Clinician's Guide to
Evidence-Based Practice

Treatment of Depression in Adolescents and Adults

Edited by
DAVID W. SPRINGER, ALLEN RUBIN & CHRISTOPHER G. BEEVERS

Clinician's Guide to
Evidence-Based Practice

Treatment of Depression in Adolescents and Adults

Edited by
DAVID W. SPRINGER, ALLEN RUBIN & CHRISTOPHER G. BEEVERS

Contents

Clinician's Guide to Evidence-Based Practice Series

Treatment of Traumatized Adults and Children
Allen Rubin and David W. Springer, Editors
Substance Abuse Treatment for Youth and Adults
David W. Springer and Allen Rubin, Editors
Psychosocial Treatment of Schizophrena
Allen Rubin, David W. Springer, and Kathi Trawver, Editors
Treatment of Depression in Adolescents and Adults
David W. Springer, Allen Rubin, and Christopher G. Beevers, Editors

Clinician's Guide to
Evidence-Based Practice Series

Treatment of Depression in Adolescents and Adults

Edited by
DAVID W. SPRINGER, ALLEN RUBIN,
and CHRISTOPHER G. BEEVERS, EDITORS

WILEY
John Wiley & Sons, Inc.

This book is printed on acid-free paper. ♾

Published by John Wiley & Sons, Inc., Hoboken, New Jersey.

Published simultaneously in Canada.

Library of Congress Cataloging-in-Publication Data:

Springer, David W.

Treatment of depression in adolescents and adults / David W. Springer, Allen Rubin, Christopher G. Beevers.

p. cm.–(Clinician's guide to evidence-based practice series; 4)

Includes bibliographical references and index.

ISBN 978-0-470-58759-1 (pbk.); 978-1-118-01538-4 (ePDF); 978-1-118-01539-1 (eMobi); 978-1-118-01540-7 (ePub)

1. Depression in adolescence–Treatment. 2. Evidence-based medicine. I. Rubin, Allen. II. Beevers, Christopher G. III. Title.

RJ506.D4S67 2011

616.85'2700835–dc22

2010047240

Series Introduction

One of the most daunting challenges to the evidence-based practice (EBP) movement is the fact that busy clinicians who learn of evidence-based interventions are often unable to implement them because they lack expertise in the intervention and lack the time and resources to obtain the needed expertise. Even if they want to read about the intervention as a way of gaining that expertise, they are likely to encounter materials that are either much too lengthy in light of their time constraints or much too focused on the research support for the intervention, with inadequate guidance to enable them to implement it with at least a minimally acceptable level of proficiency.

This is the fourth in a series of edited volumes that attempt to alleviate that problem and thus make learning how to provide evidence-based interventions more feasible for such clinicians. Each volume is a how-to guide for practitioners—not a research-focused review. Each contains in-depth chapters detailing how to provide clinical interventions whose effectiveness is being supported by the best scientific evidence.

The chapters differ from chapters in other reference volumes on empirically supported interventions in both length and focus. Rather than covering in depth the research support for each intervention and providing brief overviews of the practice aspects of the interventions, our chapters are lengthier and more detailed practitioner-focused how-to guides for implementing the interventions. Instead of emphasizing the research support in the chapters, that support is summarized in Appendix A. Each chapter focuses on helping practitioners learn how to begin providing an evidence-

based intervention that they are being urged by managed care companies (and others) to provide, but with which they may be inexperienced. Each chapter is extensive and detailed enough to enable clinicians to begin providing the evidence-based intervention without being so lengthy and detailed that reading it is too time consuming and overwhelming. The chapters also identify resources for gaining more advanced expertise in the interventions.

We believe that this series is unique in its focus on the needs of practitioners and in making empirically supported interventions more feasible for them to learn about and provide. We hope that you will agree and that you will find this volume and this series to be of value in guiding your practice and in maximizing your effectiveness as an evidence-based practitioner.

Allen Rubin, Ph.D.
David W. Springer, Ph.D.

Acknowledgments

Special thanks go to four Wiley staff members who helped make this series possible. In alphabetical order they are: Peggy Alexander, vice president and publisher; the late Lisa Gebo, senior editor; Sweta Gupta, editorial program coordinator; and Rachel Livsey, senior editor.

