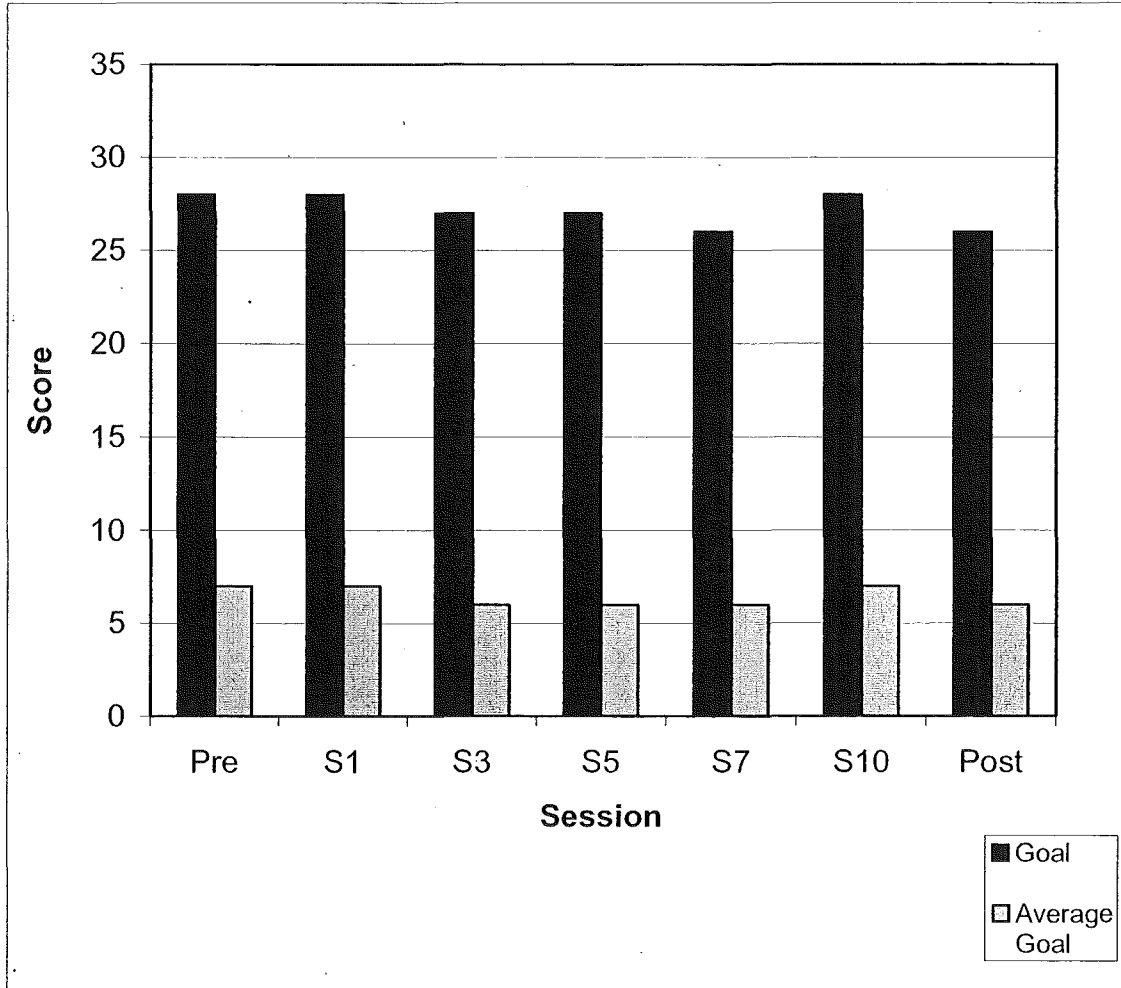


Figure 7. The relationship between Session Number, Goal and Average Goal Score. Goal is defined as the client and therapist's mutual agreement on the outcome of therapy.

5. *Benefits to Therapist.* What benefit(s) did the therapist glean from utilizing this manualized approach to treatment? It is hypothesized that the therapist will realize specific benefits (e.g. introducing an evidence-based treatment to the community mental health center, utilizing evidence-based practices to treat other diagnoses such as anxiety disorders and helping create a community of clinicians who employ evidence-based practices).

The hypothesis was partially supported. The therapist successfully implemented the manualized approach and felt that she would like to continue using the manualized treatment approach with other clients suffering with major depressive disorders in the community mental health center. The therapist enjoyed utilizing a structured format and especially felt that the homework assignments were helpful to the client. She also concluded that she could utilize other manuals based on evidence-based practices for other diagnoses such as anxiety disorders. Even though the therapist did provide monthly updates concerning the case study, her colleagues did not express a strong interest in employing manual interventions with their clientele. She was not able to develop a community of clinicians that she felt would embrace evidenced-based practices.

Rationale. According to Addis et al. (1999), the use of treatment manuals is a psychological reality in the present environment of managed care and stringent budgets in outpatient clinics. According to Wade, Treat and Stuart (1998), there is a clear benefit to the therapist who uses treatment manuals. In their study, one hundred patients were treated with a CBT manual for panic disorder (87% were panic free at completion).

6. *Difficulties to Therapist.* What difficulties with the manual will the therapist experience while utilizing this approach? It is hypothesized that the therapist will not

encounter difficulties, such as loss of creativity, pressure from colleagues, and/or lack of training, while utilizing the manualized approach. Information concerning the therapist's experience can be found in the process notes.

The results did support the hypothesis because the therapist did not encounter any difficulties; this may be due to previous clinical experience in the community mental health field and extensive CBT experience and graduate training, all of which were extremely helpful to the therapist prior to beginning the case study. When she was unsure of the manual implementation issues, the therapist relied on research information from prominent leaders in translational research and evidence-based practice.

The therapist felt that her creativity was not impaired because there was no interference from the administration. She also felt that she was able to build a strong therapeutic working alliance with the client. There also were no obstacles or barriers imposed by her colleagues during the implementation process.

Rationale. The common perception that manualized treatments turn therapists into technicians rather than genuine human beings suggests that training programs and psychotherapy researchers have not succeeded in conveying the importance of the therapeutic relationship in these treatments. Indeed, there are alliance-building strategies and creativity used in manualized treatments with which many clinicians are unfamiliar (Addis et al. 1999).

Administrative Hypotheses

7. *Administrative Support.* Will the administration provide the necessary support to implement this manualized treatment? It is hypothesized that the administration will

approve the client for the case study but is not likely to provide any other support such as training, funding or supervision.

Consistent with the hypothesis that the administration would support the implementation of the manualized treatment, the therapist received initial approval from her supervisor and the director of outpatient services to conduct the case study. The case study was approved because it did not require additional funds, additional labor and would not reduce the quality of mental health services provided to the therapist's existing clientele. Consistent with the hypothesis, the administration did not provide any additional support such as training, funding or supervision.

Data from Process Notes- As a therapist, it was appreciated that the administration approved the case study. The therapist was required to procure the two treatment manuals (one for the client and one for the therapist) and assessment tools. The therapist understood that the agency had budget constraints but she would have appreciated some allocation of funds for this extremely important project. The total cost for procurement of manuals and assessment tools exceeded \$100.00. The therapist's supervisor did not allocate any time to discuss the manual intervention. The therapist understood that the supervisor was also a fee-for-service therapist but she did hope that the supervisor would allocate some time during the case study to discuss the implementation of the manual. Additional training would also have been beneficial and appreciated by the therapist.

Rationale. Heimberg (1998) stated that advanced training was necessary for effective implementation of manualized treatments. The therapist in the case study is enrolled in a doctoral program and allocated additional time at home for preparation. This cannot be expected of other therapists who are not enrolled in advanced training programs and are

unable to allocate additional time for preparation. Addis et al. (1999) also stressed that the implementation of manualized treatments required frequent and regular supervisory sessions to ensure proper implementation.

8. *Administrative Outcomes.* Will the therapist encounter any obstacles from the administration in implementing the manualized approach? It is hypothesized that the therapist will encounter difficulties in implementing the manualized approach such as a delay in the approval of the case study and inability to present case study updates at staff meetings.

The hypothesis was challenged even though the administration did not provide obstacles to the implementation of the manualized treatment. They did not promote the new intervention. The administration permitted the therapist to speak at the supervision/staff meeting but the environment was not conducive to introducing a new treatment approach because the meeting was time limited and the overall purpose of the meeting was to introduce new policies and new administrative procedures. Even though the therapist was highly motivated and was willing to dedicate at least two hours prior to each session at home, this cannot be expected of all community mental health therapists. It can also be implied that supervision and training would have been helpful to the therapist and the client. It is possible that the outcome of therapy may have produced a more favorable outcome if these components were provided by the administration.

Data from Process Notes- The therapist felt highly frustrated during her brief presentations at the staff/supervisory sessions. She was permitted to present updates but the environment was not conducive to a presentation concerning new interventions because the staff/supervisory meeting concerned staff grievances and updates related to

new agency policies and procedures. Her supervisor who conducted the meeting also expressed little interest in the case study; the therapist felt that the supervisor's interest was necessary to aid in the motivation and interest of the professional staff.

Rationale. Southam-Gerow et al. (2006) stated that the administration is influential in determining the successful implementation of efficacious interventions and in achieving positive outcomes. Stronger administrative involvement would be helpful in endorsing the support and growth of a manualized intervention.

Chapter 6

Therapist's Reflections

Initial Concerns

The use of a manual intervention was an exciting process for the therapist because it was groundbreaking work performed in a community mental health center. The therapist was aware of the struggles of the client population at North Western Human Services; these included chronic depression, socioeconomic hardships, and a long-term mental health treatment history without positive outcomes. At the same time, the average attendance rate at appointments was approximately 20-50%, which was a reason for great concern when utilizing a 10-week manual intervention.

Concerns about Other Therapists and Administrative Staff

At the same time, it was assumed that there could be administrative and colleague criticism to this intervention. The therapist was aware that that the use of an empirically supported treatment manual would be effective in the treatment of depression, based on significant research support (Aaron, 2004). The therapist was also aware, that if the manual intervention was successful and was endorsed by the administration as a successful intervention choice, it could raise concerns from the therapeutic staff about creative restrictions (Aaron, 2004). The therapist was also concerned about resistance because there were no requirements about therapeutic choices for clients. As was

expected, there were few questions concerning the study from colleagues and no assistance from administrative staff. At the same time, there were no obstacles to the implementation of the treatment, because the agency's research board approved the manual intervention after an extensive review and the outpatient management staff received approval.

Areas not addressed

Because of the time constraints of the study and the need to follow the contents of the manual, pertinent issues in the life of the client were not addressed. The therapist was not able to learn about the client's childhood. It would have been helpful to understand the precipitating factors leading up to the client's decision to discontinue high school, and also his relationship with his father, his mother and his siblings. It would also have been helpful to understand the impact on the client not only of his father's abandonment, but also when this abandonment occurred in the client's life. The lack of involvement of his father and the impact on his mother may have greatly impacted the client's poor relationships with others. The client also required time to explore the pain behind his siblings' decision to remove him, through a court battle, from all decisions concerning his mother's healthcare and finances. A number of sessions would also have been required to understand the time period in which the client served as the caretaker for his mother. It would be helpful to explore the client's understanding of his sibling's possible criticism

and the comments regarding his decision-making as caretaker that may have precipitated the court hearing. The client also expressed the need to discuss his health care concerns. There was also the need to explore his poor social skills and the reasons behind his identification of people as objects. Additional time would have permitted the therapist to allocate social skill-building exercises. The therapist did not have time to explore the client's self diagnosed shy bladder problem. Behavioral exercises may have benefited the client if time had been allocated.

Patient's Concerns and General Mood

The client, surprisingly, expressed few concerns or criticism about his involvement in the manual intervention. This was unusual for a client who previously had not completed any therapeutic intervention. Because homework is rarely used in a community mental health setting, it was a positive surprise for the therapist that the client completed all but one assignment. The client was also unaccustomed to completing surveys and assessments and was always on time to complete these tasks and did so without any criticism. Mr. M. expressed few criticisms during therapy. His criticisms were more often about the significant others in his life and his inability to achieve his professional goals.

Despite a flat affect, poor concentration, sleep problems, anhedonia and poor energy, the client's attitude toward the manual intervention was generally positive. He was able to comprehend the new concepts in the psychoeducation sections. His most successful

accomplishments were his ability to apply the new skills to his everyday life. He was also able to recognize the relationship between his level of activity and the effect on his depressive symptoms. The client was compliant with his medications and did not report any side effects. Very few changes were needed to adjust the sessions for the client with the exception of the times when he needed refocusing because he was distracted with unrelated thoughts. It was not difficult to refocus the client and return to the agenda. The client was clearly a highly motivated individual despite his depressive symptoms.

Therapists' Feelings during Sessions

The therapist remained positive and motivated about using a manual intervention for the treatment of a major depressive disorder. This therapist had clear advantages that other therapists in the same situation would not be offered because she had experience in CBT therapy and in community mental health employment. The therapist was pleased with the client's positive reaction to his involvement in therapy. The case study was a unique and special experience for the client and the therapist. This form of therapy was a good choice for the client because it was a structured form of therapy and the client was aware of the content of each session prior to attendance. It seemed to give the client a sense of control in a world where he felt helpless and unable to make decisions. The collaborative process was helpful for him and was hopefully a stepping-stone in working on developing healthy relationships.

Effects on Creativity

The use of a manual does in a small degree affect the therapist's creativity because of time constraints. The suggestion to increase the number of sessions, which has been made in the empirical study at the completion of the dissertation, will reduce time constraints; this should increase creativity. The possibility of using manuals with choice of modules is also a good choice for therapists who are seeking to adapt therapy to better suit their clients' needs (Wilson, 1995; Jacobson & Hollon, 1996; Heimberg, 1998). In many ways creativity is accomplished because it is based on the personal style of the therapist and during the development of the therapeutic working alliance (Wilson, 1995). In all form of therapy with or without the use of a manual, a therapist can find creativity based on their unique personality and their relationship with the client (Räue, Goldfried, & Barkham (1997).

This was a good opportunity to begin a necessary step of implementing a manual based intervention at a community mental health facility. But this is only a preliminary step. Other dedicated individuals who share the same interest and commitment must continue to introduce evidence-based practices and translational research in the form of a manual-based intervention in a community mental health center.

Chapter 7

Discussion

This section is divided into four main parts. The first will review the hypotheses and results, incorporating literature relevant to the results. The second will discuss the applications of these results for clinical practice. The third section will address limitations of the study. The fourth section will address areas of potential further research

Hypotheses Review

The first hypothesis stated that there would be an increase in the client's quality of life as measured by QOLI scores and a decrease in depressive symptoms as measured by BDI-II scores over the course of treatment. The results supported the hypothesis because there was a slight improvement in the client's quality of life, which was measured by his QOLI scores. There were some slight improvements in the client's depressive symptoms as demonstrated by his BDI-II scores, which were most significant between session nine, and the post treatment session. At the same time, it can be concluded that the hypothesis was challenged because there was some variability in data points and inconsistent patterns over time. However, the client's comments in the transcripts concerning his satisfaction with the manualized treatment, his increase in pleasurable activities, and his ability to apply the new skills to his everyday life provided anecdotal evidence that the treatment was successful. According to McCollough (2000), even when response to

treatment with a chronically depressed client occurs, recovery rates are usually moderate at best.

The second hypothesis stated that the client will report greater satisfaction with the current treatment versus treatments he had received in the past. The hypothesis was satisfied because the client reported high satisfaction with the current treatment as measured by the Patient Satisfaction Questionnaire (PSQ) scores and comments in the transcripts.

Pratt and Gill (2005) concluded that high satisfaction was found among clients who participated in evidence-based practices. Manualized interventions adhere to fidelity standards, quality assessment programs, and commit to recovery models (Pratt & Gill, 2005). According to Drake (2005), a strong reason for assuming that a client will be satisfied with the use of evidence-based practices is that consumer choice is a key determinant in the effective provision of evidence-based practices. A strong reason for the client's high satisfaction with the structured format of this treatment as compared to previous treatment was his ability to choose his treatment intervention.

The third hypotheses examined whether or not the client would engage in all activities and complete the treatment. The hypothesis was validated because the client engaged in all activities, with the exception of one, and attended all sessions. The client completed 90% of all homework and found the assignments meaningful and applicable to his life.

There are a number of reasons for the client's engagement in homework and activities. The client was highly motivated to participate in the therapy. He was given a choice of therapy, which was extremely meaningful to him. Most clients in community mental health are assigned to therapists who rarely offer therapeutic choices (Mueser et al., 2001). According to Detweiler and Whisman (1999), people who enter treatment more willingly will complete homework and therefore have a greater tendency to improve. An additional reason for his engagement in the recommended activities may have been due to his strong relationship with the therapist (Lazarus & Fay, 1982). His participation in activities may also have been due to his desire to please the therapist. In addition, Burns and Nolen-Hoeksma (1992) found that client ratings of therapeutic empathy were associated with clinical improvement, as were therapist and client ratings of adherence with behavioral homework assignments. The client's activities and completion of homework assignments may also have been related to his strong working alliance with the therapist.

The client's high attendance rate was atypical for usual attendance at community mental health centers. The therapist had valid concerns about the client's attendance at therapy because of her experience at the community mental health center where the no-show rate averaged between 20- 50% weekly. Her prior experience was typical to research studies. In a controlled study by Swenson and Pekanik (1988), the no-show rate at a community mental health center at Washburn University was between 17% and 43%.

In a study by Turner and Vernon (1976), the no-show rate in a study of 1000 community mental health centers averaged between 11% and 32%. Peeters and Bayer (1999) found that the no-show rate among adults at the Maastricht community mental health center in Massachusetts was between 11% and 50%, with the lowest no show rate of 9.6% at the first appointment. The reasons for no-shows varied but included culture, psychosocial determinants, and accessibility of professional services. A better understanding of these phenomena would be helpful in utilizing manualized interventions in community mental health centers. Unfortunately, there is a scarcity of research on the poor attendance rate in community mental health but it is an area worthy of future exploration. The therapist concluded that the client's unusually high attendance rate was due to his commitment to the program, his desire to please the therapist, and the strong therapeutic working alliance.

The fourth hypothesis examined whether or not the client's satisfaction with the structured format of the manualized treatment corresponded with the client's understanding of the tasks, goals, and his relationship with the therapist, which were measured by the Working Alliance Inventory-Short Form (WAI-S). The hypothesis was satisfied because the client's satisfaction was high and did correspond with his understanding of the tasks, goals and his relationship with the therapist. The WAI-S scores indicated that Mr. M. was satisfied with the therapeutic relationship and that he was not compromised by the selection of the structured format of the manual. The client

felt that he and the therapist shared similar definitions regarding his problem. He trusted the therapist and felt that they shared the same outcome for his therapy. According to Horvath and Greenberg (1989), there is a strong correlation between empathy and the alliance dimension of the bond and a moderate relationship between empathy and goal. Also according to Horvath and Greenberg (1989), the relative importance and impact of goal, task, and bond dimensions of the alliance in the beginning, middle, and end phases of counseling need to be assessed. The literature is scant in relationship to the correspondence between the WAI-S scores and the client's understanding of the performance of tasks, goals and bond.

The fifth hypothesis questioned whether or not the therapist gleaned any benefits while utilizing this manualized approach to treatment. It was realized that the therapist gained specific benefits, which included introducing an evidence-based treatment to the community mental health center and utilizing evidence-based practices to treat other diagnoses such as anxiety disorders. She felt that she would like to continue using the manualized treatment with other clients suffering with depressive disorders. The hypothesis was challenged because the therapist was not able to create a community of clinicians to employ evidence-based practices due to disinterest by her fellow colleagues.

Hausman (2002) found that empirical practices were beneficial in the treatment of major depressive episodes in non-university based settings. Her conclusions are

consistent with accumulating evidence that the positive effects of manualized treatments for specific disorders generalize to other problem areas (Wade, Treat & Stuart, 1998).

Significant improvement was noted in symptoms of depression, social phobia, and generalized anxiety in patients treated specifically for panic disorder in a community mental health setting. (Wade et al.1988).

Thus the goal of creating a community of clinicians was not achieved even though the therapist was permitted to provide monthly updates concerning her case study at staff meetings by her supervisor and the administration. Unfortunately, her colleagues did not express a strong interest in employing manual interventions with their clientele. It is possible that the administration did not embrace the use of evidence-based practices.

Thus the goal of creating a community of clinicians was not achieved.

Hypothesis six examined the difficulties with the manual that the therapist experienced while utilizing this approach. It was hypothesized that the therapist would not experience difficulties while utilizing the manualized approach. Information concerning the therapist's experience was documented in the process notes. The

hypothesis was supported because the therapist did not experience any difficulties, including any resistance from her colleagues. Unfortunately she experienced extremely limited reactions from her colleagues, which may have been related to lack of interest or to overwork. Even though the literature was abundant with respect to therapeutic concerns related to the implementation of manualized treatments, the therapist's experience was contrary to the literature. Carrro and Nurro (2002) criticized the use of manualized interventions by stating that the therapist would experience loss of creativity and a high degree of frustration during the implementation process. The therapist did not feel frustrated and did not feel that her creativity was affected during the utilizing of the manual intervention. This may be due to the fact that this was the first time that she had implemented this manual intervention. It is possible that she may feel that her creativity is limited after repeated use in the future.

The therapist also felt that she had an effective relationship with the client while utilizing the manual intervention. Her feelings clearly contradicted the literature.

According to Addis et al., (1990), there is a shared belief among clinicians that it was not

possible to develop an effective relationship while utilizing a treatment manual. Despite the abundance of negative criticism in the literature, the therapist was able to implement the manualized treatment successfully with a positive outcome for the client.

Hypothesis seven proposed that the therapist may encounter difficulties in implementing the manualized approach without weekly supervision and without access to a highly trained supervisor to discuss implementation problems when needed. The hypothesis was supported because the therapist did not have any difficulty implementing the manual intervention without training and supervision because of her previous training in CBT methods, her community mental health experience and her willingness to dedicate extensive time to self study of research which is related to manual interventions and to review of the manual. It is important to note that these characteristics may not be found in many community mental health therapists. Heimberg (1998) argued that advanced training was necessary for effective implementation of manualized treatments. According to Addis, Wade and Hatgis (1999), training should be encouraged and should be an essential part of the implementation process. Addis et al., (1999) also stressed the fact that the implementation of manualized treatments required frequent and regular supervisory sessions to ensure proper implementation and acceptance by the therapist. The therapist did not disagree with the research that strongly supported the importance of training and supervision in the implementation process. Training and supervision is

always a helpful component when implementing a new or previously implemented intervention. It is possible that with more training and more input from an experienced supervisor that there may have been a more positive treatment outcome.

Hypothesis eight questioned whether or not the administration provided the necessary support to implement this manualized treatment. It was hypothesized that the administration would approve the case study and would not generate any obstacles when implementing the manual intervention. The specific hypothesis was supported because the administration did not provide any obstacles to the implementation of the manualized treatment. However, at the same time, they did not promote the new intervention. The administration permitted the therapist to speak at the supervision/staff meeting but the environment was not conducive to introducing a new treatment approach because the staff meeting was time limited and the overall purpose of the meeting was to introduce new policies and administrative procedures. The administration may have been more helpful in allocating more time for the presentation, asking the supervisor to speak about the importance of the case study and the possible future use of evidence-based practices in the agency; it might also been helpful in providing some training to the therapist and the staff about evidenced-based practices. According to Southam-Gerow et al. (2006), the administration is influential in determining the successful implementation of efficacious interventions and in achieving positive outcomes. Stronger administrative involvement would be helpful in endorsing the support and growth of evidenced-based interventions in

the form of manual interventions, and the acknowledgement of the need for training and supervision for these interventions.

Clinical Applications

Therapists, clerical staff, and administrative staff at community mental health agencies share common concerns and a belief that changes need to be implemented in the overall environment and delivery of services. The actual way to implement these changes may differ from feelings that change is not possible to feelings that changes need to be almost revolutionary in context (Addis et al, 1999). There is no question that changes are needed. The best way to implement these needed changes may be initially to review the problems experienced by stakeholders in the community mental health environment and bring the issues down to concrete clinical practice (Addis et al., 1999). Yet it may take time and a context of professional support, rather than threat, to engage practitioners who do not already see the value in empirically-based practice (Addis et al., 1999).

Morale Issues

Evidenced-based practices can be introduced and successfully implemented in community mental health settings after initially understanding the morale problems facing the stakeholders. One major contributing factor to the poor morale is therapists' compensation program, which is based on a fee for service schedule. Therapists are paid only when clients attend treatment sessions. Even if therapists are highly motivated and aggressive and call their clients the night before and on the day of the scheduled appointments, this does not guarantee success. Most clients in community mental health who receive benefits from Medicaid and Medicare are not required to pay any co-

payment for their services and have no financial liability for not attending their scheduled appointments. At the same time, therapists at many community mental health agencies are not permitted to terminate clients for lack of attendance without giving the clients a number of opportunities.

