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An Educational Workshop: Introducing an Evidence-Based Psychotherapy Strategy ‘Tool Kit’ for the Treatment of Chronic Depression

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Section I
Introduction

Chronic depression (CD) is a pervasive and unique illness encompassing a subset of five disorders and accounting for one-third of all depression cases (Michalak & Lam, 2002; Trivedi & Kleiber, 2001). Depression in general affects 17% of the general population in community samples and 25-30% of these patients will develop a chronic depressive course (Pignone, et al., 2002; Angst, 1997). For the purposes of this paper and project, the term chronic depression refers to unipolar, non-psychotic depression (See Appendix A for definitions and Figures 1 through 5 for graphical depictions) and focuses on adult chronic depression identification and treatment challenges. The project was the distillation and synthesis of key information and complex evidence-based strategies for the treatment of chronic depression. The material was prepared as an educational presentation in the form of a continuing education workshop for mental health professionals. The educational component was designed to address the aforementioned issues and present synthesized approaches derived from an Evidence-Based Psychotherapy (EBP) modality, Cognitive Behavioral Analysis Systems Psychotherapy (CBASP) for chronic depression and prepare providers to use the key aspects of the intervention.

The research demonstrates that depression in general is a widespread, often under-recognized and undertreated disorder (Keller, 2003; Pignone, et. al, 2002; Goldman, Nielson, & Champion, 1999; Katon & Sullivan, 1990). Further evidence supports that chronic depression presents additional clinical and treatment complexity and incurs greater impact and costs. Thus, the identification of chronic depression is necessary and significant in terms of accurate diagnosis and differentiation from other similar disorders, disease impact and the need for application of appropriate treatment. The World Health Organization (WHO) also recently
Chronic Depression launched an international initiative on depression in public health with the following objectives: “To reduce the impact of depression by closing the substantial 'treatment gap' between available cost-effective treatments and the large number of people not receiving it, worldwide” (2010, www.who.int/mental_healthmanagement/depression/definition/en/). Specific WHO aims include patient and provider education about depression and to reduce the stigma associated with depression. In addition, other goals proposed are the training of primary care personnel in the diagnosis and management of depression and regional events to increase awareness of depression and, of particular relevance to this project, workshops to strengthen the capacity to care for depression (WHO, 2010).

This project’s primary intent was to distill information and synthesize evidence-based strategies into an accessible ‘Tool Kit’ for broad use by community providers working with patients with chronic depression. The need to provide these providers with strategies to address the issues regarding chronic depression is significant. Consistent with the WHO initiative, the intervention or educational component was to provide a day long, interactive continuing education (CE) workshop piloted at the University of San Francisco (USF) for mental health providers to improve the identification of chronic depression and to learn synthesized evidence-based tools for the treatment of CD. The project was sponsored by the USF School of Nursing and co-sponsored by the School of Education, Department of Counseling Psychology and Marriage and Family Therapy. Community, public health, and mental health providers, and in particular, nurses, licensed social workers and other clinicians, from California were targeted with a minimum goal of 10-12 participants. The workshop was designed for providers to learn about chronic depression, to more effectively identify CD and to learn to apply specific strategies
developed into a “Tool Kit”, and synthesized from an evidence-based psychotherapy (EBP) modality, CBASP for CD.

Generally, the program addressed the conceptual framework and key elements of CD identification and CBASP. The therapeutic goal for clinicians was highlighted: to teach CD patients that their behavior has interpersonal consequences or effects (McCullough, 2006, 2001). The instruction for the workshop included a variety of learning objectives, tools and modules as well as case study vignettes, simulation, and role play with interactive participant exercises to solidify learning. Detailed information folders (See Attached Cox, CE Workshop Packet, October 2, 2010) and evaluative tools were disseminated to participants. Pre-assessments compiled demographic, education, and professional information and the pre and post-tests also queried key educational content areas to assess learning. Evaluations of the offering, and a two week follow-up survey regarding content application and barriers to practice were also implemented. Evaluations were reviewed to determine necessary content and implementation changes for potential future educational events. Treatment challenges and the inefficacy of established psychotherapy practices for CD patients, mandate a need for evidence-based approaches. CBASP has been shown to be efficacious in several large, rigorous studies and is specifically designed to address chronic depression (Keller et. al., 2000; Schatzberg et. al., 2005), hence the focus of this project and paper.

Clinical Relevance

Depression is a significant, prevalent public health problem and is currently the leading cause of disability for adults ages 15-44 in the United States (U. S.) (National Institute of Mental Health, NIMH, 2010; Kessler et. al, 2005; Kessler, et. al., 2003). Depression incurs high morbidity and mortality rates for individuals. In fact, major depression accounts for 60% of all
suicides while all individuals with major mental health problems are estimated to live on average 25 years less than those who do not suffer from mental illness (Healthcare Intelligence Network, HIN, 2009; Kessler, et. al, 2003). The impact of depression in general is staggering, with annual direct and indirect costs estimated at $83 billion in the United States (U. S.) and 11.5 billion Euros in the United Kingdom (U. K.) (Espinoza et. al., 2009; Lyness, Schwenk, & Sokol, 2009; HIN, 2009). Depression in general accounts for 11% of the international disease burden and is the fourth leading cause of disability with growth projections over the next ten years (WHO, 2010). In fact, the World Health Organization anticipates that depression will become the second leading killer of individuals after heart disease by the year 2020 at the current growth rate (WHO, 2010; NIMH, 2010; U.S. Public Health Service (USPHS): Mental Health: A report of the Surgeon General).

Indeed, depression is a worldwide phenomenon and rivals cardiovascular disease (CVD) in terms of disability and mortality rates, as well as the public health costs from depression itself and the associated co-morbidities (Kneisl & Trigoboff, 2009; Lyness, Schwenk, & Sokol, 2009). In particular, costs of all chronic diseases have been found to be higher when an individual suffers from a co-morbid depression (See Table I below; Melek & Norris, 2008). Notably, morbidity and mortality data show that depression in general is associated with increased risks of medical complications and co-morbidity, and specifically death from CVD and stroke, as well as suicide (15% of all depressed patients), significant disability including lost work, wages, and reduced quality of life (Lyness et. al, 2009; Keller et. al, 1998; Nemeroff et. al., 2003). Depression has also been linked to weakened immune system response, cancer, inflammatory responses, chronic and autoimmune diseases, implicating perhaps common biologic pathways
(Gross, et. al., 2010; Joynt, Whellan & O'Connor, 2003). Thus, depression in general is a widespread problem that has a significant impact on individual and public health.
Table I

Costs of chronic diseases are higher when a co-morbid depression is present.


Derived from Cox CE Chronic Depression Workshop October 2nd, 2010 slides.
Chronic Depression Significance

Chronic depression, specifically, and its subtypes derive from variations of major depression, also referred to as Major Depressive Disorder (MDD) and Major Depressive Episode (MDE) (See Table II below for DSM-IV-TR criteria and Figure 6 in appendices for graphical depiction).

Table II

The American Psychiatric Association’s (APA) Diagnostic and Statistical Manual-IV (DSM-IV, 2000) diagnostic criteria for Major Depressive Disorder (MDD) or Major Depressive Episode (MDE):

Quick Review: DSM-IV TR Diagnostic Criteria
Major Depression (MDD or MDE)

- At least 5 of the following symptoms present most of the time nearly every day (80-90% of time) for at least 2 weeks:

1. Depressed (dysphoric) mood AND/OR,
2. Anhedonia: Loss of interest or pleasure (usual activities) with:
   - Significant weight gain or loss (w/o attempt to Δ weight, ~5%)
   - Insomnia or hypersomnia
   - Fatigue or loss of energy
   - Psychomotor agitation or retardation
   - Feelings of worthlessness, or excessive or inappropriate guilt
   - Impaired ability to concentrate, indecisiveness
   - Recurrent thoughts of death or suicide (SI)
- May be Single or Recurrent episodes.
- Must represent a change in functioning with Impairment or Marked Distress

Derived from Cox, CE Chronic Depression Workshop, October 2nd, 2010 slides.
Chronic Depression

Major depression carries a lifetime risk of 10-25% in the U. S. population with women disproportionately affected at a rate of 21.3% compared to 5-12% for men across the lifespan, regardless of marital status, income, ethnicity or education (Kessler, et. al, 2005; Kessler, et. al. 2003; Nemeroff et. al., 2003; American Psychiatric Association, APA, 2000). The impact of MDD is growing and as the population increases and ages, the impact of depression and co-morbid chronic diseases are also rising (Dotson, 2009; Krishnan, et. al, 1993). Evidence supports the premise that 50-85% of patients who have one MDD will experience subsequent major depressive episodes and the remission periods in between the depressive episodes become shorter over time, suggesting that many of these patients incur a more chronic course later in life. A history of previous depressive episodes is, in fact, predictive of future episodes (Niremberg, et. al., 2003; DeBattista, 1997). Co-morbid psychiatric and substance abuse disorders (Kneisl & Trigoboff, 2009), further increase the risk for recurrence of depression and a more chronic depressive course (Niremberg, et. al., 2003; DeBattista, 1997).

More specifically, at least half of all first MDE’s will eventually recur to a second episode and of those, 90% recur to a 3rd episode. After three episodes, an individual has a greater than 95% chance of suffering another depression in the subsequent two year period (Niremberg, et. al., 2003; Keller, 2002). In addition, the greater the number of depressive episodes experienced in a lifetime, the shorter the symptom-free or inter-episode periods of recovery become, leading ultimately to a greater probability for the development of chronic depressive course. Furthermore, evidence further supports that 15-20% of all first MDE’s initially never remit and entail a chronic and unremitting from the onset (Eaton, et. al., 2008; Berlim & Turecki, 2007; Keller, 2002). Overall, 25-30% of all depressions become chronic, lasting two years or longer (Niremberg, et al., 2003; Keller, 2002).
Indeed, MDE’s become more severe, extensive, and refractory over time and with subsequent episodes (Niremberg, et. al, 2003; DeBattista, 1997; Thase, 1992). Thus, episodic major depressions often recur and progress to a more chronic course and may implicate pathophysiologic and neurologic decline (neurodegeneration) with chronicity, wherein the brain theoretically “learns” depressive pathways more efficiently and thereby, phenotypically expresses dysphoria more easily and frequently (Maes, Yirmyia, Noraberg, et. al., 2009).

While chronic depression manifests with clinically similar symptoms to episodic and recurrent depressive episodes, CD persists unabated for at least two years and can continue for much longer. Conservative estimates suggest that 20 million individuals in the U.S. or 10-12% of the population suffer from depression in general at any point in time (National Institute of Mental Health, NIMH, 2010) according to the original Epidemiological Catchment Area research study done from 1980-1985 and 1990-1992. The NIMH National Comorbidity Survey Replication (NCS-R, 2003) also suggested similar statistics while other studies indicate even higher annual point prevalence rates of upwards of 35 million Americans or over 16% of the population (Kessler, et. al, 2005; Kessler, et. al. 2003).

Chronic depression data suggest a prevalence rate of 3-5% while other studies report prevalence as high as 17% for the general population or community samples, and 9-31% for clinical populations (American Psychiatric Association, APA, Diagnostic Statistical Manual, DSM IV-TR, 2000). Despite, these large numbers, only one in three individuals seeks help and of those, it is estimated that less than 10% receive adequate treatment (Eaton, et. al, 2008; Berlim & Turecki, 2007; Keller, 2002).

Similar to depression in general, there is a vast under-recognition and under-treatment of this chronic population. Also, ineffective conventional depression treatments are often applied to
these chronic patients and due to inadequate responses, chronic patients are often referred to as ‘treatment resistant’, ‘treatment refractory’ or ‘treatment failures’, although no consistent definitions exist for the terminology (APA, 2010; Keller, 2002). Overall, chronically depressed patients are at elevated risk for relapse, recurrence, heightened disease burden, costs and complications, resulting in an overall poor prognosis.

Individuals with CD often have difficulties coping adequately with life stressors, have a history of developmental trauma, repeated interpersonal difficulties, and deficient coping tools that lead to feelings of hopelessness and helplessness (McCullough, et. al, 2003; Penza, et. al, 2003). Thus, it can be speculated that the individual with chronic depression, over time engages in behaviors and thinking that reinforce specific psychosocial, interpersonal and biological brain pathways that are more consistent with depressive symptomatology (Penza et. al, 2003). Ultimately, these psycho-social and biological underpinnings enhance the likelihood of clinical depression, accounting for a more chronic course with reduced inter-episode remissions or symptom-free periods.

Despite the significance and pervasive nature of this problem, depression benchmarks and practice guidelines do not exist specifically for chronic depression. Guidelines must be applied and tailored to this sub-population from the general depression or major depression evidence base (APA, 2010). General and major depression guidelines include a focus on accurate identification and screening for depression, early detection and evidence-based treatments (APA, 2010; Druss, et. al, 2008). The majority of the data however focus on medication guidelines while few address psychotherapy approaches for depression in general, and none target chronic depression specifically. This project distilled current practice standards for depression as they apply to the specific nuances and challenges of chronic depression. Thereby, the evidence
supports the premise that screening for depression, the accurate identification of recognized subtypes of chronic depression, application of effective and early treatment with EB approaches is essential; hence another impetus for this educational workshop.

Section II

Introduction to the Evidence Critique

This section is divided into multiple sub-sections due to the complexity and breadth of the topic of depression and as it relates to chronic depression and treatment. Included is an introductory overview and summary of the evidence that precedes a more in-depth, analytic review and critique of the specific evidence in more focused areas related to chronic depression and psychotherapy modalities. The initial overview addresses a summary of the evidence regarding depression management in general and the specific evidence base for the identification and treatment of chronic depression. Also included in a following sub-section is information regarding a particular psychotherapeutic approach, Cognitive Behavioral Analysis Systems Psychotherapy (CBASP), to specifically manage chronic depression (Swan & Hull, 2007; McCullough, 2000). Research discussing the challenges of chronic depression, appropriate identification, treatment resistance, and an evidence-based approach that considers the unique nature inherent to this disorder, are also presented in further sections.

Overview and Summary of the Evidence

To summarize, the majority of evidence supporting depression treatment in general is pharmacologically-based and while some guidelines exist for medication management, there are no guidelines for the management of chronic depression specifically, or for psychotherapeutic approaches to CD. The literature consistently supports that medication monotherapy provides some relief of acute depressive symptoms and psychosocial functioning; however the overall
efficacy is inadequate, particularly with the chronic population (Trivedi & Kleiber, 2001; Anderson, Nutt & Deakin, 2000; Howland, 1993a; Miller, et. al, 1998; Rush, et. al, 1998).

There is also a consensus in the field that manual-based or protocol-driven psychotherapies combined with medications are the gold standard for depression treatment but little empirical evidence exists to support specific manual-based therapies in general let alone for chronic depression (Weissman, 2007; Markowitz, 1994). Notably, CBASP is the only manual-based psychotherapy modality that has been tested and shown to be efficacious for chronic depression specifically (McCullough, 2003; Keller, et. al, 2000), despite widespread use of other modalities in the field for this population. Thereby, clinical and expert consensus that manual-based therapies can be effective, at least one, in this case, is supported. However, comparative psychotherapy trials for chronic depression have not yet been published. One recently published protocol (Wiersma, et. al., 2008) stated the intent to study ‘usual secondary care’ with medication and CBASP with medication to compare the overall effectiveness and cost efficacy of the two combination modalities. This potential multi-site study planned in the Netherlands has yet to be published but could enlighten the issue further.

Overall, the literature supports the premise that chronic depression is indeed different from non-chronic depression, but does not adequately respond to conventional depression treatment, and remains a significant problem for those affected (Michalak & Lam, 2002; Howland, 1993a; Howland, 1993b; Kessler, et. al, 1993; Scott, Barker, & Eccleston, 1988). Specifically, the evidence reviewed implies that the impact of chronicity is analogous to an increased likelihood for relapse and recurrence, disease burden, as well as diminished response to treatment (i.e. treatment resistance) (Michalak & Lam, 2002; Tranter, O’Donovan, Chandarana, & Kennedy, 2002; Kornstein et. al, 2000; Miller, et. al, 1998; Keller & Hanks,
The evidence also supports the idea that clinicians often do not recognize depression in general let alone chronic patients, and even when they are noted, ineffective and inappropriate treatment modalities are applied (Keller, 2003; Weissman & Markowitz, 2003; McCullough et. al, 2003; Michalak & Lam, 2002; McCullough et. al, 1996; Markowitz, 1994).

Further evidence supports the identification of subgroups of chronic depression (McCullough et. al, 2003; Michalak & Lam, 2002; McCullough et. al, 1996; Scott, Barker, & Eccleston, 1988) although again no guidelines exist for identification or treatment once a patient and depression subtype is correctly identified. The American Psychiatric Association (APA, 2010, October) and the United States Preventive Services Task Force (USPSTF 2002) have proposed guidelines for screening adults for major depression and depression in general respectively, and maintain that proper screening and diagnosis improves clinical outcomes (2010; 2002). However, no treatment guidelines exist specifically for chronic depression identification, management or follow-up and maintenance. A few randomized control trials (RCT’s) of chronic depression compare treatments that depart from conventional depression management and suggest future implications for care and this paper will discuss them.