About the Editors

David W. Springer, PhD, LCSW, is the associate dean for academic affairs and a university distinguished teaching professor in the School of Social Work at the University of Texas at Austin, where he is also investigator of the Inter-American Institute for Youth Justice and holds a joint appointment with the Department of Psychology. Dr. Springer received his PhD in Social Work from Florida State University, where he also received a Master of Social Work degree and a Bachelor of Arts in Psychology. Dr. Springer's social work practice experience has included work as a clinical social worker with adolescents and their families in inpatient and outpatient settings and as a school social worker in an alternative learning center with youth recommended for expulsion for serious offenses. His interest in developing and implementing effective clinical interventions continues to drive his work. His areas of interest include: evidence-based substance abuse and mental health treatment with youth; forensic social work with juvenile delinquents; intervention research with adolescents; and applied psychometric theory and scale development. He currently serves on the editorial board of several professional journals and on the National Scientific and Policy Advisory Council of the Hogg Foundation for Mental Health. Dr. Springer has co-authored or co-edited several other books, including: *Substance Abuse Treatment for Criminal Offenders: An Evidence-Based Guide for Practitioners*; *Developing and Validating Rapid Assessment Instruments*; *Social Work in Juvenile and Criminal Justice Settings* (3rd ed.); and *Handbook of Forensic Mental Health with Victims and Offenders: Assessment, Treatment, and Research.* Dr.

Springer recently served as chair of a Blue Ribbon Task Force consisting of national and regional leaders, which was charged with making recommendations for reforming the juvenile justice system in Texas. In recognition of his work with the Blue Ribbon Task Force, the National Association of Social Workers (NASW), Texas Chapter/Austin Branch, selected Dr. Springer as the 2008 Social Worker of the Year.

Allen Rubin, PhD, is the Bert Kruger Smith Centennial Professor in the School of Social Work at the University of Texas at Austin, where he has been a faculty member since 1979. While there, he worked as a therapist in a child guidance center and developed and taught a course on the assessment and treatment of traumatized populations. Earlier in his career he worked in a community mental health program providing services to adolescents and their families. He is internationally known for his many publications pertaining to research and evidence-based practice. In 1997 he was a co-recipient of the Society for Social Work and Research Award for Outstanding Examples of Published Research for a study on the treatment of male batterers and their spouses. His most recent studies have been on the effectiveness of EMDR and on practitioners' views of evidence-based practice. Among his 12 books, his most recent is *Practitioner's Guide to Using Research for Evidence-Based Practice*. He has served as a consulting editor for seven professional journals. He was a founding member of the Society for Social Work and Research and served as its president from 1998 to 2000. In 1993 he received the University of Pittsburgh, School of Social Work's Distinguished Alumnus Award. In 2007 he received the Council on Social Work Education's Significant Lifetime Achievement in Social Work Education Award.

Christopher G. Beevers, PhD, is an associate professor and director of the Mood Disorders Laboratory (http://www.psy.utexas.edu/MDL) in the Department of Psychology at the University of Texas at Austin. He is also a licensed psychologist in the state of Texas. Dr. Beevers received his PhD in Clinical Psychology from the University of Miami and completed his post-doctoral training in mood disorders research in the Department of Psychiatry and Human Behavior at Brown University. Dr. Beevers' research examines the etiology, maintenance, and treatment of depression. His most recent work examines the effectiveness of a cognitive bias modification program as an adjunctive treatment for depression. He is also currently investigating genetic, neural, and behavioral associations with cognitive vulnerability to depression. Dr. Beevers has received research funding from the National Institute of Mental Health (NIMH) and the Department of Defense. He currently serves on the editorial board of several leading journals in his area of research, including the *Journal of Consulting and Clinical Psychology, Behavior Therapy, and Cognitive Therapy and Research*. He has been a grant reviewer for national and international organizations, including the National Institutes of Health, Swiss National Science Foundation, Netherlands Organization for Scientific Research, and the National Institute for Health Research (United Kingdom). In 2006 he received the President's New Researcher Award from the Association of Behavioral and Cognitive Therapies. In 2009 he was a Beck Scholar at the Beck Institute for Cognitive Therapy and Research.

About the Contributors

David Baruch, MA, is a PhD student in clinical psychology at the University of Wisconsin–Milwaukee. His clinical interests include the treatment of depression and the integration of spirituality to enhance treatment efficacy of ESTs. David's primary research interests include the development of protocols to maximize homework completion in therapy, to integrate spirituality into ESTs for depression, and to design novel means of training therapists in ESTs.

William Bowe is a PhD student in clinical psychology at the University of Wisconsin–Milwaukee. His clinical interests include the treatment of depression, borderline personality disorder, and impulse control disorders using empirically supported interventions. In line with his clinical work, William's primary research interests are the development and dissemination of empirically supported treatments for depression that are culturally adapted for underserved ethnic minority populations.