Many therapists also feel pessimistic about the outcome of their therapeutic treatments because the belief shared among clients in community mental health is that they will not recover and will be members of the mental health system for life (Shadish, 1989).

Therapists are aware that there are long held defeatist beliefs shared among their clients (Mosher & Burti, 1994). Many therapists are also cognizant of the fact that clinicians and researchers in university settings may treat clients for shorter periods of time and experience positive treatment outcomes with their interventions (Mosher & Burti, 1994).

Community mental health therapists, however, often feel that they are trapped in a negative environment without career advancement, in places where they will never realize positive outcomes with their treatment interventions for their clients (Mosher & Burti, 1994). At the same time, many community mental health therapists feel that they do not have the credentials and the understanding of the university setting to be attractive applicants to university settings or to other environments outside of the negative environment of community mental health (Mosher & Burti, 1994; Test & Stein, 2000).

Another reason for low morale among therapists in community mental health is a lack of exposure to training programs and new treatment interventions. Community mental

health therapists also receive no reimbursement for outside attendance at professional training conferences or reimbursement for professional subscriptions to journals.

Therapists in community mental health agencies cannot be expected to receive, positively, evidence-based research in the form of manual interventions when they have no familiarity with the concepts and feel that these programs will only add additional responsibilities to their already cumbersome jobs. It has been proven that extensive training clearly affects how therapists perceive and integrate evidence-based research and translational research into their treatment interventions (Southam-Gerow, & Kendall, 2006)

Supervision can be sparse and often not available to therapists in community mental health agencies (Mosher & Burti, 1994). This lack of supervision often leads to great frustration among community mental health therapists who desire to seek supervision from individuals with expertise and advanced learning (Southam-Gerow, Ringeisen, & Sherrill, 2006).

According to Southam-Gerow & Kendall (2006), an active supervisor should collaborate with therapists in a high level to facilitate a sense of efficacy and resourcefulness in the clinical setting. The supervisor should also meet regularly, practice strategies, use role-playing, encourage future learning and encourage problem solving. Unfortunately, the supervisor in community mental health is usually a working therapist who does not have time to perform the role of a supervisor (Mosher & Burti, 1994; Test & Stein, 2000).

Therapists' morale is also affected by their large caseloads, which prohibit them from researching and learning new treatment interventions. Therapists in community mental health are aware that research environments encourage their staffs to balance their time between research and training. Such differences shape how therapists are trained and supervised (Southam-Gerow, & Kendall, 2006).

According to Southam-Gerow and Kendall (2006), the therapist should view herself or himself as a change agent. This is not the case of the therapist in a community mental health agency, who often has a negative view of the environment, which she feels, can not be changed. Many therapists develop negative views of their jobs and overall negative reactions to any suggestions that involve change (Southam-Gerow et al. 2006).

Steps and Solutions

The community mental health field will not embrace evidenced-based practices without initially dealing with immediate concerns and overall morale issues of therapists and then initiating steps that prove that evidenced-based practices are a viable treatment option (Addis et al., 1999). A number of issues including compensation, no-show rates, supervision, training and a need for assessment procedures during treatment need to be addressed.

Compensation

Community mental health therapists often feel demoralized by the fee for service

compensation program in which they are not compensated for no- shows and do not receive any benefits. One possible solution could be the development of an incentive program in which therapists are rewarded for a high show rate, strong working alliances as measured by the Working Alliance Short Form (WAI-S), reductions in depressive symptoms and anxiety symptoms as measured by the Beck Depression Inventory-II (BDI-II) and The Beck Anxiety Inventory (BAI). These programs will obviously need development and approval by the administration but will be a way to compensate therapists and move therapists closer to rewards for treatment outcomes. Therapists also could be involved in determining the number of sessions for which they will permit lack of attendance prior to termination of services.

No Show Rates

No-show rates contribute to morale problems among therapists in community mental health. Administration may consider adding a small co-payment, which may add value for the service received by the client. It will be necessary to research if there are any Medicare or Medicaid restrictions for co-payments. It may be helpful to limit the number of sessions provided to clients. As seen in the case study, the client may have valued a more structured limited number of sessions. The therapist may respect an administration that permits him or her to set the limits for lack of attendance prior to termination of services.

Assessment

The use of assessment measures is often foreign in community mental health settings because of cost, time constraints, and training needs (Aarons, 2004). In the community mental health agency in the case study, assessment measures were not used during any treatment interventions. Generally, members of administration, therapists and clientele in community mental health environments prefer brief assessment tools (Aarons & Sawitsky (2006). Assessment measures including the Beck Depression Inventory-II (BDI-II), The Beck Anxiety Inventory (BAI), The Working Alliance Inventory-Short Form (WAI-S) are recommended for their brevity in administration. The Evidence Based Practice Scale (Aarons, 2004) has been recommended as an assessment tool in assessing the multiple dimensions of behavioral health service provider attitudes toward adoption of evidence-based practices. Another way of evaluating the success of evidence-based practices in field settings sometimes focuses on implementation effectiveness as evidenced by evaluating the fidelity of implementation. According to Drake et al., (2001), there is some justification for this focus because, by definition, practices classified as evidence-based are supported by research demonstrating a direct positive relationship between high-fidelity practices and outcomes.

Feasibility Issues

Concerns by therapists about being rushed may be addressed by slowing down specific components of treatment, by increasing the number of sessions or by assigning additional homework as smaller tasks (Addis et al., 1999). Cost issues are a concern in

the implementation of evidenced-based practices. Manual costs can be allocated over several therapists because manuals can be shared and many therapists often treat similar diagnoses (Addis et al., 1999). Training costs are an additional financial need, not allocated in the community mental health budget.

Training

According to Rogers (1995), more formal training is associated with increased adoption of new innovations. Training is a crucial factor in implementing manual interventions. Education is positively associated with endorsement of evidence-based treatment services (Kendall, 2005). Training of most clinical professionals involves an internship experiences. Interns in specialty mental health clinics report more positive attitudes toward using evidence-based assessment protocols compared with clinicians who have not participated in internships (Aarons & Sawitsky, 2006). Clearly, more and improved supervision is needed for therapists in community mental health centers, and clearly, cost is an issue in receiving quality training. Alternative avenues for training if funding is not available could be to approach universities and request the support of doctoral students.

Supervision

According to Kendall (1995), recommended supervision for therapists utilizing a manual intervention would involve audio-taping all sessions, videotaping of select sessions, and at least weekly supervision. It is essential that community-based therapist

receive quality supervision, which may be provided through university-based personnel or doctoral students. Creativity may be needed in approaching university administration for supervision; however, doctoral students may be willing to provide training in exchange for a research setting for a doctoral dissertation or an internship site.

Collaboration

Eliciting practitioner input into psychotherapy research is essential to successful implementation of evidence-based research in the form of manual-based interventions. Practitioners can generate useful questions to be addressed by psychotherapy researchers. Because practitioners are the end users of manualized treatments, their input is necessary for researchers to consider in developing outcomes for clinical practice (Addis, Wade & Hatgis, 1999). Researchers, community mental health therapists and administrators need to take more proactive approaches in forming partnerships in order to collaborate in developing manual interventions. Personnel in community mental health fields often lack the experience or administrative support to implement such programs in their environments without assistance (Nuns, Carroll & Bickel, 2002). The bridge between the worlds of research, practice and policy is challenging to build but extremely necessary (Hudgins & Allen-Meares, 2000).

Creativity

Fortunately, therapists are offered choices with specific manuals when they are asked to select modules (Wilson, 1995; Jacobson & Hollon, 1996). According to Southam-

Gerow and Kendall (2006), the failure to fit newly developed treatments to providers may contribute to their slow deployment. Heimberg (1998) concluded that the use of manual-based treatments would continue to be a controversial topic because it reaches the heart of therapists' desire for freedom and self-determination. It is important to offer more treatment manuals that offer flexibility to providers. According to Wilson (1996); Southam-Gerow; Ringeisen & Sherrill (2006); Addis et al., (1999), the concept of flexibility in manuals is not new. The concept of modules in treatment manuals offers therapists the ability to choose specific sections that are pertinent to their clients. This flexibility will also reduce the criticism voiced by many therapists that their creativity is lost when using a manual intervention (Wilson, 1995). The use of modules, training and supervision will help reduce resistance of manual interventions by therapists in community mental health settings. Because therapists receive more training and supervision they will not view manuals in a negative and dehumanizing way (Southam-Gerow & Kendall, 2004)

It is critical that the mental health field continues to grow with programs like evidence-based practices and translational research. With improvements in morale in the community mental health environment, improved training and supervision, use of modules and assessment tools, the use of evidence-based practices in the form of manual-based interventions will become accepted by therapists. The integration of evidenced-based practices in community mental health will take professionals with

perseverance, passion and a shared belief that these methods and concepts will enhance treatment interventions.

Limitations with Current Study

There were numerous limitations with the current study, all of which suggest areas of further study. First, a case study is a cost effective way to study a new treatment but there remain questions of generalizability of results because of the sample size of $n=1$. This suggests a need for additional studies with larger sample sizes.

Second, the individual for the case study was selected quickly. He was the third prospective client, diagnosed with a depressive disorder who was interested in receiving treatment with a manualized approach. It cannot be assumed that interested participants will be identified this quickly. Additional information should be accumulated over time in the community mental health field to glean a better understanding of the timing and contribution factors involved in the selection process of clients in manualized treatments.

Third, the client's attendance was 100%, which was greatly appreciated by the therapist but was not consistent with community mental health standards. The therapist also questioned whether or not the client's attendance was based partially on his desire to please the therapist.

Fourth, the client's engagement in activities was 90%, which was due to his high level of motivation and his initial ability to determine his participation in the manualized treatment. It is difficult to predict if other client's from a community mental health center

would generate a similar level of engagement in homework activities. Present therapy interventions at this community mental health center do not include homework assignments. Research in this area is scant concerning homework participation among clientele in community mental health settings.

Fifth, the attitude of this therapist was positive despite the lack of training and supervision at the community mental health center because of her high level of motivation and commitment to the case study. Her performance was not affected because of her training in CBT procedures, experience in community mental health, willingness to research the area of evidence-based research, translational research and dedication of substantial time at home to prepare for each session. It cannot be assumed that these traits will be found in all community mental health therapists.

Sixth, supervision and training were substantially lacking at the community mental health center. Both are extremely helpful in implementing a manualized-based training. This case study was successful without these necessary requirements because of independence and experience of the therapist. This will be an ongoing concern and continual need at the community mental health centers.

Seventh, there were limitations in the intake process because the therapist needed to rely on information provided by the intake coordinator and the psychiatrist. She had limited information concerning the client's background or previous therapies.

Eighth, there were insufficient numbers of sessions in the case study to address client

needs and to assess the outcome of the treatment adequately. It is suggested to increase the number of sessions from 10 to 16, in addition to an intake and post-treatment session.

Ninth, the author/researcher and the therapist were the same person, which may have resulted in bias. It may have been advisable if the researcher and the individual conducting the study were two distinct individuals.

Future Directions

The author is proposing a new study, which will incorporate CBT treatment modalities while utilizing a manualized approach to treat individuals suffering with major depressive disorders. The use of treatment modalities of choice will reduce therapists' concerns about loss of creativity (Kendall, 1995) and will help the therapists individualize the therapy for their clients. The therapists will continue to utilize assessment measures but the author is proposing to increase the number of assessments conducted in order to validate the treatment outcomes with greater certainty. Homework assignments will be offered with more flexibility for the therapists. Increased number of sessions, therapists' involvement in the intake process, increased supervision and training, and involvement of the administration will also be encouraged.

Introduction and Approval Process

The use of the manual intervention will be approved by the administration of the community mental health agency. The therapists will notify their supervisor that they are interested in participating in the study and will receive initial approval. There will be no

requirements for therapists' participation, with the exception that they will use an approved evidenced-based manual based on CBT principles to treat depressive disorders, assign homework to their clients, use approved assessment measures, and participate in training and supervision.

Intake Procedure

All clients at the community mental health center will participate in the intakes administered by the intake coordinator and then an intake administered by the psychiatrist. An additional intake will not be scheduled for the therapist. It is assumed that the additional four sessions will provide sufficient time for the therapists to ask questions that have not been asked during the previous assessments.

Increased number of sessions and assessments

The number of sessions will be increased from the previous case study from 12, which included an intake and post-treatment session to 16 sessions in order to include more time to introduce new modules to address clients' needs for social skills, problem solving and job skills, budgeting, and other economic issues. Assessment measures will be administered during more sessions to clarify the effect of treatment outcomes. The Quality of Life Measure (QOLI) will be administered during pretreatment, session 3, 7 and post treatment instead of only during pre and post treatment. The BDI will be administered during all sessions including pre and post treatment and will be administered during the additional 4 sessions.

Administrative Involvement

The therapists will be required to send weekly updates not only to the director of the outpatient mental health agency, but also to their supervisors. The update should include

client attendance, completion of homework, and assessment information without client identification. The administration will be encouraged to ask questions during the study by the research board which will be composed of a member of the administration and a representative of a selected university.

Use of Modules

The therapists will be able to choose modules, which will permit flexibility and promote creativity. According to Kendall (2006), modules may be helpful in individualizing the client's therapy. The therapists, after selecting specific modules, must notify their supervisors in writing. The choice of modules cannot be changed during the course of treatment.

Homework Flexibility

Because homework is an essential component of CBT, it is important that it is incorporated in the client's treatment. Even though the therapists are encouraged to follow the general format of the homework assignments, there is some flexibility in the assignment of homework. The therapists may add homework assignments that are relevant and may delete aspects of homework assignments that they feel are time-consuming or redundant; this may be done without prior approval.

Training and Supervision

Each therapist is suggested to meet with his or her supervisor on a weekly basis for 30 minutes. It is also suggested that all therapists, despite their levels of education, should participate in an hour CBT introductory course during which basic CBT principles and concepts are discussed. It is also recommended that an introductory course to manual interventions and evidence-based principles occur for 30 minutes at the agency. All

therapists should attend monthly training during which evidenced-based practices are reviewed. It is understood that deviations from this proposal may occur at the community mental health agencies. The administration and therapists should attempt to adhere to the above-suggested standards as closely as possible. The suggestions are based on research on evidenced-based practices, manual interventions and translational research. The hope is that these suggestions and improvements from the previous case study will promote creativity, reduce resistance from therapists, incorporate requested client skills, and involve all necessary stakeholders in the implementation process.

Chapters 8

Proposal for Empirical Study

Background

The previous case study conducted by the author examined the feasibility of the implementation of a manualized treatment for depression, which was developed at a university based setting, based on evidence based practices. There were improvements in new skills learned, slight decreases measured by the Beck Depression Inventory Scores (BDI-II), slight increases in the client's quality of life scores as measured by the Quality of Life Inventory (QOLI) and a strong working alliance between the therapist and the client, which was not affected by the structured format of the manualized intervention. The author is proposing a new study, which will build on previous work by the author to examine the feasibility of three treatment modalities for depression in a community mental health setting.

Objective

The primary aim of this study is to examine the efficacy of three treatment interventions for the treatment of major depressive disorder. The interventions will be compared to determine their relative effectiveness in reducing the participants' depressive symptoms and increase their quality of life.

Study Design

The empirical proposal will be a randomized, controlled trial (RCT), utilizing a MANOVA repeated measures design.

Intervention Description

Intervention I- Control group- This group will receive treatment as usual. In this intervention, the therapist will receive no instruction regarding the treatment of choice, other than length of treatment. The therapy will include 10 sessions excluding the assessment period, which will occur over 2 hours and 30 minutes. There will also be 2 pre-treatment sessions and 2 post-treatment sessions.

Intervention II- CBT Manualized Approach- This group will receive the manualized treatment approach as described in the manual, *Overcoming Depression*, Emery (2000). The manualized approach will be 10 sessions. There will also be an assessment period, which will occur over 2 hours and 30 minutes, 2 pre-treatment sessions and 2 post-treatment sessions.

Intervention III- CBT Manualized Treatment with Modules- *the clients will receive the CBT manualized treatment approach (10 sessions) with an additional 4modules selected by the therapist with emphasis on socioeconomic and life issues.* (See Appendix E – Empirical Proposal Flow Chart and Appendix F – Empirical Proposal Timeline). There will be an assessment period which will occur over 2 hours and 30 minutes, 2 pre-treatment sessions and 2 post-treatment sessions. The additional modules will occur prior

to the post treatment session in the manual. Socioeconomic topics may include relationship issues, job interviewing, problem solving techniques, the importance of attending additional educational and skills training classes, where to attend GED and computer courses, and legal and budgetary resources. These suggestions are based on research literature which suggests that more recent mental health programs have included specific psychosocial training because these benefits help reduce psychological distress in clients, increase long term well-being and affect variables such as depression (Creed, Hicks, and Machin, 1998). Dooley (2003), in his studies of underemployed individuals, found that inadequate employment involves both economic and psychosocial losses. Creed et al., (1998) found that long term unemployed individuals who attended occupational skills/personal development training courses reported increased well-being which included reductions in depression, psychological distress, increased self-esteem, increased life-satisfaction and reductions in guilt, anger and helplessness.

Research Question and Hypotheses

Will there be different results related to the changes in depressive symptoms and quality of life scores in clients enrolled in the three interventions for the treatment of a depressive disorder in a community mental health center?

Hypothesis I- Intervention I vs. Intervention II vs Intervention III– It is proposed that

Intervention I will be less successful than Intervention II and III in reducing depressive symptoms and in increasing quality measures for the subject.

Hypothesis II- Intervention II vs. Intervention III- It is proposed that Intervention II will be less successful than intervention III in reducing depressive symptoms and in increasing quality measures for the subject.

Hypothesis III- Intervention III vs. Intervention I- It is proposed the Intervention III will be more successful than intervention I in reducing depressive symptoms and in increasing quality measures for the subject.

Setting

The setting will be an outpatient mental health clinic. The assessment coordinator will be a master's level therapist. The staff psychiatrist will be a licensed MD. The therapists will have graduate degrees either in counseling psychology or in social work.

Participants

Therapists

A total of 9 therapists will be recruited to participate in the research study.

Inclusion Criteria

All therapists must have a master's degree in counseling, psychology or a related subject or a degree in social work. They must agree to participate in the required supervision and training and to participate in the random selection process for treatment.

Exclusion Criteria

Any therapist who does not meet the educational, training, or supervision

requirements will be excluded from the study.

Therapist Selection and Training

The therapists will consent to participate in the study. The therapists will participate in a one-day, paid workshop, which should be conducted by a trained CBT therapist for Interventions II and III. Treatments will be randomly assigned to Intervention I, Intervention II, and Intervention III conditions. A training workshop which will review counseling skills will be offered to the therapists in Intervention I in order to avoid any confounds to the experiment. Training should be kept separate for each group, but the same trainer will perform training for all training sessions. Supervision will occur for one hour for all therapists on a weekly basis. All therapists will be instructed about how to complete the informed consent forms and assessment forms

Subjects

Subjects will consist of 90 adults who will be randomly assigned and treated at the community mental health center.

Inclusion Criteria

The subject must be 18 years of age or older to qualify for services at the community mental health agency. They must participate in the initial intake and the psychiatric intake at the agency. In order to participate in the manualized intervention, the subjects must receive a diagnosis of a major depressive disorder both at the initial intake and at the psychiatric intake, based on criteria stated in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)-Fourth Edition. The subject may participate in the study if

he or she is presently taking medication(s) or if he or she is prescribed medication(s) by the staff psychiatrist. There would be no exclusions for preexisting medical conditions.

Exclusion Criteria

A subject would be excluded from the study if he or she was under the age of 18 years. Individuals who were diagnosed with Axis II disorders or mental retardation would be disqualified from the study. Individuals who were presently undergoing treatment for alcohol or drug rehabilitation would not qualify for the study.

Procedures

The subjects will be given instructions at the intake session concerning the treatment modalities and interventions. Informed consent will also be obtained during the initial session. Subjects will be assigned to a therapist specifically trained in his or her assigned intervention. At the beginning of participation, a research assistant will assign an identification number to each subject; that subject will now be referred by that identification number. The identification number will be placed on the consent form, which will be obtained at the intake session. Both the therapist and the outpatient supervisor may have contact with the client, based on specific needs or requests by the client. All sessions will be audio taped with prior written consent of the clients. The clients may request to work with a case manager who will be a staff member at the outpatient clinic for additional services, including housing and financial assistance. The client will receive either 10 sessions or 14 sessions, depending on the treatment condition. The time period of fourteen sessions, excluding the two-day assessment period, will include careful screening of the client and an ongoing review of the treatment

modality. There will also be two pre-treatment sessions and two post-treatment sessions. The tasks and agenda will be introduced at each session of Intervention II and III. The therapist, at the beginning of each session, will ask the client if there is any prescription change and will subsequently report such change on a prescription log.

Intakes

The participants will be required initially to attend the intake conducted by the intake coordinator at the community mental health agency. At the intake, which will occur over 2 hours, the intake coordinator will gather background information pertaining to the prospective client's treatment and prescriptions, drug history, family, job and educational history, financial and healthcare status, and demographic information. The intake coordinator will observe a formal assessment form, which will aid in the development of a diagnosis of the prospective client. The prospective client will also be asked to sign required consent forms in order to be eligible to receive care at the agency. The individual will then meet for approximately 30 minutes with a staff psychiatrist who will review the diagnosis and either confirm or change the diagnosis. Prescription medications will be prescribed if required.

The Beck Depression Inventory II (BDI-II) will be administered during each session in all interventions (Beck, Steer, Brown, 1996). The BDI-II will also be administered during the pretreatment and post treatment sessions. The Quality of Life Inventory (QOLI; Frisch et al. 1992) will also be administered during pretreatment and post treatment sessions and during sessions 1, 3, 7, and 10. The Working Alliance Measure-Short Form (Horvath & Greenberg, 1986) will be administered at the completion of Sessions 1, 3, 7, and 10 and during the pretreatment and post treatment sessions. All

measures will be administered during Intervention I, II, and III.

At completion of the study, a committee previously selected by the community mental health facility and PCOM will review the results of the data and follow-up plans will be suggested.

Measures

Beck Depression Inventory II- The client's depression level will be assessed at each session including the intake and post treatment session. The Beck Depression Inventory II (BDI-II), a 21 item self-report instrument, is designed to assess the severity of depressive feelings over the previous week using a 4-point likert scale (Beck et al. 1996). Each item requires participants to endorse one of four options reflecting the severity of a given depressive symptom. Scores of 0 to 3 are applied to each option within the BDI-II, items with higher scores indicating more severe symptoms. Individual item scores are totaled for a score designed to indicate severity of depression.

Quality of Life Inventory- The client will complete the quality of life at intake and post treatment to assess changes in the client's quality of life. The Quality of Life Inventory (QOLI), consisting of 17 items, is based on an empirically validated, linear and additive model of life satisfaction that assumes that an individual's overall life satisfaction consists largely of the sum of satisfactions in particular areas of life deemed important (Frisch et al, 1992). Each of the 17 areas of life deemed potentially relevant to overall life satisfaction is rated by respondents in terms of its importance to their overall happiness and satisfaction (0=not at all important, 1=important, 2= extremely important) and in terms of their satisfaction with the area (-3= very dissatisfied to 3= very satisfied). The inventory's scoring scheme reflects particular areas of life that are weighted by their

relative importance to the individual.

Working Alliance Inventory – Short Form

The client will complete the working alliance inventory to assess the therapeutic alliance at sessions 1,3,5,7,10, and at intake, and posttreatment. Horvath and Greenberg developed, the Working Alliance Inventory, (WAI), therapist and client versions. The Working Alliance Short Form (WAI-S) is designed to yield three alliance scales: Goal, Task, and Bond (Andrusyna et al. 2001).

Analytic Plan

The SPSS Computer package will be used for all computations. To determine whether or not significant changes in symptoms occurred, a repeated measures multivariate analysis of variance will be used to analyze the results of the BDI-II scores, the QOLI scores and WOL-S scores. . If this analysis reveals that changes from pre to post – treatment are highly significant, follow-up paired t tests will then be performed separately for each of the three dependent measures. Type I error= $p < .05$, power=80%. This will require 30 subjects per cell or N=90. This is based on an moderate f (effect size) estimated to be .25, $F(2, 90)$. The F will be calculated using the SPSS software based on an estimated degrees of freedom (2,90) after the data is gathered. There will be one group with three levels by eighteen levels of time (Depression). There will be one group with three levels by eight levels of time (Quality). There will be one group with three levels with eight levels of time (Working Alliance).

Recruitment Plan

Based on the average number of assessments at the site of the case study, it is assumed that there will be 5 completed intakes per week. Based on literature, the average no-show

rate is 32% (Swenson & Pekanik, 1988; Peeters & Bayers, 1999). The no-show rate at the community mental health agency was between 40-50% per week. Because 50% of the people may not show or may not return for therapy, two people will remain. Based on RCT literature, a conservative rate of participation is 50% (Venable, Carey, Carey, Maisto, 2002). This will result in 1 participant per week. In any given month, four people may enter the study. In year 1, there will be 36 participants in the study, in year 2, there will be 48 participants in the study. In year 3, there will be 9 participants in the study. In year 3, there will be sufficient time to review data, summarize results and present findings.