Please refer to Appendix B for the analytic methods used to critically appraise existing literature in the following sections and Appendices C and D for the specific articles reviewed. In addition, based on the available evidence, practice guidelines for chronic depression have been developed despite significant gaps in the knowledge base (See Appendix E). A detailed text summary of the practice guidelines is also included in Appendix F.
Chronic Depression

Critique First Search Category: Chronic Depression Identification, Screening, and Disease

Impact

Several articles in the initial search on the identification of chronic subtypes and disease impact revealed primarily expert opinion pieces (Trivedi & Kleiber, 2001; Howland, 1993a; Howland, 1993b; Scott, Barker, & Eccleston, 1988), although one excellent review article of key randomized controlled trials (RCT’s) was elucidated as well and is deemed good quality, type I (See Appendices C, D & E; Michalak & Lam, 2002). Another article indirectly discusses chronic depression by citing that one-third of depression patients are non-responders and inferring that they incur a chronic course (Katon & Sullivan, 1990) but due to the remote date, opinion only, and lack of specificity to chronic depression, it is poor quality for the purposes of this review. In general, recent good quality evidence was scarce. The expert opinion manuscripts are overall considered fair quality evidence (USPSTF, 2002; See Appendix C) in that they are limited in number and have remote dates of publication, but are nevertheless consistent in their conclusions.

Only two well done and thorough review articles were located (Michalak & Lam, 2002; Angst, 1997) and the 1997 article reported data derived from longitudinal outcome studies (1966-1997) that depressive disorders often become chronic in 25% of patients (Angst, 1997). Both are considered good evidence (USPSTF, 2002) despite the Angst article being somewhat older. Moreover, only one, more recent, large descriptive study of chronic depression nomenclature, was located and it was derived from a rigorous well-designed RCT of 681 outpatients (incidentally the same study that is discussed later in this paper in the RCT’s section concerning the efficacy of CBASP) (McCullough, et. al, 2003; Keller, et. al, 2000).
All the aforementioned articles consistently discuss the symptom criteria for the identification of chronic depressions listed in the Diagnostic and Statistical Manual (either DSM-III-R or DSM-IV depending on their publication date), which is considered the gold standard and currently accepted American Psychiatric Association’s (APA) empirically-based psychiatric diagnoses (2000, 1994). Due to the common reference to the APA’s DSM, there was agreement in chronic depression definitions amongst all articles and is considered good evidence (See Appendices C & E). Moreover, these articles cited similar prevalence rates for chronic depression subtypes from 3-5% and 9-31% in community and clinical samples respectively.

Similarly, there is a consensus that no evidence exists for chronic depression identification rates but there is significant evidence for poor prognosis, treatment resistance and high co-morbidity rates, even when chronic depression is correctly identified. The authors agree that the evidence supports that significant numbers of chronic patients receive suboptimal treatment if any treatment at all. This data is consistent with depression data in general and so it is considered fair quality as it may have external validity and be considered applicable to a wider population, type IV or V (expert panel or opinion pieces; See Appendices C, D, & E) despite the lack of empirical research support needed to earn a good quality or type I-A (See Appendices C & D) rating per the criteria chosen for this review.

Some of the evidence discusses the premise that if and when chronic depression is identified correctly, there are poor outcomes and inadequate treatment (Michalak & Lam, 2002; Keller, et. al, 2000). Thus, screening is considered by several experts (opinion pieces, type IV or V; See Appendix D) in the field to be an important step in terms of appropriate identification. Several opinion articles suggest a variety of methods for appropriate screening for chronic depression although there is little specific agreement or evidence to support any one particular
method (Keller, 2003; See Appendix E). No current best-practice guidelines exist for screening chronic depression, although the USPSTF indicates screening for adult acute (non-chronic) depressions improve outcomes (Pignone, et. al, 2002) and other evidence-based guidelines for depression in general, have also been clinically generalized to include chronic patients (Anderson, Nutt, & Deakin, 2000). Thus, the quality of this evidence is also somewhat consistent and thereby fair quality, but similarly has the problem of a lack of specificity to chronic depression.

In addition, several of the expert opinion pieces (type IV or V as per Appendix D criteria) identify specific methods for identification and screening but only one recent rigorous and well-designed, multi-site, large RCT provides strong data that the utilization of depression self-report questionnaires is helpful in identifying chronically depressed outpatients (Rush, et. al, 2005). Hence, this latter article is the only evidence specific to chronic depression with a type I-A good quality rating (See Appendix E). However, a significant gap in the data in general, is that many chronically depressed patients are not in treatment, and or may only come into contact with service providers through primary care. Primary care is a level of prevention and care that still shows abysmal detection rates (30-50%) for depression in general, let alone chronic depressions (Pignone, et. al, 2002; Trivedi & Kleiber, 2001; Goldman, Nielson, & Champion, 1999).

The next search area included the impact of chronicity or treatment resistance and any guidelines for identification, screening and management. After discovering that there is minimal evidence concerning chronic depression specifically, the search was expanded to depression in general to try to elucidate chronic references by including the term ‘treatment resistance’ but again this search yielded little additional evidence.
Summary of Search Category One: Chronic Depression Identification, Screening, and Disease Impact

Thus, the initial search of articles provided information confirming the unique impact of chronic depression and the identification of specific subtypes of the disorder. The evidence revealed through Medline, NCBI-pub med and Google scholar searches consistently supports the premise that chronic depression does indeed differ from episodic and recurrent depression and it is typically viewed as having four to five subtypes depending on the authors’ use of defining criteria. Generally speaking however, there is a lack of evidence specific to chronic depression and much of the evidence is based on depression in general and extrapolated by experts to include chronic depression. Screening is an area that is considered necessary but there is little agreement in terms of the best approach.

Critique Second Search Category: Treatment

This search area generally revealed that there is scant empirical evidence for chronic depression from identification and screening through management. However, numerous well-constructed research articles provide evidence for the benefits of a unique treatment approach to the chronic depression problem. Eight of the articles look at different aspects from one large, well-designed, randomized, double-blind, multi-site, clinical, comparative treatment trial, including the specific psychotherapeutic modality for chronic depression, CBASP. Additional smaller rigorous studies also support these initial research findings. Overall, this compilation of data is the strongest evidence to date and is deemed good quality type I-A (See Appendix E), due to the specificity with regards to chronic depression, recent dates of study, large sample sizes, and strong randomized designs. These well-designed quality studies generally all support the
efficacy of CBASP alone and even superiorly in combination with medication for chronic depression treatment and with specific psychopathological co-morbidities.

*Detailed Evidence Base Summary for CBASP*

The first and perhaps most prominent study was published by *New England Journal of Medicine* (NEJM) in 2000 by Keller and colleagues and attempted to determine the relative efficacy of medications and psychotherapy for chronic depression. In this national multi-site study, 681 outpatients (18-75 years) with chronic non-psychotic unipolar major depression were randomly assigned to either 12 weeks of antidepressant treatment, Nefazodone (Serzone maximum daily dose 600 mg), or 16-20 sessions of CBASP, or a combination of Nefazodone and CBASP therapy. Nefazodone, a post-synaptic serotonin receptor antagonist (5HT-2) moderately inhibits both serotonin (5HT) and norepinephrine (NE) reuptake and has been shown efficacious with depression in general (Denton, et. al., 2010; Keller, et. al., 2000).

Notably, one of this study’s and the associated protocols’ largest limitations is that there is no comparative psychotherapy group or ‘placebo’ control therapy group structured into the design, such as a ‘usual treatment’ circumstance (i.e. what a typical patient might encounter at a general health or mental clinic). Despite these limitations however, roughly half (48%) of the patients in this particular study had a response to either Nefazodone or CBASP, but the combination treatment was significantly superior (73% response) to either treatment group alone (Keller, et. al, 2000). Thus, the combination of Nefazodone (Serzone) and CBASP was found to be more efficacious than either treatment alone in CD. CBASP was equal in efficacy to Serzone after 12 weeks and again after 4 months of monotherapy. In addition, 85% of responders after 12 weeks of treatment maintained the treatment response in the 4 month continuation phase (Keller, et. al, NEJM, 2000)
This data is consistent with studies looking at recurrent and episodic depression and consensus findings that combination medication and Cognitive Behavioral Therapy (CBT), an EBP for depression in general, are efficacious. These findings are relevant to clinical practice since in the era of managed care; many patients with depression are started on medication treatment alone and not in psychotherapy due to access, preference, cost, time and insurance coverage issues. However, due to the complexity and treatment challenges of CD, most chronic patients are started on medications initially. Thus, the improved outcome data described in this well-constructed large study mandates further consideration by providers for the use of a combination of CBASP and medication therapy for chronic patients.

A second study, found that 12 weeks of CBASP appears to be efficacious for non-responders to Nefazodone in a crossover design of chronically depressed adults from 12 nationwide sites (Schatzberg, et. al, 2005). The research focused on three subtypes of chronic depression; chronic major depression, double depression, and recurrent major depression without full inter-episode remission (See Appendix A and Figures 1, 2 and 3). This study is notable for being the first prospective controlled trial to evaluate the efficacy of psychotherapy following non-response to an antidepressant trial. It is further significant because a large proportion of depressed patients do not respond to initial trials of either medication or therapy, called stage I antidepressant resistance (Schatzberg, et. al, 2005). Few empirical guidelines exist in assisting treatment approaches and thus this study is an important premier step in that process.

Similarly, Koscis and colleagues demonstrated that combination treatment (Nefazodone and CBASP) may carry protective effects against relapse. The authors found that combined therapy was associated with less symptom re-emergence during continuation compared to either monotherapy after 16 weeks (2003), and during maintenance compared to the control group.
consisting of only follow-up assessments (Klein, et. al, 2004). Additionally, CBASP was found in another related study to have significant effects on psychosocial functioning independent of depressive symptom changes, demonstrating that regardless of how much or little improvement in depressive symptoms occurs, there is still significant improvement in overall life functioning in those patients who engage in CBASP regularly (Hirschfeld, et. al, 2002).

CBASP may also be an essential element in the treatment of patients with chronic forms of major depression and with a history of childhood trauma. Not all that surprisingly, in this study, chronic depression patients who reported a loss of parents at an early age, or a history of physical, sexual abuse or neglect, improved more with CBASP monotherapy than with antidepressant therapy alone. Similar to previous studies, the combination treatment of antidepressant and CBASP was superior to either singular treatment in the child abuse cohort (Nemeroff, et. al, 2003). This is significant since 50% of chronic patients have co-morbid psychopathology (Keller, et. al, 2000).

Another recent study found that the combination of CBASP with Nefazodone was twice as successful and CBASP monotherapy was superior to medication alone after 12 weeks of treatment in terms of dyadic discord (marital, couples, long-term intimate partnership dissatisfaction). In this study, both CBASP alone and in combination with Nefazodone were found to more effectively reduce the severity of depressive symptoms than medication alone. One limitation in this study was that the reported data improvements were from the patient only and the partner was not assessed. However, valid and reliable measures were used in this study enhancing the rigor (also used in all of the aforementioned protocols) including: the 30-item Inventory of Depressive Symptomatology–Self-report (IDS-SR-30), the Hamilton Rating Scale
for Depression (HRSD), the Social Adjustment Scales (SAS), the Marital Adjustment Scale (MAS, this study only) (Denton, et. al, 2010).

In another offshoot study Blalock and colleagues (2008) analyzed data from the seminal Keller study (2000), and found that a combination of CBASP with Nefazodone was successful in improving maladaptive cognitions and coping, especially with escape-avoidance coping (Blalock, et. al, 2008).

Similarly, another effort stemming from the Keller study (2000), found CBASP to be an effective long-term treatment for CD. In this particular analysis, CD responders (n=82) to acute (12 weeks) and continuation phases (16 weeks) with CBASP were randomized to one year of monthly CBASP or ‘Assessment-Only’ sessions. The findings included that significantly fewer CBASP group patients experienced recurrence (Klein, et. al, 2004).

Finally, a patient’s therapeutic skill acquisition and response to psychotherapy, alone or in combination with Nefazodone, was analyzed from the Keller and colleagues (2000) original data. Even though differences were demonstrated in terms of the speed of depressive symptom reduction, with combination treatment being superior, there were no differences found in the rate or overall level of skill acquisition when comparing CBASP alone to combination therapy. In fact, CBASP alone was found to be just as effective, even though combination treatment brought about more rapid symptom reduction; a more efficient process, perhaps implicating a synergistic response. However, that authors concluded from their results that medication alone does not enhance skill acquisition or effective participation in psychotherapy in CD patients who are doing CBASP (Manber, et. al., 2003).
Summary of Second Search Category: Treatment

Additional research concerning treatment for chronic depression does not address specific combination (medication and psychotherapy) approaches although one rigorous review article of RCT’s suggests that combination medication and psychotherapy is the optimal approach for chronic depression. Thereby, there appears to be consensus in the evidence that combined modalities are optimal for chronic depression adding strength from this expert review to the aforementioned studies reviewed. However, there remains little consensus as to which therapeutic modality is most efficacious in the review manuscript. Thereby, it is difficult to conclude since the main limitation of all of the aforementioned trials is the lack of a control or psychotherapy group, and with no comparative psychotherapy trials to date little evidence currently exists to support any one modality over another.

In summary, the findings in this area indicate that CBASP alone or in combination is efficacious for the treatment in both the short-term and maintenance treatment of chronic depression. However, extensive gaps remain in the treatment knowledge base and confirm the need for future research of modalities designed to further manage this unique disorder that depart from traditional depression treatment approaches and compare efficacies of those approaches.

Critique of Third Search Category: Evidence-Based Guidelines for Depression

Cochrane, Ovid, National Institutes for Health and Clinical Excellence (NICE), Institute for Healthcare Improvement (IHI), National Guideline Clearinghouse, and the Center for Disease Control (CDC), searches yielded no evidence of empirically supported guidelines for the identification and or treatment of depression, let alone chronic depression. The Agency for Healthcare Research and Quality (AHRQ), National Institute of Mental Health (NIMH), and World Health Organization (WHO) databases revealed one article each, with the most recent and
specific being the Texas Medication Algorithm Project for chronic depression, an expert opinion piece (Trivedi & Kleiber, 2001; See Appendix E). The authors suggest identification of chronic depression subtypes and the progressive steps for treatment starting with specific options of medication monotherapies to later treatment with psychotherapy in general. No detail however is offered as to optimal type or duration of psychotherapy and it is almost mentioned as an afterthought without much empirical support. Thereby, this evidence is not especially helpful and is considered type V-B fair by the standards (See Appendices C, D & E) since it is an expert opinion article, insufficient in scope, but does pertain to chronic depression specifically. However, this piece adds to the consensus data regarding subtypes of chronic depression.

The American Psychiatric Association (APA) recently published, for the first time in over ten years, new Practice Guidelines (PG) on October 1, 2010 for MDD (APA, 2010; Brauser, 2010). The updated treatment guidelines for adult major depression include new evidence-based recommendations compiled from a review of over 13,000 scientific articles published from 1999-2006. An independent review board without ties to the pharmacological industry acknowledges relationships and the perception of potential industry conflicts of interest by the authors but pronounces the manuscript to be free of ostensible bias MDD (APA, 2010; Brauser, 2010).

These new practice guidelines (APA-PG) primarily discuss medication strategies with brief mention of CBT and other interpersonal, psychodynamic and group therapies (2010). There is scant discussion of chronic depression overall in the 152 page document and no mention of CBASP is included. There are no guidelines for chronic depression specifically, although Dysthymia, Double Depression, and Chronic Major Depression are alluded to as chronic mood disorders and the combination of pharmacotherapy and psychotherapy are suggested as superior
to monotherapy (APA, 2010), in concurrence with the clinical trials discussed in a previous section of this paper. However, no specific psychotherapy modality is discussed and it is reported that “Unfortunately, clinical trials provide little evidence of the relative efficacies of particular agents” (p. 62) in terms of medication for these chronic disorders.

In addition, the guidelines tout the superiority of combination psychotherapy and medication for treatment resistant or ‘non-response’ and allude to ‘depression-focused’ psychotherapy as augmentation strategies for non-responders but few additional details are noted (APA 2010). In particular, psychotherapy (cognitive-behavioral therapy CBT, cognitive therapy, CT, behavioral therapy, BT, or interpersonal therapies, IPT) with antidepressant medications are recommended for the initial treatment of moderate to severe depression (APA, 2010). In the initial treatment of milder depressions, psychotherapy alone was found to be helpful especially when there are psychosocial stressors, interpersonal, or intra-psychic problems, and or co-morbid personality disorders; all issues with particular relevance to chronic depression. In addition, the guidelines purport that CBT and IPT psychotherapy are less effective than pharmacotherapy alone for chronic depression acutely (APA, 2010). The APA-PG propose that psychotherapy may “foster the development of social skills and confidence after years of depression-related impairments” (2010, p, 47) another item with particular significance to the CD population and supported in literature. Thus, few guidelines exist to date specifically for chronic depression.