Andrew Busch is a postdoctoral fellow at the Centers for Behavioral and Preventive Medicine at the Alpert Medical School of Brown University. His research interests include behavioral treatments for depression and the adaptation of Behavioral Activation for novel populations.

Esteban V. Cardemil is an associate professor at Clark University in Worcester Massachusetts. He received his PhD in clinical psychology from the University of Pennsylvania. His research focuses on the effects of race, ethnicity, and social class on psychopathology, and he has developed a particular focus on the development of prevention interventions for depression. Dr. Cardemil has written extensively about the process

of adapting evidence-based practice for different cultural groups, and he is currently the principal investigator of a National Institute of Mental Health–funded grant to examine the help-seeking process for depression among Latino men.

Jonathan W. Kanter, PhD, is associate professor, director of the Depression Treatment Specialty Clinic, and Psychology Department Clinic Coordinator at the Department of Psychology at the University of Wisconsin–Milwaukee. He is also a core scientist with the Center for Addictions and Behavioral Health Research at the University of Wisconsin-Milwaukee. Dr. Kanter has published more than 50 articles and chapters on behavioral activation, behavioral theory of depression, and using the therapeutic relationship in behavior therapy and has presented numerous workshops and talks on these topics. Currently, Dr. Kanter is funded by the National Institute of Mental Health to develop Behavioral Activation for Latinos with depression and is the recipient of an NIMH award to his clinical training program as a Program of Excellence in Empirically Validated Behavioral Treatments.

James P. McCullough Jr., PhD, is distinguished professor of psychology and psychiatry at Virginia Commonwealth University where he has worked since 1972. He developed the Cognitive Behavioral Analysis System of Psychotherapy (CBASP) during the early 1970s, the only psychotherapy model constructed specifically for the treatment of the chronically depressed patient. He has conducted psychotherapy research with the chronic patient for almost four decades. Dr. McCullough has served as a principal investigator in three national randomized clinical trials involving more than 2,200 chronically depressed outpatients. In addition, he has participated in the

American Psychiatric Association's revisions of the *DSM-IV* and *DSM-V* unipolar mood disorder nomenclature.

Oswaldo Moreno is a clinical psychology doctoral student at Clark University in Worcester, Massachusetts. He serves as a graduate research assistant on an NIMH-funded mixed-methods investigation of help-seeking for depression among Latino men. His research interests are in the area of mental health disparities and mental health care in Latinos, as well as religiosity/spirituality among Latinos.

Cory F. Newman, PhD, ABPP, is director of the Center for Cognitive Therapy, and associate professor of psychology in psychiatry at the University of Pennsylvania School of Medicine. Dr. Newman is a diplomate of the American Board of Professional Psychology, with a specialty in behavioral psychology, and a founding fellow of the Academy of Cognitive Therapy. Dr. Newman has served as both a protocol therapist and protocol supervisor in a number of large-scale psychotherapy outcome studies, including the Penn-Vanderbilt-Rush Treatment of Depression Projects. Dr. Newman is also an international lecturer, having presented scores of cognitive therapy workshops and seminars across the United States and Canada, as well as 13 countries in Europe, South America, and Asia. Dr. Newman is the author of dozens of articles and chapters on cognitive therapy for a wide range of disorders and has co-authored four books, including *Bipolar Disorder: A Cognitive Therapy Approach* (APA, 2001).

J. Kim Penberthy, PhD, is director of training for the Center for Addiction Research and Education and associate professor in the Department of Psychiatry & Neurobehavioral Sciences at the University of Virginia School of Medicine. She is the North American representative for the CBASP Network International and

co-investigator on over ten large NIH-funded psychopharmacotherapy trials for depression and/or addiction. Dr. Penberthy's research focus is on development and implementation of evidence-based treatments for chronic depression as well as for addictions and co-occurring disorders, with a focus on acquisition learning. She conducts and supervises clinical research and practice. In addition, Dr. Penberthy publishes and lectures internationally on these and related topics.

Paul Rohde, PhD, is a senior research scientist at Oregon Research Institute (ORI) and has 22 years of experience as a research scientist with a substantive focus on the etiology, treatment, and prevention of adolescent depression and comorbid psychopathologies. Dr. Rohde received his PhD from the University of Oregon in 1988 and has been a licensed psychologist since 1990. He has directed or co-directed 21 federally funded research projects, including five randomized controlled trials (RCTs) evaluating adolescent depression treatment interventions and two RCTs evaluating adolescent depression prevention interventions. His most recent adolescent depression treatment research includes participation in TADS (Treatment for Adolescents with Depression Study), which evaluated the effectiveness of Cognitive Behavioral Therapy (CBT) and fluoxetine for the treatment of adolescent major depression, and his direction of a NIDA-funded study evaluating service delivery methods for integrating CBT and family-based treatment for adolescents with comorbid depressive and substance use disorders.