Potential Confounds

Potential confounds may include the retention rate of the clients in therapy and their possible refusal to complete or to engage in treatment due to increased depressive symptoms or uncomfortable feelings toward treatment. These confounds may be controlled or reduced by careful screening and assessment measures prior to beginning the therapeutic intervention. Collaborative efforts by the therapist and client will assist in controlling confounds. Therapist turnover can be controlled with a plan for new therapists entering over a course of time, based on a training plan with additional scheduled training sessions.

Contribution to Future Research – This study will add to the research in the field of treating major depressive disorder in the community mental health field. The research study will test whether or not specific interventions, treatment as usual, a CBT empirically proven manual intervention, or a modified CBT empirically proven manual intervention with modules chosen by the therapist, will result in greater reductions in

depressive symptoms, improved quality of life and /or improved working alliance. An additional contribution may result if the introduction of modules in Intervention III will increase creativity for the therapists and reduce the resistance toward the use of evidence-based practices through the use of a manualized intervention.

Concerns –It is also assumed that there will be terminations and no-show rates, which occur at the community health center. This may be an impediment to the results of the study. The therapists' ability to motivate and retain the clients will be an essential element to the success of the study. Limitations can be handled analytically using statistical packages that can accommodate missing data.

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If you believe that you have suffered injury or illness in the course of this research, you should notify the PCOM Research Compliance Specialist at (215) 871-6782. A review by a committee will be arranged to determine if your injury or illness is a result of your being in this research. You should also contact the PCOM Research Compliance Specialist if you think that you have not been told enough about the risks, benefits, or other options, or that you are being pressured to stay in this study against your wishes.

VOLUNTARY PARTICIPATION

You may refuse to be in this study. You voluntarily consent to be in this study with the understanding of the known possible effects or hazards that might occur while you are in this study. Not all the possible effects of the study are known.

You may leave this study at any time.

If you drop out of this study, there will be no penalty or loss of benefits to which you are entitled.

I have had adequate time to read this form and I understand its contents. I have been given a copy for my personal records.

I agree to be in this research study.

Signature of Subject: _____

Date: 4/12/06 Time: 2 AM/PM

Signature of Witness: Mary Stember, MS LPC

Date: 4/12/06 Time: 2 AM/PM

Signature of Investigator or Designee _____
(circle one)

Date: / / Time: AM/PM

I agree to have the therapy sessions that are a part of this research project audiotaped.

Signature of Subject: _____

APPENDIX B
Outline for Manual

I. Sessions

A. Session 1- Intake

1. Client Goals

2. Assessment

a) Current Symptoms

b) History of disorder

c) Treatment History and medications

d) Comorbidity

e) Strengths

3. Urgent Interfering Conditions

a) Suicide

b) Violence and self-injury

c) Psychosis

d) General Mental Status

e) Substance Abuse

4. Depression Severity

5. Risk of suicide review of medication use

6. Treatment Recommendations

7. Session summary

8. Feedback from client

9. Homework

B. Session 2- Understanding Depression

1. Monitoring of Current Status

2. Agenda

3. Review of Homework

4. Concept and Skills

a) Psychoeducation

b) The nature of negativity

c) Awareness of the Symptoms

d) Recognizing Negativity

e) Building Cases

5. Good Moods

a) Skill Building

b) Action Building

6. Steps in Activity Monitoring

a) Write down activities on an hour-by-hour basis

b) Rate mastery and pleasure from 1 to 5

c) Rate the action quickly

7. Session Summary

8. Homework

a) Fill out action Schedule (See Appendix)

b) Read Session 2 in client manual

C. Session 3

1. Monitoring of Current Status

2. Agenda

a) Review client's understanding of action schedule

b) More in-depth discussion of action schedule

c) Complete Depression Questionnaire from manual

3. Review Homework

4. Concepts and Skills

a) Scheduling your day

b) Taking Action

c) Skill building and how to schedule actions

5. Session Summary

6. Feedback from Client

7. Homework Assignment

a) Schedule your actions for the day

b) Follow what is on schedule

c) Read session 3 in client manual

D. Session 4- Confronting Avoidance

1. Agenda setting
2. Review of Homework
3. Concepts and Skills
 - a) Understanding Avoidance
 - b) Action Reinforces Thoughts
 - c) Action as Commitment
 - d) Active vs. Reactive
4. Skill Building
 - a) Tips for taking action
5. Session Summary
6. Feedback from Client
7. Homework Assignment
 - a) Pick a task you have been avoiding
 - b) Break it down into steps; then do them
 - c) Fill out the tasks on action schedule
 - d) Read Session 4 in client manual

E. Session 5

1. Agenda Setting
2. Review of Homework

3. New Concepts and Skills

- a) Automatic Thoughts
- b) Skill Building- using the thought record

4. Session Summary

5. Feedback from Client

6. Homework Assignment

- a) Fill out at least one thought record a day (see attachments for thought record).
- b) Write a situation, the thought, and the type of error (e.g. jumping to conclusions, over generalization, or either/or thinking).

F. Session 6

1. Monitoring of Current Status

2. Agenda Setting

3. Review of Homework- review how client did with catching negative thoughts

4. New Skill- Changing the Circumstances vs. Choosing a Different Outlook – Skill building exercise- three questions

- a) What's the evidence that the thought is true?
- b) What is another way of looking at situation or thought?
- c) How bad are consequences?

5. Session Summary

6. Feedback from Client

7. Homework Assignment- complete one extended thought record each day- see attachments for form p. 81 manual

G. Session 7

- 1 Monitoring of Current Status
- 2 Agenda Status
- 3 Review of Homework
- 4 New Concepts and Skills- review thought/feeling connection
- 5 Skill building – notice patterns in thinking, identification of dysfunctional thoughts- id (noting and dropping thoughts)
- 6 Review the difference between emotional, cognitive and physical symptoms
- 7 Introduce Concept of Critical Incidents
- 8 Session Summary
- 9 Feedback from Clients
- 10 Homework Assignment- complete one extended thought record each day, practice noting and dropping thoughts

H. Session 8

1. Monitoring of Current Status
2. Agenda Setting
3. Review of homework
4. Review of Beliefs and negative thoughts

5. Review of Core beliefs and early learning
6. Skill building- find the belief, choose, take action, question belief, and clarify beliefs
7. Session Summary
8. Feedback from Clients
9. Homework- Do one extended thought record on a situation generated by client's central belief and practice noting and dropping thoughts

I. Session 9

1. Monitoring of Status
2. Agenda Setting
3. Review of homework
4. New Concepts and Skills
 - a) Points to keep in mind- overthinking, the mind has a self-limited
 - b) Capacity to process information
5. Skill Building- noting and replacing, good feelings
6. Session Summary
7. Feedback from Client
8. Homework- complete one thought record a day on a situation, practice noting self-talk (Overthinking), complete the program satisfaction questionnaire- see attachment for form

J. Session 10

1. Monitoring of Current Status
2. Agenda
3. Review of Homework
4. Evaluate Progress
5. Skill Building- Minimizing Relapse
6. Session Summary

APPENDIX C

Transcripts

Intake Session

Therapist- today we will be talking about a unique approach to therapy based on the use of a manual which has been proven to be successful in treating depression in university and research settings. We will begin with a review of the informed consent form, which will explain the study/approach to you and discuss your responsibilities.

Client- Okay

Therapist- The first thing we will go over is the informed consent form. The title of this study means that a proven method will be used; one that has helped many people in a university or research setting and will now be applied in a community mental health center. If you have any questions along the way, feel free to stop me.

The purpose of the study is to use a workbook which is based on Cognitive Therapy. Before we started the session, you said that you were somewhat familiar with Cognitive Therapy from earlier treatment that you received.

Client- A little. I participated in therapy at Penn years ago for a short time.

Therapist- What did you think about your previous therapy in regard to the result of the therapy, the content of therapy, your therapist?

Client- I never completed the previous therapy or any therapy. I didn't like my therapist.

He didn't respect my feelings. He didn't understand my problems or me. He just talked to me. He didn't even know what a shy bladder problem was. People don't respect poor people who don't have high school degrees. I want to hear about cognitive therapy. Why should I waste time talking about another therapist when you will only tell me that my time is over?

Therapist- Cognitive Therapy is a short term approach that deals with challenging negative thoughts and finding ways to make changes in your life to reduce your symptoms of depression and improve your quality of life. The reason that you are involved in this study is due to your volunteering to participate in the study to help reduce your depression that was diagnosed by the staff psychiatrist. You have experienced depression and related symptoms for approximately 5 years. This study will be overseen by the school where I am receiving my doctoral degree and will be overseen by a trained and experienced psychologist whose name appears on the informed consent form.

I am now going to go through what the procedures are. This is a first meeting where we will review the informed consent form, and discuss some of the causes of depression, review some concepts of Cognitive Therapy and have you complete certain forms.

Client- OK

Therapist- The first form is known as the Working Alliance Inventory. This form will measure how you feel that we are working together. Another form is known as the Quality of Life Form. We will look at how you view your quality of life and how it may

change throughout therapy. Every session you will also complete the Beck Depression form which will measure your level of depression. You will complete this form during every session.

We are going to take a few minutes now to talk about the features of depression. Some people may have a depressed mood, a loss of interest or pleasure in activities, and an irritable mood, a feeling of guilt, thoughts and fears of death. Some clients may have a sleep disturbance, weight loss or weight gain, symptoms of anxiety, low energy and inability to concentrate. A client with depression needs to meet at least 5 of these criteria.

Client- I definitely have problems sleeping. I have lost interest in activities and I feel guilty. I have gained weight and I feel anxious.

Therapist- I am going to continue discussing certain features of depression because education is an important part of our therapy. Depression may be caused by your physical make-up and it may be caused by negative thoughts and an overall negative view of yourself, your world and your future. Cognitive therapy focuses on your view of yourself, your environment and your future. We will also look at your view of the future

Cognitive therapy is attributed to the work of Aaron Beck and the author of this manual has written books with Dr. Beck. The main approach of cognitive therapy is to educate you and teach you concepts and skills that you can use to help you manage and hopefully reduce your depression.

Client-That makes sense.

Therapist- Cognitive therapy is a general treatment approach that has been used successfully to help people overcome depression. The symptoms that we will focus on first are the behavior symptoms. When clients become depressed they become inactive and withdrawn from others. We will work on encouraging you to keep track of your activities and increase them over time.

Client- I definitely don't want to do anything.

Therapist- We will then work on your negative emotions or feelings. These negative feelings can affect and maintain your depression. The third area we will address is the how you think about certain things. These errors in thinking may make you feel depressed. We will use certain forms during our therapy to keep track of your activities and your thoughts.

Let's take a few minutes to talk about the research. Cognitive therapy has been proven to help people reduce their depressive symptoms. Your treatment will last for 12 sessions.

During the next session we will talk about what you think causes your depression. It is helpful for me to learn about the history of your depression; how your depression affects your ability to function, prior treatment you have been receiving, your coping strategies, and the medications that you take or have taken. This information will help me in developing a treatment plan. Homework is also an important part of therapy. This will help me in understanding your activities and eventually your thoughts. It will also help you to practice some of the new skills we have learned. Next week we will start the first

session

Client- I am looking forward to this. This sounds like a good approach.

Session 1

Therapist- How are you doing today?

Client- Not great. I am worried that I didn't use a number 2 pencil to complete the forms.

Therapist- That is ok because they will not be scored by a computer

Client- I didn't finish all the questions on the Quality of Life form. My neighborhood isn't a problem that affects my quality of life.

Therapist- That's okay, it's important to do the best that you can.

Are there any problems that affect your quality of life based on your neighborhood

Client- Well my neighborhood doesn't have a lot to do. It doesn't have a pub with music to go to.

Therapist- You did a really good job. Thank you, with the forms. Did you get a chance to look at the manual? Any thought about the manual?

Client- I think that it looks very logical

Therapist- Well, there are certain forms that you will receive during every session and some that you will receive only during certain sessions. The Beck Depression Inventory, BDI, will be completed at each session to measure your level of depression and to monitor for any changes. Now I will give you a few minutes to complete the BDI and the Working Alliance. The Working Alliance is used to measure how you feel that we are working together and if this approach to therapy affects our relationship. That is what we

are going to do now.

Okay, We are going to talk about areas of depression and your goals for therapy. What do you think are the major reasons that brought you to therapy?

Client- I think that I got depressed about six years ago when my mother's health got worse and I needed to stay home and take care of her. It just became a very difficult time for me. I felt powerless about my mother's ailing health and I felt out of control.

Therapist- You think that your mother's ailing health was one of the triggers that brought on your depression. What do you think caused you to seek therapy to help with your depression?

Client-Actually, a friend recommended that I get therapy for my depression.

Therapist –Okay, it is helpful to get a background about your depression and what brought you to therapy

Client- I was also angry.

Therapist- You were angry? Angry at being depressed?

Client- No my life's situations, there was a lot of frustration. I was going through an angry phase, so I started therapy. The anger was not directed at anyone. It was more that I was angry with myself.

Therapist- That is helpful information. One thing we will be doing throughout your therapy is to set goals concerning therapy. What do you hope is the outcome or what do you hope you will get out of therapy?

Client- I hope to get better so that I can work things out so that I am not so insecure and as depressed as I am right now. But I am not sure that anything can really help.

Therapist- Well, we will work together to try to help you to find new ways to manage your depression. Also, are there any other significant events in addition to your mom's illness that may have triggered your depression or any other concerns that you have?

Client- Well I lost my job in medical sales. I was spending too much time at home. I then gave up my career. I am depressed about this. I don't know what to do to make a living.

Therapist- Let's talk about your symptoms. What symptoms are bothering you?

Client- Well, my sleep is messed up. I sleep all day and I don't have time to do anything else. I would like to look for another part time job. It is hard because it is my job that is wreaking havoc on my sleep. There is a certain feeling of hopelessness right now since my job doesn't pay enough money and I feel hopeless.

Therapist- Are there any specific times when you feel hopeless or down? When do you feel hopeless?

Client- Sometimes when I am in the apartment and Loretta isn't home, I feel hopeless and feel that I should be doing something more than just being home.

Therapist- What certain situations trigger this? Is it when you are home and Loretta is at work?

Client- Yes.

Therapist- Are there any other times?

Client- I can't relax since I know that I wouldn't be able to take on another job. It feels that I can't defeat my own demons.

Therapist- The symptoms you described, do they prevent you from going anywhere?

Client- I try to avoid crowds, I don't go places with a crowded bathroom, and it is a social phobia. I am afraid that I won't be able to go to the bathroom. That is why I avoid certain situations.

Therapist- we are going to switch gears now. When do you think your symptoms first began?

Client- I'd say about 1999.

Therapist- What can you remember specifically about that time? Did anything bring your symptoms on?

Client- I had a job selling cars. I felt that I was close to doing the job. After 11 weeks of training they let me go. I couldn't manage to keep a job and that brought on a lot of sad feelings.

Therapist- Did that bring on the depression? Do you think that your depression has changed at all?

Client- Yes; that brought on the depression and it has changed a lot.

Therapist- How do you think it has changed?

Client- Well, um, I'm depressed most of the time. I have a feeling of hopelessness since I can't overcome personal problems. I feel like that I am not motivated. I have lost my

motivation. What ever I do it will come back to embarrass me. I think about losing the job.

Therapist- How have your symptoms changed from the original onset?

Client- When it started I didn't feel as hopeless as I do know. I feel that whatever I will do I will fail at it.

Therapist- Why do you think your symptoms have changed?

Client- Because I am experiencing a broader spectrum of negative feelings. Before I thought that it was just one job and I will be all right. Now I think that I will fail at everything.

Therapist- Do you have a theory about when your symptoms began?

Client- My theory is that I had difficulties in a job in sales, I wasn't selling a lot. Then I took a job. I was selling coffee and they got rid of me after 11 weeks. That was depressing. Then my mother having Alzheimer's that was depressing. Then having to fight with my family over her guardianship, that was also depressing.

Therapist- How do your symptoms interfere with your daily functioning?

Client- Well, I don't feel motivated to go look for a job. I might see something in the paper maybe a salesperson at a car dealership. I just think negative thoughts. I wouldn't be able to go to the bathroom. I don't have the right clothes, I wouldn't be properly attired. My lack of computer skills. They will get rid of me. That is all depressing.

Therapist- Let's talk about your family history for a second. Does anyone in your family

have a history of mental health issues?

Client- My sister has a problem with her nerves. Her hair falls out in clumps. She takes xanax.

Therapist- Does anyone in your family have similar symptoms to you?

Client- For the most part they are well adjusted. They are all doing pretty good for themselves. It is just my sister. Even though others have had divorces. They seem to be able to take good care of themselves.

Therapist- Ok let's switch gears again and talk about your treatment history.

Have you or are you taking medication?

Client- I take Wellbutrin XL once a day, and klonopin, and xyprena (xyprena)

Therapist- Does your medication help you and have other medications helped you?

Client- My medication helps me to sleep. I don't remember the other medications
The Wellbutrin helps with my depression. Antidepressants in the past didn't work very well.

Therapist- Have you received psychotherapy before?

Client- Just talk therapy.

Therapist- What other ways have you tried to treat your symptoms?

Client- Um, Well I try to rationalize my fears and realize that people are not paying as much attention to me as I think they are. I am a little paranoid. I am too sensitive to other people's comments. I have missed opportunities due to my psychological problems and I

can't deal with people.

Therapist- We are going to talk about co-morbidity, which is when you have more, that one diagnosis. This is very common with depression. Is there anything else that you are suffering with, like anxiety or panic attacks?

Client- I have a lot of anxiety. I check things to make sure. I have a list. I check things many times. It's like obsessive-compulsive things. I check the coffee pot a lot of times.

Therapist- Do you feel anxious in social situations?

Client- I feel anxious at work.

Therapist Do you think that any other conditions play a role in your depression?

Client- I don't know, it is hard to say. Just the anxiety. Nothing else I can think of now

Therapist- You did say that you have compulsive behaviors of checking things.

Do you have any other compulsive behaviors like gambling?

Client- No, I don't drink alcohol or take any illegal drugs.

Therapist- We are going to talk about your strengths, your coping skills and your support systems. What do you think that you bring to treatment? Do you think that you are a strong person?

Client- I think I am a strong person. I do have my problems.

Therapist- Do you think that you are a sensitive person?

Client- Yes

Therapist- Do people tend to lean on you in the past?

Client- No not really, only just my mother.

Therapist- Would you say that you are assertive?

Client- I can be.

Therapist- Do you have a trusted person to talk to.

Client- I have you to talk to. But not really a friend outside of therapy.

Therapist- How about your girlfriend?

Client- We are not on the same wavelength.

Therapist- Do you have people who trust you?

Client- Yes my family trusts me. I am a good visitor with my mother. They trust me with my mother

Therapist- Have you ever had any thoughts of killing yourself?

Client- Yes, I have had thoughts of killing myself. I don't think that I would carry them out though.

Therapist- Do you have problems with daily tasks?

Client- Yes I do, I have problems concentrating. I have problems with my sleep. I'm grateful for the drugs. Sleep is good for your soul. I slept today till 12pm.

Therapist- Have your eating patterns changed?

Client- I am hungrier, it may be from the medicine. I have gained 15 pounds.

Therapist- Have you ever attempted suicide?

Client- No.

Therapist- Are you ever afraid that your family or friends will hurt you.

Client- I am afraid that my family will say things that will hurt me.

Therapist- Have you ever hurt yourself deliberately?

Client- Um, Not deliberately but I have hurt myself.

Therapist- How have you hurt yourself?

Client- I don't want to answer that.

Therapist- You said that it wasn't deliberate. Was it an accident?

Client- Yes

Therapist- If you want to talk about this at a later time feel free to bring it up.

We are going to talk about cognitive therapy and how it looks at how you view yourself, your world and your future. When someone is depressed he is more likely to have low self-esteem. We are going to go back to another topic. Do you ever think that people are talking about you?

Client- Yes

Therapist- Do you ever receive any special messages?

Client- Like my girlfriend and her mother talk about us getting married. I have never discussed marriage with her. There are people talking about me.

Therapist- Do people go out of their way to cause you problems?

Client- No

Therapist- Do you have any special powers?

Client- Yes

Therapist- Can you hear things that others can't or see things.

Client- I see things with certain clarity that others don't. I knew Loretta's sister wouldn't be happy or her mother.

Therapist- Well, you are talking about insight. Have you had any drinks in the past week or do you ever get drunk?

Client- No

Therapist- Let's talk about the severity of the depression. Are there times when the depression feels worse?

Client- I feel depressed when I see Loretta come home from work, I feel depressed about the relationship.

Therapist- Are there times when you feel more depressed in a day?

Client- I feel depressed at work. It is bad before we go to work. It doesn't get better at work. It only gets a little better when it is time to go home.

Therapist- Have you had a physical lately?

Client- No, I haven't had a physical in years. I just can't afford it.

Therapist- So you don't know when you may get a physical

Client- No

Therapist- When do you feel most depressed?

Client- I feel depressed concerning work and in social situations. I didn't go to a family

reunion because I was scared.

Therapist- Do you think you would be avoiding social situations if you were not depressed?

Client- No

Therapist- Are there any other things that depression may be keeping you from doing?

Client- I am not only depressed, I am broke. Exercise seems to be the only thing that helps with my depression but I can't find the time.

Therapist- We are going to switch gears again and talk about cognitive therapy. It is clear from the diagnosis that you are suffering from depression and are also affected by anxiety, which is common with depression. Depression is often looked upon as a cognitive distortion. You may tell yourself that you can't do something; it may not be totally factual; that is why we call it a distortion. Your interpretation and thoughts may be clouded by the depression. You may also have automatic thoughts that are affected by your depression. You may feel hopeless and think that you can't do anything. You may have problems concentrating; have sleep problems, loss of energy, and loss of interest in activities. That is how some people describe depression that way.

Client- That sounds just like me.

Therapist- One thing that is written in the literature is that cognitive therapy is an effective form of therapy in treating depression. Cognitive pertains to thoughts, behavior pertains to actions. We will be working on both areas. This approach has proven effective

in treating depression but as we have discussed, it does require a lot of work. In future sessions we will be focusing on education about cognitive therapy and depression. We will concentrate on your activities and hopefully work on increasing your activities. As you said, exercise helps you. We will also look at your thoughts in future sessions. That is pretty much what we will be doing today.

Client- That sounds good.

Therapy- We will work on your activities during the early sessions and in later sessions we are going to look at your thoughts. I need you to read session one of the manual for your homework and bring any questions and concerns with you. I want to take time now to see if you have any questions and concerns and ask you if any areas of the therapy have been helpful and if any areas have not been helpful.

Client- All right, I don't have any questions. I think the structured approach is helpful.

There isn't anything that has been not helpful

Session 2

Therapist- Are there any concerns or issues that have come up since the preceding session?

Client- The therapy session was fine but I feel like I am back in school again. I am also having problems with Loretta since she wants me to move with her to her mother's.

Therapist- What did you tell her?

Client- I told her Okay, even though I don't want to. I have no choice.

Therapist- During the course of this therapy we will be discussing that depressed people often feel hopeless. I also hope that the use of the action schedule and this program will help you in making good choices for your life so that you don't feel hopeless.

Client- I hope so because I do feel hopeless.

Therapist- That was helpful, getting an update from you. Your comments are helpful. We will cover the nature of negativity and depression so that clients can begin to correct mistaken attributions about your symptoms. You will also learn to use the action schedule before you leave the session today.

Client- I hope that it isn't too much work but I will give it a try.

Therapist- Okay we are going to talk a little more about the concept of negativity. When you are depressed, you may attribute your symptoms to yourself rather than to your state of mind. In this session, we are going to work on learning that the true culprit of depression is negativity, which involves your mood and state of mind. NOT YOU? When you are depressed you may become negative. This creates a negative feedback loop or vicious cycle when you become more depressed about being depressed and about being negative. Negativity makes sense if you look at it as a response to frustration and the constraints of depression.

Client- I do constantly think negative thoughts and I do feel bad that I don't think any positive thoughts.

Therapist- Well, the first step to getting out of depression is to accept that you do have and will have negative thoughts. That is part of depression

Client- I feel better that you are giving me permission to think negative thoughts.

Therapist- In a way negative thoughts are a symptom of depression. It is not necessarily bad because it serves a function. Acceptance of your negative state of mind is the first step.

Client- I feel guilty about being so negative.

Therapist- Negative thoughts are an automatic part of how you think when you are depressed. You can look at it in a way that a negative switch is turned on and a positive switch is automatically turned off.

Client- I feel a little better with your explanation.

Therapist- You can also look at it in a way that things are reversed in your life from being positive to being negative when you are depressed. Your body may be telling you that you can't do things or you may feel that you don't have the energy or interest to do things.

Client- I don't want to do anything. I also feel that I don't do anything.