The only other article providing a guide to depression treatment is somewhat outdated, a 2000 revision of the 1993 British Association for Psychopharmacology guidelines for treating depressive disorders in general (Anderson, Nutt & Deakin, 2000; See Appendix E). These guidelines were developed for antidepressants alone, with no mention of psychotherapy models and no application to chronic depression specifically, but formulated based on extensive review
of the literature and expert consensus. Therefore, the evidence is here is considered type IV-B, fair quality, although not especially helpful for the specificity of the present topic.

Summary of Third Search Category: Evidence-Based Guidelines

Thus, few evidence-based guidelines are published and none are ideal or fully adequate with regards to the specificity of chronic depression treatment and psychotherapy.

Critique Fourth Search Category: Expanded search for generalized depression psychotherapy

There exists an overwhelming amount of evidence for non-chronic depression traditional treatment modalities but detailed critique falls beyond the scope of this paper. The consensus in this information base considers that depression in general is a treatable disorder, with favorable treatment responses pharmacologically, and most optimally in combination with specific types of psychotherapy including; Cognitive and Behavioral Therapies (CT, BT and CBT), Interpersonal Therapy (IPT), and Psychodynamic psychotherapy.

Much of the psychotherapy literature includes studies of empirically-validated psychotherapy for major depression by at least two different investigators, conducted occasionally with manuals, and at least two between group and randomized controlled designs, primarily focused on non-chronic Major Depressive Disorder (MDD) and the following specific modalities: Behavior Therapy (BT) (Jacobsen, et. al, 1996; McLean & Hakstian, 1979), Cognitive Therapy (CT) (Medvide, 2005; Dobson, 1989), Cognitive Behavioral Therapy (CBT) (Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; Elkin, et. al, 1989), and Interpersonal Therapy (IPT) (DiMascio et. al,1979; Elkin et. al,1989). In general, the evidence is type I-II and A-B, good to fair quality, and supports a variety of psychotherapy approaches that are widely embraced in the field for non-chronic depression. Again, no comparative psychotherapy trials in
particular for chronic depression are published, and thus this significant gap mandates further study.

Summary of Fourth Search Category: Expanded search for generalized depression psychotherapy

Despite agreement regarding the efficacy of many of these conventional psychotherapy approaches for non-chronic depression, the evidence supports the premise that there remain significant numbers of depressive patients who do not respond or only partially respond to treatment, and or relapse into a more chronic course, often associated with high psychiatric and medical co-morbidities, as well as societal costs (Keller, et. al 2000; Keller, et. al, 1998a; Howland, 1993; Thase, 1992). Many of these patients are likely unrecognized chronic patients, highlighting the need for further depression symptom, pattern and chronology assessment and research. Thus, while the lack of empirical evidence in this area does not negate the efficacy of CBASP, the evidence generally supports a deficiency of these traditional psychotherapy approaches with regard to chronic depression and the new APA-PG support this idea (APA, 2010). Thereby, it is difficult to discern relative quality of therapy across modalities without further comparative trials and research. Thus, it behooves clinicians to ultimately choose the only demonstrated efficacious evidence-based approach, CBASP, pending further convincing psychotherapy research.

Critique Fifth Category Search: Manual-Based Psychotherapies

While there has been an information explosion for evidence-based medication therapy for major depression (APA, 2010) and depression in general, lesser recognized psychotherapy practices and in particular, protocol-driven or manual-based psychotherapies (such as those discussed in the previous search section), are consistently proposed to be the most effective by
experts in the field (Weissman 2007; Weissman & Markowitz, 2003). Again however, little
empirical evidence exists to support these opinions specifically for chronic depression (with the
exception of CBASP).

Thus, departing from monotherapy with medication, the evidence exists predominantly as
expert opinion articles touting manual-based psychotherapies as optimal for treating depression
typically in combination with medications. Only one 1992 meta-analysis of 11 studies was
discovered that reviewed the efficacy of manual-based, brief dynamic psychotherapies alone and
in general (i.e. not merely for depression) and thus is considered poor quality evidence for the
purpose of this paper, due to the remote date, lack of generalizability to chronic depression, lack
of combined modalities, and the limited number of articles. The article highlights that one of the
largest challenges in these types of studies is a lack of control and treatment variable specificity
(Crits-Cristoph, 1992) which again adds to the poor rating.

Summary of Fifth Category Search: Manual-Based Psychotherapies

Ideally, adequate screening and prevention of recurrent depressive episodes may
ultimately become the primary approach to the development of chronic depression, but
inconsistent guidelines and data fail to demonstrate what evidence works best. Although many
authors in these expert opinion and review pieces cite this premise, exhaustive searches resulted
in no chronic depression treatment or screening guidelines and yield a general lack of empirical
evidence in this area. Additionally, while experts similarly tout the use of manual-based
psychotherapies, little empirical support for their efficacy in chronic depression exists, with the
sole exception of the RCT’s that support the efficacy of CBASP, a manual-based psychotherapy
alone and in combination with medication.
Thus, much evidence from the arena of non-chronic depression has been generalized to chronic depression somewhat inadequately, highlighting the need for further study. The primary gaps in the data are best screening tools and identification procedures, comparative psychotherapy trials, alone and in combination with medications as well as maintenance and follow-up guidelines for relapse, and relapse-prevention strategies.

Section III
Implementation Plan

The conception for the workshop originated and developed from personal training in CBASP, experience with its efficacy and an interest in broadening the knowledge and use of aspects of the modality in a more accessible manner in line with the WHO initiative. Despite the demonstrated efficacy and effectiveness of CBASP for over a decade, the certification and training process are rigorous, timely and expensive. Thus, few CBASP providers exist and as a modality, it remains not widely recognized or applied. Market analysis indeed supports that few CBASP providers exist locally (See Appendix G Market Analysis). There are probably numerous reasons for this particular outcome, but according to James McCullough PhD, CBASP founder, to become a CBASP provider involves a time-consuming process that includes (intensive training) plus ongoing weekly supervision via video (for 4-5mos), and the use of a provider skills manual (2003, 2000). In addition, to become a ‘certified’ CBASP provider, incurs even more time, ratings, inter-rater reliability, and additional training and supervision (McCullough, 2003).

Thus, the modality is not easily accessible to most providers, let alone patients. The therapy was originally tested and conceived to be 1-2x/week hour-long sessions with homework in between, imposing further barriers to accessibility and application (See Appendices H & I for
CBASP characteristics and implementation details). While access is limited, expensive, intensive, and time-consuming, many patients may not be able to use therapy even when accessible, due to other restrictions, such as current economic and health care insurance limitations. The workshop premise evolved as an opportunity to bring a synthesis of specific CBASP strategies to more providers in a broader way, analogous to how CBT or IPT are now widely used with varied application across specialties. Thus, the workshop was designed with a mix of didactic and interactive simulation and case vignette exercises for practical application for use ‘in-the moment’ by the provider with any patient encounter.

Specific implementation included a trainer with specialty experience and knowledge of CBASP and the development of teaching materials (See Appendix J for Workshop Course Outline and Attached Cox CE Workshop Packet from October 2, 2010). Potential participants were targeted through mental health websites, postal and e-mail addresses, intra and inter-professional contacts, as well as electronic postings, e-flier announcements (See Appendix K for Workshop E-flier) and a USF alumni mailing list (yielding >3000 addresses), as well as San Francisco/Bay Area mental health, inpatient and community health settings via postcards and electronic advertising fliers.

The workshop’s overarching objective was to distill key approaches from a complex evidence-based psychotherapy modality for community providers to impact current practice. The educational intervention’s aim was to provide the distilled evidence-based strategies in an accessible “Tool Kit” to a variety of community and mental health providers, and to seize opportunities for patients to experience these approaches that might not otherwise have the chance. The workshop was viewed as an opportunity to apply the concepts and tools of this EBP, in a wider more accessible and more frequent way to mental health professionals who
come into regular contact with chronically depressed patients and can interact with them ‘in-the-moment’ in the community, inpatient settings, clinics, at the bedside, and even in the patient’s homes.

The underlying idea of distilling the conceptual CBASP strategies and presenting the synthesized ‘Tool Kit’ was to impact current practice by changing the treatment environment, and from a culturally competent standpoint, bringing these approaches to the patient in his/her environment. This idea ultimately fits exceptionally well within the CBASP perspective since one of the underlying concepts is that the CD patient is disconnected from their environments and the clinician role is to reconnect them. Provider participants were thereby encouraged to bring the tools back to their respective clinical settings and adapt them in ways that work for the patients and the setting; recognition that one size does not fit all was essential and this application process was evaluated.

Specifically, the two main educational intervention workshop objectives were: 1). To improve participants’ knowledge-base in the identification of chronic depression (CD) patients and, 2). To introduce and synthesize therapeutic strategies and tools from Cognitive Behavioral Analysis Systems Psychotherapy (CBASP), an Evidence-Based psychotherapeutic (EBP) approach for the treatment of CD, to impact current practice. The continuing education (CE) objectives for the Board of Registered Nursing (BRN) and Board of Behavioral Sciences (BBS) were to:

1. Learn to accurately identify chronic depression (CD).
2. Learn evidence-based strategies to work more effectively with chronically depressed clients.
3. Learn tools from Cognitive Behavioral Analysis Systems Psychotherapy (CBASP), a therapeutic modality, specifically designed for treatment of chronically depressed clients.
4. Practice therapeutic strategies for the management of chronically depressed clients.
5. Recognize common problems associated with the CD patient and treatment approaches.
6. Identify resources for the CD patient and provider.
The workshop was held from 8:45am until 5:00pm and the course outline is provided (See Appendix J). From 9:15 to 10:15am the workshop’s morning session officially opened with the educational content and slide show addressing ‘What is Chronic Depression?’ The unique aspects of chronic depression, the subtypes, treatment challenges as well as strategies and tools for CD identification, monitoring and application were also presented. Throughout the workshop, participation and discussion were encouraged, and attention was given to additional resources and educational items for application in the corresponding Cox-CE folder and resource packet. A break was offered from 10:15 to 10:30 am followed by another hour a half of content including, the introduction to CBASP, and an overview of the tools and evidence-base. This section started with a role play of the case presented in the pre-assessment, Evaluation A, to demonstrate a typical CBASP approach and highlight the similarities and differences from more traditional psychotherapy practices.

The afternoon session opened with an hour and forty five minutes of content addressing the specific CBASP Skills including, the strategies and official "Tool Kit” along with practical exercises for each tool. The tools included specific CBASP strategies such as: the significant other history (SOH), situational analysis (SA), assertiveness and interpersonal discrimination exercises (IDE), the proactive use of transference and negative reinforcement, maintaining an active patient role and the patient’s ‘attentional focus’, highlighting maladaptive patient cognitions and a facilitative provider role with disciplined personal involvement, and mood monitoring tools and evidence-based measures; all synthesized in a fashion to be utilized in-the-moment with patients. Another brief 15 minute break was offered and from 3:00 to 4:30 pm an interactive discussion including group work and simulation case exercises for practical application was included. From 4:30 to 5:00 pm, a wrap-up with concluding summary
statements, additional resources offered and dissemination of the post-assessments and reminders regarding the two-week follow-up survey were done to conclude the workshop.

Consistent with the WHO initiative (2010), implementation of the workshop is deemed a timely, evidence-based, effective and efficient venue to present relevant information to a broad variety of mental health and community providers. The endeavor inherently was designed to heighten awareness of the chronic depression problem and allow any participant an equal opportunity to learn, adapt and disseminate the therapeutic strategies and tool kit (See Appendix L for Workshop Tool Kit) in their respective professional settings, in a patient-centered and culturally competent manner.

The original workshop goal was to obtain a minimum of 10 participants with a maximum capacity for this type of learning format set at 25 attendees. The official number of registrants was 20 plus two doctorate-prepared nurse assistants, who participated in the workshop but not the evaluations (due to their assistance in the development of the workshop and evaluative measures), and the trainer for a total of 23. Two student assistants also helped with the program event including registration and administrative support, but also participated in the workshop and the evaluations and thus are counted in the evaluative measures. Thus, the actual number of participants who attended and participated on October 2^{nd}, 2010 was 19 minus the two nurse assistants for an N=17 for the evaluation purposes. Thus, the minimum participant goals were exceeded. USF Institutional Review Board (IRB) approval was obtained. The board determined the project to be safe and declined the need to further evaluate the project based on the premise that it is a continuing education (CE) workshop and an educational intervention with no manipulation of subjects.

Section IV
Evaluations Overview

Four evaluations were disseminated to all workshop participants. A pre-assessment, Evaluation A, and two post-workshop Evaluations B (event day) and D (a two week follow-up survey) were distributed and queried demographic information and content knowledge in a multiple choice format (See Appendices M, N and P). Each evaluation also included one case study exercise to offer an opportunity for participants to qualitatively respond from the provider perspective. An evaluation of the offering, Evaluation C, was also dispensed at the close of the workshop to meet board requirements (See Appendix O). Outcomes data were analyzed and compiled (See Tables III through XVI below for summary data and Tables XVII through XIX after the Appendices for individual participant outcome data).

More specifically, the first evaluation or pre-assessment (Evaluation A, See Appendix M) was dispensed during the morning registration period and queried demographic and professional information as well as pre-workshop content knowledge. Every evaluation (except Evaluation C for the offering) was assigned an identifier number so that answers were confidential (not anonymous), in order to compare pre and post-workshop individual participant responses. The post-assessment (See Appendix N for Evaluation B) was dispensed at the close of the workshop and collected as participants departed. The evaluation of the offering (See Appendix O for Evaluation C), a Board of Registered Nursing (BRN) and Board of Behavioral Sciences (BBS) requirement, and the two week post-assessment follow-up survey (See Appendix P for Evaluation D) will be discussed separately in later sections.

In Evaluations A, B and D, the participants were asked to write a brief response to each case scenario with potential provider and client responses. The idea was to see if any CBASP tools or principles were applied in their responses to each case. Three ‘expert’ raters coded each
of the participants’ responses based on a numerical key (See Appendix R). The ‘expert’ raters included: a CBASP trainer and two additional raters with prior knowledge of CBASP who also attended the training (but did not participate in the evaluations except in terms of development). All three raters were blinded to each other’s responses and coded every participant’s response to each of the three cases. The participant responses were transcribed verbatim, then rated with an assigned numerical code (See Appendix R) and highlighted in Table III below.
Comparison of Raters (R) 1, 2 and 3’s assessment of each participant’s responses to Eval A, B and D cases.

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The overall premise of the case scenarios was essentially to see if participants were able to apply CBASP tools and principles to the cases. Specifically, the idea was to discern if any common themes developed, or did the ratings capture any degree of agreement between the raters or any differences between the pre and post assessments. Despite a generally increased use of CBASP-tools in the post-assessments, as seen in the aforementioned table, there was little consistency in ratings between raters and even within each individual rater across items. Moreover, despite the strong intentions, there was no standardized training or practice with the measure and numerical codes. Thus, no definitive conclusions can be drawn due to a lack of rigor, internal validity, inter-rater and intra-rater reliability; potential issues to address in any future evaluative measures.

Pre-Assessment (Evaluation A) Results Summary

Demographic data derived from the Pre-Assessment (Evaluation A, Appendix M), found the cohort of 17 respondents to be a diverse group in terms of age, ethnicity, educational background, professional roles and certifications. The majority of the group, or 41% of participants, reported that they are between the ages of 51-60 years while 24% fell into the 31-40 year old age category. Eighteen percent identified as 41-50 year olds and 6% of participants each (or 3 individuals) had their own category from 20-30 years to 71+ years. The majority of registrants, or 71%, were women and 35% identified as Asian or Filipino, followed by 29% Caucasian and 18% Latino/Hispanic origin. Another 18% (or 3/17) chose not to respond to this cultural background item.

In terms of educational background, 47% (8/17) reported a Master’s degree or Master’s of Science in Nursing (MSN) with one master’s in nutrition, and 24% (4/17) attained a highest level of education at the Bachelor’s degree (Bachelor of Arts, BA, or Bachelor of Science in
Nursing, BSN). Two of the 17 participants or 12% reported a highest educational level at the Associate’s degree and 18% (3/17) had doctorate degrees. The majority or 71% of the respondents, were registered nurses (RN’s, both BSN and Associate’s degree level). Two participants identified as medical doctors (MD’s, one board-certified Rheumatologist and one medical doctor from Mexico), and others identified as the following: one Licensed Vocational Nurse (LVN), one Certified Recreational Therapist (CRT), one Doctorate of Nursing Practice (DNP), two Masters degrees in Public Health (MPH), and two case managers (CM).