Monica Sanchez is a clinical psychology doctoral student at Clark University in Worcester, Massachusetts. She completed her undergraduate work at the University of California, Berkeley. Using a community

participatory approach, her research focuses on understanding the particular mental health needs of minority and disadvantaged communities. She is currently studying the role that cultural definitions of mental illness, in addition to cognitive factors, play in mental health help-seeking for Latinos.

Chapter 1

Introduction: Evidence-Based Practice for Major Depressive Disorder

Christopher G. Beevers

Major depressive disorder (MDD) is a common, recurrent, and impairing condition that predicts future suicide attempts, interpersonal problems, unemployment, substance abuse, and delinquency (Kessler & Walters, 1998). According to the World Health Organization, 121 million people are currently suffering from MDD and it is a leading cause of disability worldwide among people 5 years old and older. The annual economic cost of MDD in the United States alone is staggering—$70 billion in medical expenditures, lost productivity, and other costs (Greenberg, Stiglin, Finkelstein, & Berndt, 1993; Philip, Gregory, & Ronald, 2003). Further, MDD accounts for more than two-thirds of the 30,000 reported suicides each year (Beautrais et al., 1996). Given this enormous impact at societal and individual levels, there is a clear need to develop and disseminate efficacious treatments for this disorder.

Fortunately, a number of empirically supported interventions are available for depressed adolescents and adults. In-depth descriptions of some of the most established treatments are included in this book—Cognitive Behavioral Therapy (CBT), Behavioral Activation (BA), and Cognitive Behavioral Analysis and

System of Psychotherapy (CBASP). We include chapters on the application of CBT with adolescents and adults. Further, we include a chapter on how to apply these interventions to diverse populations, such as people with diverse racial and ethnic backgrounds. Each chapter provides a detailed, clinician-focused guide on how to implement these interventions. A review of the research base for each intervention is included in Appendix A.

Prior to reviewing the contents of each chapter in this introduction, we first provide an overview of how depression is defined, a brief description of its epidemiology, and then how depression is typically assessed. We then review other treatments (both pharmacological and nonpharmacological) that have empirical support for the treatment of depression but are not included in this volume. We finish with a brief overview of this volume's chapters.

Major Depressive Disorder: Definition, Epidemiology, and Course

The *Diagnostic and Statistical Manual of Mental Disorders* (4th edition—*DSM-IV*) defines Major Depressive Disorder (MDD) as the presence of five (or more) of the following nine symptoms during the same 2-week period:

1. Depressed mood most of the day, nearly every day.

2. Markedly diminished interest or pleasure in almost all activities (anhedonia).

3. Significant weight loss/gain or decrease/increase in appetite.

4. Insomnia or hypersomnia.

5. Psychomotor retardation or agitation.

6. Fatigue or loss of energy.

7. Feelings of worthlessness (or excessive or inappropriate guilt).

8. Diminished ability to concentrate or make decisions.

9. Recurrent thoughts of death.

Symptoms must be present most of the day, nearly every day, and should represent a significant change from previous functioning. Importantly, one of the nine symptoms has to be either depressed mood or anhedonia. In adolescents or children, irritable mood can be substituted for depressed mood. Less than 5% of depressed adolescents typically endorse anhedonia (Rohde, Beevers, Stice, & O'Neil, 2009), so depressed or irritable mood tends to be the hallmark symptom of adolecent depression. Significant weight loss or gain is typically defined as 5% or more change in body weight in a month when not dieting. These symptoms must cause significant distress or impairment in social, occupational, or other important areas of functioning. Finally, these symptoms should not be attributable to substances (e.g., drug abuse, medication changes), medical conditions (e.g., hypothyroidism), or the death of a loved one.

Recent epidemiological research indicates that the 12-month prevalence rates for MDD was 6.6% (95% CI, 5.9%–7.3%) among adults residing in the United States. Lifetime prevalence for MDD was 16.2% (95% CI, 15.1%–17.3%). Put differently, approximately 13.5 million adults experienced MDD in the past year, and 34 million adults have experienced MDD at some point in their lives. Approximately 51% who experienced MDD in the past year received health-care treatment for MDD, although treatment was considered adequate in only 21% of the cases (Kessler, Berglund et al., 2003). Thus, MDD is a prevalent and pervasive mental health disorder that is unfortunately not treated optimally in the United States.