Therapist- Well we will address that belief when we start working on the action schedule in this session. Just to conclude the discussion of being negative, when people are depressed they have plenty reasons to feel bad. To get un depressed, you need good reasons to feel different or to feel good.

Client- That makes sense. I don't feel that I have any reasons to feel good.

Therapist- We are going to use two basic tools to fight depression – the action schedule and the thought record. Now let's talk about the action schedule. First you will write down the activities on an hour-by-hour basis. You will then write an M for Mastery or P for Pleasure. Mastery relates to your sense of accomplishment. A low score means little effort, a moderate score (3) means little effort and a high score (5) means greater effort. Pleasure relates to your sense of enjoyment. 0 relates to little enjoyment, (3) relates to moderate enjoyment, and (5) relates to a high level of enjoyment. It is better to record the activity and the mastery and pleasure score soon after the occurrence since it may be difficult to remember at a later time. It is important that you do this task. Many depressed people feel better when they are active and this will show you that you may be accomplishing more in a day and in a week than you imagined. Completion of this form will also show your commitment to the program.

Client- That sounds okay.

Therapist- Now, let's take a few minutes to review what we covered in today's session. Remember that you are always doing something. Unfortunately, depressed people often feel that they are not doing anything so the action schedule is helpful. Remember that you don't need to include all of your activities in the schedule. Include as many activities that fit into the box, we spoke about the effect of negativity of depression. The goal was to help you to begin to correct mistaken attributions about your symptoms. We also learned

how to use the action schedule, which is your homework for the week. It would also be helpful if you review this session in the manual.

Client- That sounds like a plan that I can accomplish. I think that the negativity discussion was helpful in me understanding my depression.

Therapist- I'm glad that was helpful. I'll see you next week.

(Prior to taping the session the client stated that he was uncomfortable with the form since the form did not include time for his night work hours)

Session 3

Therapist- Overall how are you doing and how are you doing with the homework?

Client- I'm doing all right. The problem is that my days are somewhat redundant. I go to sleep, visit my mother. I feel stupid writing it down.

Therapist- Why do you feel stupid writing it down? Maybe we can make some changes.

Client- If social security gets a hold of this it could ruin my social security claim.

Therapist- It isn't going to be shown to social security. This won't go in your file. When it comes to changing the hours we, can change the form. What time do you start working?

Client- I start working at 12 pm.

Therapist- We could change the hours of the form or you could add your work hours at the bottom of the form. What do you think works best for you?

Client- Okay, I don't know if I should get some white out. Don't mind me, my tongue

feels like a swollen fish. This is so hard.

Therapist- We could pick different hours? What time does your day start? You could start your day at 12pm. The purpose of the schedule is to keep track of your schedule and to measure what you enjoy and how you feel your mastering it. It seems easier just to add your work hours at the bottom of the day. Your schedule does reflect a number of activities including exercise, eating breakfast and visiting your mother.

Client- Okay

Therapist- Do what ever is more comfortable for you. It seems that you want to show your work.

Client-Yes it does show a degree of mastery and pleasure.

Therapist- Okay, why don't we write the interval of time that you work at the bottom of the sheet?

Client- Okay, that sounds confusing but I think that I can do it.

Therapist- Do you have the BDI with you for the week? You will need to do a new BDI and a working alliance inventory

Client- Okay, Yes I did it

Therapist- Are you okay with the assignments? Are you finding the homework overwhelming?

Client- Yes. It is manageable. I just don't feel like having homework.

Therapist- Were there any significant concerns or issues that have come up since the

previous session?

Client- no

Therapist- Are there any significant concerns in your life?

Client- I am worried about my mother but nothing has changed.

Therapist- I know that your mother's health and emotional state must be very worrisome for you.

Client- It is.

Therapist- We are going to set the agenda for our session. This is something that we will do in every session. In the last session, we spoke about the action schedule. How did you do with the action schedule?

Client- I think that I did a good job, but like I told you it reminds me of homework.

Therapist- It is homework. But is an important skill to help you to keep track of your activities. In this schedule we will continue working on using the action schedule. The action schedule is used to help you shift out of your negative patterns by taking positive constructive steps. Before we review the homework, Will you please complete the BDI?

Client- Okay

Therapist- Now we will review the homework. Homework is an important part of the therapy session. It is a way for you to practice important skills that we learned in therapy. I am very proud of you for doing your homework. This should help you in practicing the skills that we have learned.

Client- It wasn't easy. I want to get better.

Therapist- I can see that from your hard work. You did a good a good job with your action schedule and rating your level of mastery and pleasure. Do you see that your level of activity is greater than you predicted?

Client- I was surprised with my level of activity. You remember I thought that I did nothing but go to my part time job and visit my mother. I also see Loretta doing many more things than I thought. She goes to work, visits her mother and watches soap operas. This helps me to put things into perspective when it comes to her.

Therapist- That is good. Now you are able to use the tool and apply it to Loretta. You are gaining a greater perspective of what Loretta does. It is sort of an added benefit.

Client- Yes.

Therapist- Now let's look at your action schedule. You did a good job in rating your level of mastery and pleasure concerning exercise, making breakfast and visiting your mother.

Client- Yes, I can see that exercise is enjoyable.

Therapist- Do you see any effect on your level of depression?

Client- Yes, I do. I also feel less depressed when I exercise. Sometimes I don't want to stop.

Therapist- If you were to add the interval of time for working, how would you rate it?

Client- For mastery, it is extremely hard to get there. I get moderate pleasure there. I would give it a 5 for mastery and a 3 for pleasure.

Therapist- You should add your work each work day. You did a really good job. I can see that you put a lot of effort toward this. How does it make you feel?

Client- I think that it is a very thorough way of evaluating your actions. It is definitely helpful. It is unfortunate that I have this little throat problem or I would have written more.

Therapist- You don't need to write every hour of the day. That is why this is an important tool and activity. We are now going to spend time on the psychoeducation part of our session as we did last week. We will discuss scheduling your day. Some clients feel that they see little point in keeping track of their actions. But you have already seen that the action schedule is helpful by demonstrating your level of activity. It is also helpful in overcoming anxiety, despondency and other emotions. We can use this tool when you experience different levels of emotions. The action schedule is a tool that you can use to record the severity of your symptoms and utilize it to pinpoint the times that you are likely to have symptoms. Constructive actions are one of the best ways to shift away from negative thoughts and reduce your depression.

Client- I do feel better when I am doing things. I even feel better after I reviewing the activity schedule for last week. Since, I can see that I do a lot more than I thought. I am finding the book very interesting. I see how it works.

Therapist- That's great. Now let's talk about taking actions. In the prior session we spoke about negativity. One way of shifting from negativity to positive thoughts is by doing

things. The common trigger of depression is a major disappointment in your life.

Disappointment can stop you from taking actions. The clients who have said that have personally given up.

Client- I can see that I feel better when I do things. I also see how disappointments affect my life and worsen my depression. That describes me. After I lost my sales job I gave up on myself.

Therapist- That is wonderful insight. It is also important for you to know that you have little to do with negative events in your life. You do have a choice about how you think about it and how you face it.

Client- I can see that.

Therapist- I wanted to take a minute and {talk} about why it is important to take constructive actions when you are depressed. Can you think of any good reasons?

Client- Well, I feel better when I do things.

Therapist- That is an excellent response. Actions often help you feel better. It is important that you choose actions to meet your needs. For example, if you are feeling lonely it may be helpful to schedule time with other people instead of staying alone in your house. It is important to schedule actions that will help serve as a relief from your symptoms.

Remember, you may not feel motivated to take actions until you do something. That is one of the hardest parts of depression. Your body is telling you to avoid actions. The best thing for you to do is to do things. This is also important to acknowledge that all actions

are not your doing. The only thing that you can control is your thoughts. Do you think, for example, that when things didn't work out and the only thing that was in your control was your thoughts.

Client- Yes. When I was fired from my sales job, I felt that I was incompetent, discouraged and ultimately gave up. I guess that I could have said that I could explore other areas. This was when the job wasn't everything.

Therapist- That is excellent thinking.

Client- I know what you mean. I am often afraid to be around other people. I rather sleep.

Therapist- That makes sense when you are depressed. Let's take a few minutes and review the session; make some suggestions about how to better work on the activity schedule and see if you have any questions about the session and the homework assignment. I'm glad that you brought up your concerns about the actions schedule concerning your work hours. I have some suggestions. It is helpful to schedule one or two days at a time rather than the whole week. It is important to be flexible with your scheduling. If an unexpected event comes up, you can make alternative plans. If you don't do the scheduled action, it is not necessary to make up what you missed. It is also okay to finish an action earlier than you planned. It is also important as a general rule to not lie down when you are depressed. It will only make you more tired and depressed.

Client- These are all helpful suggestions.

Therapist- Now let's take a few minutes and summarize the suggestions. We have

examined the value of getting active in the face of depression. We spoke about ways to address the action schedule in different and new ways. The action schedule may be helpful in reviewing your actions so that you can make better decisions about activities that are more challenging or pleasurable for you. Any feedback or comments about the session?

Client- I am enjoying this approach and the manual. I can't tell you that I like doing homework. I have a busy life and I really don't have time. But I am going to give it a try.

Therapist- I appreciate your feedback and honesty. Your homework assignment for next week will be to schedule your actions for that day. Read session 3 in the client manual. I look forward to seeing you next week.

Session 4

Therapist- Overall how are you doing, and how are you doing with the homework?

Client- I'm doing all right. But days are somewhat redundant. I get up, go to work, and visit my mother. I feel stupid writing it down.

Therapist- Why do you think it is stupid writing it down?

Client- I just write the same thing down each day. Maybe it is more interesting to write things down on days when things are more interesting. For example, when I spoke to the lawyer about not getting my social security and he spoke to me about switching over to a different kind of medical disability.

Therapist – I wouldn't worry about making it different or interesting for me. Most people do the same things each day. The first thing that I need you to do today is to complete the BDI.

Client- Didn't I just do that?

Therapist- Even though the forms may seem repetitious, it is important to keep track of your level of depression.

Client- Okay, I'll do it if it is important.

Therapist-. During this session, we will be discussing the concept of avoidance, which is at the heart, or foundation of depression. Depressed clients usually find themselves failing to keep or follow through on agreements and often have several big projects that they are avoiding. Avoidance is a big part of depression. This avoidance can make depressed clients believe that they have lost the ability to get things done. This often affects the individual's self-esteem. In this session, you will learn how to attack bigger jobs in a systematic way. In the previous session, the focus was on taking actions in general. In this session, we will stress taking action on what clients have been avoiding. We will continue on working on the action schedule.

Client- This sounds like an important topic for me. I often avoid things and then I don't feel good about myself.

Therapist- Now that you have finished the BDI measure, we will review your homework. How did you do with the scheduling activities and measuring your pleasure and mastery

of the activity?

Client- I did ok with the activity. It's tough. A nurse at the nursing home burned to death while driving to work.

Therapist- That's horrible. I'm sorry to hear that. It is important to remember that when you are depressed, simple tasks may require more mastery than when you are feeling well. Let's take a few minutes and look at your schedule. There are certain things that you experienced pleasure {in}, like watching TV and visiting your mom. There are some areas that you gave a lower level of pleasure. Like working in the mailroom. That is to be expected. There are areas of mastery that you included. Like visiting your mom. That isn't an easy activity. You did a really good job. It is good to see that you are experiencing pleasure with a number of your activities. You didn't avoid activities. I noticed that you didn't add the work time that was important to you. Is there any reason?

Client- No.

Therapist- I know that the work is important to you.

Client- My boss gave me compliments and gave me more responsibilities even though it didn't include a raise. She gave me a higher title. I guess for being there. There is some mastery there.

Therapist- That's great. Did that give you a degree of pleasure when that happened? That may be a good reason to add work on your schedule

Client- Yes, It made me feel good.

Therapist- Now, that's great. Now let's go on. As in all sessions, we will spend time on the psychoeducation section. We will work on understanding avoidance. Some people may tell you to just take on responsibilities that you avoid. You may feel disappointed that you avoid certain activities. It is important for you and others to understand that there is a great deal of difficulty on taking on certain activities. Why do you think that you avoid certain activities?

Client- It doesn't matter. Why bother doing things? I avoid going to bathroom in public.

Therapist- Can you think of any other things that you are avoiding?

Client- I am avoiding getting a full time job because I am afraid of going to the bathroom.

Therapist- Why do you think that you do that?

Client- I guess that I am embarrassed.

Therapist- It is also important to look at your thoughts. That is the one thing that you can control. Do you think that it would be helpful or make you feel better not to have a certain task hanging over your head?

Client- I guess so, but I still don't want to do it.

Therapist- What is the most compelling reason for avoiding an activity?

Client- I can't go to the bathroom in public. I don't want to embarrass myself.

Therapist- Why don't we take a second a talk about the power of negative thinking? This will help you in not blaming yourself for any failure to overcome a specific avoidance. It is helpful if you understand that when you are not depressed and are simply

procrastinating, it's good advice to get yourself in and get things done. But when you're depressed, it's more complicated than this. Most people don't understand why, when you're depressed, you put off important tasks. The reasons are that you think you won't do an adequate job or that you won't get enjoyment or satisfaction out of doing things. These negative thoughts can be powerful and can stop you from trying anything. They can stop you from enjoying or getting satisfaction from the activity even if you can eventually get yourself to do it.

Client- I do have a negative tape in mind. It goes on and on with negative scenarios. This causes my depression

Therapist- Right.

Client- I need to replace them with more positive thoughts.

Therapist- Very good. I want to take a few minutes to give you some suggestions about why taking action is important. Taking action helps people move forward. Then you gain mastery. By doing something you feel a sense of accomplishment. You feel better. It is important to take action and program yourself for the experiences that you want to achieve. Action is the key. And when you take action, like when you talked about a tape. Action helps you send yourself a message. You are also building evidence. When I go to work and do a good job, you then see that your boss notices and rewards you. Taking action also proves to your mind that you are serious about making changes. You will also gain insight. Can you think of an example of gaining insight? Remember last week when

you said that anyone could do the job but now you see that you do the job better than others and you have a good work ethic. Do you think that it shows anything else to your boss?

Client- It shows that I am sincere and I work hard. I don't ask for extra days off.

Therapist- That is really good insight that you have gained. You now see that you are doing a really good job. This contradicts your previous belief that anyone can do your job. Another important point is that action is related to motivation. It strengthens motivation and makes you feel better. Taking action also increases your focus. You will feel better and have more energy. When people are passive and don't do things they have less energy.

Client- Right. It is changing from a negative cycle to a positive cycle.

Therapist- That is good work. Taking action also helps reduce your depression. We have covered the importance of taking action which helps increase your energy and helps reduce depression. Action also reinforces certain kinds of thoughts. What kinds of thoughts?

Client- It reinforces that I am a good person who is motivated. Someone who gets the job done and enjoys accomplishments. I get satisfaction and feel better.

Therapist- Taking action is not just a temporary thing. It helps you stay less depressed and hopefully be un-depressed. Taking action also requires a commitment. Taking action shows a degree of commitment. It changes the negative framework to a positive

framework. Instead of saying should have, could have, you say- I did it.

Client- Okay.

Therapist- Another term is talking about a shift from reactive to active. You shift from being a victim to an active actor in your life. You may want to try to move in this direction. It doesn't mean that you are expected to do everything. It is important that you can look back on your week and say, "I did this and I enjoyed and mastered certain things."

Client- I need to schedule activities around work. It is hard since I want to sleep since I work hard hours.

Therapist- You definitely have a hard schedule. Another tip is to take a stand. This helps avoid procrastination. You will gain your own approval and increase your self-esteem by doing things. Another suggestion is to surprise yourself. You may feel good that you did something new and that you could do it and enjoy it. This answers your concern about having the same schedule each week. Change with depression usually comes in steps. Take the easiest step first.

Client- I am taking the easiest step by going to work and just doing what they want me to do.

Therapist- Let me give you an example. If you needed to go to the doctor, a first step may be to look up the doctor's phone number. A second step may be to call the doctor. Now let's summarize the session. In this session, we talked about overcoming avoidance. You

learned in the past session about the importance of being active. Now you need to approach things you've specifically been avoiding. The reason it's important to face your avoidance and to refute the feeling of being helpless. If there is a job that you think is to overwhelming and you are avoiding it, you are feeding into your feelings of hopelessness. Approaching tasks you are avoiding helps you deal with these thoughts. You will feel stronger and increase your self-esteem

Therapist – Any comments

Client- No, this makes sense

Therapist- Ok, now let's talk about your homework. You will need to pick a task that you have been avoiding. You should break it down into steps and then do it. Fill out the tasks you want to accomplish on this week's schedule. You should also read session 4 in the client manual.

Session 5

Therapist- In today's session, we will begin by having you complete the BDI and the Working Alliance Form.

Client- Okay.

Therapist- Just to touch base with you since last session, how are things going with you?

Client- I am paying the bills and hanging in there. I'm grateful for that. But I haven't been feeling well.

Therapist- Hanging in is an important part of dealing with life and depression.

Client- I'm still taking my medicine, Wellbutrin. I guess it helps.

Therapist- It is also hard to tell if it is working when you don't feel well.

Client- My throat is hurting me and I am still taking penicillin.

Therapist- Just to give you an overview of what we are going to talk about today: our agenda will focus on negative automatic thoughts and the connection between negative automatic thoughts and depression. We are also going to learn about a new form known as the Thought Record and we are going to practice completing one in the session today. This form will be used to track and write down your automatic thoughts. The book shows examples. You don't have to complete the form exactly like the book but the completed form in the book gives you a good idea how to complete the form when you are at home. A big part of our therapy is for you to take the tools and use them yourself outside of the sessions at home. After we review the homework from last session, we will also review the status of your depressive symptoms. Do you have any questions?

Client- What was my homework?

Therapist- Your homework was to work on the activity schedule in a different way?

Client- I didn't do it because I forgot and I wasn't feeling well.

Therapist- You were supposed to pick a task that you were avoiding and break it down in different steps by using the activity schedule. Last week we spoke about an example where someone needed to go to the dentist. They may look up the phone number, then

call the dentist, and make a practice drive, schedule an appointment and then attend the appointment. You have been doing a very good job with your homework. Since you haven't been feeling well, we can work on the homework together in the session. In the previous session, you had suggested that you would work on the tasks of avoiding applying for a job or avoiding the use of public bathrooms.

Client- How about changing jobs?

Therapist- That sounds good. Okay we will work on this later. How do you feel about the procrastination of tasks in your life? For example, how have you done with tackling the task of getting a new job?

Client- Well, I looked at the classified ads. I didn't really see anything. In really, I see myself trying to get a job and getting discouraged because of my short comings including having a poor wardrobe, not having the appearance of being a successful business person and not having references. When I think about these things, I get discouraged because it will end up with a negative result.

Therapist- Okay. Just the topic of changing jobs is a good example of procrastination. If you were to break it down into steps, like looking in the classified section. That was a good first step. What then happened was a negative automatic thought came to you. You automatically thought that you couldn't get a job because you didn't have a wardrobe and references. What do you think that these thoughts lead to?

Client- It leads to procrastination.

Therapist- And what did the procrastination lead to?

Client- I guess it made me feel bad and I got more depressed.

Therapist- This is a good example that will help you learn about automatic thoughts. I would like you to take this task of getting a job and break it down into more steps. Your first step of looking at the classified ads is a good first step. This assignment will help you with the other assignment of using the thought record to keep track of automatic thoughts. Can you think of other approaches that you have used in the past?

Client- I looked in different areas not just in medical sales.

Therapist- Those are good steps of breaking down your search into parts. Can you think of other steps?

Client- I have worked with recruiters and job coaches in helping me with my resume.

Therapist- So you could reconnect with these people. These are all good things. Why don't we move on now to automatic thoughts? Very often when people experience negative emotions this is often related to automatic thoughts, which can lead to increased feelings of depression. When thoughts are automatic it's because they come to use quickly. So one of the most common feelings people have are feelings of despair or hopelessness. Sometimes people may feel sensations in their bodies or feelings of anger, despair, and /or hopelessness. Everyone experiences depression differently but they are usually related to negative automatic thoughts. There is a real connection between what we feel and what we think. Very often if a person thinks that they have lost something

valuable like not being able to get a job, they feel sad or depressed. Very often what happens to depressed clients is that they jump to negative conclusions about their future, which is what you were getting to. I didn't have the right references or wardrobe so a negative outcome would occur, which is I wouldn't get the job. A person may over-generalize or jump to a negative conclusion. A person may personalize things and this negative feedback makes the person feel worse. In the next session we will continue to work on this. You will continue to explore your feelings and thoughts. The bad news is the more someone gets depressed the louder these negative thoughts get. The more negative one thinks, the more depressed one gets. It is sort of like painting a bad picture.

Client- Right

Therapist- The good news is that you will learn to recognize your negative thoughts so that you will become less depressed. So, tell me what you are thinking right now.

Client- I am trying to grasp these concepts. I can see that negative thoughts lead to my depression. I probably avoid applying for certain jobs because I want to avoid failures. I know that I can go out there and do a good job for someone.

Therapist- That is a good positive thought to introduce when you are feeling depressed. You will hopefully feel less hopeless. Do you know how these thoughts popped up when you were not depressed?

Client- These thoughts were stored in a box in my mind. They were recollections of past failures, past losses etc.

Therapist- Let's talk more about how to use the thought record. Let me show you a sample one and a blank one. Let's just talk about the concept behind it. Usually thoughts, situations and beliefs lead to negative thoughts. The thought record will help you to record your thoughts. Even though your thoughts may have some truth to them, they also contain distortions. Like before, you were able to change your negative thoughts to a positive statement about your belief that you could do a good job. If you were able to overcome these thoughts with more adaptive ones, you can ask yourself what you have to lose.

Client- I think that it is doable.

Therapist- The expectation is to catch yourself when you experience negative thoughts. Unfortunately, negative thoughts lead to overgeneralization. You may blame yourself for the mistake. Instead of looking at other areas as you suggested by looking at other part-time(??) areas of the want ads. Trying to come up with steps. It doesn't happen overnight. Let's look at the thought record and consider the situation.

Client- I was looking at the want ads

Therapist- What feelings did you notice when you were reading the want ads?

Client- I was feeling apathetic and angry.

Therapist- I also want you to rate the level of how you felt from 1-10, for example, in the case of anger with a 10 being the most severe level of anger. You would also identify your automatic thought and identify the thinking error. Ask yourself, "Am I engaging in a

thinking error involving overgeneralization, either or thinking, etc?" Usually negative automatic thoughts involve thinking errors.

Client- I need a new briefcase, a few new suits or I can't get a job

Therapist- Could you be overgeneralizing or using "either or" thinking?

Client- I guess I could.

Therapist- You will identify the situation, the feelings associated with the situation, rate the intensity of the feeling, identify the automatic thought and identify the thinking error.

We are going to, next time, talk about different type of automatic thoughts and concentrate on errors that often occur. This is a learning skill; you are not expected to change over night. Two common things that occur is that the clients don't ask questions or think that they should know how to complete these forms and use these skills without practice. The purpose of this therapy is for you to practice and hopefully use these skills in your everyday life. Can you think of a time that you have felt sad or angry in your life?

Where were you?

Client- I was visiting my mother.

Therapist- You would write down under the situation- Visiting your mother. You would then write down your feelings.

Client- I felt angry that I was the only person visiting my mother who did not have a full time job. I also experienced apathy.

Therapist- Feelings can include happiness, sadness, apathy, anger etc. I want you to close

your eyes and think about the situation when you visited your mother and try to remember the automatic thoughts.

Client- I felt embarrassed that I wasn't working.

Therapist- Then we want to look and see if any distortion occurred in your thinking. Did you jump to conclusions, did you overgeneralize did you engage in either or thinking?

That is what you will be doing in this form. During this session we have discussed the importance of the impact of automatic thoughts in increasing depressive symptoms and possibly generating thought errors. Let's review the parts of the thought record that we have discussed. You will look at the situation, the feelings, and the intensity of the feelings and the possible use of thought errors. Let's take a few minutes to review the session and what you thought about it.

Client- It seems very logical by looking at automatic thoughts and thought errors.

Therapist- Next week we will move on to the next session. Thank you.

Session 6

Therapist- The first thing we are going to do is have you complete the BDI form and then review the homework.

Client- I don't feel that I did a good job.

Therapist- Why do you feel that you did a bad job? You completed the forms and completed each of the areas. You recognized the situation; you recognized the feeling

you were experiencing; you rated the emotion and you stated the thinking error. I would say that you did a good job. When people have a problem with the homework, they have problems recognizing the situation. They may confuse the feeling and the emotion and they may have difficulty recognizing the thinking error. You did a good job with all of these areas.

Client- Right

Therapist- Let's take a look at some of your examples. Let's look at the situation. Your first situation: you were getting ready for work. You stated that you felt anger and rated it a 5. You next had to recognize the automatic thought. You were disgusted with the work you were doing. You then needed to recognize the thinking error. You recognized it as overgeneralization. Why did you choose this type of thinking error?

Client- I thought that I was overgeneralizing at the moment. It's tough but it is a job and they are paying me for it. Maybe I should be more accepting.