Subspecialty certifications and areas of practice covered a broad spectrum (with several individuals carrying multiple roles) ranging from veterans to hospice and geriatrics, community HIV, Rheumatology/pain management (private MD practice), substance abuse/Methadone Maintenance Treatment (MMT), long-term care (LTC), business administration, case management, public health, inpatient nursing and community and residential mental health arenas and the majority (77%) worked with adults ages 18-65 or older. Almost 77% of individuals work full-time, 30+ hours per week, while the remaining members of the cohort worked either part-time or per diem, with one unemployed new graduate volunteering four hours weekly. Fifty-three percent identified their work settings as being comprised of upwards of 51% licensed nursing personnel while only 24% identified their setting as having less than 10% non-nursing mental health professionals. The demographic data is summarized in Table IV below.
### Participant Demographic Summary: Table IV

<table>
<thead>
<tr>
<th>AGE</th>
<th>(n=17)</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-30 years</td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>31-40 years</td>
<td></td>
<td>24%</td>
</tr>
<tr>
<td>41-50 years</td>
<td></td>
<td>18%</td>
</tr>
<tr>
<td>51-60 years</td>
<td></td>
<td>41%</td>
</tr>
<tr>
<td>61 + years</td>
<td></td>
<td>12%</td>
</tr>
</tbody>
</table>

| GENDER | | |
|--------|--------|
| Female | 71%    |
| Male   | 29%    |

| ETHNICITY | |
|-----------|
| Asian/Filipino | 35% |
| Caucasian      | 29% |
| Latino/Hispanic| 18% |
| No response identified | 18% |

| HIGHEST LEVEL OF EDUCATION ATTAINED | |
|-----------------------------------|
| Associate degree                  | 12% |
| Bachelors degree                  | 24% |
| Masters degree                    | 47% |
| Doctorate degree                  | 18% |

| PROFESSIONAL ROLE | |
|-------------------|
| LVN (licensed vocational nurse) | 6% |
| RN (registered nurse) or BSN   | 71% |
| MD (medical degree)            | 12% |
| MPH (masters degree public health) | 12% |
| Other-CRT (certified recreational therapist) | 6% |

| POPULATION CARED FOR | |
|----------------------|
| Ages <18 years       | 12% |
| Ages 18-65 years     | 77% |
| Ages 66+ years       | 35% |

| WORK STATUS | |
|-------------|
| Full-time (30+ hours/week) | 77% |
| Part-time (<30 hours/week) | 12% |
| Per diem, Unemployed/Volunteer | 12% |

| WORK SETTING STAFF MIX | |
|------------------------|
| Over 50% professional nursing personnel | 53% |
In terms of content knowledge on the pre-assessment (Evaluation A), the overall data is summarized in Tables V, VI, and VII below.

**Table V**

Evaluation A Individual Participant’s Total Percent Correct Score on Items A-11 through A-17

|          | 43% | 71% | 57% | 29% | 29% | 29% | 29% | 43% | 14% | 43% | 43% | 43% | 29% | 29% | 71% | 71% | 57% |
|----------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|

**Table VI**

Evaluation A Total Percent Scored Correctly for each item by all participants

<table>
<thead>
<tr>
<th>Item A-11 CD Identification</th>
<th>Item A-12 CD Types</th>
<th>Item A-13 CD Epidemiology</th>
<th>Item A-14 CD Response to Traditional Treatment</th>
<th>Item A-15 Identification of EBP for CD</th>
<th>Item A-16 CD areas of Dysfunction</th>
<th>Item A-17 % of CD with Axis II personality disorders</th>
<th>Item A-18 Efficacy of providing hope response to CD patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>35%</td>
<td>18%</td>
<td>65%</td>
<td>71%</td>
<td>6%</td>
<td>6%</td>
<td>76%</td>
<td>24%</td>
</tr>
</tbody>
</table>

**Table VII**

Evaluation A Summary of Participant Overall Results

| % Participants Scoring 10-25% correct overall on Evaluation A | 6% |
| % Participants Scoring 26-50% correct overall on Evaluation A | 65% |
| % Participants Scoring 51-75% correct overall on Evaluation A | 29% |
| % Participants Scoring 76-100% correct overall on Evaluation A | 0% |
Comparison of Pre-Assessment (Evaluation A) and Post-Assessment (Evaluation B) Results

One particular interesting outcome on Evaluation A is the finding that the majority (11/17 or 65%) of the cohort was unable to accurately identify the correct length of time (2 years or longer) required for a client to be determined chronically depressed. This data stands in contrast to the post-evaluation (B) after the event when 100% correctly answered this particular content question. Thus, this area of content appears to be clear by all the participants after the workshop content presentation. The majority, or 82% of participants, again incorrectly responded to the content regarding the recognized and Evidence-Based types of CD on the pre-assessment (Evaluation A). On the post-evaluation (Evaluation B), the cohort improved and half were able to correctly identify CD types in a ‘select all that apply’ format, that also captured a majority of correct responses along with any incorrect answers. Sixty-five and 75% respectively, answered correctly on the pre-test items inquiring about typical CD response to therapeutic approaches and the epidemiology of CD and this was similarly reflected on the post-test B for both content items.

The majority of participants however, incorrectly identified effective evidence-based psychotherapeutic modalities for the treatment of CD in the pre-assessment. This knowledge improved on post-assessment B to 67% correct responses, again in a ‘select all that apply’ format, indicating that had any correct response been allowed and scored, the percentage would have risen. Only 6% (1/17) of the participants correctly responded to the statement regarding the areas of typical dysfunction for CD clients whereas 100% responded correctly on post-assessment (Evaluation B). Participants wholeheartedly (77%) believed before the workshop that ‘providing hope’ to a CD patient is important message to offer in treatment. This question was poorly worded as the answer was intended to be false, to capture the ineffectual nature of
providing hope to CD clients, but it was misleading and makes it difficult to make any comparison or inferences on the post-assessment.

Three post-evaluation (Evaluation B) content areas (See Tables VIII, IX and X below for results) looking at the primary goals of CBASP, the optimal provider skills in terms of CBASP and the use of positive reinforcement all scored poorly on post-evaluation perhaps indicating a need for more clarity in this content. Also, the nature of ‘select all that apply’ questions that are scored only if answered entirely accurately, may skew the results further. Thus, it is a consideration for future evaluative measures, to employ a one answer option or use a different scoring method to improve this aspect for analysis.

Table VIII

Evaluation B Individual Participant’s Total Percent Correct Score on Items B-1 through B-9

<table>
<thead>
<tr>
<th>Item B-1 CD Identification</th>
<th>Item B-2 CD Types</th>
<th>Item B-3 CD Epidemiology</th>
<th>Item B-4 CD Response to Traditional Treatment</th>
<th>Item B-5 Identification of EBP for CD</th>
<th>Item B-6 % of CD with Axis II personality disorders</th>
<th>Item B-7 CD areas of Dysfunction</th>
<th>Item B-8 Skills needed to work with CD patients</th>
<th>Item B-9 Use of positive reinforcement in CBASP</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>50%</td>
<td>53%</td>
<td>80%</td>
<td>100%</td>
<td>87%</td>
<td>38%</td>
<td>50%</td>
<td>67%</td>
</tr>
</tbody>
</table>
Table X

Evaluation B Summary of Participant Overall Results

| % Participants Scoring 10-25% correct overall on Evaluation B | 0% |
| % Participants Scoring 26-50% correct overall on Evaluation B | 19% |
| % Participants Scoring 51-75% correct overall on Evaluation B | 31% |
| % Participants Scoring 76-100% correct overall on Evaluation B | 50% |

Post-Assessment (Evaluation C) Results Summary

The post-assessment, Evaluation C (See Appendix O) is a BRN and BBS requirement and concerns the offering of the workshop including trainer preparation, information presented and the facility. The most common way that participants were informed of the workshop (56%) was through the electronic announcement or e-flier that was sent out via email and was also posted in various health care venues including the Veteran’s Administration Medical Clinics (VAMC), San Francisco General Hospital (SFGH), El Camino Hospital and Kaiser Permanent (KP) systems, and the University of California at San Francisco’s (UCSF) Langley Porter Psychiatric Institute (LPPI). The e-flier via email or posters then directed those interested to the website on the USF Nursing home page for further information and to register. At least two of the 16 respondents (12.5%) reportedly learned about the workshop directly from the website.

Also according to Evaluation C, 59% (10/17) of participants are currently working as community or inpatient nurses and 35% are USF alumni and another 18% (3/17) are current USF
nursing students and also 18% are current USF faculty (not including the two doctoral committee USF faculty assistants).

No participant stated learning of the workshop through addressed and mailed postcards; an interesting finding since this was the most time-consuming and expensive advertising cost and route. The expense was approximately $140 including postage for an order of 150 ‘Zazzle.com’ postcards designed by the trainer. Thirty of the postcards were postal-stamped, addressed and mailed to various healthcare and mental health facilities. Also of note, is that this was the advertising form that was sent out at the earliest date (in August) while the remaining post-cards were either hand- delivered or disseminated via nursing preceptors, instructors and managers, with whom the trainer has personal and professional contacts (in early September). However, at least 3 of 17 participants reportedly learned of the workshop through ‘word of mouth’ or a professional colleague (and the assumption is that the colleagues learned of the workshop from the trainer who handed out the postcards for delivery. Additionally, 18% also learned of the workshop through a USF faculty member again perhaps either via word of mouth or from a postcard reminder. Thus, while the postcards generally were more time-consuming and costly to produce and disseminate, a scaled back effort might still be worthwhile in the future in terms of talking points with personal and professional connections for advertising.

The e-fliers were sent out 2-3 weeks prior to the workshop (behind schedule) but yielded the best results (56% of the respondents) (See Appendix K for e-flier). Moreover, only two potential registrants from the over 3,000 USF alumni addressees who received the e-flier announcement responded to the trainer to mention that if they had been given more advanced notice, they would have been able and interested in attending. However, both registrants were living and working out of the state of California and were not necessarily the intended or target
Nevertheless, a future consideration should be to send out the alumni e-flier mailings sooner with perhaps a reminder announcement 2-3 week prior to the event. Also, a separate announcement in the alumni E-Newsletter is another helpful reminder. This was an incidental and unplanned, yet fortuitous occurrence for this workshop, despite it being sent out the last week of registration (several registrations were received the last week prior to the workshop).

For future projects, coordinating (with Thomas Listerman, the USF alumni email manager) the timing of the event to coincide a week or two after the E-Newsletter is sent out would be beneficial for future endeavors as well). In addition, since no participant represented the USF School of Education or counseling psychology programs, it would also be prudent to send out an alumni announcement to this group.

The remaining items on Evaluation C are denoted by a likert scale (a psychometric scale used in survey research) with the following codes: 1=strongly agree, 2=somewhat agree, 3=somewhat disagree and 4=strongly disagree; results are coded in Table XI below.
Table XI

Qualitative Data from Evaluation C (the offering)

Likert Scale: 1=strongly agree, 2=somewhat agree, 3=somewhat disagree, 4=strongly disagree

<table>
<thead>
<tr>
<th>Participant Responses</th>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I enjoyed the workshop”</td>
<td>94%</td>
<td>6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“The trainer was well prepared.”</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“…Workshop provided necessary information …”:</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“…to increase knowledge regarding CD”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“… and tools to increase more accurately identify CD patients”</td>
<td>88%</td>
<td>12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“…to understand CD treatment challenges”</td>
<td>94%</td>
<td>6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“… to apply EB strategies for the therapeutic management of CD clients”</td>
<td>94%</td>
<td>6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“… for further resources &amp; trainings re: CD”</td>
<td>94%</td>
<td>6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“The workshop allowed adequate time for practice exercises.”</td>
<td>88%</td>
<td>12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I enjoyed the format (introduction, questions, timing, info., cases, practice, discussion.”</td>
<td>94%</td>
<td>6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“The facilities met my expectations (room, buffet, reception)”</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Ninety-four percent of participants strongly agreed (and 6% or 1/17 participants somewhat agreed) that: a). they enjoyed the workshop, b). they enjoyed the format (introductions, timing, information, questions, cases, practice exercises, discussion etc), c). the workshop provided the necessary information to understand the CD treatment challenges, d). the workshop provided the necessary information to apply EB strategies for the therapeutic management of CD clients and, e). the workshop provided the necessary information for further resources and training regarding CD. The participants strongly agreed (88%) or somewhat agreed (the remaining 12%) that the workshop provided the necessary tools to more accurately identify CD clients, and that the workshop provided adequate time for practice exercises.

One hundred percent of the attendees strongly agreed that the trainer was well prepared, that the workshop provided the necessary tools to increase their knowledge of what constitutes CD (also consistent with the learning improvement from pre to post assessment) and that the facility met the expectations (room, reception, buffet). Additional items asked for comments on what the participants considered to be most helpful about the workshop, least helpful and any future suggestions. The following are the list of all the comments:


Least Helpful: “n/a”, “nothing”, “0”, “writing scenarios”.

Future Suggestions: “follow-up on future events on depression with adolescents as well”, “watch video of CBASP interaction. Thanks!”, “Keep going!”, “follow-up workshop do simulations, lots of them-really here for them”, “medical/pain and depression seminar”, “more role playing! More practice working the steps and tools...maybe more examples of
conversations highlighting the specific tools”, “no-excellent workshop”, “perfectly planned”, “having live video interventions would be great”.

Hence, the feedback was positive and all of the suggestions are reasonable and can easily be applied when planning future efforts.

Two week follow-up Post-Assessment (Evaluation D) Results Summary

For the majority of content questions on Evaluation D (See Appendix P for Evaluation D) the N=12 and for a few of the application to practice setting items the N=11, as one respondent is not currently working and responded that these items were “N/A” (hence was coded as a 0). Questions were assessed on a Yes/No and True/False and coded as 1 and 2 respectively (See Appendix ----for Table----for individual participant responses). Items were also evaluated on a likert scale and designated as “Strongly agree” on one end of the continuum to “Strongly disagree” on the other pole. The likert items were coded numerically for analysis from 1 to 7 with the following descriptors assigned after receipt of responses: Strongly agree (1), moderately agree (2), mildly agree (3), neutral response (4), mildly disagree (5), moderately disagree (6), and strongly disagree (7). Other content questions queried asked respondents to select one option or ‘select all that apply’.

Item number one inquired about any changes in the provider’s practice setting. Eighty three percent reported no change in their work setting, while 17% (n=2) reported a change but one appeared to have misinterpreted the item to imply some impact from the training. In terms of CBASP application, or the respondent’s belief that he/she was able to fully apply CBASP principles in the respective practice setting, 25% (3/12) strongly agreed while 6/12 mildly to moderately agreed so 75% of all respondents agreed to some degree that they were able to fully
apply CBASP principles in their practice setting. Eight percent responded neutrally while 17% (2 out of 12) rated mild to moderate disagreement with this statement.

Seventy-five percent of respondents strongly agreed that they found the CBASP tools kit easy and useful while one responded neutrally and 17% mildly to moderately disagreed. Sixty-seven percent strongly to mildly disagreed that diagnosing CD is difficult while 25% mildly agreed but only one respondent strongly agreed to this statement. Incidentally, this respondent answered all items with a rating of 1 perhaps indicating either a misinterpretation of the question or a rushed response and bias. Twenty-seven percent of respondents found tools to identify CD clients useful and easy to apply and an additional 55% rated mild to moderate agreement with this statement. Thus, a majority or 82% found the CD diagnostic tools useful and easily applicable. One participant responded neutrally and one mildly disagreed as to the ease and usefulness of the CD diagnostic tools. Only 36% or four of 11 respondents strongly agreed that their current practices are similar or consistent with CBASP strategies while six of 11 or 55% mildly to strongly disagreed to this statement (and one respondent rated a neutral response).

Sixty-four percent of participants responded that their practice setting was very open to the use of CBASP tools for CD while three of 11 respondents were neutral and one mildly disagreed. Only 33% correctly responded to an item evaluating their ability to accurately diagnose CD. However, the question’s wording may have posed some confusion perhaps accounting for this low accuracy response. On the other hand, 50% correctly identified all three items on a question with 6 possible items covering the common manifestations of CD clients from a CBASP perspective while 92% and 100% correctly answered content questions respectively covering CD epidemiology and useful CD screening tools.
Also, 67% and 50% respectively, correctly responded to items inquiring about a typical CBASP response and optimal CBASP provider stance. Notably, however for both of these items almost 100% chose the correct answers but also offered incorrect responses with their correct answers, thereby deeming an overall incorrect coded response to the question, but still demonstrating some competency in this content area. Importantly, 100% of respondents reported that if they were not currently using CBASP tools, they planned to use the workshop tools in the future and felt they the ability to implement these into their practice setting (see Tables XII, XIII, and XIV for summary of Evaluation D results).

Table XII
Evaluation D Individual Participant’s Total Percent Correct Score on Items D-10 through D-15 and Item D-17.