Obtaining adequate treatment is important, as the course of MDD tends to be relatively prolonged. One of the largest studies of MDD recovery among individuals seeking treatment found that 50% of the sample recovered from MDD by 6 months, 70% within 12 months, and 81% within 24 months. Approximately 17% did not recover within the 5-year follow-up period (Keller et al., 1992). The first 6 months represents a particularly important time period for MDD recovery, as the rate of MDD recovery significantly slows after 6 months. Similarly, Kessler (2009) writes that time to recovery of MDD in nontreatment-seeking populations "appears to be highly variable, although epidemiological evidence is slim" (p. 29). One study found that 40% had recovered from MDD by 5 weeks and 90% had recovered within 12 months (McLeod, Kessler, & Landis, 1992). Another study reported that mean time to recovery was 4 months and that approximately 90% had recovered by 12 months (Kendler, Walters, & Kessler, 1997). Taken together, these data suggest that most participants from a community sample recover from MDD within 12 months.

Risk for MDD is especially pronounced during adolescence (Blazer, Kessler, McGonagle, & Swartz, 1994; Lewinsohn, Hops, Roberts, & Seeley, 1993). Prevalence rates range from 10% to 18.5% (Kessler & Walters, 1998). This is especially true for adolescent girls, who are approximately twice as likely to experience depression as adolescent boys (Hankin et al., 1998). Longitudinal studies show that increases in MDD prevalence for women occur at approximately 15 years of age and persist into adulthood (Hankin et al., 1998; Kessler, Berglund et al., 2003; Lewinsohn, Hops et al., 1993; Nolen Hoeksema & Girgus, 1994; Prinstein, Borelli, Cheah, Simon, & Aikins, 2005).

Treatment for adolescents with subthreshold symptoms of MDD may be particularly important, as adolescents with elevated symptoms (but who do not meet criteria for MDD) are at high risk for future onset of MDD. Lewinsohn, Roberts, and colleagues et al. (1994) found that elevated depressive symptoms was one of the most potent risk factors for future MDD onset over the subsequent year out of dozens of risk factors. Seeley, Stice, and Rohde (2009) recently examined a broad array of putative risk factors (e.g., parental support, negative life events, depressive and bulimic symptoms, substance use, attributional style, body dissatisfaction, physical activity, social adjustment, delinquency) for MDD onset in a longitudinal study of 496 adolescent girls 15 to 18 years old. Among 18 variables tested, the strongest predictor of future MDD onset was subthreshold depressive symptoms. Girls with elevated symptoms were at approximately five times greater risk for future MDD onset than girls with low symptoms (28% versus 6%).

Unfortunately, treatment utilization among depressed adolescents is also lacking. Approximately 60% of adolescent with MDD receive treatment (Lewinsohn, Rohde, & Seeley, 1998). Individual outpatient psychotherapy administered by a mental health provider is the most common form of treatment. Adolescents with more severe depression, a comorbid condition, a past history of MDD, a history of suicidal attempts, and academic problems, and females were more likely to receive treatment. However, those who had received treatment were not less likely to relapse into another episode of depression during young adulthood (Lewinsohn et al., 1998). This suggests that the typical treatment received by depressed adolescents may not have been effective at changing the underlying cause of depression onset.

Assessment of Depression

A number of questionnaires and diagnostic interviews are available to assess depression symptoms and MDD in adolescents and adults. We review these assessments for adults and adolescents separately.

Adults

The Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID) diagnoses is the most common method for determining whether an adult meets criteria for MDD (and many other *DSM-IV* diagnoses). This is a semistructured interview that inquires about current and past symptoms. Length of an SCID interview can be quite variable—individuals with no past or current symptoms can complete the interview in about 15 minutes. Individuals with more complex symptom presentations can take several hours to complete a SCID interview. A typical SCID interview takes about 90 minutes. With adequate interviewer training, the SCID interview has excellent reliability and has been used extensively in depression research. Determining the validity of the SCID is more complex, as it is typically used as the gold standard to determine a diagnosis. Nevertheless, there is ample evidence that an SCID diagnosis converges with diagnoses derived from other diagnostic interviews (First, Spitzer, Williams, & Gibbon, 1995). For more detail on the SCID, see http://www.scid4.org/.

The World Health Organization (WHO) Composite International Diagnostic Interview (CIDI) is a psychiatric diagnostic interview designed to be administered by nonclinicians. The CIDI assesses for most Axis I disorders (including MDD) as defined by the *DSM-IV* and the ICD-10. It also assesses service use, use of medications, and barriers to treatment. There is substantial evidence for