Therapist- I think that you did a good job. Let's take a look at some of the other examples that you recorded. A common mistake that people make is that they recognize only one mood. You recognized anger more often but you also recognized sadness. When you spoke about the situation of borrowing money from your sister, you recognized the feeling of sadness. Your automatic thought was that, "My sister will think that I am a moocher". Why did you think that you were jumping to conclusions?

Client- She may think that I am trying to find a way to get by.

Therapist – I congratulate you. I clearly feel that you did a good job with using the concepts and recording your thoughts. Now we are going to discuss some new concepts since it is not necessary to spend any additional time on the previous concepts, which you grasped and handled very well. What we are going to talk about now is changing circumstances versus choosing a different outlook. What happens when clients are depressed {is} they feel that they need to change circumstances in order to not be depressed. For example, you may feel that you need to change jobs before you can feel less depressed. Can you think of a different way of thinking without changing the circumstances?

Client- You can hold on to what you have and keep working the job and look for a second part time job. So that you don't lose out.

Therapist- So instead of thinking that you need to change the circumstance and change jobs in order to get rid of your depression, you have decided to look for a second part time job. You can then experience a new environment and explore new opportunities.

Client- That's right.

Therapist- Changing circumstances often takes a lot of time but changing thoughts can happen quicker. A client for example may think that they need to change something about themselves before they can feel better. Sometimes you can change how you think about things. For example, last week you spoke about how your boss recognized your ability at work and how this made you feel better about yourself and less depressed. The

week before you stated that the job could be done by anybody. This is a good example of how to think differently about a situation. What does this show you?

Client- This shows me that I am dependable and my boss can count on me.

Therapist- This is a good example of not changing the circumstance but changing your outlook. Before you were looking at the job negatively and now you can recognize how you do the job better than others. One thing that we are going to start working on is three questions that are the main part of this session. We have already worked on ways to recognize distorted thinking, which includes overgeneralization, “either, or” thinking, etc. Important things to look at are, “What is the evidence that this thought is true?” So for example, consider the thought that I am a complete failure because I lost my job. Can this be looked at objectively? You want to look at the evidence. Instead of jumping to a conclusion, which we learned in the last session, we now want to ask yourself, “What is the evidence that this is the case instead of saying that I am a loser?” In a way it is like being a detective and gathering information.

Client- I feel that I can't get a new job.

Therapist – That is an example of jumping to conclusions. It is important to gather facts.

Client- I am able to get a job and I did receive positive feedback from my supervisor.

Therapist- I can see that you are starting to use the tools that we have learned in the sessions in your everyday life. The second question to ask yourself is, “What is a different way of looking at it?” For example, if someone lost their job could it be looked

upon as a way of getting a better job or an incentive to learn new skills? For example, a way of looking at things differently is when you initially said that anyone can do your job and then you looked at it in a different way.

Client- Yes, I could see that she trusted me and valued my work. This is a part of my life that I am doing things right.

Therapist- Can you see the difference in the level of depression between how you originally looked at your job and the positive way you are recognizing your contributions and your bosses' reinforcement?

Client- Yes I can see that the depression level was much worse, based on the first way that I looked at the job.

Therapist- Very good! The third question we are going to look at is, "Even if the evidence or conclusion is true, how bad are the consequences?" You could still feel that if I lose a job I will still be successful, I'll be okay and find another job. What are the worst consequences?

Client- I won't do my job right. I could lose my job and be unable to find another job. If I am more positive about it, I could say that I will go to work, do a good job and continue to receive positive reinforcement.

Therapist- Suppose we use an example from the workbook. If you think that no one likes you. We are going to do a role-play.

Client- No one likes me.

Therapist- We are going to use the three questions. What evidence exists? What could an answer be?

Client- No one ever talks to me. I feel all alone

Therapist- If I were to say, "Well, the receptionist always talks to you when you come in. People make positive comments about the way you dress and speak to them". Could that be evidence against your thought that no one likes you?

Client- Yes

Therapist- All evidence is not to prove that a negative comment is true but may be to disprove a negative comment and state a positive comment. Someone could also say, "Well, not everyone likes me but my case manager meets with me and likes me". The person could come back and say, "That only includes a few people - the receptionist and the case manager". But it does disprove the thought that everyone does not like me.

Client- I have found at work that I get along with all of the people even those who are negative. I am able to see that other people have problems toward work but not toward me.

Therapist- Well that is a good example; you are able to see that it is not that people don't like you but that people have their own problems or issues or just don't get along with other people. So you are gathering evidence and already using these techniques.

Client- Yes.

Therapist- Now the second question we are using is, "What is a different way at looking

at the situation?” We could say that other people have their own problems or issues it does not relate to them not liking me. If someone doesn’t say” hi “to me, it could be that they have their own issues or are absorbed in their own life.

Client- I can see that.

Therapist- Once again, by looking at that, you can see that there is a different way of looking at things. Hopefully this will help you feel less depressed.

Client- I can see in my own life that I am with someone and their mother who are potentially depressed. She is from a family that is very busy and no one is taking anytime to help her. Her depression makes me angry. Even though I try to do good things like going out to get groceries.

Therapist- Right.

Client- I try to bring home money and contribute to paying the bills she is still down in the dumps.

Therapist- Right.

Client- I like to be active; I don’t like being with someone who only likes to watch TV.

Therapist- You are beginning to look at the situation differently.

Client- I can’t wait to get out of this relationship. Because it is pulling me down.

Therapist- Right.

Client- My first reaction was I am angry. My second reaction is how do I get out of this situation, which is pulling me down? I know that I need to make more money so that I

can get my own apartment.

Therapist- You are starting to look at things in different ways.

Client- Right

Therapist- We have so far talked about gathering evidence, other ways of looking at things and now, what if your conclusions are correct? What if your conclusion that your girlfriend and her mother are depressed and you are stuck in a negative relationship? We are going to assume that they are correct.

Client- She is often crying.

Therapist- OK, we are going to look at this example and say even if my girlfriend is depressed, I don't need to be depressed and what is the worse thing that could happen in this situation? You could find out why you are feeling depressed and what you could do different about this. Even if you are depressed, things are not going to get worse. This also brings you back to the action schedule of things that you can do to reduce your depression.

Client- I can visit my mother more.

Therapist- Now if we go back to the example in the book when the person says that everyone doesn't like them. We could say, "What is the worst thing that could happen?" You could also say, "Is this true?" Now in your present situation, you could say even if the situation with your girlfriend is negative and may not change. Are there things that you can do to change the situation for yourself?

Client- Yes, there are.

Therapist- Without once again changing the circumstances, are there things that you can do to better things?

Client- I could visit my mother more at the nursing home instead of just sitting with my girlfriend and watching soap operas.

Therapist- We are going to learn how to use the extended thought record for your homework to aid with these new skills. You are going to write the situation as you did before: What is the feeling, and rating it, with 10 being the most severe and what is the error in thinking? You are going to add: What is the evidence? What is an alternative way of looking at things? What is the worst thing that could happen if your thoughts are correct? Do you see these areas on the form?

Client- Yes.

Therapist- Okay, this is all listed in the book. What action can you take and after you take a certain action? Let's say, for example, that the environment is what it is; your girlfriend is depressed; there is not an alternative explanation to her depression. Things may stay the same. You could take an action like exercising, which has helped you in the past.

Client- I have not been exercising. I feel worn out because of my throat.

Therapist- Well, you have not been feeling well. Now if you look in the book there is a section that lists the outcome that the person experiences. Outcome is related to feelings. The person may feel sad. We are building on the different things that we have learned.

Client- What are some of these outcomes?

Therapist- They are feelings. Actions could be, for example, going to the doctor because they are worried that they have a lump. They may feel relieved or notice a reduction in anxiety. It could now be a 1 or a 2 instead of a 10. Okay, so that is what we are doing; we are building on what we have been working on. The major points of the thought record are becoming aware of your thoughts and feelings and trying to sort out an action, and then test the action or thought to examine the result. Well I did this; do I feel different? I was worried about my health. Do I have a serious illness? You went to the doctor, you felt less anxious. Your outcome could be that you feel less depressed. We looked at how negative thoughts affect depression and we examined 3 new questions. We talked about even if a thought is true, what is the worse thing that can happen? We looked at challenging negative thoughts. Before we get some feedback, you will be filling out the extended thought record where you will be using the 3 new questions. In your manual there are questions with examples.

Client- Where are these examples?

Therapist- Here is the original thought record; here is the extended thought record and here are examples. Also on page 68, which I will mark for you, shows you the three new questions. Here are examples. Once again you don't need to fill out the form exactly like the book. You have been doing a very good job with the homework. The homework is actually a building process. Taking the old concepts and adding to them. Why don't we

take a few minutes and get your reflections?

Client- I think that is very helpful and could help others with depression. If she put things in proper perspective she may not feel as depressed.

Therapist- I think you did a great job with the thought record and I look forward to seeing next week's work.

Session 7

Therapist- Charles, today we are going to work on the 7th session in the manual.

Client- Okay

Therapist- First, I want to ask you how you are doing?

Client- I am doing alright. Not necessarily bad. Somewhere in the middle. I am struggling; it is not easy. I'm not doing great. I am struggling. I am having financial problems and personal problems.

Therapist- With depression change happens slowly. The fact {is} that you are saying that you are doing somewhat better. Depression doesn't get better over night. Someone doesn't usually wake up and say that they are doing great. The fact that you are doing somewhat better and seeing some improvement is a positive.

Client- Right

Therapist- We are going to stop for a second and complete the BDI, depression inventory that we do every session.

This session is called dropping thoughts. We are going to work on negative thinking by learning a technique called, “noting and dropping thoughts”. We are going to learn about this today. The important part of this is learning to adapt skills so that you can use it out of this environment and use it with different symptoms and with different life events outside of the session. Okay, the first thing that we are going to do today is to look at your homework. It looks like you did a very thorough job. How do you think that you did at challenging thoughts?

Client- I think I did alright.

Therapist- We are going to check over your extended thought record to see how you did. As I told you in the last session, you did a very good job. The thought record from last week is the first part of the extended thought record. Did you have any problems with the homework?

Client- Not really

Therapist – What were your thoughts about writing down your thoughts?

Client- I realized that it wasn't very difficult so I thought that in order to go along with the program I would write down my thoughts.

Therapist- Well, I appreciate that. Let's look at some of the things that you have done. Well, the first thing that you did was to look at a situation. You looked at thinking about going to the doctor. You said that you were concerned about the throat problem that you have had for about six weeks.

Client- For about six weeks.

Therapist- Now the next question was, "What was your feeling associated with that?" and you said, "Anxious". Can you elaborate on that?

Client- Well I am anxious to find out what is wrong with me and a little afraid.

Therapist- And the thought that you are having with this? You wrote, "I am afraid that I have cancer". So you are afraid that it is worse than a sore throat. Could there possibly be an error in your thinking? You said, "Jumping to conclusions".

Client- There is no proof that I have cancer. Probably because I am a little depressed.

Therapist- Are you applying any of the skills during the week?

Client- Yes, I am using this with my girlfriend, Loretta. She has complaints about her job. She is upset because people aren't having lunch with her. I am telling her, "So what that these people don't have lunch with you? They may be jealous that they didn't receive a promotion like you. There is always more than one way to look at things".

Therapist- So with your throat problem you are trying to find other ways to look at things. One thing that you can do is say, "What is the evidence?" What is the evidence that you have cancer? You are starting to be a detective and gather evidence?

Client- Well if I had cancer I wouldn't be able to talk at all.

Therapist- Okay, so what are the actions that you will take to improve upon the situation? You said, "I am going to go to the doctor". So instead of you playing doctor,

you are going to go to a doctor so that he can tell you what the problem is? Now, the outcome? We don't know what the outcome is until you go to the doctor. How do you feel? Right now you say that you feel anxious. Even though you made the appointment, you are saying that you feel a little less anxious. It has gone from a 5 to a 2. Why do you think that it has gone down?

Client- It hurts a lot but it does feel better.

Therapist- Any other example from your thought record that you feel you would like to go over.

Client- Anyone that you want? No any one is okay.

Therapist- Okay let's review the one about visiting your mother. You say that your feeling is guilt. What do you think that you are experiencing feelings of guilt?

Client- That is because I don't spend more time with her. That was your thought? When it came to errors you thought that maybe you were overgeneralizing.

Therapist- Why do you think that was a possible error?

Client- Well, because I am already spending more time than any of my brothers or sisters.

Therapist- Okay, so when you started to gather evidence you said that you were already spending more time than any of your brothers or sisters. You said, "Well I am visiting a certain number of times a week and I am visiting more than my brothers and sisters".

You chose an outcome of setting certain times a week. Can you explain it?

Client- Yes, I think that I would feel better if I set aside certain times of the week when I would visit my mother.

Therapist- So you feel that you would feel better with this approach. You said that you still feel guilty but the guilty process went from 6 to 1. Why do you think this occurred? Do you think that this technique is relevant? Could you use these techniques in your real life?

Client- Yes. I think that a lot of other people would benefit too. I know a lot of people who are suffering from depression and suicidal thoughts and they are not getting the help that they need. If they were getting the help like I am getting now it would do them the world of good.

Therapist- Okay, That's great.

Client- I see people that I know saying things like, "I am going to throw myself down the steps". They need help.

Therapist- Once again I commend you, you are doing a really good job. I am going to review your complete worksheets. The two examples that we reviewed were excellent. We are going to move on to the education section of the lesson. We are going to discuss the thought-feeling connection of the session. With thoughts there are feelings. There are connections between what we think and what we feel. It's important to look at this connection. This is also a connection between having a thought, having a feeling and being depressed. When you discussed the thoughts about your mother you said, "I don't

see my mother enough". Your feeling was guilt and a resulting feeling could be feeling depressed. We often need to look at the action that you take, the feeling and the connection with depression. I see a clear distinction between your thoughts and feelings.

Client- I really should have a clipboard to carry around with me.

Therapist- You could do this, or you could write your thoughts and feelings at home.

Client- This is so enlightening for me. I want to share this with others. Other people have distorted feelings and thoughts. They don't get it. When I say, "So what; they aren't getting any help".(??)

Therapist- It is great that you are using these concepts in your everyday life. It is also to also important to note that thoughts are a big part of being depressed. If you were to keep thinking that, "I don't do enough for my mother", can you see how this thought can perpetuate your depression?

Client- Yes. An important thing to think about is thinking and acting differently and looking at things in a different way. I really want to share the things that I have learned with others. So they can get a better grip on their life.

Therapist- Are you referring to your girlfriend?

Client- and her mother. She is calling the pharmacist and threatening that this is the last time that she will talk to him. She is threatening that she is going to put her Jack Russell terrier who is only one year old, asleep.

Therapist- Why is she doing this?

Client- Because she can't care for him anymore.

Therapist- Is this definitely happening?

Client- No, she is just saying this

Therapist- Okay, let's step back for a second. You are seeing that by gathering evidence, by rating your emotions, you are also seeing a change in your feelings. I am glad that you are saying that you see a moderate to large change in your depression. Even if you were only seeing a small change in your depression, that would show progress because with depression, change usually happens slowly. You don't need to expect to see large changes. It doesn't always have to be that way.

Client – I understand.

Therapist- Okay, let me ask you a few questions. When you are challenging your thoughts does this make you feel better?

Client- It was a little difficult at first.

Therapist- Did answering or challenging your automatic thoughts change your belief in them?

Client- The problems are serious and may not change but I know that the way that I look at the problems can change.

Therapist- Very good! Did your answers include any different actions to take?

Client- Yes. Instead of having knee jerk reactions like to the guy at work who asked me for a ride home. I told him that I wasn't able to take him home, which would take me out

of my way. I initially felt guilty but I told myself that he took the bus here so he can take the bus home.

Therapist- Right.

Client- It shouldn't be my concern how he gets home from work.

Therapist- Okay. Is there anything else that you learned from the assignment?

Client- That my thoughts and feelings affect my mood and my depression.

Therapist- Very good! We are going to move to the new skills which are called "noting and dropping". The important thing {is} that once a client understands that their negative thoughts are not correct or useful then they can go about managing them and letting them go. You will also start noting patterns and identifying dysfunctional thoughts. You may notice your feelings first and your thoughts second. That is not unusual. But by noting these things, a client can stop letting thoughts go underground and keeping them. You can simply count your thoughts. There are certain options for counting thoughts: you can use a golf counter, a food counter, pennies, or you can simply put little dashes on a piece of paper. By counting, you can note your thoughts and try to release them. This helps in not holding on to thoughts, letting them go and not dwelling on them. How does that sound to you?

Client- It sounds like a good plan. I don't know that I have many negative thoughts that I hold on to. They are automatic thoughts that come to me.

Therapist- Do you think that it is a hard thing to do, to let go of these thoughts?

Client- Yes, it is very hard. You need to train yourself to let go of these thoughts. Trying not to feel guilty or feeling bad. Things like guilt don't really serve a purpose.

Therapist- Even though it is a hard thing to do, it doesn't mean that you can't try and practice to let go of thoughts.

Client- Right

Therapist- Okay, we are going to practice for a second. I want you to close your eyes and every time you have a thought, I want you to say the word, "Thought" and try not to let the thought come back. Just say the word, " thought"

Client- Thought, thought, thought, thought, thought.

Therapist- So you see that no matter what you are doing: sitting still, walking around or being active that thoughts will keep coming to you.

Client- Right.

Therapist- You did a really good job recognizing your thoughts. Did you find this hard to recognize the existence of thoughts?

Client- No.

Therapist- It is almost impossible not to have thoughts. We want to work on trying to drop negative thoughts and recognize what the value of them is. Let's talk about emotional symptoms of depression. It is helpful to jot these thoughts down. It is also helpful to note the feelings that accompany thoughts. If your thought was, "I can't go on

the interview because of my throat". What could the emotion be and what is the accompanying action? It could be procrastination. Before, we were just looking at the thought and the action. Now we are looking at more steps. Very often with depression people will react passively.

Client- A lot of people who don't have experience with psychology will often react fatalistically and say, "I want to throw myself down the flight of stairs". This type of psychology helps you to break things down and stop yourself before a thought becomes very negative.

Therapist- Simply noting a thought can help a client in refocusing. Instead of being overwhelmed with a thought, you can refocus and acknowledge the thought. You may not recognize the full circumstance of a thought and the role that others have played in it. Like in your previous example of when family members told you that you should go to the nursing home more often or you felt that way. Hopefully you can acknowledge your responsibility for a thought and then move on. People can also have cognitive symptoms in addition to emotional symptoms. In addition to behavioral symptoms concerning how we act, emotional symptoms concern how we feel. We may also have cognitive thoughts concerning how we think. There are all different ways to look at thoughts. One kind of cognitive thought with people who are depressed is suicidal thoughts. This happens in 75% of the time with depressed patients. Like the example with your mother-in-law.

Client- Yes, she says that she wants to throw herself down the steps.

Therapist- Although very few people harm themselves, even thoughts can be disconcerting. Many people do not harm themselves even when they have suicidal thoughts. It is important to look at things and say, "Even though I am having a scary thought it does not mean that it will lead to an action". The most prevalent reason for suicidal thoughts is the feeling of hopelessness.

Client- Yes

Therapist- We have been talking about suicidal thoughts and how they are often a sign of hopelessness. It is helpful to realize that many people have these thoughts and the best step is to find ways to prevent the hopelessness. Some of the ways that you have learned in the past is by recognizing the thoughts, noting the thought, gathering evidence, taking action and very often the hopelessness can lead to ruminating when you think about the same thoughts over and over again.

Client- Yes .

Therapist- Like your thought, "I can't get a new job because I don't have computer skills". You think about the same thought over and over again. You have certain thoughts that go on and on. These thoughts are called ruminating. Sometimes people feel hopeless because they feel that their thoughts have no answers. I need for you to think if you have thoughts that have no answers. Even if you have these kinds of thoughts it doesn't mean that there will never be a solution.

Client- Right.

Therapist- Even if it is not an immediate thought. Do you have thoughts that don't have answers?

Client- I think that I have thoughts that don't have answers. Some of the things that I see with my girlfriend and her family are a result of distorted thinking.

Therapist- One way to look at it is even if there isn't a solution today, that isn't necessarily a problem.

Client- Right.

Therapist- Some people may look at a problem and think that there must be a solution. It is okay for you to tell yourself that it is okay if there isn't an immediate solution, today or tomorrow or the immediate future. That may take away hopelessness by taking away the expectation.

Client- Right

Therapist- With negative thoughts in addition to having emotions and cognitions, people often have physical symptoms. We talked about this before. Insomnia may be a physical symptom. It may be a result of taking too many naps during the day. It may be a result of feeling lethargic or fatigued. Sleep problems are not an unusual part of depression.

People may have physical pain as part of depression. We spoke about this a little concerning your girlfriend.

Client- She does.

Therapist- Physical problems are often part of depression. Depression has many different pieces to it.

Client- It manifests in different ways.

Therapist- You can use the action schedule or the thought record to monitor many of these symptoms by asking yourself, "What are my thoughts, what are my feelings, are they emotional feelings or physical symptoms?" A client {will} change the symptoms of depression by breaking them down into pieces and tasks. As with any new skill it takes time to learn how to use it. You did a great job with the worksheet but you aren't going to always complete one or carry it around with you. It is important to practice these skills.

Critical incidents need to be recognized. Critical incidents will occur when you need to go with the symptom or combat it with some of the techniques {you} have learned. It is important for you to learn to look at critical incident. A good technique will be to look at a critical incident and see if you can do the opposite of what you feel that you should do.

For example, a critical incident at work- a guy at work says you have to give me a ride at work. You didn't react and you do what you didn't want to do. How did it make you feel?

Client- I initially felt guilty and then I felt good. He had many opportunities to offer me money. You know gasoline is expensive these days.

Therapist- You did the opposite thing and felt better. You were not stuck in a situation.

That is good. Let's summarize. We discussed a lot today. We talked about noting and dropping thoughts. We spoke about dropping thoughts in order not to ruminate. Dropping

thoughts can lead to taking an action, giving yourself permission not to take an action, by behaving in an opposite way, as you did with the co-worker. Now that you have become more familiar with automatic thoughts you will have a greater ability to spot them as they come up. And when they do, you have learned to note them and let them pass. Instead of feeling guilty about seeing your mother, you are going to try and not feel guilty and give yourself permission not to put more pressure on yourself. This will help you get better control over your life. You will complete another extended thought record and practice noting and dropping thoughts. Any questions or thoughts?

Client- No, not now. I think that I have been dropping thoughts when it comes to my relationship with Loretta. I realize that it is not me but her.

Therapist- That is an opposite way of looking at things. You are not blaming yourself but realizing that she may be holding on to negative thoughts.

Client- She is. When our lease runs out she wants us to move in with her mother. There is no way that I am going to do this.

Therapist- You are identifying what you need to do for you. I will get you another copy of the thought record and note when you have a thought.

Client- It will mean more to me if I write it down the thought instead of just writing down tick marks.

Therapist- Great.

Session 8

Therapist – How was your week?

Client- About the same. You know my problems with Loretta. My throat is bothering me. I hate my job.

Therapist- Were you able to work on the skills that we have learned and apply them to your life?

Client- I can see that I am doing that. It does seem helpful even though my problems aren't solved.

Therapist- Well, I am glad that the skills are helpful. Change takes time. Today we are going to work on addressing a topic known as faulty belief systems. Often these types of thoughts lead us to be depressed. We are going to examine beliefs that you have had probably for a long time and see how they may potentially affect your depression.

Client- That sounds interesting.

Therapist- How did you do with noting and challenging your thoughts?

Client- I think that I was able to note and challenge some thoughts. It is hard work. It is hard work to come up with these thoughts.

Therapist- Yes, it is. I thought that maybe we could practice a role play to increase your practice with these skills

Client- That sounds good.

Therapist- You're having trouble coming up with answers to your thoughts?

Client- I have a lot of negative thoughts. They are not distortions. I can't come up with positive thoughts.

Therapist- Okay, let's try switching roles. I am going to play the part of the negative thought machine.

Client- Okay

Therapist- I think that you can't do anything

Client- I wouldn't say that I can do anything,

Therapist- Name one thing you can do.

Client- I can visit my mother.

Therapist- But, you can't do things that are important.

Client- It is very important to visit my mother. Someone needs to keep track of her care. You know bad things can happen in nursing homes.

Therapist-Let's start again. You can't do anything that is important.

Client- I don't agree with you.

Therapist- What do you mean by that?

Client- It is very important to care for my mother. I make a difference in her life.

Therapist- Okay, let's try another one. You are a total failure.

Client- Maybe I'm not as successful as my brothers and sisters but I am not a total failure.

Therapist- You don't have a full time job.

Client- That's right. But I do a needed job and my boss has recognized me.

Therapist- Good, work. It shows that you can challenge the negative thoughts. It is important to give yourself credit. What grade would you give yourself for the way you answered the negative thoughts.

Client- I guess a "B".