<table>
<thead>
<tr>
<th>Item D-10 CD Identification</th>
<th>Item D-11 CD symptoms</th>
<th>Item D-12 CD Epidemiology</th>
<th>Item D-13 CD Tools</th>
<th>Item D-14 Typical CBASP Response</th>
<th>Item D-15 Optimal CBASP Provider Stance</th>
<th>Item D-17 Planned use of CBASP Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>67%</td>
<td>67%</td>
<td>44%</td>
<td>33%</td>
<td>78%</td>
<td>78%</td>
<td>78%</td>
</tr>
<tr>
<td>33%</td>
<td>50%</td>
<td>92%</td>
<td>100%</td>
<td>67%</td>
<td>50%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table XIV

Evaluation D Summary of Participant Overall Results

| % Participants Scoring 10-25% correct overall on Evaluation D | 0% |
| % Participants Scoring 26-50% correct overall on Evaluation D | 8% |
| % Participants Scoring 51-75% correct overall on Evaluation D | 67% |
| % Participants Scoring 76-100% correct overall on Evaluation D | 25% |

There were several themes provided in response to what if any barriers were encountered in the implementation of CBASP tools in their practice settings including: time constraints, cost versus productivity, budget or service cuts, patient resistance and the problems with collaborating with colleagues who are unfamiliar with the CBASP approaches. The following are responses to inquiry regarding specific tools that respondents are currently using and had found useful since the workshop two weeks prior:

“All of the tools!” “Stamp”, “SOH”, “SA”, “interviewing techniques”, facilitative/active patient role”, “scenarios were fantastic”, “confronting the issues”, “refocusing the client”, “focus client in-the-moment”, “reacting honestly to client” (genuine response), “assertiveness”, “Personalize it.”

Interestingly, every tool addressed in the workshop was mentioned at least one time by at least one participant. Thus, while not all tools may be useful or work for every provider in every practice setting, at least one tool has been found to be useful within a 2 week period in terms of application to these particular provider settings and clients.
Pre and Post Assessment Comparison Results Summary

A comparison of the pre and post assessments in terms of the individual participant’s scores (total percent correct) on all the content items is presented in Table XV below.

Table XV

Comparison of each individual participant’s overall total (percentage correct) scores on Evaluation A, B and D.

<table>
<thead>
<tr>
<th>Participant ID#</th>
<th>Total % Correct Eval A Pre-Assessment</th>
<th>Total % Correct Eval B Post-Assessment</th>
<th>Total % Correct Eval D 2 Week Follow-up Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>43%</td>
<td>67%</td>
<td>71%</td>
</tr>
<tr>
<td>3</td>
<td>71%</td>
<td>67%</td>
<td>57%</td>
</tr>
<tr>
<td>5</td>
<td>57%</td>
<td>44%</td>
<td>71%</td>
</tr>
<tr>
<td>6</td>
<td>29%</td>
<td>33%</td>
<td>N/A</td>
</tr>
<tr>
<td>7</td>
<td>29%</td>
<td>78%</td>
<td>71%</td>
</tr>
<tr>
<td>8</td>
<td>29%</td>
<td>89%</td>
<td>71%</td>
</tr>
<tr>
<td>9</td>
<td>29%</td>
<td>78%</td>
<td>86%</td>
</tr>
<tr>
<td>10</td>
<td>43%</td>
<td>78%</td>
<td>86%</td>
</tr>
<tr>
<td>11</td>
<td>14%</td>
<td>89%</td>
<td>57%</td>
</tr>
<tr>
<td>12</td>
<td>43%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>13</td>
<td>43%</td>
<td>56%</td>
<td>86%</td>
</tr>
<tr>
<td>15</td>
<td>43%</td>
<td>56%</td>
<td>N/A</td>
</tr>
<tr>
<td>16</td>
<td>29%</td>
<td>78%</td>
<td>N/A</td>
</tr>
<tr>
<td>17</td>
<td>29%</td>
<td>78%</td>
<td>57%</td>
</tr>
<tr>
<td>18</td>
<td>71%</td>
<td>67%</td>
<td>43%</td>
</tr>
<tr>
<td>19</td>
<td>71%</td>
<td>78%</td>
<td>71%</td>
</tr>
<tr>
<td>20</td>
<td>57%</td>
<td>44%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Note: ID#1, 4, and 14 did not attend, no responses entered.

** “N/A”: missing data; no response received.
In summary, 24% of participants consecutively scored better across each assessment (A, B and D) and while 77% improved overall on at least one pre to post-assessment total score. Notably, five participants did not follow-up with at least one or both of the post-assessments. Only 12% (2/17) of the participants’ overall scores declined across the two post-assessments consecutively, while an additional participant’s score declined from the pre-evaluation A to post-evaluation B only. Nevertheless, in all of these cases, the scores were relatively close. Generally speaking however, the participants’ overall scores on content items improved across pre and post-test content, perhaps indicating some learning of content knowledge (See Table XVI below). However, without a larger cohort and more rigorous statistical analyses, no definitive conclusions or implications can be derived from this data.

Table XVI
Summary Comparison Table of Participants’ Total Percent Correct Scores on Content Items across Evaluations A, B and D.

<table>
<thead>
<tr>
<th></th>
<th>Evaluation A</th>
<th>Evaluation B</th>
<th>Evaluation D</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Participants Scoring 10-25% correct overall</td>
<td>6% (1/17)</td>
<td>0% (0/16)</td>
<td>0% (0/12)</td>
</tr>
<tr>
<td>% Participants Scoring 26-50% correct overall</td>
<td>65% (11/17)</td>
<td>19% (3/16)</td>
<td>8% (1/12)</td>
</tr>
<tr>
<td>% Participants Scoring 51-75% correct overall</td>
<td>29% (5/17)</td>
<td>31% (5/16)</td>
<td>67% (8/12)</td>
</tr>
<tr>
<td>% Participants Scoring 76-100% correct overall</td>
<td>0% (0/17)</td>
<td>50% (8/16)</td>
<td>25% (3/12)</td>
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</table>
Section V

In terms of continuous quality improvement (CQI) this project meets all the core criteria including the formation of a team (doctoral committee expert advisors, student and administrative assistants), clear and defined aims (as aforementioned). It also encompassed an understanding of and provided education regarding the unique needs of the chronic depressive population who are ultimately served by those multi-disciplinary professional providers who attended the workshop. Furthermore, identifiable measures of outcomes for the successful accomplishment of the workshop’s objectives were also utilized and provided (See Appendix Q for CQI criteria). The implementation process further involved a collaborative, open discussion process regarding strategies for producing improvement and involved planning, collection and use of evidence-based data for the workshop development, benchmarks, implementation and evaluation (See Appendices E, F, M, N, O, and P for the evidence-base guidelines and the evaluations measures and Tables III through XIX for outcome data).

Section VI

Summary of Process and the Lessons Learned

The continuing education workshop entailed detailed planning and oversight for the greater part of six months and was overall a successful endeavor although several areas for improvement were highlighted. In the implementation process, from the planning stages, to marketing, to presentation of the content and the follow-up evaluations, several lessons were learned.

Specifically, the number of participants for this type of interactive format was ideal with one trainer, but this workshop could also be implemented with fewer or larger numbers of participants, depending on room space and the level of expertise of the assistants. With more experienced trainers this workshop could be opened to larger numbers so long as the ability to
provide individual and small group focus, feedback and instruction is maintained. Another possibility would be to offer a larger lecture portion of the training on one day or half of one day and then hold smaller breakout sessions with individual experienced trainers for the interactive case vignette and role play simulations on a second day or second half of one day. Certainly there is sufficient information and activities to allow an expanded offering for a two day, weekend training and overall feedback from participants was uniformly positive regarding the interactive activities and for the possibility of additional practice.

Moreover, in terms of the content and teaching methods, perhaps an increased focus on assessment and how to identify chronically depressed patients with more interactive exercises might be helpful. According to the evaluations and feedback, this area was one of the more challenging content areas. Thus, there is a capacity to allow for improvement and more interaction in the morning, content-heavy lecture portion of the workshop, by modifying the teaching in this manner to address this issue. Additional practice exercises, case vignettes and perhaps video examples of the application and use of CBASP interactions and tools were also suggested and could easily be implemented.

At least one participant noted he did not enjoy or find useful, the writing exercises (responses to case vignettes on the evaluations). Similarly, since several other participants also did not fill out these sections of the evaluations and rating them was perhaps tedious and did not yield rigorous or insightful data, perhaps using fewer or applying them in the lecture part of the workshop as teaching and interactive group content with review and discussion, might prove more interesting and helpful overall.

In addition to the potential evaluation changes and scoring methods aforementioned, an increased focus on methods to improve participants’ correct responses on the evaluations with
regards to teaching content is an area for further enhancement and modification. Adding more interactive case exercises to the content heavy morning session may improve learning and content application.

In terms of the advertising and marketing, time and costs may be reduced by focusing on electronic announcements and postings as well as the alumni list-servs since these areas yielded the best results in terms of the number of registrants (compared to the yield from the post cards and the mailing time, labor and costs). Moreover, tailoring the content and tools to target different areas of health care and providers and in particular primary care providers, might also be an important future effort since a high number of individuals are seen and treated for depression in primary care and this would also meet another WHO initiative goal.

In general, however, this pilot project served as a very successful initial effort with minimal cost and budget, to test the feasibility and outcomes of meeting the project’s objectives and to set the stage for future workshop implementation in a similarly efficient and cost-effective manner.

**Dissemination Plan**

Two potential descriptive manuscripts will be completed and submitted to professional mental health or nursing publications to further disseminate information. One article is feasible to describe the knowledge and information distilled and synthesized for this project from the complex concepts and evidence-based psychotherapy modality. A second manuscript can describe the implementation of the educational intervention as one possible approach to sharing this information and experience. Any additional opportunities or invitations to disseminate the seminar information will be embraced, including poster sessions, presentations, teaching opportunities or staff in-services. Perhaps most importantly, the experience and post-analysis
have provided feedback regarding future implementation and the foundation for future
collaborative and continuing educational efforts.

Implications for Advanced Nursing Practice and Conclusion

Chronically depressed patients all too often receive well-intentioned but inadequate care
from primary and even specialty care settings. Application of evidence-based psychotherapy
strategies and in particular the synthesized CBASP tools, may reduce long term costs, improve
care and efficacy of providers, hope and quality of life for chronically depressed patients and
their communities. Future efforts should focus on continuing to bring this knowledge and
distilled strategies to nurses and mental health professionals who encounter this patient
population. In addition, perhaps tailoring events for primary care or pain management clinicians
who frequently attend to the chronically depressed community may further impact this
population.

CBASP is based on a biopsychosocial model of psychopathology and health and views
depression as stemming from faulty coping that results in a perceptual disengagement of the
individual from the environment (McCullough, 2000). Nursing’s biopsychosocial framework,
focused on learning, problem-solving, skill-building, coping, strengths and symptom
management, cognitive and behavioral treatment approaches, makes CBASP an eminently ideal
fit for the profession.

Considering the complexity and treatment challenges, the consequences of increased
morbidity and mortality rates, and the associated impact on individual quality of life and greater
public health of chronic depression, it is imperative that mental health providers and in particular
advance practice nurses (APN’s) that encounter depressed clients, recognize the unmet needs of
this population and respond. Nurses, especially those working in the community, primary care,
or mental health arena, are uniquely trained and in the position to effect change by correct patient identification and appropriate treatment or referral. By embracing and utilizing available assessment, problem-solving and management tools as presented in this project and educational intervention, nurses can more accurately identify chronically depressed patients. Understanding the shortcomings of conventional treatment on a chronic population and armed with the knowledge of evidence-based approaches, like the CBASP tools, nurses may improve patient care and impact this growing societal problem at the bedside and in the patient’s environments.
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Acknowledgments

The writer would like to formally acknowledge and thank her doctoral committee for their ongoing, tireless patience and assistance and overall positive support throughout this entire process. I am eternally grateful to my Chair, Dr. Judith Karshmer, PhD, whose contribution and support was invaluable especially with regards to the workshop conception and implementation and general ‘can do approach’. I would also like to thank my preeminent Committee members, Dr. Robin Buccheri and Dr. Betty Carmack, both of whom provided endless support, words of encouragement, editing and specific assistance throughout the past several years. Thank you all for all of your sage advice, support and constructive feedback throughout the past several years. This process would not have evolved as smoothly or successfully and resulted in its current state, without each of your valuable input and ideas. Thank you all so much! One could not have asked for a more intelligent, positive and better committee!

I would also like to acknowledge and thank my former CNL-7 students, Maria Stone and Alicia Talavera for their volunteer assistance at the workshop and for taking the initiative to keep everything from registration, coffee and food to the evaluation dissemination and collection running so smoothly. Your competence and confidence really inspired and calmed me during the workshop. Thank you also to Christina Tai who was especially integral in activating the workshop’s website, registration form, e-flier and alumni announcements and to Ryan Daugherty whose patience and essential assistance with the food, registration and financial management is unsurpassed.

Finally, thank you to my loving partner Jason who spent many a countless day watching and entertaining our son so that I could finish this project and to Devin my precocious two year
old who gave up many days and nights with mommy so I could accomplish this goal. I promise to make it up to both of you!
Appendix A
Chronic depression and chronic subtypes defined

Chronic depressions differ from the more widely recognized Major Depressive Disorder (MDD), also sometimes referred to as Major Depressive Episode (MDE), in terms of symptom severity, duration and persistence. DSM-IV, MDD (or MDE) consists of symptoms of persistent low mood and or anhedonia (low interest) with five additional symptoms including sleep or appetite disturbances, concentration difficulties (or indecisiveness), low energy or fatigue, psychomotor retardation or psychomotor agitation (subjective perception), feelings of worthlessness and or inappropriate guilt, and suicidal ideation. These symptoms typically persist 80-100% of most days for at least two weeks and represent a distinct change in the individual’s usual functioning with some level of life impairment or marked distress (APA, 1994).

In contrast with episodic or recurrent major depressive disorders, the chronic depressions show similar symptoms but they persist unabated for at least two years (Trivedi & Kleiber, 2001; Howland, 1993a; Scott, Barker, & Eccleston, 1988). Individuals with chronic depression often have difficulties coping adequately with life stressors and often have a history of developmental trauma, repeated interpersonal difficulties, and deficient coping tools that lead to feelings of hopelessness and helplessness (McCullough, et al, 2003a).

There are five chronic course patterns identified in the literature and considered subcategories of chronic depression. Probably the most familiar is ‘Dysthymia’, defined as mild to moderate depression symptoms occurring more days than not (typically more than 50% of the week) for a period of two years or longer. Prevalence data for dysthymia is about 6% (APA, 1994). Dysthymia frequently begins in childhood or adolescence and while the symptoms overlap with MDD they tend to be more chronic, persisting for years but with generally less
severity. The onset is often insidious and patients may report feeling depressed for as far back as they can recall, assuming that it is a part of their personality (APA, 1994). For the latter reason, patients may not seek treatment and often go unrecognized.

A lesser recognized, but commonly occurring subtype in 20-25% of patients with MDD is denoted as ‘Double Depression’ (McCullough, 2000; Scott, 1988). This subtype has a course pattern comprised of a single or recurrent MDD episode superimposed on a dysthymic disorder lasting two months or more without any symptom-free period. In addition, these double depression patients often start out with a dysthymic disorder and progress to periods of major depression without ever fully gaining remission, and eventually return to their baseline dysthymic level.

The third subtype is chronic major depression. Individuals with this type meet criteria for unipolar MDD but symptoms persist for two years or longer (McCullough, 2000). Recurrent MDD is a fourth course pattern consisting of consecutive MDD episodes for two years or longer but without full recovery between episodes (APA 1994). Per DSM-IV, this type is designated by a chronic and longitudinal course specifier; Major Depression, “recurrent, without full interepisode recovery, with no dysthymic disorder” (APA 1994, p.382, 387-389). Recurrent major depression patients may experience diminished severity of many of their symptoms, or partial remission, but without a two month or longer period of full recovery. The final subtype was identified in a national study by Keller and colleagues (1998b) as ‘double depression/chronic major depression’ for patients who simultaneously meet criteria for double depression (dysthymia with superimposed recurrent episodic major depressions without remission) and subsequently progress to chronic major depression.
While these subtypes may seem confusing and a challenge to accurately diagnose, they need to be correctly differentiated from their non-chronic counterparts in order to be appropriately treated. Although chronic depression research is still in its infancy, treatment is now being distinguished and needs to be applied. Thus, possessing a basic understanding of the subtypes is helpful diagnostically, to effectively discern course patterns. McCullough and colleagues (2003a) found that the DSM III-R and DSM–IV chronic depression subtypes had few demographic, psychosocial, family history, clinical or treatment response variable differences (McCullough et al, 1996). Therefore, it is important to view them functionally as a single, broad chronic depression entity distinguished from non-chronic types.
Appendix B

Literature Review Methodology

The clinical problem is that chronic depression is a unique disorder that differs from general depressive disorders and thereby applying standard depression management approaches are unlikely to be adequate. The evidence search was organized into several subtopics and narrowed to the adult population. Articles were searched internationally through a variety of search engines and websites to be discussed in further detail. Google scholar, Medline, NCBI-www.pubmed.gov, and following reference leads or ‘related links’ on-line from original articles were the ideal methods for obtaining relevant and specific articles. Searches under chronic depression result in a rather broad arena but there is a scarcity of specific evidence with regards to treatment and psychotherapy in particular, so the research is narrowed by these inherent restraints.

Evaluation of the quality of the evidence utilizes the USPSTF (2002) (via the AHRQ website) quality of evidence tool (See Appendix C) and the Johns Hopkins Nursing Evidence-Based Practice Research Evidence Appraisal (Newhouse, et. al, 2005; See Appendix D). Quality was also evaluated based upon several other factors including date of article publication and authorship credentials since the search yielded an abundance of expert opinion pieces. Also, well-designed RCT’s or systematic reviews were included and considered ‘good’ (A) quality evidence based on the criteria outlined in Appendix B while evidence relating to chronic depression specifically or just depression in general was also considered in the ratings (See Appendix C). All articles utilized for this paper derive from rigorous peer-reviewed journals and resources.
The initial search looked at what is chronic depression and sought to confirm how it differs from non-chronic depression in terms of definition, subtypes, impact and disease burden. Additional prevalence data, screening, treatment resistance, and disease burden of chronicity evidence was also evaluated. Another search focused on depression treatment in general and any evidence for manual-based psychotherapies. The final search delineated evidence for the specificity of treatment modalities for chronic depression, and any future implications and needs. All major search categories are critiqued and then summarized individually in the proceeding sections of this paper with a few added search subsections based on the data found.
Appendix C

Quality of Evidence Tool: United States Preventive Services Task Force (USPSTF, 2002);

3-point scale for the quality of overall evidence (A=good, B=fair, and C=poor):

A. Good: Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess the effects on health outcomes.

(For the purposes of this paper, RCT’s or systematic reviews of RCT’s in addition to criteria listed).

B. Fair: Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

(For the purposes of this paper, any evidence that refers specifically to ‘chronic depression’ specifically in addition to criteria listed).

C. Poor: Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

(For the purposes of this paper, any evidence that concerns ‘depression’ generally and must be generalized to chronic depression specifically).

http://www.ahrq.gov/clinic/3rduspstf/depression/depressr.htm originally retrieved 11-18-07,
http://www.ahrq.gov/research/mentalix.htm#Depression and
## Appendix D

### Description of Evidence Level

<table>
<thead>
<tr>
<th>Level</th>
<th>Study Design Description</th>
</tr>
</thead>
</table>
| **Level I** | Study design: Experimental, Randomized Controlled Trial (RCT)  
- Subject random assignment: treatment (tx) or control group  
  - Blind: subject (s) unaware of group assignment (control versus tx)  
  - Double-blind: both subjects and investigators are unaware of group assignment  
  - Open: both subject and investigator are aware of group assignment  
Study design: Meta-analysis of RCT's  
- Quantitative synthesis of data and results from multiple studies investigating similar research question(s)  
- Statistically combines results from independent studies in order to compare data and results. |
| **Level II** | Study design: Quasi-experimental  
- No random assignment of subjects  
- No control group  
- Independent variable is manipulated |
| **Level III** | Study design: Non-experiment (Descriptive, Naturalistic, Comparative, Observational, and Relational studies)  
- Independent variable is not manipulated  
- May use interviews, observations, focus groups to provide baseline information about unknown topics  
Study design: Meta-synthesis  
- Synthesis of multiple qualitative studies’ findings  
- Goal is to interpret and analyze findings |
| **Level IV** | Expert Consensus Opinion, Clinical Practice Guidelines, Systematic Review  
- Nationally recognized experts base opinions on research or consensus panel  
- Evidence-based guidelines derived from research, clinical expertise, patient values and choice |
| **Level V** | Individual Expert Opinion, Case Studies, Literature Reviews  
- Non-research evidence  
- Recognized expert experience or personal opinion |

**Reference:** Newhouse, et. al, 2007; Newhouse, et. al, 2005a; and Newhouse, et. al, 2005b
<table>
<thead>
<tr>
<th>Appendix E Practice Guidelines for Chronic Depression Procedure</th>
<th>Rationale</th>
<th>Evidence Citation(s)</th>
<th>Evidence Ratings based on Appendices B &amp; C guidelines</th>
</tr>
</thead>
</table>
Implement antidepressant pharmacotherapy in combination with CBASP (psychotherapy) for chronic depression patients.

- Manual-based psychotherapies are generally considered best practice for depression in general.
- Evidence suggests pharmacological treatment improves general depression outcomes and chronic depression specifically.
- Evidence suggests pharmacological treatment also improves chronic depressions.
- *Evidence supports the efficacy of CBASP in combination with medication is appropriate and beneficial for chronic depressions.

- Weissman, (2007)
- Crits-Cristoph (1992)
- Markowitz (1994)
- Trivedi & Kleiber, (2001)
- All articles also listed below under next group-CBASP evidence*
  - Keller, et. al, (1998a)
  - Keller, et. al, (1998b)
  - Thase (1992)
  - Swan & Hull, (2007)
  - Schatzberg, et. al, (2005)
| Follow CBASP guidelines per provider manual, McCullough, 2003; McCullough 2000; Also see Appendixes G & H for details. | Correct application of CBASP tools via the provider manual is necessary to support efficacy as studied in empirical studies reviewed above. Provider manual outlines application and use from accurate diagnosis of subtype of Chronic Depression to implementation of CBASP approach and maintenance treatment. Gap in data—no evidence to support how long patients require maintenance or follow-up to retain remission. | • Keller, et. al, (2000)  
• Hirschfeld, et. al., (2002)  
• McCullough, 2003; McCullough 2000;  
• Swan & Hull (2007)  
• McCullough (2003)  
• Jehle & McCullough (2002)  
• McCullough (2000)  
• McCullough (2001) | • I-A  
• I-A  
• V-A  
• V-A  
• V-C  
• V-B  
• V-B |
Appendix F

Detailed practice guidelines for chronic depression

1. Screen all adults in for depression in clinical settings per: Screening for Depression in Adults: A Summary of the Evidence for the U.S. Preventive Services Task Force (USPSTF) (2002). Settings must meet criteria outlined in these guidelines to support systems and accurate diagnosis. The consensus of experts maintains that screening has been shown to improve accurate identification of adults with depression in general in primary care settings and with that identification and subsequent treatment, clinical outcomes improve in terms of decreased morbidity. Depression screening and accurate identification allows for accurate assessment of client histories in order to delineate if their depression course might meet criteria for a chronic (prolonged 2-year or greater) course. Expert opinion pieces and reviews articles suggest screening for depression across clinical settings enhances identification of potential chronic patients which in turn may improve outcomes. Multiple screening tools are suggested and there are numerous widely recognized, empirically supported tools that accurately identify depression in general and allow for further follow-up screening and identification of chronic depressions following DSM-IV-TR criteria and the evidence supported (and discussed in this paper) chronic subtypes (APA, 2010) (See Appendix A). Note: The establishment and maintenance of a therapeutic alliance and appropriate treatment setting, completion of a thorough psychiatric assessment, evaluation of patient safety, coordination and collaboration of the patient’s care with other clinicians and disciplines, is implied to have occurred prior to these recommendations as per APA and other pre-existing practice guidelines (2010).
2. Identification of Chronic Depression and subtypes: Once a patient is screened and identified as having a possible depression, a further, more in depth assessment of symptomatology and duration or course of illness may be made. If the course of illness meets the duration of two years or longer per consensus and DSM-IV-TR (2000) criteria, then a diagnosis of chronic depression should be made (regardless of subtype). Current evidence does not differentiate treatment based on chronic subtype although one review article suggests that treatment response may not differ across subtypes. However, differential treatment response is an important area for future study along with long-term management, relapse prevention and maintenance therapy. Careful consideration to co-morbid diagnoses should also be made since evidence suggests high co-morbidities compound treatment and outcomes although none of the evidence or RCT’s studied addressed the commonly co-occurring diagnoses, such as substance abuse and axis II personality disorders (i.e. they were study exclusions) except the very recent APA practice guidelines as mentioned in this paper (2010). Thus, the impact on management and treatment outcome cannot be determined at this point and these patients may need alternative approaches or referrals.

3. Apply medication therapy (see medication guidelines outside scope of this paper and APA, 2010). Application of clinical medication guidelines (multiple additional texts exist to provide medication guidelines for depression treatment in general although no specific guidelines exist for chronic depression).

Follow CBASP implementation guidelines per McCullough’s provider manual.

Follow manual based-psychotherapy guidelines for CBASP: 1-2 sessions/week for 16-20 weeks (See Appendices H & I).

5. Per CBASP guidelines and APA guidelines (2010), use standardized measures to monitor and follow symptoms. Specific application of regular Beck Depression Inventory (BDI) scores to monitor the patient’s progress and to determine if there is generalization of the skills learned in CBASP is recommended with the chronic patient (McCullough, 2003, 2000).

6. Long-term maintenance and follow-up guidelines research is needed but patients should be monitored at least monthly in person, by phone follow-up or on-line weekly logs, as well as intermittent and as needed (prn) therapy sessions and medication adjustments.

7. Patient and family psycho-education and support is recommended throughout the process. There is no recommendation for the use of alternative treatments but little evidence exists to support the definitive benefits of adjunctive complementary therapies such as nutritional, herbal supplements and other alternative treatments. However, use with medical monitoring has not proven harmful in most cases and can be useful with patient interest and support (APA, 2010).
Appendix G

Market Analysis

The official CBASP providers’ list indicates only two certified CBASP providers in the greater Bay Area (http://www.cbasp.org/pro.htm). Training in this modality with founder, Dr. James McCullough at Virginia Commonwealth University (VCU), access to the official online CBASP workgroup and a complete list of CBASP providers, further supports the premise that there is dearth of providers in this region. While CBASP providers exist, they are in scarce supply worldwide. An exhaustive internet search of the San Francisco and the Bay Area further confirms the fact that mental health practitioners in general, providing CBASP therapy services are minimal, with even fewer nurses employing CBASP (See below list for details).

The American Psychiatric Association (APA) published a study (2009) describing projections for the future number of physicians and almost all specialties are expected to drop in the coming years (http://pn.psychiatryonline.org/content/44/2/local/complete-issue.pdf). This same journal advertised a training session for the May 2009 APA national conference in San Francisco to enhance providers’ recognition of CD and to introduce CBASP (APA, Psychiatric News, 2009). Thus, nurses and those in particular with mental health training, offer a valuable skill set and are in optimal positions to bridge these care gaps. Nurses with their widespread work settings and diverse positions can provide essential early referral services as well as treatment with CBASP. While barriers exist for the provision of this modality, the largest barriers are the lack of provider knowledge and use and patient access to adequate care. Studies support the inadequacy of treatment and some even suggest that less than 10% of depressed patients receive appropriate care (Greden, 2001). Under-recognition, inaccurate identification and even well-intentioned providers applying insufficient treatment to the chronic population are
further obstacles compounding the problem. Thus, this project is an initial, yet important step, in bridging the care gap by enhancing identification and knowledge of an EBP treatment for CD.

List of San Francisco Bay Area CBASP Providers

1. Gateway Psychiatric Services, Inc (GPS) (San Francisco, CA)  [www.gatewaypsychiatric.com](http://www.gatewaypsychiatric.com)
   Kimberleigh Cox MSN, CNS, NP: trained 3/07, not currently working at clinic.
   Rochelle Frank PhD: Clinical psychologist, trained 5/09, practices part-time in SF and part-time in the East Bay.
   Peter Forster MD: Practice owner, Psychiatrist-UCSF-affiliated.

2. San Francisco Bay Area Center for Cognitive Therapy (Oakland, CA)  [http://www.sfbacct.com](http://www.sfbacct.com)
   Jacqueline Persons-Director and Clinical PhD Psychologist, UC Berkeley affiliated
   And 3-4 other clinical psychologists trained in Cognitive Behavioral Therapy but no actual listing for CBASP.

3. Stanford University Medical Center, (Palo Alto, CA)  [http://psychiatry.stanford.edu/](http://psychiatry.stanford.edu/)
   Dr. Bruce A. Arnow MD.
   Dr. Lisa Post MD. Stanford University Medical Center, Department of Psychiatry & Behavioral Sciences. Stanford, CA.
   Dr. Eric Levander, M.P.H. Beverly Hills, CA.
   (Note: these are the only “certified” CBASP providers listed in California per the official CBASP website:  [http://www.cbasp.org/](http://www.cbasp.org/)

   Lists all national depression and bipolar clinical trials. Only one clinical trial of CBASP currently listed. Cornell Medical Center NY, NY (as of 12/2010).
Appendix H

Characteristics of CBASP

CBASP is outlined by McCullough in a structured skills manual for clinicians (2001) and patient manual (2003b). The therapeutic goal is to teach chronically depressed patients that their behavior has interpersonal consequences. Patients become motivated to change their behavior through learning relationship skills and problem-solving tools in therapy. Through structured exercises, called Situational Analysis (SA), they learn to interact differently with their personal environments. The chronic patient inevitably deals with the therapist as someone they are making up; as someone from their past or an imaginary copy of an abusive significant other. Initial sessions begin with taking a significant other history (SOH) to learn what “stamps” were left on the patient by significant others (McCullough 2006, McCullough 2000). This is to consider the impact major players had on the patient that may continue to play a role in his or her thinking, life interpretations, and behavior.

There is a proactive use of transference that teaches the patient to deal with actual therapist and not a symbolic person from their past. This is done through a therapeutic tool called Interpersonal Discrimination Exercises (IDE) and through disciplined personal involvement which contrasts the clinician’s behavior and responses with the patient’s significant others’ elicited in the SOH (McCullough, 2006).

Situational Analysis (SA), the primary tool of CBASP, is a structured, guided, clinical exercise designed to exacerbate psychopathology within the therapy session (McCullough, 2000). This is done by increasing the patient’s discomfort or negative affect in order to enhance the impact of the negative reinforcement, and the problem-solving tools they will learn in order to minimize these feelings. The consequence of not doing anything or not making changes is that
the patient continues to feel depressed. The learned skills and subsequent behavior change make
the patient feel better, and subsequent learning may become easier for the chronic patient once
they focus on this aspect. In addition to this situational learning, another goal is to redevelop the
patient’s ability to see the cause and effect of their behavior with the therapist and in their
interpersonal relationships (McCullough, 2000). The SA exercise provides a vehicle to
specifically examine how the person’s interpretation of a particular situation affected their
behavior and how that in turn led to an outcome that was not desirable. The approach and
exercises are client-centered and generated, again an easy fit within the nursing perspective.
Appendix I

Implementation of CBASP

McCullough’s (2001, 2000) approach to Situational Analysis (SA) includes three phases implemented sequentially; Elicitation, Remediation and Generalization. During the elicitation phase, the patient is asked to describe a specific situation within a time-limited framework. During remediation, there is a revision of the patient’s interpretations and behavior in the situation and the focus turns to ways of changing the outcome. The patient is asked whether or not any feelings or thoughts assisted or hindered in their obtaining what they wanted in the situation. Alternative perspectives are derived and how these differences may have impacted or changed the outcome is discussed. The goal is to see how thoughts during a specific scenario have different effects that can alter events and outcomes. In the generalization phase, skills learned in the focused sessions in therapy are eventually applied to reality and to greater life experiences, and the patient is better able to anticipate and manage future challenges (McCullough, 2003b, 2001, 2000).

Through SA repetition, the patient will begin to generalize this learning to their greater lives. ‘The Skills Training Manual for Diagnosing and Treating Chronic Depression’ outlines the process in further detail and is a helpful resource for clinicians (McCullough, 2001). The patient manual is often useful prior to initiating CBASP (McCullough, 2003b). Both manuals can be ordered on-line or found in many university bookstores. Beck Depression Inventory (BDI) scores are also recommended to better monitor and quantify the patient’s depression levels.
The event was easily accessible on a Saturday at USF, in Cowell Hall rooms 211 and 212, centrally-located smart technology classrooms, on the San Francisco, California campus. The rooms were sufficiently spacious and the larger classroom, where the predominant teaching occurred, had a maximum capacity for 44 seated individuals. The registration cost was not prohibitive at $40 per participant (and included lunch courtesy of the campus Bon Apetit service), thereby enhancing the likelihood of attendance and allowing providers and professionals of many different educational and professional backgrounds to participate (See Appendix K for Workshop e-flier announcement). Tuition fees were waived for the four assistants who also participated in the event.
Attention Nurses, Managers, Educators, and Mental Health Providers,

**Chronic Depression Training!**

Saturday, October 2nd, 2010 (8:15 AM to 5:00 PM)

(Register soon! Space is very limited.)