Therapist- Well a "B" is a good grade. You can challenge your negative thoughts. It is also important to take actions when you challenge your thoughts. Taking actions has the effect of correcting errors in thinking and reinforcing more adaptive thinking.

Client- I can see that.

Therapist- Great work! Now we are going to work on the psychoeducation section of the session. It is related to beliefs and negative thoughts. You can use the same method that you use to spot automatic thoughts when identifying your underlying beliefs. Once you can identify your beliefs, you can then trace your automatic thoughts back to the beliefs. You can also then look at alternatives and more realistic ways of seeing yourself and the world around you. Another way to look at this is to consider that the brain is prewired to adopt rules or beliefs. They help us to survive, make sense out of our life, select goals and adjust our behavior. Sometimes it is helpful to look at extreme beliefs that often happen when someone is depressed.

Client- I definitely have certain beliefs about myself. Some aren't good for me.

Therapist- That is a great observation. The beliefs that we are talking about are called core beliefs. They usually involve beliefs about love, health, achievement and attractiveness. These beliefs usually develop early in our lives. Can you think about a belief that you have?

Client- I believe that I am a loser because my sisters and brothers are successful. I believe that I can never be happy. I also believe that I am stuck in this horrible relationship with Loretta since I can't make more money.

Therapist- Those are good examples of negative beliefs. These beliefs may be part of the reason that you are depressed. We need to challenge these beliefs in helping you get less depressed.

Client- That makes sense.

Therapist- Instead of changing beliefs that you have had for a long time, we are going to work on developing a moderate or middle position. It would be helpful if you could be more flexible with changing your beliefs. We are now going to work on taking action.

Client- Okay, I'll give it a try. But I don't know if I can change these beliefs.

Therapist- Well, let's give it a try. Taking action helps change beliefs. Maybe it is unrealistic to have a Ph.D. in science like your sister. It is important to try not to impress others and develop realistic changes to your beliefs. We are going to work on questioning your beliefs. This will help you in developing realistic actions to take.

Client- Okay.

Therapist- I am going to ask you some questions that may be helpful in questioning your beliefs. Do I honestly need to be extremely successful? Do I need a new job to be in a new relationship? Why is it impossible to be happier, what steps could you take?

Client- They seem like realistic questions. I need to think about them.

Therapist- It is important to remind yourself that your depression grows out of dysfunctional beliefs. You can work on clarifying your beliefs through self-reflection, staying in the present and not focusing on the past, and approaching your fears. Before we summarize this session, do you have any questions?

Client- No, it seems to make sense. I just don't know if I can change my beliefs.

Therapist- It takes time. Remember to try to concentrate on moderate changes that are realistic in your life.

Client- Okay, I'll try to do that.

Therapist- Okay, in this session, we explored the concept of core beliefs. We spoke about how they contribute to your depression. We spoke about first identifying your negative beliefs and then work on challenging them. Changing your negative beliefs should help you in reducing and avoiding being depressed. For your homework, please do one extended thought record based on a situation that is generated by a central belief. Continue to practice noting and dropping thoughts. I'll see you next week.

Session 9

Therapist- We are working on session 9 today. You said that you had a question.

Client- The working alliance inventory, I am not sure of. In the statement, " Marcy and I have different ideas, what are problems are." I wrote very often but what I meant to say was not often

Therapist- You would need to change it if you wrote the wrong answer. This question is asking if the therapist understand how the client sees his problems.

Client- Then I will correct it and write, "error".

Therapist- I don't look at the working alliance until we are finished with the therapy sessions in full. I will just put it away in the envelope. You said that your throat is feeling better and you will let me know how things go.

Client- I didn't do that much this week because I didn't feel well.

Therapist- What is going on with your health?

Client- I am worried about going to the doctor. I am having problems concentrating.

Therapist- Did you try to use any of the skills that we have learned?

Client- The reality is that these are for people who have distorted thoughts. My thoughts aren't distorted about going to the doctor. I had an MRI. This is the real thing.

Therapist- It is hard for you to concentrate when you are going for all of these tests.

Client- Right

Therapist- I appreciate the time that you did put into the homework. I know that it was a hard week for you.

Client- There wasn't much to say.

Therapist- Last week you did much more than you needed to. This is okay.

Client- I can do better than this. I'll work on it.

Therapist- Let's talk about the agenda for today. The primary agenda is to move toward the completion of our sessions as we approach the last session. We are approaching session 10. We will be talking about what therapy you may or may not need in the future. Some people are able to stop after session 10 and sometimes people need other services. I wanted to talk about some of the tools that we have learned. Do you see any advantage in practicing the tools on your own?

Client- I can but it is a little bit cumbersome. I need to get a clipboard. So when I think that something is good to write down or challenge. You may be driving in Philadelphia and you have thoughts. If you have clipboard you can write it down and not forget it. That way you wouldn't need to wait to the end of the day and make a project out of it.

Therapist- Just to go back to the previous question. Do you see any advantage in practicing the skills outside of therapy?

Client- Yes.

Therapist- What type of advantage do you see?

Client- In the case of self-actualization. You will recognize what is going on and not let your mind trick you in to thinking other things. Depressed thoughts may become undepressed.

Therapist- Right. Do you think that if you pushed forward on your own and practiced these skills that you would feel good about that?

Client- I would feel good about it only if I did it when the ideas are fresh in my mind. Saving it to the end of the day is a drag.

Therapist- You need to do it in a way that is best for you.

Client- I need to get a little clipboard.

Therapist- Very often when people do things, they feel more autonomous and responsible for their actions and they feel like they are running the show. As opposed to feeling dependent on someone else they feel autonomous. What do you think about that?

Client- Yes, it does help your self-esteem.

Therapist- What we are going to do now is to go over the homework. You said that you had a hard time doing the homework because you didn't feel well and had concentration problems.

Client- I just had a lot of doctor's appointments.

Therapist- In reviewing the homework, we will look at some of the things that you were concentrating on. Very often clients can engage in two different kinds of thinking.

Thoughts can be task-relevant thinking – like I need to go to work or do a certain thing.

Thoughts can be irrelevant, over- thinking, thinking about things that interfere with your functioning. They can be negative thoughts. A lot of the work that you have been doing has to do with thoughts. Even though it has been presented in different ways with the thought record and the extended thought record. Sometimes clients can over-think, they may think more than what is required. One thing that you are saying is that you didn't do enough.

Client- Right

Therapist- It is okay to give yourself permission that you didn't feel well and you couldn't do more homework. You could say that you did the best that you could.

Client- all right

Therapist- You can also do what is called self-talk when you talk to yourself. It is like an inner dialogue. So, for example, instead of saying to yourself that you didn't do well on your homework, you could say to yourself that you didn't feel well and you had a lot of pressures. And that is self-talk and that can be helpful also. Sometimes you may think that you can find a solution to a problem even if you think enough about it. But thinking about it actually keeps the problem going. So if you keep thinking, "I didn't do a good job, I didn't do a good job- I will be a disappointment". This will not help the situation. When you are involved with thinking that you did a bad job, it creates negative thoughts. So overthinking isn't always a good thing for people.

Client- I can see that it lowers your self-esteem and make you feel depressed.

Therapist- Right. After we look at your homework today, we will talk about some new skills, one of these skills is self-talk. Sort of giving yourself permission to be human.

Client- Right

Therapist- Okay let's look at your thought record for a second. You talked about going to the doctor. You wrote that you thought that you had cancer. What would have been another way of looking at that?

Client- I have an infection that is resilient to antibiotics.

Therapist- Very good. And when you were asked about the evidence to your fear of cancer, you wrote there is no evidence. I need to wait for the results. You really need to use the skills.

Client- Right

Therapist – I know that it is a real concern and you are not feeling well. It is helpful to say to yourself, “What is the evidence?” You wrote, “I have to wait for the doctor’s results from the tests”. I know that is a hard thing to do. In response to the question, “What action do you need to take?” you wrote, “Be patient and wait to see what the doctor has to say”. Your outcome was that you still feel worried but you feel less worried. There was a slight decrease in your worrying.

Client- Right

Therapist- I am really glad that you are using the skills in your everyday life.

Client- Right

Therapist- That was an excellent example.

Client- I am glad.

Therapist- The other part of the homework was to identify thoughts. You could just write down tick marks and close your eyes and say, 'thought'. Did you work on that at all?

Client- No I didn't actually. I forgot about it.

Therapist- If you were to use the skills that we worked on, how would you do it?

Client- Could someone make copies of the forms for me?

Therapist- What would be a way of looking at things so you didn't blame yourself?

Client- I need a form to carry with me like the extended thought record.

Therapist- Okay let's talk about some of the new concepts and skills that we will discuss today. Some of them you may have heard of before. One is the concept of overthinking.

When someone overthinks, their focus turns inward and they stop seeing the facts objectively. Also with overthinking, someone can miss many of the facts because they are thinking too much or too negatively about something. Overthinking can sometimes be an endless loop that keeps going and going. What we want to do is to try and quiet down the mind and try not to speed up this dialogue. It is helpful to say this is just a thought and I have had thoughts throughout the day. Sometimes people think that thinking helps them but it may make them more vulnerable. So problems can get worse because the client may get caught in what is going on.

Client- Right

Therapist- Distraction can be a good thing because someone's focus needs to be changed. Since the person is looking at problems and negative events, self-talk can be futile if you think of the same negative thing over and over again. It is helpful to note the thought and move on to a new thought.

Client- Right

Therapist- Last week we spoke about a skill known as "noting and dropping". Today we will talk about "noting and replacing". Did you get a chance to read about this topic?

Client- No, Is this the final session?

Therapist- No this is session number 9. The process is known about "noting and replacing".

Client- No, I don't know what that is.

Therapist- Okay we will talk about that today. In this session we will talk about noting negative thoughts and replacing them with a good feeling. Sometimes clients can stop negative thoughts but you do have a choice about how you react to these thoughts and what you replace it with. Like before, you were saying, "I think I have cancer", you were able to replace it with " I need to wait for the test results". That was a good example.

Sometimes it is helpful to recognize a thought as just a thought and then replace it.

Sometimes you can just disregard a thought or replace it like when you said, "I just have

a bad infection”. A thought can be negative or positive. A thought can be positive.

Client- Right

Therapist- When you get lost in overthinking. When you think over and over again, your perceptions can get narrow. When you find yourself continually going over a negative thought like, “I think I have cancer, you can change your thought by first saying the word, “ Thought”

Client- Right.

Therapist- You would then try to find a positive thought.

Client- Okay

Therapist- Which is what you did last week in your homework. You had a thought, “ I think I have cancer.” You then said, “ Thought”. You replaced it with the thought, “I may just have an infection”. This is what you are already doing in your life. What do you think about what you did? I think that you did a really good job.

Client- I guess I did all right. I just tried to fill out the forms and put in the appropriate answer.

Therapist- The good part is that it did relate to your everyday life and what you were going through.

Client- I had so many doctor appointments.

Therapist- Even with the doctor appointments and not feeling well, you still were able to

apply and work on the skills. You were able to look at things a little bit differently.

Client- Yes

Therapist- This is a way of saying that this is a skill that I can apply to my life.

Client- I don't want to write a bunch of small thoughts that are not relevant. That's why if

I had a clipboard and carried it around and wrote down things that meant something to me. I don't want to make up stuff, trite, unremarkable things and write it down.

Therapist- That's good. You are taking this very seriously and applying it to real life situations. That is the hope of therapy, to use these skills in your everyday life. So it is not just a homework assignment. That is what I see you doing.

Client- Right

Therapist- We are talking about thoughts. They can be about comparing or judging yourself and that doesn't have a real value. If you kept telling yourself that you didn't do enough of the homework that would not be a productive thought. What do you think about that?

Client- I agree, it is good to challenge thoughts that are negative.

Therapist- That is great. You are starting to utilize these skills. Let's just step back for a second and think about a thought that is bothering you.

Client- Yes, they cut my hours back at work.

Therapist- Can you think about this negative thought and when it comes to your mind during the session, say the word, "thought"? Try to replace this thought with something

potentially more positive. I am not saying that having your hours cut at work is positive.

Is there a more positive way that you could look at this?

Client- It is an opportunity to go and look for something else.

Therapist- Okay. In the past sessions, you had said that your hours are sometimes cut and then readjusted. It may be a temporary thing. I am not saying that this is positive but you could say that my hours may be readjusted like in the past. You could say this is a time to look for another job or gather the evidence and say that this has happened before.

Client- You wonder why they are giving other guys more hours instead of me? I wonder why I have gone from 6 to 4 days.

Therapist- Let me ask you a question. Could you ask yourself to find a good thought and say the word, 'thought'?

Client- Thought

Therapist- Were you able to find a good thought?

Client- Yes

Therapist- Could you share it?

Client- My tests may turn out good.

Therapist- Very good. So you can find a good thought. It may come quickly or it may take a while. The purposes that negative thoughts serve may be to make you feel bad, less able to cope. Have you ever had a negative thought that didn't make you feel bad?

Client- A negative thought may be the fear of overdrafting my checking account or

getting a bill from the hospital that I know that I can't pay because the insurance won't cover it. Losing my wallet or my keys. These are the kind of things that make me really upset.

Therapist- Right

Client- But still it is not worth getting upset about since there is nothing that can be done about it. I can lose my self control.

Therapist- So gaining better perspective may feel better and gain better control.

Okay, now we are going to talk about good thoughts. We are going to work on ways to help yourself where good thoughts can lead to good feelings. Once again the relationship between thoughts and feelings. Good thoughts are often associated with good feelings. Bad thoughts are often associated with bad feelings. Good thoughts may help you gain insight, reduce negative thinking, help you be more adaptive, as we said before, "I will use the time to look for a job" or "Cutbacks have happened before and work resumes".

What will good thoughts do for you?

Client- Good thoughts will help me look for a new job and not be so aggressive and desperate at the paper to look for more hours.

Therapist- The research shows that the more good thoughts you have the more resourceful you will be. You will become more flexible and able to deal with problems.

Client- I think that the psychology has worked for me. I look at other people and they look like children when they are handling their situations. Like my girlfriend, my

girlfriend's mother. They are getting themselves worked up over little things and subsequently getting depressed and not realizing that they are depressed.

Therapist- Right

Client- They are not any fun to be around.

Therapist- Right. It is also understandable that people have difficulty finding good thoughts. But the more that you work on this, the easier it will be to find good thoughts. The plan or the intention is for you to feel better and feel less hopeless. You always have the potential to feel better and look at things different. It doesn't mean that you will feel good about having your hours cut.

Client- I am on good terms there. I could still be looking for a job. I have stayed longer than others have. It is because I am passive and not aggressive. Whatever they give me I take. I am not forcing them to give me more than they want to.

Therapist- What you started today is by looking at a situation and looking at it differently. Hopefully you will not feel trapped and will start looking at things differently. So by feeling better during this session, you have been able to refocus. You have been able to switch from negative thoughts to more positive thoughts. I want to encourage you to keep practicing this. It is not that the situation is negative but I am encouraging you to look at things differently so that you feel less hopeless.

Just to summarize, what we did today was to ask you to keep practicing the skills and

techniques learned. The best thing to avoid relapses is by using the skills learned and by practicing. This will hopefully help depression's getting worse and taking over. For next week what I want you to do is work on one thought record a day. Try to concentrate on dysfunctional thoughts. Concentrate on noting self talk and overthinking. Hopefully generating positive thoughts. I am also going to give you the patient satisfaction questionnaire. I appreciate your help and I know how hard it is for you to talk and work on the homework.

Client- I have not been feeling well, it is very hard. You want one thought record for each day.

Therapist- Try to do that. Any feedback?

Client- The homework is cumbersome in writing things down. If I go to Staples and get a clipboard, it will help me. I can write these thoughts down as I go through the day. If I save them and Loretta is watching soap operas and I am in pain, it will be hard to write things down.

Therapist- Thank you.

Session 10

Therapist- We are going to start session 10 today. You said that you are going to see a specialist.

Client- Yes

Therapist- Who did you see?

Client- Abington Memorial hospital's MRI department. They did a CAT scan and an MRI. I also saw an ear nose and throat doctor.

Therapist- Did that doctor make any recommendations?

Client- He recommended that I see another ENT at Temple. I need to get my records and take them to Temple.

Therapist- Has it gotten worse?

Client- It is hard to gauge. I tell everyone about this, people at work.

Therapist- What did the doctor say?

Client- They don't know anything. Hopefully I will be able to get my records and see this guy.

Therapist- I would do anything you can to get those records. Maybe you should just go over there. What do you think about that?

Client- I am going to do that.

Therapist- I am sorry that you are in pain and going through a hard time. How do you feel about working on the session today?

Client- I want to do that.

Therapist- I am sure that it has been a hard week to work on the homework.

Client- I still worked on it.

Therapist- I appreciate your help.

Client- I saw the psychiatrist last night and had to wait for over an hour. It is hard to come up with answers.

Therapist- Well, you worked on the thought record and did a good job despite going through a hard time with tests and medical appointments

Client- I appreciate that.

Therapist- A lot of the situations and thoughts relate to your doctors' appointments. This is a hard time for you since you are in limbo and don't know what the recommendations will be. Hopefully, when you have a clearer plan you will feel a little better. This is a hard time.

Client- I know. I am really lucky that I have insurance. I don't want to apply for social security and screw up my health insurance.

Therapist- I can understand that. Maybe you could talk with your case manager so that you can better understand what your options are.

Client- That sounds good.

Therapist- Hopefully you will have more definitive answers after your next appointment.

How is Loretta doing?

Client- She has non-stop complaints and is only worried about herself. She wants to go with me to the appointment. She wants her mother to go with us. I don't want them.

Therapist- Do you think that she is trying to be supportive?

Client- She only cares about her health and her soap operas.

Therapist- I think that she cares about you. This is a time when you need support. It is often helpful for someone else to hear what the doctor has to say and not to be alone.

Client- It will only turn into a three ring circus.

Therapist- You need to do what ever is best for you.

Client- I think that Loretta is worse off than me. She is a wreck.

Therapist- Could it be that she is worried about you?

Client- It has been an ongoing problem. She is like a dishrag. She has no pep at all. I am not even like that. She is always tired, achy and complaining. I am not letting her talk to a doctor.

Therapist- Do what is ever better for you.

Client- She thinks that she is going to die of a heart attack.

Therapist- Sometimes people have more physical symptoms when they are worried and anxious.

Client- Maybe

Therapist- Okay if it is good for you, why don't we continue with the session. This may be a good time for you to use some of the skills that we have discussed and you have learned. We can finish up the session and take more time in the end of the session to talk about your medical issues.

Client- I can see that. I think that the book is excellent. I have no complaints with the concepts and skills discussed. It is difficult to write significant things

Therapist- You have written significant thoughts despite going through hard times. I can see that you are applying the skills in your everyday life. I think that you may be critical of yourself. You are using the skills at work and with your relationships. How do you think that you are doing with applying the skills that we have discussed?

Client- I think that I have learned the skills and that I am using them. I think that the program would be good for a lot of people with depression.

Therapist- How do you think that the skills have affected your depression?

Client- I think that it is better. I think that I will use some of the skills. I have learned that thoughts affect your feelings and your depression.

Therapist- You have applied the skills to real life situations. You have learned how to challenge your thoughts.

Client- I have? I wish that other people would use these skills. Loretta should use them. I am using the skills with regard to my illness. I think that my problem was caught early. I think about my sister who has recovered from cancer.

Therapist- You are doing a good job applying the skills during a hard time.

Client- I can see that. In many ways I still blame myself for not having a full time job.

Therapist- It may be helpful to look at the positive steps that you are taking including

using a job coach, reading the classified ads, attending interviews.

Client- You're right.

Therapist- I wanted to take some time to talk about how not to have relapses. This is not a time to judge your progress. You have made progress during the course of this program by challenging your thoughts, increasing your activities.

Client- I am so attached to this new kind of thinking. I can understand myself and others better.

Therapist- I am glad to hear this. One thing to think about is the progress that you have made and the hard work that you have done.

Client – Thank you. I have worked really hard

Therapist- Other things to think about in helping yourself is to consider getting involved in a support group some time in the near future.

Client- That sounds like a good idea. I know that even if it is cancer it is not a death sentence.

Therapy- That is good work. You have the power to help yourself think differently and help yourself.

Client- I like the thought record. I don't have anyone at home to bounce my thoughts off of. I now think when Loretta talks she is jumping to conclusions, and using "either or" thinking?

Therapist- You have learned a number of important skills. The next session we will have is a follow-up session. You will complete a number of forms. Please let me know how things go with the doctor.

Client- I will; thank you.

Post treatment session

Therapist- During today's session I will ask you to complete a number of forms so that I can better evaluate the effectiveness of this program and its impact on your depression.

Client- Okay, But I will miss meeting with you. I still don't know if my health is okay.

Therapist- You can give me a call and let me know how you are doing. You can also set up a follow-up session if you feel that we should review any of the concepts or if you see an increase in your depression. The administrator at the agency will assign the client to a new therapist if he would like to continue therapy. The therapy will probably not follow a manual approach.

Client- Well, I am glad that I have options. I think that I am using the skills in my life but I still feel depressed. I am also very worried about my health.

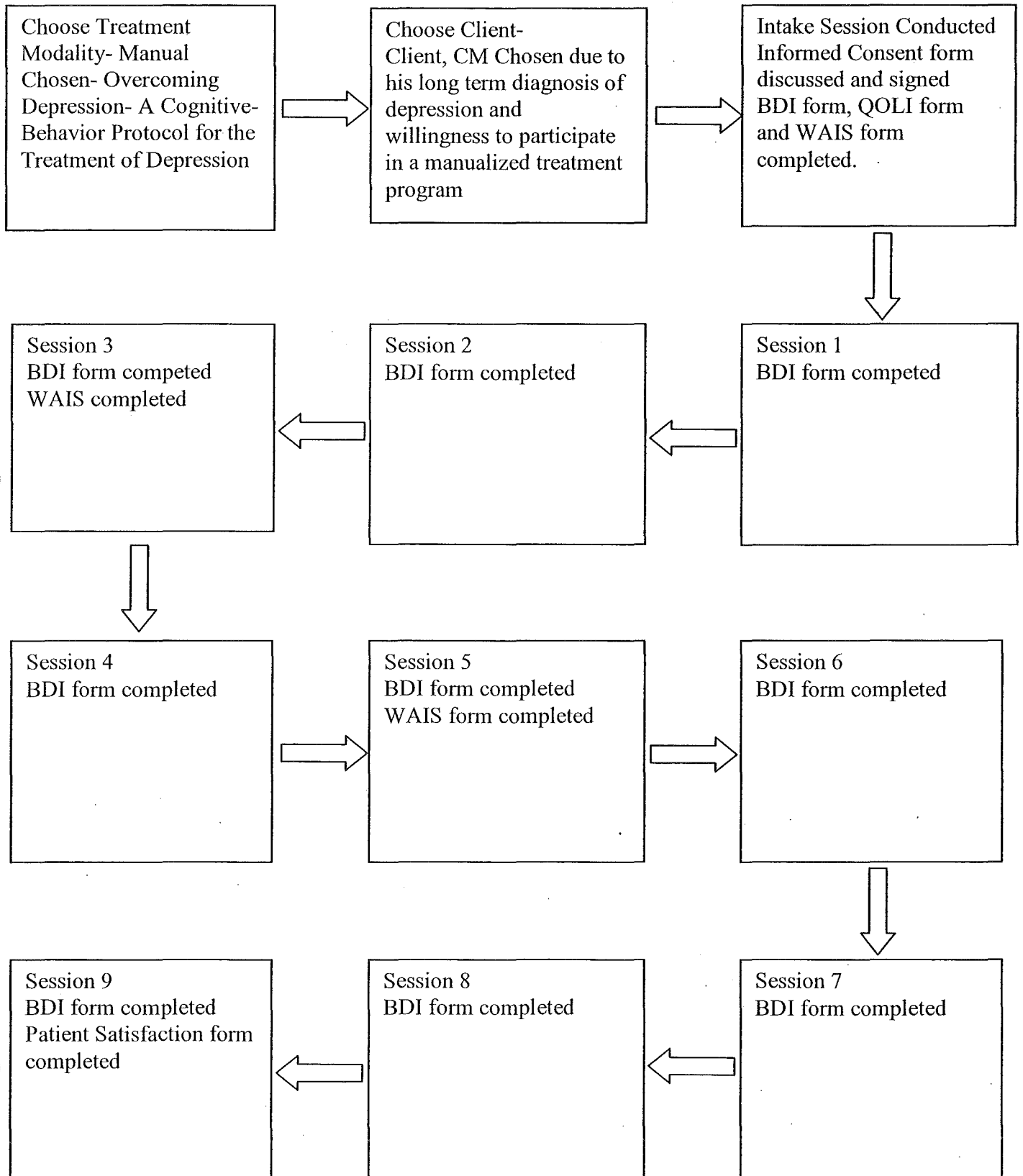
Therapist- I hope that your throat gets better. As we discussed, changes in depression occurs in steps over time. Now, I would like to ask you to complete the BDI, the Working Alliance and the Quality of Life Inventory that you did during the very first session.