*Sponsored by the University of San Francisco, School of Nursing* and

*Co-Sponsored by the USF School of Education, Department of Counseling Psychology, Marriage & Family Therapy Program*

Are you or your staff frustrated working with depressed clients?

**MEET THE CHRONIC DEPRESSION CHALLENGE!**

Chronic Depression is a difficult and often frustrating, treatment resistant disorder that challenges the skills of many nurses and mental health providers.

Join us for a one day Chronic Depression Skills Workshop.

Learn real skills for real problems and earn CEU credits while learning to apply practical strategies to manage chronically depressed clients! The workshop will introduce an evidence-based approach to the management of individuals with chronic depression and will focus on strategies to identify clients and apply innovative, evidence-based tools, in order to more effectively manage these challenging clients.

**Target Audience:** This workshop is designed for nurses (RN’s) and other mental health clinicians (including social work, marriage and family therapy, psychiatric techs etc.) who work with or have contact with the adult chronically depressed population and specifically who work in the mental health, public health, and community health arenas.

**For more information and to register:** (Register soon! Space is limited!)

[http://www.usfca.edu/nursing/chronic_depression_training/](http://www.usfca.edu/nursing/chronic_depression_training/)

**Chronic Depression Skills Workshop Details:**

*When:* Saturday, October 2nd, 2010 (8:15 AM-5:00 PM)

*Where:* Cowell Hall rooms 211, 212 University of San Francisco, School of Nursing, 2130 Fulton Street, San Francisco, CA 94117

*Cost:* $40 (advance, lunch provided), $45 (day of event, if space available)

*CEU’s:* 8 contact hours will be awarded to nurses, (CA-BRN) and California Board of Behavioral Sciences CE’s awarded to MFT, LCSW, LPCC and LEP Licenses.
Appendix L

Workshop CBASP Tools Kit

TOOLS KIT OVERVIEW

1. Depression Screening: Variety of valid, reliable measures:
   - BDI-II, HRDS-24, GDS, PHQ-9

2. Patient Assessment:
   - Chronic Depression Identification:
     - Graphs, timelines, mood monitoring charts, journals, structured tools, DSM-IV

3. Facilitative Provider Role
   - Optimal CBASP provider qualities
     - Self-Assessment (Tools): IMI, kiesler-circle, transference/counter-transference

4. Patient Assessment-CBASP Tools:
   - Significant Other History (SOH), 'Stamps’
     - Situational Analysis (SA)-Coping Survey Questionnaire (CSQ)
   - Identifying Cognitive Dysfunction-Maladaptive Interpretations
   - Maintaining Active Patient Role
     - Maintain Attentional Focus
     - Assertiveness Training Exercises
     - Disciplined Personal Involvement
     - Interpersonal Discrimination Exercises (IDE)
     - Proactive Use of Transference
     - Use of Negative Reinforcement/Patient Motivation

5. Follow-up: (5 M's) Mood Monitoring, Measures, Meds, Maintenance
Appendix M

UNIVERSITY OF SAN FRANCISCO

SCHOOL OF NURSING

EVALUATION A

Chronic Depression Pre-workshop Self-Assessment

ID #:______

Please tell us a little about yourself:

1. Age? (check one)
   □ 20-30 years
   □ 31-40 years
   □ 41-50 years
   □ 51-60 years
   □ 61-70 years
   □ 71 years +

2. Gender?
   □ Male
   □ Female

3. Cultural background that you most identify with:______________________________

4. Highest level of education?
   □ Associate degree in (list specific)____________________________________________
   □ Bachelors degree in (list specific)____________________________________________
   □ Masters degree in (list specific)_______________________________________________
   □ Doctorate degree in (list specific)______________________________________________

5. Please list you’re a) professional role, b) credentials and c) job title (eg. for Nursing: LVN, RN, NP, CNS, DNP, EdD, DNSc; For Social Work and other professionals: LCSW, LPCC, LEP, MFT, etc please list out any acronyms that may not be commonly recognized):
   a.)____________________________________________
   b.)____________________________________________
   c.)____________________________________________
6. Please list any specialty areas in which you work or hold certifications (eg. mental health, public health, community health, adults, geriatrics, couples): ____________________________

________________________________________________________________

7. Which one of following most accurately represents the setting in which you practice the majority of your professional time?:

□ Outpatient, Community, or Clinic setting
□ Residential, or Home Care
□ Forensics
□ Veterans Administration
□ Inpatient setting
□ Emergent or Urgent Care setting
□ Skilled Nursing Facility
□ Long-Term Care Facility
□ Academic Institution
□ Private specialty practice (specify specialty)___________________________
□ Other______________________________________________________________

8. I work in this setting____ hours/week.

□ Full-time (30+hrs/week)
□ Part-time (10-29hrs/week)
□ Other (eg. per diem____hrs/month)_______________________________
□ Volunteer ____hrs/week

9. I spend the majority of my time with which of the following client age groups?

□ Children and Adolescents (ages <18)
□ Adults (ages 18-65)
□ Adults(ages 66+)

10. My work setting is comprised of what staff mix? (select any that apply)

□ 0-9% licensed nursing personnel
□ 10-25% licensed nursing personnel
□ 26-50% licensed nursing personnel
□ 51-75% licensed nursing personnel
□ 76-100% licensed nursing personnel
Now we’d like to explore the knowledge our workshop participants have prior to today’s workshop. Please help us evaluate that aspect.

11. A client diagnosed with a chronic depression has depressive symptoms that persist for at least how long?

☐ 2 months  
☐ 6 months  
☐ 12 months  
☐ 24 months  
☐ 36 months

12. Which are evidence-based types of chronic depression: (select all that apply)

☐ Major Depression  
☐ Dysthymia  
☐ Cyclothymia  
☐ Chronic Major Depression  
☐ Double Depression

13. Chronic Depression affects 5% of all clients diagnosed with a depressive disorder?
☐ True  
☐ False

14. Chronic Depression typically responds to therapeutic approaches that are used for most major depressive disorders.
☐ True  
☐ False

15. Which of the following psychotherapy modalities are effective evidence-based modalities for the treatment of chronic depression? (check all that apply)

☐ Cognitive Behavioral Therapy (CBT)  
☐ Interpersonal Therapy (IPT)  
☐ Psychodynamic psychotherapy  
☐ Cognitive Behavioral Analysis Systems Psychotherapy (CBASP)
16. Chronic depression clients typically have difficulties in what area(s) of functioning? (select all that apply)

- endocrine functioning
- social and interpersonal skills
- mathematical and calculation abilities
- perceived self-efficacy in the world
- short to long-term memory conversion
- empathic responses (the ability to interact with empathy)

17. Chronic depression patients frequently have co-morbid Axis II personality disorders.

- True
- False

18. Providing hope that “things will get better” is an important message to offer in treatment for the chronic depression client.

- True
- False

19. Case scenario: “Allen”, a 45 yr old male client complains of never feeling happy since as far back as he can recall. He grew up in a large family and did not receive much individual attention or praise as a child. Allen was a decent student and never got into much trouble as a teen but has rarely succeeded or fulfilled much potential in life. Recently, his mood became worse after he received a job promotion. The client has been working with a psychiatrist for many years who has diagnosed him with chronic depression and tried numerous different medications to manage the depressive symptoms. Allen has experienced some relief of his symptoms with various med regimens but never a full recovery and has experienced numerous relapses despite reasonable anti-depressant management. He is otherwise healthy and has no current notable medical problems or lab abnormalities. The client reports “Ever since I got promoted I feel worse. I don’t know but I really don’t think I deserve this new position. I’m not sure I can accept the job offer. No matter what I do, I never make the right decisions and I just keep feeling bad.”

Describe (in as much space and detail as you need) how you, as the clinician (RN, SW etc), would next respond to this client? What would you say, ask, or do? Describe how you think Allen might respond to your statements, requests, questions, or actions and then add a few additional responses of your own. Please use next page and write legibly. Thank you for your responses!
1. A client diagnosed with a chronic depression has depressive symptoms that persist for at least how long?
   - □ 2 months
   - □ 3 months
   - □ 6 months
   - □ one year
   - □ two years

2. Which of the following are evidence-based types of chronic depression: (select all that apply)
   - □ Dysthymia
   - □ Major Depression
   - □ Bipolar II
   - □ Double Depression
   - □ Recurrent Major Depressive Disorder without full remission

3. Chronic Depression affects roughly one third of all clients diagnosed with a depressive disorder.
   - □ True
   - □ False

4. Chronic Depression typically responds to CBT and IPT, approaches that are used for most major depressive disorders.
   - □ True
   - □ False

5. CBASP, the only effective evidence-based psychotherapeutic modality specifically designed for the treatment of Chronic Depression, is based on a biopsychosocial model of psychopathology and health, and views depression as stemming from faulty coping that results in a perceptual disengagement of the individual from the environment.
   - □ True
   - □ False
6. Roughly half of all clients with chronic depression also meet criteria for a personality disorder.
   ☐ True
   ☐ False

7. The primary goal(s) of CBASP is (are) to do which of the following (select all that apply):
   ☐ To correct faulty thinking errors through logical disputation.
   ☐ To ensure that clients learn required behaviors necessary for healthy interpersonal interactions.
   ☐ To teach clients to read others accurately in order to interact empathetically with them.
   ☐ To teach clients to feel and behave effectually in their environments.

8. Important skills needed for mental health professionals to effectively work with chronically depressed clients include which of the following (select all that apply):
   ☐ Ability to maintain a neutral and nonreactive demeanor with the client.
   ☐ Ability and comfort in taking over the responsibility when the client is emotionally or behaviorally stuck.
   ☐ Ability to track moment to moment emotional reactions in oneself and the client.
   ☐ Ability to tolerate moderate to severe negative affect in oneself and clients.

9. Positive reinforcement is the strongest motivator for chronically depressed clients to make behavioral changes.
   ☐ True
   ☐ False

10. Case responses: “Brenda”, a 52 year old married woman with a long history of mood disturbances is recently brought in to your clinic as a new client following a recent admission to the local inpatient unit for suicidal ideation with intent, plan and means. She was released to home with this appointment and is under the supervision of a clinic psychiatrist who is continuing the medications that were started in the hospital. The psychiatric nurse practitioner’s assessment notes a chronic depression diagnosis. Brenda’s acute suicidality is diminished but her depression remains significant. She consistently criticizes herself and tells you that she feels “worthless” and has for many years.

   Describe (in as much space and detail as you need) how you, as the clinician (RN, SW etc), would next respond to this client? What would you say, ask, or do? Describe how you think Brenda might respond to your statements, requests, questions, or actions and then add a few additional responses of your own. Please write legibly. Thank you for your responses!
APPENDIX O

UNIVERSITY OF SAN FRANCISCO
SCHOOL OF NURSING

PROGRAM EVALUATION

CHRONIC DEPRESSION WORKSHOP
Saturday Oct 2nd, 2010 (8:15am -5pm) 8 Contact Hours/CEU’s awarded
PRESENTER: KIMBERLEIGH COX, MSN, NP, CNS, DNPc

Program Objectives

At the end of the workshop the participants will be able to:

1. Learn to accurately identify chronic depression (CD).

2. Learn evidence-based strategies to work more effectively with chronically depressed clients.

3. Learn tools from Cognitive Behavioral Analysis Systems Psychotherapy (CBASP), a therapeutic modality, specifically designed for treatment of chronically depressed clients.

4. Practice therapeutic strategies for the management of chronically depressed clients.

5. Recognize common problems associated with the CD patient and treatment approaches.

6. Identify resources for the CD patient and provider.

EVALUATION FORM

Please give us your feedback regarding the presentation. Your opinion is important for planning future events. Thank you for your participation!

1. How did you hear about this event?

☐ Electronic announcement for event
☐ USF website
☐ USF calendar of events
☐ Postcard announcement for event
☐ USF faculty member
☐ A professional colleague
☐ Word of mouth
☐ Other________________________________________

__________________________________________________________
2. Are you a(n): (select all that apply)

☐ USF Alumnus
☐ USF Student
☐ USF Faculty member
☐ Faculty member from another school
☐ Community LVN or RN
☐ Community LCSW, MFT, LPCC, or LEP
☐ Other

Please respond to the following statements on a scale of 1-4:
(1= strongly agree, 2= somewhat agree, 3= somewhat disagree, 4= strongly disagree).

3. I enjoyed the workshop:

☐ 1. strongly agree  ☐ 2. somewhat agree  ☐ 3. somewhat disagree  ☐ 4. strongly disagree

4. The trainer was well prepared:

☐ 1. strongly agree  ☐ 2. somewhat agree  ☐ 3. somewhat disagree  ☐ 4. strongly disagree

5. The workshop provided necessary information to increase knowledge regarding what constitutes chronic depression.

☐ 1. strongly agree  ☐ 2. somewhat agree  ☐ 3. somewhat disagree  ☐ 4. strongly disagree

6. The workshop provided necessary information and tools to more accurately identify chronic depression clients.

☐ 1. strongly agree  ☐ 2. somewhat agree  ☐ 3. somewhat disagree  ☐ 4. strongly disagree

7. The workshop provided necessary information to understand the chronic depression treatment challenges.

☐ 1. strongly agree  ☐ 2. somewhat agree  ☐ 3. somewhat disagree  ☐ 4. strongly disagree
8. The workshop provided necessary information to apply evidence-based strategies for the therapeutic management of chronic depression clients.

□ 1. strongly agree  □ 2. somewhat agree  □ 3. somewhat disagree  □ 4. strongly disagree

9. The workshop provided necessary information for further resources and trainings regarding chronic depression.

□ 1. strongly agree  □ 2. somewhat agree  □ 3. somewhat disagree  □ 4. strongly disagree

10. The workshop allowed adequate time for practice exercises:

□ 1. strongly agree  □ 2. somewhat agree  □ 3. somewhat disagree  □ 4. strongly disagree

11. I enjoyed the format: (introductions, questions, timing, information, case studies, practice exercises and discussion).

□ 1. strongly agree  □ 2. somewhat agree  □ 3. somewhat disagree  □ 4. strongly disagree

12. The facilities met or exceeded my expectations (room, reception, buffet).

□ 1. strongly agree  □ 2. somewhat agree  □ 3. somewhat disagree  □ 4. strongly disagree

13. The most helpful aspect(s) of this workshop were:______________________________

______________________________________________________________________________

14. The least helpful aspect(s) of this workshop were:______________________________

______________________________________________________________________________

15. Suggestions for future workshops or other comments:______________________________

______________________________________________________________________________

Thank you for your feedback!
Appendix P

UNIVERSITY OF SAN FRANCISCO
SCHOOL OF NURSING
EVALUATION D

Chronic Depression Workshop: Two-week follow-up Survey

ID #:_____

1. Have there been any changes to your employment situation since your attendance at the Chronic Depression Workshop at USF?
   □ No  □ Yes. Describe:__________________________________________________

Please circle the X that most accurately represents your opinion:

2. I believe I am able to fully apply the principles of CBASP in my practice setting.
   X X X X X X X X
   Strongly Agree  Strongly Disagree

3. I find using the CBASP tools kit of strategies easy and useful.
   X X X X X X X X
   Strongly Agree  Strongly Disagree

4. I find diagnosing someone with Chronic Depression is difficult.
   X X X X X X X X
   Strongly Agree  Strongly Disagree

5. I find the tools to better identify Chronic Depression clients useful and easy to apply.
   X X X X X X X X
   Strongly Agree  Strongly Disagree

6. My current practices are similar or consistent with the CBASP strategies.
   X X X X X X X X
   Strongly Agree  Strongly Disagree

7. My practice setting is very open to the use of CBASP tools with chronic depression clients.
   X X X X X X X X
   Strongly Agree  Strongly Disagree

8. What, if any, are the barriers that I have encountered in the implementation of CBASP tools in my practice setting?
   1.________________________________________
   2.________________________________________
   3.________________________________________
9. Case: “Carl” is a 44 year old Caucasian gay male who grew up in a small conservative town before moving to a larger city and coming out as a gay-identified male. Carl lives with his 65 year old partner of 10 years and they work together in a small business that his partner owns. Carl is somewhat estranged from his very traditional family who live in the town he grew up in, several hours away. The family tolerates his visits occasionally but they do not regularly seek out his company or accept his gay lifestyle. When Carl visits his family, his partner is not welcome and Carl is required to deny his lifestyle and sexual orientation. He presents to your clinic and is very depressed following a weekend visit to his family for a niece’s birthday, several weeks ago that he attended alone. He reports that subsequent to this visit, he began getting into more arguments with his partner and is now fearful that if they were to break up, his partner’s financial, living, and employment support might end. He wants to figure out why his depression and irritability are so persistent and to work on improving his “attitude”. He is willing to take medications and do ‘whatever it takes therapy-wise’. His diagnosis is Dysthymia with a concurrent recent Major Depressive Episode. You understand this to be a chronic depressive course. When you meet Carl, he makes good eye contact, responds appropriately and thoroughly to your questions but soon becomes very emotional and begins tearing up while telling you about the reason for his visit. He states “I am so sorry. I really didn’t want to cry. You must think I’m really pathetic.”