Client- That sounds okay. I enjoyed working with you and learning these techniques. But I am afraid of not getting better with my depression.

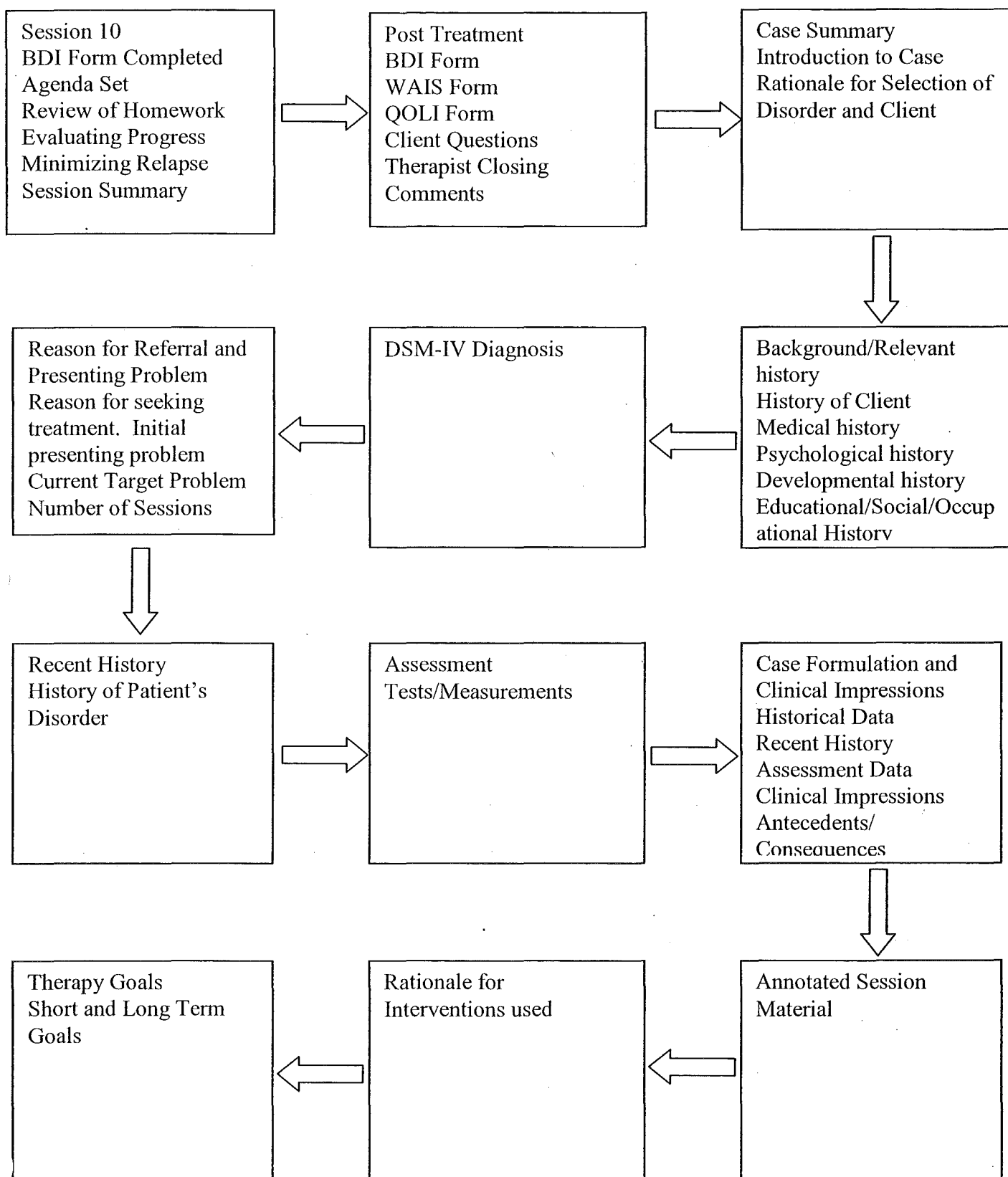
Therapist- I think that you have made progress during the course of our sessions. I hope that you will practice the skills that you learned and try to apply them to your life. I wish you continued success. It has been a pleasure working with you.

Client- Thank you. I will try to use the skills. I am sure that I wouldn't do homework every week. I'll keep in touch.

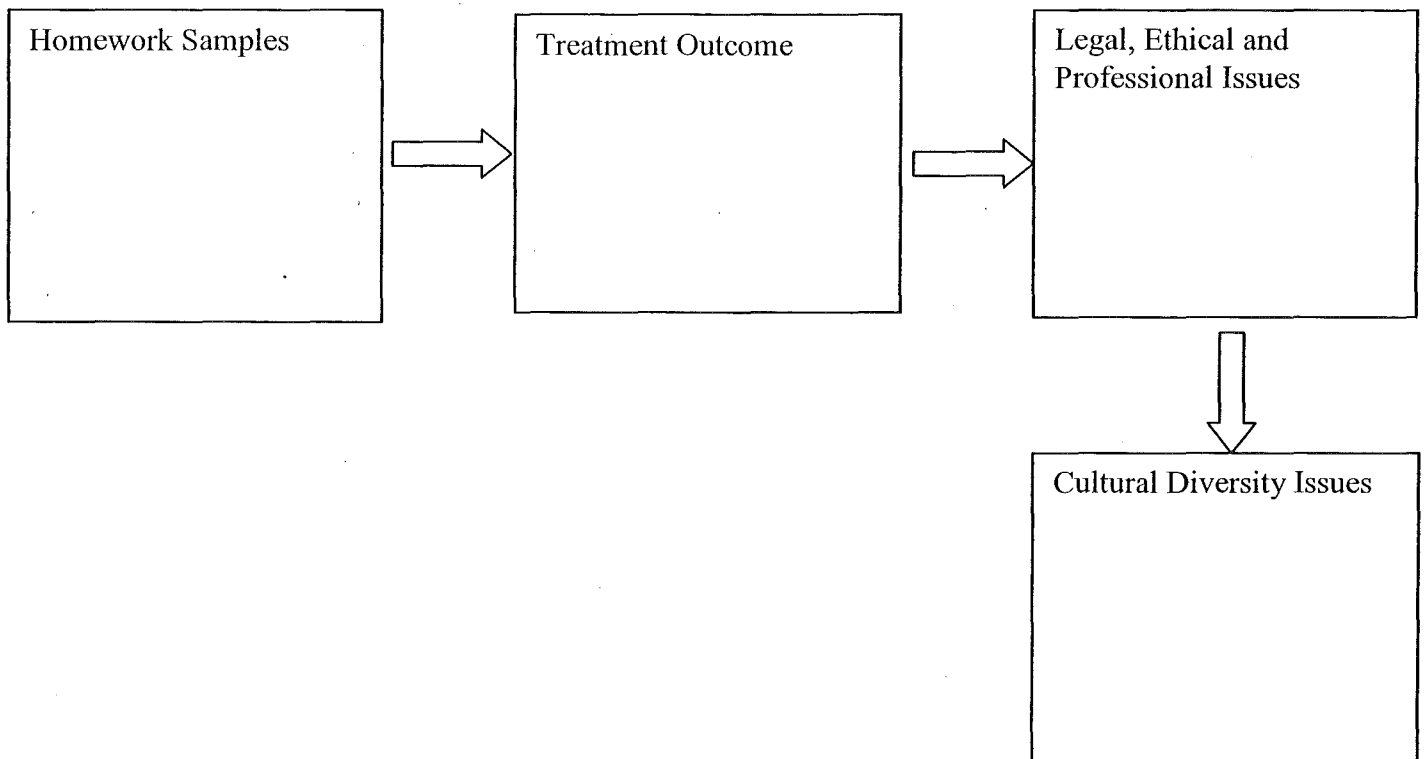
APPENDIX D
Flow Chart



Flow Chart (Continued)



Flow chart (Continued)



APPENDIX E

Process Notes

Process Note (Initial Intake)

Patient Name- CM

Therapist Name – Marcy Shoemaker

Session Date/ Time Involved

1. What tasks have been accomplished in the session as suggested in the treatment manual? The client was introduced to the manual. A description of the principles and effectiveness of cognitive therapy were discussed. The informed consent form was reviewed and signed by the client. The importance of homework was discussed and the responsibilities of the client were discussed. The client completed the BDI, The WAIS and the Quality of Life form.
2. What obstacles occurred in the session? (patient, administrative, therapist etc). There were no obstacles from the patient who was enthusiastic about participating in the study. No obstacles from the administration occurred, related to this session. The therapist did not receive any obstacles related to this session.
3. What areas were not addressed? All areas were addressed during the session.
4. What areas of concern or difficulty were expressed by the patient? The patient was enthusiastic and did not express any concerns. This may be a reaction to his excitement of participating in the study and his hope that this approach will help reduce his depressive symptoms when other approaches have been unsuccessful.
5. What was the patient's general mood, feelings expressed and any areas of self-reflection? The client exhibited a flat affect and a low energy level. He expressed the idea that he was depressed especially about his economic problems, poor job prospects and problems going to the bathroom in public places. He showed some self-reflection and understanding of his depression.
6. Any concerns expressed about medication (compliance, side-effects, improvements etc.). The client is compliant about his medication and is not experiencing any side-effects. He feels that his medicine is helpful especially with his sleeping.

7. Any changes or adjustments made or needed to agenda or structure of session? At this preliminary state, no adjustments are needed. Very few adjustments will be made because the purpose of the study is to adhere to the standardized manual.
8. Other comments and reflections- The client was clearly depressed and had suffered from depression for at least 6 years. He answered questions clearly and was very positive about participating in the study.
9. What patient characteristics contribute to the patient acquiring new adaptive skills? The client expressed a desire to reduce his depression which he felt will help him in obtaining another employment opportunity.
10. What do I as a therapist want to understand about the patient's experience? It is important to understand the etiology of his depression and previous treatment. It is helpful to understand if his medication helps manage his depression or only aids in his sleep problems.
11. How did I feel about providing therapy based on the constructs of a manual? What did I feel were the patient's perspectives, administrative staff's attitude etc? At this point, I am looking forward to proceeding with future sessions. The patient was very positive about trying this approach. I did not receive any feedback from the administrative staff at this point.
12. Did the use of a manual affect the therapist's degree of creativity? The manual was not the main source of the therapy today. The majority of the session was focused on reviewing the content of the informed consent form and completing the BDI and the QOLI measures. The use of a manual did not affect creativity in this session.
13. Were there any training issues? There were no training issues during the session for the therapist because training was not provided by the agency and preparation occurred by the therapist's preparing for the first session and by meeting with the advisor.
14. Were there any effects on the therapeutic relationship? There was no effect on the therapeutic relationship. The patient was cooperative and enthusiastic about his involvement in the manual based treatment sessions.
15. Was the therapist and client satisfied with the therapy session? Both the therapist and the client were satisfied with the session.
16. Was fidelity difficult to achieve? Fidelity measures were not difficult to achieve.
17. Was the therapy effective? It is too preliminary a point in therapy to measure effectiveness. Effectiveness will be measured by a decrease in depression as indicated by the BDI results, by improvement in the client's quality of life as measured by the QOLI and by the effect of the working alliance as measured by the results of the WAIS-S

Process Note-Session 1

Patient Name CM

Therapist Name Marcy Shoemaker

Session Date/ Time Session 1 hr

1. What tasks have been accomplished in the session as suggested in the treatment manual? The client's goals were discussed. His symptoms were reviewed; these included a low energy level, concentration problems, weight gain, loss of hope, low activity level etc. He discussed the fact that he feels more depressed due to his work situation, economic problems and mother's Alzheimer's. The client also felt that his depression was attributed to his fear and inability of urinating in public places. He also felt that his dissatisfaction with his relationship with his girlfriend contributes to his depression. A brief history of his disorder was reviewed; this included a discussion of his treatment history and medication usage. The client stated that he has not committed suicide but alluded to hurting himself. He refused to elaborate on this matter.
2. What obstacles occurred in the session? (patient, administrative, therapist etc). The patient was cooperative but guarded about certain questions especially his past behavior of hurting himself. He quickly stated that he had no alcohol / drug problems or usage. This area was not questioned, which leaves the therapist with concerns about his possible defensive reaction. The client also stated that he had no recollection of the previous medications that he had been prescribed. This answer is possible but did not seem consistent with the detail of other answers. There were no obstacles with the administration. The therapist felt that the client was not freely answering all questions. This leaves the therapist with concerns about his openness and ability to cooperate with other difficulty areas or questions.
3. What areas were not addressed? All areas were addressed in the manual with the exception of the above stated areas that the client did not answer.
4. What areas of concern or difficulty did the patient express? The patient expressed difficulty urinating in public places which he felt contributed to his employment and social problems. He referred to compulsive behaviors that he experiences. The client tended to blame others for his problems, especially his girlfriend's and mother's health.
5. What were the patient's general mood, feelings expressed and any areas of self-reflection? The client's affect was flat and he exhibited a low energy level. He seemed well versed in mental health terms, especially when he referred to his obsessive/compulsive behaviors. He did not seem to understand the question about hearing things that others did not hear. He feels that he has a greater instinct than others,

especially his girlfriend.

6. Any concerns expressed about medication (compliance, side-effects, improvements etc.). The client states that he is compliant with his medication but does not seem to understand or see any benefit to the use of an antidepressant and anti anxiety drug. He feels that the only benefit of his medication is to aid his sleep problems. I also question his usage of xyprexa and wonder if it is possibly related to his statement of paranoid feelings. I also wonder why he has no recollection of previous medications prescribed.

7. Any changes or adjustments made or needed to agenda or structure of session? No changes were made to the agenda at this time

8. Other comments and reflections- I am concerned about the client's comments about feelings of paranoia and his belief that he has greater intuitive powers than others. I am concerned about his comment about hurting himself and his unwillingness to discuss the details of this incident. I am also concerned about the actual length of his depression and if this client is an accurate reporter of his depression and related problems.

9. What patient characteristics contribute to the patient acquiring new adaptive skills? The client states that he is highly interested in the format of this therapy. He has been compliant with homework assignments.

10. What do I as a therapist want to understand about the patient's experience? I would like to have a greater understanding about the onset of his depression. I also need to understand more about his shy-bladder problems and if this is used as an excuse for his depression. I would like to learn more about his paranoid feelings and learn more about his incident of hurting himself.

11. How did I feel about providing therapy based on the constructs of a manual? What did I feel were the patient's perspectives, administrative staff's attitude etc? I am looking forward to working with this approach because it is based on evidence-based practices and may give me a new perspective concerning the treatment of depression. The patient appeared to be positive about this approach. I am concerned about the overall poor attitude among the staff in the clinic. I don't know if their dissatisfaction could impact on my ability to share my findings with other therapists.

12. Did the use of a manual affect the therapist's degree of creativity? The use of a manual did not affect the therapist's degree of creativity.

13. Were there any training issues? All training and preparation for the session and all subsequent sessions occurred prior to the session. There will be no training at the mental health clinic.

14. Were there any effects on the therapeutic relationship? There were no negative effects on the therapeutic relationship, as noted by the therapist. The client appeared cooperative and was willing to participate in homework assignments.

15. Was the therapist and client satisfied with the therapy session? Both the therapist and the client appeared satisfied with the therapy session.

16. Was fidelity difficult to achieve? Fidelity measures were not difficult to achieve.

17. Was the therapy effective? The therapy session was accomplished and all assignments were completed. Depression and quality of life measures were not reviewed at this session.

18. Other issues- The activities are being accomplished as outlined in the manual. The sessions remain to cover???? 1 hour which exceeds the 50 minute suggested time by the agency. I do not foresee any problems with the extra 10 minutes as long as I do not delay the start of my next counseling session. There are no training issues because training does not occur at the agency. I believe that it may be difficult for other therapists to adhere to this manual or to related manuals due to the lack of training at the agency. I am able to be successful due to my training and reinforcement from my dissertation chairs. There are no cost issues because I am assuming all costs. This type of therapy would produce cost issues for other therapists because they would need to purchase the manuals, measures and spend extra time outside of the session in interpreting the measures and preparing for future sessions.

Process Note: Session 2

Patient Name: CM

Therapist Name: Marcy Shoemaker

Session Date/ Time Involved- 1 hour

1. What tasks have been accomplished in the session as suggested in the treatment manual? The concept of negativity and its effect of depression were introduced. The action schedule was introduced and the key concepts of mastery and pleasure were discussed.

2. What obstacles occurred in the session? (patient, administrative, therapist etc). The patient needed to be redirected to return to the agenda in the manual and not concentrate on discussing issues in his personal life. He was easily redirected. There were no issues from the administrative staff with the exception of the overall poor morale that exists among the therapeutic staff and the administrative staff concerning the working conditions and the pay at the agency. I did not experience any obstacles during this session.

3. What areas were not addressed? All areas were addressed during the session.

4. What areas of concern or difficulty did the patient express? The patient expressed some negativity about doing homework and stated that he felt that he was back in school.
5. What were the patient's general mood, feelings expressed and any areas of self-reflection? The patient maintains a high level of depressive symptoms including low energy, feeling overwhelmed, a poor view of himself, his world and the future and lack of interest in pleasurable activities. The patient expressed the idea that he views himself as a second class citizen due to his depression.
6. Any concerns expressed about medication (compliance, side-effects, improvements etc.). The patient states that he is compliant with his medication but feels that the only benefit of the medication is in aiding him with his sleep problems.
7. Any changes or adjustments made or needed to agenda or structure of session? No changes are needed at this time to the agenda or structure of the session.
8. Other comments and reflections- I am concerned about the patient's long-term history of depression. He is unable or unwilling at this point to challenge his negative thoughts.
9. What patient characteristics contribute to the patient acquiring new adaptive skills? The patient has a strong belief in the benefits of therapy and is excited about participating in a new treatment approach.
10. What do I as a therapist want to understand about the patient's experience? I would like to have a better understanding about his mother's illness and its effect on the client's depressive symptoms. I would like to have a better understanding of his work history and his reasons for lack of success in his jobs. I would like to know why the patient did not complete college or pursue a GED course.
11. How did I feel about providing therapy based on the constructs of a manual? What did I feel were the patient's perspectives, administrative staff's attitude etc? I am excited about administering therapy, based on a manualized approach. At the same time, I am concerned about the patient's ongoing willingness to participate in homework assignments.
12. Did the use of a manual affect the therapist's degree of creativity? As a therapist, I did not feel limited or constrained by the use of a manual.
13. Are there any training issues? There were no training issues.
14. Were there any effects on the therapeutic relationship? The therapeutic relationship remains positive.
15. Were the therapist and client satisfied with the therapy session? Both the therapist and the client appeared to be satisfied with the therapy session.

16. Was fidelity difficult to achieve? Fidelity measures were not difficult to achieve.

17. Was the therapy effective? The therapy was effective in the sense that all areas of the session were completed.

18. Other issues- I will receive limited supervision from my supervisor and will have limited time to speak to colleagues about the use of a manual. I believe that the therapeutic relationship is developing. The client seems satisfied with this form of therapy but I am concerned that he may feel that appropriate time is not being allotted to discuss other areas of his life. He is accustomed to less structured forms of therapy and may feel that this therapeutic approach limits the therapist from addressing his personal problems.

Process Note: Session 3

Patient Name: CM

Therapist Name: Marcy Shoemaker

Session Date/ Time

1. What tasks have been accomplished in the session as suggested in the treatment manual? The client's status was monitored. The therapist worked with the client in setting an agenda. The therapist mentioned last session's introduction to the action schedule. The therapist reviewed the homework with the client. The psychoeducation section concentrated on scheduling the client's day with an emphasis on making better choices to aid in reducing depression. A common symptom of depression, disappointment, was discussed. The concept of being able to control thoughts during times of disappointment was introduced. The action schedule was discussed in more detail with a concentration on choosing actions that are appropriate to increase pleasure, generate motivation and aid in reducing depression.

2. What obstacles occurred in the session? (patient, administrative, therapist etc). The patient needed to be redirected to return to the agenda in the manual and not concentrate on discussing issues in his personal life throughout the session. The client was easily redirected. There were no issues from the administrative staff with the exception of the overall poor morale that exists among the therapeutic staff and the administrative staff concerning the working conditions and the pay at the agency. The administrative staff has not been involved in the administration or review of the manual. I did not experience any obstacles during this session.

3. What areas were not addressed? All areas were addressed during the session.

4. What areas of concern or difficulty did the patient express? The client feels that the activity schedule does not meet his needs because he works night hours.
5. What were the patient's general mood, feelings expressed and any areas of self-reflection? The client maintains a high level of depressive symptoms including low energy and feelings of neglect by his family. The patient expresses a feeling of dissatisfaction with his work life and relationship.
6. Any concerns expressed about medication (compliance, side-effects, improvements etc.). The client states that he is compliant with his medication.
7. Any changes or adjustments made or needed to agenda or structure of session? The client will work on adjusting the activity schedule to reflect his night work schedule, which is an important area of his life.
8. Other comments and reflections- I am concerned about the client's long-term history of depression. I am concerned about the client's procrastination to look for a new job, which he communicates as an important goal in his life.
9. What patient characteristics contribute to the patient acquiring new adaptive skills? The client has a strong belief in the benefits of therapy. He is highly motivated and expresses a desire to improve his quality of life.
10. What do I as a therapist want to understand about the patient's experience? I would like to understand more about the client's family relationships and the impact of his father's separation from the family
11. How did I feel about providing therapy based on the constructs of a manual? What did I feel were the patient's perspectives, administrative staff's attitude etc? I am excited about administering therapy, based on a manualized approach. I do feel pressured to accomplish the tasks in the manual and am concerned about not permitting the client to discuss other important matters in his life.
12. Did the use of a manual affect the therapist's degree of creativity? I was concerned with not being able to complete the full contents of the session due to the client's lengthy discussion about why the activity schedule did not accommodate his night work hours. I was concerned that I would not accomplish the entire session in the allotted time. My creativity was affected because I was not able to explore his feelings about the importance of his work and his feeling that his work time was being neglected
13. Were there any training issues? There were no training issues. I would have preferred having a supervisor available to discuss the client's obsession with his feeling that the action schedule did not adequately meet his work schedule.
14. Were there any effects on the therapeutic relationship? I was able to spend time with the client in discussing his concerns about the limitations of the activity schedule.

15. Was the therapist and client satisfied with the therapy session? I feel that both the therapist and the client were satisfied with the session.

16. Was fidelity difficult to achieve? Fidelity measures were not difficult to achieve.

17. Was the therapy effective? The therapy was effective because the session was completed in full and the client was able to spend time on his concerns with the limitations of the activity schedule.

18. Other areas addressed: The activity scheduling process is continuing and the client is improving his mastery of this task. The client has been extremely cooperative in showing up early for sessions to complete these tasks. There has been no involvement with my supervisor and I do not expect that this will change throughout the sessions. I believe that I am accomplishing the tasks that are designated in the manual with strict adherence to fidelity measures.

Process Note: Session 4

Patient Name: CM

Therapist Name: Marcy Shoemaker

Session Date/ Time Interval

1. What tasks have been accomplished in the session as suggested in the treatment manual? The client's status was monitored. The therapist worked with the client in setting an agenda. The therapist mentioned last session's introduction to the action schedule. The therapist reviewed the homework with the client. The psychoeducation section concentrated on discussing the concept of avoidance and the importance of taking actions to reduce avoidance. The therapist spoke about how taking actions in small, reasonable steps would have the effect of increasing energy, motivation and self-esteem. The ultimate goal is to reduce and hopefully eliminate depression. The client was asked to work on approaching a task that he is avoiding in simplistic steps.

3. What obstacles occurred in the session? (patient, administrative, therapist etc). There were no obstacles with the patient; the patient was highly cooperative and showed insight into the multiple purposes of the activity schedule. He also was able to point out areas that he avoided and understood the connection between avoidance and depression. There were no issues from the administrative staff with the exception of the overall poor morale that exists among the therapeutic staff and the administrative staff concerning the working conditions and the pay at the agency. The administrative staff has not been involved in the administration or review of the manual. I did not experience any obstacles during this session.

2. What areas were not addressed? All areas were addressed during the session.
3. What areas of concern or difficulty were expressed by the patient? The patient expressed some negativity about doing homework. He seemed to concentrate on his shy bladder problem and felt that this problem would prevent him from progressing in the program.
4. What was the patient's general mood, feelings expressed and any areas of self-reflection? The patient maintains a high level of depressive symptoms including low energy, feeling overwhelmed, a poor view of himself, his world and the future and lack of interest in pleasurable activities. The patient is noticing a direct benefit between increasing his activities and a reduction in depression during the periods of action. He was able to state examples of times when he was able to change his negative thinking. He stated an example when, in a previous session he stated that anyone could do his job. In this session, he commented on receiving praise from his employer and noted that he felt less depressed and experienced increased self-esteem. He was able to comment on activities in which he experienced pleasure and mastery. Even though he maintains a high level of depression, a slight improvement is noted by the patient.
5. Any concerns expressed about medication (compliance, side-effects, improvements etc.). The patient states that he is compliant with his medication.
6. Any changes or adjustments made or needed to agenda or structure of session? No changes are needed at this time to the agenda or structure of the session.
7. Other comments and reflections- I am concerned about the patient's long term history of depression. He tends to blame his depression on his shy bladder problem. I am concerned that he will use this problem as an excuse for not progressing in the therapy.
8. What patient characteristics contribute to the patient acquiring new adaptive skills? The patient has a strong belief in the benefits of therapy and is excited about participating in a new treatment approach. He remains somewhat optimistic about participating in this form of therapy and is willing to complete all assignments. The patient likes the personalized attention that he is getting as a participant in this program.
9. What do I as a therapist want to understand about the patient's experience? I need to understand more about the relationship with the patient's depression and his shy bladder problem.
10. How did I feel about providing therapy based on the constructs of a manual? What did I feel were the patient's perspectives, administrative staff's attitude etc? I am excited about administering therapy, based on a manualized approach. At the same time, I am concerned about the patient's ongoing willingness to participate in homework assignments. I am concerned that I may feel restricted by the manual at some time in the future.

11. Did the use of a manual affect the therapist's degree of creativity? I did not feel that my creativity was affected during this session.
12. Were there any training issues? There were no training issues that occurred during this session.
13. Were there any effects on the therapeutic relationship? There were no effects on the therapeutic relationship.
14. Was the therapist and client satisfied with the therapy session? Both the therapist and the client appeared satisfied with the session. There were no concerns expressed by the client.
15. Was fidelity difficult to achieve? Fidelity was not difficulty to achieve.
16. Was the therapy effective? The client is increasing his activity level and is compliant with homework assignments. Depression and Quality of life measures have not been compared with previous sessions. This will occur at the end of the next session.
17. Other areas addressed: The activity scheduling process is continuing. The session lasted for 1 hour and the client spent 10 minutes prior to the session in the waiting room while completing his measures. The client has been extremely cooperative in showing up early for sessions to complete these tasks. I don't believe that the therapeutic relationship is affected by the use of a manual as compared to other forms of therapy.

Process Note – Form Session 5

Patient Name- CM

Therapist Name – Marcy Shoemaker

Session Date/ Time Involved

1. What tasks have been accomplished in the session as suggested in the treatment manual? The client was introduced to the connection between negative thoughts and his depression. The client learned how to use a thought record to track and evaluate automatic thoughts.
2. What obstacles occurred in the session? (patient, administrative, therapist etc). The client was not prepared with his homework because he continues to experience health problems related to a strep throat.
3. What areas were not addressed? All areas were addressed even though the homework assignment was completed during the session.

4. What areas of concern or difficulty did the patient express? The client continues to express concern about his inability to find a new job and participate in the search for a new job. He expresses concern about his relationship with his girlfriend which he feels is an obstacle in moving forward in his life.
5. What were the patient's general mood, feelings expressed and any areas of self-reflection? The client continues to express a flat affect and expresses the presence of depressive symptoms. His BDI scores continue to reflect a high level of depression.
6. Any concerns expressed about medication (compliance, side-effects, improvements etc.): No concerns were expressed about the client's medication with the exception that he is experiencing a low level of energy which may be intensified (??) from his viral symptoms.
7. Any changes or adjustments made or needed to agenda or structure of session? The homework needed to be completed during the session because the client did not complete the homework at home.
8. Other comments and reflections- The client seems to understand the principles taught in the session and he is beginning to use the skills in his life.
9. What patient characteristics contribute to the patient acquiring new adaptive skills? The client is motivated to learn the skills taught in therapy and he is eager to attend therapy and perform successfully during the sessions.
10. What do I as a therapist want to understand about the patient's experience? I need to gain a better understanding of his reliance on his girlfriend and his reasons for staying in the relationship. This may not be possible due to the time constraints of the therapy.
11. How did I feel about providing therapy based on the constructs of a manual? What did I feel were the patient's perspectives, administrative staff's attitude etc? I, along with the patient, feel positive about using the manual as the main construct of the therapy sessions.
12. Did the use of a manual affect the therapist's degree of creativity? I do not feel that my creativity was affected. I feel that I have time constraints may limit me in exploring other areas because I feel that it is more important to complete the items in the manual.
13. Were there any training issues? There were no training issues. I believe that I do not have training issues because I receive support and advice from my dissertation committee. I am concerned that other therapists may have many training issues because they do not have the support that I receive.
14. Were there any effects on the therapeutic relationship? The therapeutic relationship continues to be positive.

15. Were the therapist and client satisfied with the therapy session? Both the therapist and the client appeared to be satisfied with the therapy session.
16. Was fidelity difficult to achieve? Fidelity was not difficulty to achieve during the session.
17. Was the therapy effective? The therapy was effective in the sense that the session was completed and the client appeared comfortable with the principles.
18. Other areas addressed. The client was given limited time to speak about his viral illness and his concerns about his relationship.

Process Note – Form Session 6

Patient Name- CM

Therapist Name – Marcy Shoemaker

Session Date/ Time Involved 1 hour

1. What tasks have been accomplished in the session as suggested in the treatment manual? The client was introduced to three new questions concerning the following: What is the evidence? What's another way of looking at the situation or thought? and Even if it is true, how bad are the consequences?
2. What obstacles occurred in the session? (patient, administrative, therapist etc). There were no obstacles in the session concerning the client, administration or therapist.
3. What areas were not addressed? All areas were addressed.
4. What areas of concern or difficulty did the patient express? The client continued to express health concerns, concerns with getting a new job and problems with his relationship.
5. What were the patient's general mood, feelings expressed and any areas of self-reflection? The client continues to exhibit depressive symptoms and shows a flat affect.
6. Any concerns expressed about medication (compliance, side-effects, improvements etc.). There were no concerns about medication.
7. Any changes or adjustments made or needed to agenda or structure of session? No changes or adjustments were needed to the agenda or structure of the session.

8. Other comments and reflections- The client continues to remain stuck in his relationship and with his inability to look for a new job. He is excelling in acquiring the new skills and is beginning to apply them to his life.
9. What patient characteristics contribute to the patient acquiring new adaptive skills? The client attends all therapy sessions and wants to excel with his new skills.
10. What do I as a therapist want to understand about the patient's experience? I would like to learn more about the client's romantic relationship and prior relationships. I would like to know if he has chosen individuals who help him financially but do not meet his emotional needs.
11. How did I feel about providing therapy based on the constructs of a manual? What did I feel were the patient's perspectives, administrative staff's attitude etc? I remain positive about applying therapy, based on the constructs of the manual.
12. Did the use of a manual affect the therapist's degree of creativity? I do not feel that my creativity has been reduced.
13. Were there any training issues? The client is grasping the new concepts and additional training issues or concerns have not developed.
14. Were there any effects on the therapeutic relationship? The therapeutic relationship remains positive.
15. Were the therapist and client satisfied with the therapy session? Both the therapist and the client appeared satisfied with the therapy session.
16. Was fidelity difficult to achieve? Fidelity was not difficulty to achieve.
17. Was the therapy effective? The therapy appeared effective in the sense that the session was completed and all new concepts were covered and learned effectively.
18. Other areas addressed. I feel that the client is beginning to benefit from the new concepts and is starting to apply them in his life. I am concerned that his BDI scores remain in the severely depressed area.

Process Note – Form Session 7

Patient Name- C.M.

Therapist Name – Marcy Shoemaker

Session Date/ Time Involved 1 hour

1. What tasks have been accomplished in the session as suggested in the treatment manual? The client reviewed his completed, extended thought record and learned the new skills of noting and dropping.
2. What obstacles occurred in the session? (patient, administrative, therapist etc). There were no obstacles in the session. The client is suffering from throat problems that have persisted for at least 6 weeks; this makes it difficult for him to speak loudly. There are concerns about the quality and clarity of the tape recording.
3. What areas were not addressed? All areas were addressed in the session.
4. What areas of concern or difficulty did the patient express? The client expressed problems speaking due to his ongoing throat problems.
5. What were the patient's general mood, feelings expressed and any areas of self-reflection? The client stated that he is noting a slight improvement in his mood even though that was not reflected in the BDI score. He is beginning to apply the skills to his life outside of therapy. He is beginning to show insight about his depression and the positive effect of applying the new skills in his life.
6. Any concerns expressed about medication (compliance, side-effects, improvements etc.). The client did not express any concerns about his medication.
7. Any changes or adjustments made or needed to the agenda or structure of the session? The session went smoothly and no changes were needed.
8. Other comments and reflections- The therapy sessions seem to be going well. The client is highly cooperative and willing to learn new skills. He is beginning to apply his skills outside of therapy.
9. What patient characteristics contribute to the patient acquiring new adaptive skills? The client remains very enthusiastic about participating in the study and learning the new skills.
10. What do I as a therapist want to understand about the patient's experience? I would like to learn how the client motivates himself and why he is experiencing ongoing difficulties with beginning the job interviewing process. He does exhibit traits of persistence in regard to his therapy.
11. How did I feel about providing therapy based on the constructs of a manual? What did I feel were the patient's perspectives, administrative staff's attitude etc? I had no difficulty using the manual to provide therapy.
12. Did the use of a manual affect the therapist's degree of creativity? I did not feel that the manual restricted my ability to be creative. I did feel pressured to accomplish the full

session and did not feel that I had time to properly address the patient's concerns about his health problems and relationship issues.

13. Were there any training issues? There were no training issues in this session.
14. Were there any effects on the therapeutic relationship? The therapeutic relationship remains strong.
15. Were the therapist and client satisfied with the therapy session? Both the therapist and the client appeared to be satisfied with the therapy session.
16. Was fidelity difficult to achieve? Fidelity was not difficult to achieve.
17. Was the therapy effective? The therapy appeared to be effective because the client is beginning to apply his skills to his life outside of the therapy session.
18. Other areas addressed. During the supervisory session today, a therapist inquired about my study. She appeared interested in the skills addressed in the manual but stated that she was unwilling to invest in the manual or the measures that were being used.

Process Note – Form Session 8

Patient Name- C.M.

Therapist Name – Marcy Shoemaker

Session Date/ Time Involved- 1 hour

1. What tasks have been accomplished in the session as suggested in the treatment manual? The patient learned about the concept of core beliefs, the need to set moderate goals when challenging his negative beliefs. We discussed the fact that negative beliefs are a major factor in depression. We discussed that core beliefs usually develop at a young age and we worked on questions to help challenge negative beliefs.
2. What obstacles occurred in the session? (patient, administrative, therapist etc). The client stated that he does not have negative beliefs or distortions but believes that they are factual occurrences in his life. This belief may deter progress in helping the client recognize his negative beliefs that are increasing his depressive symptoms.
3. What areas were not addressed? All areas were addressed in the session.
4. What areas of concern or difficulty were expressed by the patient? The client found the exercise of “noting and dropping” thoughts difficult.
5. What was the patient's general mood, feelings expressed and any areas of self-reflection? Through the role playing, the client was able to recognize his positive traits

and to challenge his negative beliefs about himself. He recognized the importance that he plays in his mother's life and was also able to realize that he is not a failure even though he is not as accomplished academically as his brothers and sisters.

6. Any concerns expressed about medication (compliance, side-effects, improvements etc.). There were no concerns expressed about medication.

7. Any changes or adjustments made or needed to agenda or structure of session? There were no changes or adjustments made in the session.

8. Other comments and reflections- The client is beginning to use the tools learned in his daily life. He also remains enthusiastic about learning new techniques. He found the discussion of core beliefs interesting and was insightful in recognizing his core beliefs. He was able to identify a core belief that he is a loser, which may be the cornerstone of his depression.

9. What patient characteristics contribute to the patient acquiring new adaptive skills? The client is intelligent, intuitive and enthusiastic to learn new skills.

10. What do I as a therapist want to understand about the patient's experience? I would like to understand when his belief of being a loser first developed. I wonder if there were any significant events or feedback from role models in his life that contributed to his overriding negative belief.

11. How did I feel about providing therapy based on the constructs of a manual? I remain enthusiastic about providing therapy based on a manual.

12. What did I feel were the patient's perspectives, administrative staff's attitude etc? The client's perspective was very positive and he expresses (?) reflective, positive comments about the usefulness of the therapy. The administrative staff remains uninvolved in the process or therapy. Did the use of a manual affect the therapist's degree of creativity? I don't believe that my creativity was affected due to the use of a treatment manual.

13. Were there any training issues? There were no training issues.

14. Were there any effects on the therapeutic relationship? The therapeutic relationship remains positive and seems to get stronger during each session.

15. Were the therapist and client satisfied with the therapy session? Both the therapist and the client appeared satisfied with the therapy session.

16. Was fidelity difficult to achieve? Fidelity was not difficult to achieve

17. Was the therapy effective? Therapy was effective because the client found the new skills helpful and meaningful to his life. The client continues to complete his homework

assignments and apply the skills to his relationships.

18. Other areas addressed. The client expressed his concerns about not making greater progress with his depression. He was assured that depression is a gradual process and that change takes place over time. The client seemed relieved with this explanation.

Process Note – Form Session 9

Patient Name- C.M.

Therapist Name – Marcy Shoemaker

Session Date/ Time Involved 1 hour

1. What tasks have been accomplished in the session as suggested in the treatment manual? The patient was introduced to the concept of self-talk and over thinking. We also spoke about recognizing negative thoughts and replacing them with positive thoughts. We concentrated on the effect of positive thoughts on mood and depressive symptoms.
2. What obstacles occurred in the session? (patient, administrative, therapist etc). The client continued to experience health problems and found it difficult to concentrate on his assignments even though he completed all assignments. The client was fearful about his health problems but still remained interested in completing the session.
3. What areas were not addressed? All areas were addressed based on the constructs of the manual. I felt that I was unable to spend more time discussing the client's fears about his health.
4. What areas of concern or difficulty were expressed by the patient? The client is concerned about his throat problems and also continues to experience relationship problems with his girlfriend. He is unable to recognize any positive aspects about his relationship with his girlfriend or acknowledge his reasons for remaining in the relationship.
5. What was the patient's general mood, feelings expressed and any areas of self-reflection? The client was fearful due to the uncertainty of his health problems. He continues to improve in the area of self reflection. He is recognizing the helpfulness of the skills learned in therapy and feels that the skills would be helpful for others in his life.
6. Any concerns expressed about medication (compliance, side-effects, improvements etc.). The client did not express any concerns about his medication.

7. Any changes or adjustments made or needed to agenda or structure of session? Some time was allotted to discuss the client's health concerns and his dissatisfaction with his relationship.
8. Other comments and reflections- The client is enjoying his participation in therapy and is finding the skills helpful and applicable to his everyday life. The client continues to blame his girlfriend for many of his problems and does not take responsibility for any problems in the relationship.
9. What patient characteristics contribute to the patient acquiring new adaptive skills? The client continues to be interested in learning new skills and is enthusiastic during sessions.
10. What do I as a therapist want to understand about the patient's experience? I would like to understand the client's early expectations about his relationship with his girlfriend. I would like to understand more about other significant relationships in the client's life to see if there is a pattern of blaming others and overall dissatisfaction.
11. How did I feel about providing therapy based on the constructs of a manual? I continue to remain positive about using a manual for therapy but am concerned about not having adequate time to address problems in the client's life.
12. What did I feel were the patient's perspectives, administrative staff's attitude etc? The client is positive about therapy and feels that the concepts learned are relevant and helpful to his daily life. The administrative staff remains uninvolved in the therapy with the exception of a brief overview of the status of therapeutic process during the monthly group supervision.
13. Did the use of a manual affect the therapist's degree of creativity? The use of a manual did not affect the therapists' degree of creativity.
14. Were there any training issues? There were no training issues.
15. Were there any effects on the therapeutic relationship? The therapeutic relationship continues to strengthen over time.
16. Were the therapist and client satisfied with the therapy session? Both the therapist and client were satisfied with the therapy session. The therapist was concerned about not spending adequate time addressing the client's health and relationship concerns.
17. Was fidelity difficult to achieve? Fidelity continues to be achieved with ease.
18. Was the therapy effective? The therapy was effective as demonstrated by the client's increased insight, enthusiasm, demonstration of skills learned and ability to apply the skills and concepts to his daily life.

19. Other areas addressed. The client was encouraged to attend all scheduled medical appointments and consider bringing his girlfriend to his appointments for support.

Process Note – Form Session 10

Patient Name- C.M.

Therapist Name – Marcy Shoemaker

Session Date/ Time Involved- 1 hour

1. What tasks have been accomplished in the session as suggested in the treatment manual? This will be the final session in which key concepts will be reviewed, progress discussed, and question time for the client, and a discussion of how to avoid relapses.
2. What obstacles occurred in the session? (patient, administrative, therapist etc). The patient is experiencing health problems and is concerned about the treatment options recommended at an upcoming specialist appointment. He is very much concerned about his health, ability to maintain his job and is very angry toward his girlfriend. Even though the session was completed in full, it was difficult to focus the patient on a review of the concepts covered during the course of therapy.
3. What areas were not addressed? All areas were addressed in the session. Sufficient time was probably not given to the client to explore his fears of his upcoming doctor's appointment and treatment possibilities.
4. What areas of concern or difficulty were expressed by the patient? The patient was able to understand and utilize the concepts discussed throughout the course of treatment. He is unsure about his future and is extremely worried about his health.
5. What was the patient's general mood, feelings expressed and any areas of self-reflection? The patient was depressed, expressed a flat affect and demonstrated feelings of anger toward his girlfriend.
6. Any concerns expressed about medication (compliance, side-effects, improvements etc.). There were no concerns about medication.
7. Any changes or adjustments made or needed to agenda or structure of session? More time was allotted in discussing the patient's concerns due to his health problems.
8. Other comments and reflections- I was surprised to learn that the client is a smoker which was denied during the intake. I also have been thinking about other areas of strong denial during earlier sessions especially about smoking, drinking and using illegal drugs. I feel that I don't have a complete picture of the client especially about his lack of achievement, beginning with not completing high school. The client continually

represented in his BDI that he attended some college, which has proven not to be factual. I wonder why the client dropped out of high school and question why his family member, in court, challenged his guardianship rights toward his mother.

9. What patient characteristics contribute to the patient acquiring new adaptive skills? The client, despite experiencing a health crisis, completed his homework and was interested in completing the final session. It would be understandable if he had preferred to allocate the full session to his health concerns. He is exhibiting resilience and is using the skill of challenging his negative thoughts when remaining optimistic about his health outcomes.

10. What do I as a therapist want to understand about the patient's experience? As stated earlier, I would like to know more about the time when the client dropped out of high school. I believe that there are more explanations for his career failures and depression.

11. How did I feel about providing therapy based on the constructs of a manual? What did I feel were the patient's perspectives, administrative staff's attitude etc? I feel that the manual is well written and the material is well distributed throughout the manual. I question if sufficient time is allocated to dealing with life crises.

12. Did the use of a manual affect the therapist's degree of creativity? I don't feel that my creativity was reduced.

13. Were there any training issues? There were no training issues

14. Were there any effects on the therapeutic relationship? The therapeutic relationship has remained strong throughout therapy.

15. Were the therapist and client satisfied with the therapy session? I feel that both the client and therapist were satisfied with the therapy sessions.

16. Was fidelity difficult to achieve? Fidelity was not difficult to achieve.

17. Was the therapy effective? The therapy was effective in teaching the patient new skills and witnessing the utilization of these skills by the patient in his everyday life.

18. Other areas addressed. I am concerned about the patient's health outcome. This is truly an example of a case study in which challenges occur during the course of therapy.

APPENDIX - F

Outline for Empirical Proposal Sessions

I. Sessions

A. Session 1- Intake

1. Client Goals

2. Assessment

a) Current Symptoms

b) History of disorder

c) Treatment History and medications

d) Comorbidity

e) Strengths

3. Urgent Interfering Conditions

a) Suicide

b) Violence and self-injury

c) Psychosis

d) General Mental Status

e) Substance Abuse

4. Depression Severity

5. Risk of suicide review of medication use

6. Treatment Recommendations

7. Session summary

8. Feedback from client

9. Homework

B. Session 2- Understanding Depression

1. Monitoring of Current Status

2. Agenda

3. Review of Homework

4. Concept and Skills

a) Psychoeducation

b) The nature of negativity

c) Awareness of the Symptoms

d) Recognizing Negativity

e) Building Cases

5. Good Moods

a) Skill Building

b) Action Building

6. Steps in Activity Monitoring

a) Write down activities on an hour-by-hour basis

b) Rate mastery and pleasure from 1 to 5

c) Rate the action quickly

7. Session Summary

8. Homework

a) Fill out action Schedule (See Appendix)

b) Read Session 2 in client manual

C. Session 3

1. Monitoring of Current Status

2. Agenda

a) Review client's understanding of action schedule

b) More in depth discussion of action schedule

c) Complete Depression Questionnaire from manual

3. Review Homework

4. Concepts and Skills

a) Scheduling your day

b) Taking Action

c) Skill building and how to schedule actions

5. Session Summary

6. Feedback from Client

7. Homework Assignment

a) Schedule your actions for day

b) Follow what is on schedule

c) Read session 3 in client manual

D. Session 4- Confronting Avoidance

1. Agenda setting

2. Review of Homework

3. Concepts and Skills

a) Understanding Avoidance

b) Action Reinforces Thoughts

c) Action as Commitment

d) Active vs. Reactive

4. Skill Building

a) Tips for taking action

5. Session Summary

6. Feedback from Client

7. Homework Assignment

a) Pick a task you have been avoiding

b) Break it down into steps, then do the steps

c) Fill out the tasks on action schedule

d) Read Session 4 in client manual

E. Session 5

1. Agenda Setting

2. Review of Homework
3. New Concepts and Skills
 - c) Automatic Thoughts
 - b) Skill Building- using the thought record
4. Session Summary
5. Feedback from Client
6. Homework Assignment
 - a) Fill out at least one thought record a day (see attachments for thought record).
 - d) Write a situation, the thought, and the type of error (e.g. jumping to conclusions, over generalization, or either/or thinking).

G. Session 6

1. Monitoring of Current Status
2. Agenda Setting
3. Review of Homework- review how client dealt with catching negative thoughts
5. New Skill- Changing the Circumstances vs. Choosing a Different Outlook – Skill building exercise- three questions
 - a) What's the evidence that the thought is true?
 - b) What is another way of looking at situation or thought?
 - c) How bad are consequences?
5. Session Summary

6. Feedback from Client

7. Homework Assignment- complete one extended thought record each day- See attachments for form p. 81 manual

G. Session 7

1 Monitoring of Current Status

2 Agenda Status

3 Review of Homework

4 New Concepts and Skills- review thought/feeling connection

5 Skill building – notice patterns in thinking, identification of dysfunctional thoughts- id ??(noting and dropping thoughts)

6 Review the difference between emotional, cognitive and physical symptoms

7 Introduce Concept of Critical Incidents

8 Session Summary

9 Feedback from Clients

10 Homework Assignment- complete one extended thought record each day, practice noting and dropping thoughts

H. Session 8

1. Monitoring of Current Status

2. Agenda Setting

3. Review of homework

4. Review of Beliefs and negative thoughts
5. Review of Core beliefs and early learning
6. Skill building- Find the belief, choose, take action, question belief, and clarify beliefs
7. Session Summary
8. Feedback from Clients
9. Homework- Do one extended thought record on a situation generated by client's central belief and practice noting and dropping thoughts

I. Session 9

1. Monitoring of Status
2. Agenda Setting
3. Review of homework
4. New Concepts and Skills
 - a) points to keep in mind- overthinking, the mind has a self-limited
 - b) capacity to process information
5. Skill Building- noting and replacing, good feelings
6. Session Summary
7. Feedback from Client
8. Homework- complete one thought record a day on a situation, practice noting self-talk (Overthinking), complete the program satisfaction questionnaire- see attachment for

form

J. Session 10

1. Monitoring of Current Status
2. Agenda
3. Review of Homework
4. Evaluate Progress
5. Skill Building- Minimizing Relapse
6. Session Summary

K. Sessions 11-14 (Therapist's Modules of Choice)

1. Possible Choice – Social Skills
2. Possible Choice – Problem Solving Skills

APPENDIX – G

Empirical Proposal Timeline

	Pr1	Pr2	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Post1	Post2
I#1	QOLI	QOLI	QOLI	BDI WAIS	BDI QOLI	BDI	BDI	BDI	BDI QOLI WAIS	BDI	BDI	BDI QOLI WAIS	—	—	—	—	BDI	BDI
I#2	BDI QOLI	BDI QOLI	BDI QOLI WAIS	BDI	BDI QOLI WAIS	BDI	BDI	BDI	BDI QOLI WAIS	BDI	BDI	BDI QOLI WAIS	—	—	—	—	BDI	BDI
I#3	BDI QOLI	BDI QOLI	BDI QOLI WAIS	BDI	BDI QOLI WAIS	BDI	BDI	BDI	BDI QOLI WAIS	BDI	BDI	BDI QOLI WAIS	BDI	BDI	BDI	BDI	BDI	BDI