Describe (in as much space and detail as you need) how you, as the clinician (RN, SW etc), would next respond to this client? What would you say, ask, or do next? Describe how you think Carl might respond to your statements, requests, questions, or actions and then add a few additional responses of your own. Please write legibly.
10. A client has a history of symptoms that meet criteria for several recurrent major depressive episodes. This client would meet criteria for chronic major depression, if which of the following circumstances is also met:
- The periods between the recurrent major depressive episodes meet criteria for dysthymia.
- The periods between the recurrent major depressive episodes are less than 2 months.
- The periods between the recurrent major depressive episodes are less than 6 months.
- The periods between the recurrent major depressive episodes are less than 12 months.

11. Common manifestations of chronically depressed clients from the CBASP perspective are: (Select all that apply)
- prelogical, precausal thinking
- the tendency to monologue
- a lack of perceived self-efficacy in the world
- the ability to engage in formal operational thinking
- empathic responsivity

12. Chronically depressed clients are among the highest users of medical services, have high comorbidities and poorer treatment outcomes.
- True
- False

13. Tools such as the symptom timelines, the Beck Depression Inventory (BDI), Coping Survey Questionnaire (CSQ), and forms of Mood Charting, are all especially useful when working with chronically depressed clients.
- True
- False

14. Which of the following represents a typical CBASP response (s) when working with an angry or hostile, chronically depressed client? (Select all that apply)
- Ignore the anger and redirect the client.
- Deal with the anger by gently trying to challenge the client’s misperceptions, faulty reasoning and distorted conclusions.
- Ask the client “Why do you want to treat me this way?” in order to teach the client that their behavior has consequences.
- Ask the client “Why are you so angry and where do you think this feeling comes from?”
- Respond to the client by interpreting their anger for them “Every dinner time, you become angry and perhaps this is related to your childhood and the distress in your home around meals.”
- Reflect their anger back to them. “You seem angry. What’s going on with you?”
15. The optimal stance for a provider working with chronically depressed clients from the CBASP perspective is one that is: (select all that apply)

☐ Moderately Dominant-Friendly and Friendly-Submissive.
☐ Very Dominant and Very Friendly.
☐ Very Submissive and Very Friendly.
☐ A mirror to (or the opposite of) whatever the client “pull” is at the time.
☐ Mildly hostile and dominant.
☐ Moderately Submissive-Hostile and Hostile-Dominant.

16. Please list any specific CBASP strategies or tools, addressed at the workshop, that you find useful in your practice setting:

______________________________________________________________________________
______________________________________________________________________________

17. If you are not yet using any of the workshop tools, do you plan to use any or do anticipate being able to incorporate any into your practice setting?  Yes_____  No______

You are done! Thank you for taking the time to fill out this survey. Your answers and feedback are much appreciated!

Please ensure that the survey is completed as fully as possible and returned as soon as possible and within one week if possible, in order to receive the full 8 CEU credits.
Please either scan and email this survey back to kccox@usfca.edu or FAX: to 415-422-5618. Once the survey is received, you should receive confirmation with an electronic CEU certificate within 2 business days.
Appendix Q

“Continuous Quality Indicators (CQI) Definitions

- “Quality is defined as meeting and/or exceeding the expectations of our (health care consumers).
- “Success is achieved through meeting the needs of those we serve.”
- “Most problems are found in processes, not in people. CQI does not seek to blame, but rather to improve processes.”
- “Unintended variation in processes can lead to unwanted variation in outcomes, and therefore we seek to reduce or eliminate unwanted variation.”
- “It is possible to achieve continual improvement through small, incremental changes using the scientific method.”
- “Continuous improvement is most effective when it becomes a natural part of the way everyday work is done.”

“Core Steps in Continuous Improvement”

- “Form a team that has knowledge of the system needing improvement.”
- “Define a clear aim.”
- “Understand the needs of the (population) … served by the system.”
- “Identify and define measures of success.
- “Brainstorm potential change strategies for producing improvement.”
- “Plan, collect, and use data for facilitating effective decision making.”
- “Apply the scientific method to test and refine changes.”

Taken from the following resources:

http://www.fpm.iastate.edu/worldclass/cqi.asp

Appendix R

Participant Responses to case scenarios on Evaluations A, B and D with coded ratings from raters. Raters were blinded to each other’s scoring.

All of the following participant responses are rated from the provider perspective using the following numerical rating scale. (Note: all responses are transcribed verbatim.)

**Code:** (See Table VII for results)

1=offering support, encouragement
2=use of therapeutic communication (reflection, clarification, active listening, empathic provider responses)
3= information-seeking or inquiry
4=challenging faulty logic or reframing irrational and distorted thinking errors for the patient
5=interpreting for the patient, or attempts to get the patient to gain insight
6=preaching to, shaming, predicting the future for the patient (fortune-telling), or offering false hope
7 =neutral provider stance
8=non-neutral provider stance (disciplined personal involvement)
9=facilitative provider (allows client to do the work; avoids passive pulls)
10=interpersonal discrimination exercise (“How would your significant other ___ have reacted to you in this situation?” and contrasts with provider reaction)
11=stays focused in the present moment
12= proactive use of transference (deals with client in the moment around hot spots)
13=maintains passive patient role
14=maintains active patient role (avoids dominant take-overs and passive patient pulls)
15=use of significant other history or stamps
16= use of positive reinforcement
17=use of negative reinforcement or intentionally exacerbating patient’s discomfort in the moment (and enhancing cognitive dissonance)
18=use of situational analysis (SA) - all or parts of it: (event description, patient’s interpretations and behaviors, remediation of maladaptive thinking/distortions, specific learning to generalization)
19=makes learning explicit and maintains patient’s attentional focus
20=providing psycho-education about illness, meds, symptoms etc.

**I. ‘Evaluation A’ Case Scenario Participant Responses for Pre-Evaluation:**

#2A: “Allen you didn’t receive much attention or praise as a child, you’ve accomplished a lot recently, a job promotion is very significant. Is it possible your having difficulty giving yourself the praise or attention you deserve?”

Ratings:

#3A: missing data (item blank)
#5A: “Acceptance, acknowledge, change. Acknowledge the issue or the indecision to take job and (_? illegible__). Promote dialogue and support that he get some help/counseling for his life changing decision and support as well decision. Discuss medication compliance and counseling. All client to (?) with counselor/psychologist with referral as well.”

Ratings: Rater 1 (R1) ; Rater 2 (R2) ; Rater 3 (R3)

#6A: missing data (item blank)

#7A: “Some where I would like to have him explore the “never” he uses. What is important to you? Is it possible?-Is it yours? Need to explore what “feeling bad” means to him. What kind of music does he like? Eventually explore how does he make decisions? How did he come to make decisions this way? Other feelings he has ever experienced? Am not sure how he would respond. Goal-communicate genuine interest in him as a person.”

Ratings: (R1) ; (R2) ; (R3)

#8A: “Allen why do you think you were promoted to this position? What qualities did you exhibit to receive this promotion. Allen might respond he doesn’t know why. Allen, what are your duties and job description? Allen might respond with a job description. Allen, how many of your duties do you complete? Do you do anything helpful that you are not asked to do? Allen will probably respond yes to these questions because most likely he likes praise of appreciation. I would suggest Allen make a list of qualities. I would ask if he had to make decisions in his present job and how were they successful.”

Ratings: (R1) ; (R2) ; (R3)

#9A: missing data (item blank)

#10A: “This client might benefit from talking through some of his “global thinking”. I might ask: ‘When was a time when you have made the right decision?’ I might give him insight that these feelings are symptoms of his chronic depression, and that he could benefit from reframing his thought patterns. Since the med regimen has been ineffective in relieving his symptoms, I may refer him to a program such as CBASP or DBT. Without concurrent therapy with his pharmaceutical tx, his depressive thought patterns will persist. Allen may respond by negating suggestions, and finding fault in his success. I might point out that thought pattern, and ask how he came to that conclusion. Allen needs to begin to take an active role in changing these negative thought processes in order to make lasting change.”

Ratings: (R1) ; (R2) ; (R3)

#11A: “I would respond t the pt. in a calm nonjudgmental manner. I would say to him that I understand how he feels but thinks he has a lot of negative thoughts. He needs to stop the automatic negative thoughts and focus more on positive thinking and his pass success. I would give him tools I know such as CBT.”
Ratings: (R1) ; (R2) ; (R3)

#12A: missing data (item blank)

#13A: “It must be frustrating to feel this way all the time. Would you be willing to learn how to adjust your thinking? Can we focus on self-appreciation? Talk about your strengths?”

Ratings: (R1) ; (R2) ; (R3)

#15A: missing data (blank)

#16A: “What concerns about the new job do you have?”

Ratings: (R1) ; (R2) ; (R3)

#17A: “I would ask Allen—What makes you feel that you don’t deserve this new position? I think the pressure from accepting new position may make his depression worse adding increased anxiety because new responsibilities that come with new role. As he grow up he never receive a praise for his actions, maybe he needs a support and encouragement for his thoughts and actions. I hope that Allen would open-up and explain his thoughts. I would ask him to give me a particular situation to assess why he is feeling bad about certain things. May be try Shuttle technique. I like to think about the situation as... Growth comfort anxiety

 discomfort

You cannot solve the problem with the consciousness that created that.”

Ratings: (R1) ; (R2) ; (R3)

#18A: “I am really excited about your promotion. Can you tell me why you think you deserve the promotion and why you think you cannot do the job.”

Ratings: (R1) ; (R2) ; (R3)

#19A: “Can you tell me why you don’t think you deserve the new position?”

Ratings: (R1) ; (R2) ; (R3)
#20A: “What has ever worked for you? What makes things easier for you? What are the little things that get you down? Who, if anyone, is helpful to you? What, if anything, helps?”

Ratings: (R1) ; (R2) ; (R3)

II. ‘Evaluation B’ Case Scenario Participant Responses for Post-Evaluation:

#2B: “Can we focus on your feeling of ‘worthless’. What does that mean to you? Can you be specific and describe it to me... after clarification Can you explain the way you feel I’ve responded to you here today? Is there a difference? What would be on goal for yourself?”

Ratings: (R1) ; (R2) ; (R3)

#3B: “Ask why she feels worthless. Find out when she felt worthy and what that felt like.”

Ratings: (R1) ; (R2) ; (R3)

#5B: “1. Deal with now/What is making worthless/or feel positive. 2. Dialogue on positive and what is working...Respond in redirecting –if goes back to worthless-understand and have her look at you and say it again.3. Clarify and see if anyone has made her feel positive in her life.”

Ratings: (R1) ; (R2) ; (R3)

#6B: missing data (item blank)

#7B: “Would need to have CBASP formula (?much) to group with this new approach.”

Ratings: (R1) ; (R2) ; (R3)

#8B: “I would begin by asking client how she felt today-go from there to find opportunity to use SOH and Stamp tools to begin discussion on family dynamics.”

Ratings: (R1) ; (R2) ; (R3)

#9B: “I would ask her to describe her interpretation of her worth. She might describe her feeling worthless. I would ask where she got that and differentiate her stamp from this current relationship.”

Ratings: (R1) ; (R2) ; (R3)
#10B: “Who made you feel this way? Who taught you to feel this way? Pt answers with significant other. How would they react when you do something good? How did I react?”

Ratings: (R1) ; (R2) ; (R3)

#11B: “I would ask her why she thinks of herself as ‘worthless’. And what were the event(s) that happened to her which made her feel this way. I would ask about what her other significant had said to her and how she interprets those statements. I would ask her what she did when she feels ‘worthless’ and what is the goal or desired outcome she wants to achieve...I would make sure that her answers are explicit. If not, I would keep asking until I got them, even though she is uncomfortable about my questions. I would let her know about how I feel about her. I would be supportive, tolerance, and accept who she is no matter what. Continue to engage in the conversation until she starts to read the environment and understand my feelings.”

Ratings: (R1) ; (R2) ; (R3)

#12B: missing data (form not handed in).
#13B: missing data (item blank)
#15B: missing data (item blank)

#16B: “Tell me about which was going on BEFORE your suicide attempt? What did this event mean to you? What did you do in this situation? How did it come out for you?”

Ratings: (R1) ; (R2) ; (R3)

#17B: “I would ask Brenda what makes her feel ‘worthless’. I will do SI assessment. Ask her about compliance with meds. Tell me what happened that made you try to kill yourself? Is there any other way to deal with the problem (situation, feelings, etc)? Tell me how you think you can deal with the situation? How do you see the outcome? What is the desired outcome?”

Ratings: (R1) ; (R2) ; (R3)

#18B: missing data (item blank)
#19B: missing data (item blank)
#20B: “What does Brenda see as the current problem? She made it to this appointment— you are glad to see her. Since CD clients often focus on their depression, ask Brenda in what circumstances does she do better.”

Ratings: (R1) ; (R2) ; (R3)

III. ‘Evaluation D’ Case Scenario Participant Responses for 2 week follow-up Post-Evaluation:

#2D: “Why do you think you feel this way?
How would your family have reacted to you in this situation?
How did I react to you?
What do you think it means that I acted differently?
How does it apply to other situations”
Pt: “You’re a mental health nurse, you’re supposed to be supportive. No one else (in my life) acts that way!”
“Tell me about a specific situation—give me an example…”
What did you say or do…What was the outcome? How would you like it to be different? What could you have said or done differently, based on what you’ve learned here?”

Ratings: (R1) ; (R2) ; (R3)

#3D: “I would ask Carl why he would think he was pathetic and how would his family rate him crying. I would talk to him about his 10yr relationship and commend him for staying in such a committed relationship. I would ask him what kept him and his partner together for so long. Then I would ask why he felt he would if he broke up with his financial, living, and employment support would end. I would have him share about what skills/talents he adds to the business.
I would continually show him in my words, tone and actions that his sexuality does not affect how I treat him. I would have him compare my positive interactions with his family’s. I would have Carl reflect on how it feels when I accept him and happy he has been in such a loving relationship for 10 years.”
“I would maybe use SOH tool so I could help Carl identify what “stamp” these people have left in his life.”

Ratings: (R1) ; (R2) ; (R3)

#5D: “I noticed that the issues at hand are making you cry. Let’s talk about the effect that all of this is having on you. Do you see me now, I’m listening! The reality is that this is influencing you in the relationship of family and your partner! Do you not think that the issue surfaced on a recent home visit with family. Tell me what this means to so you! How would you like this weekend to have turned out” (Listen and say nothing for a moment or more.)

Ratings: (R1) ; (R2) ; (R3)
#7D: “What am I doing to communicate ‘pathetic’? Why would I think ‘pathetic’? What does this feel like -----a previous time? What brought you here? Most immediate?”

Ratings: (R1) ; (R2) ; (R3)

#8D: “Therapist-I’d like to congratulate you on courage of willingness to recognize there is a problem and to work towards dealing with this problem.
Client: Thank you.”

Ratings: (R1) ; (R2) ; (R3)

#9D: “Honestly I would probably have tears in my eyes and have to express to the client that I do not think he is pathetic, that crying is allowed, and that his pain is very real and he is communicating it well.”

RN: No, I don’t think you are pathetic. It seems to me that you are hurting.
Carl: I have been, for so long now, I can’t remember...
RN: And now you’re here, talking about it.
Carl: I don’t know what else to do. I know I’ve made mistakes...
RN: Mistakes.
Carl: I haven’t treated me Partner very well.
RN: How do you want to treat your partner?
Carl: I think he deserves someone who’s in a better mood, not irritable all the time.
RN: How does he respond to your depression?
Carl: I’m afraid he’s going to leave.
RN: What would happen then?
Carl: That would be the end of everything.

I would continue to focus client on his fear of relationship ending. I would set a goal, “What is the one thing I want to help him achieve in our therapy,” and I could work toward that in each session. I would react to his statements, particularly irritability, in an honest open way so client could see he is having an effect on another person. I would use mood journaling to document his mood and reflect on his improvement.”

Ratings: (R1) ; (R2) ; (R3)
#10D: “What from my body language would give you the impression I find you pathetic?” (Use concerned and attentive body language)
Carl might respond: “I don’t know.”
“Who makes you feel that way?”
Carl might respond about his family, their lack of concern for him/his lifestyle.
Carl states how his father might respond.
“How am I responding to you?” (show concern, empathy)

Ratings: (R1) ; (R2) ; (R3)

#11D: 1) Elicitation Phase

**Event Description**

_I would let him know that it’s OK for him to cry and I would want him to tell me specifically what was the situation that makes him so upset at that particular moment. This is to ask the patient to focus on one thing in this short therapy session. The important thing is to help the client to change specific thoughts and behaviors. Not everything can be changed at once, but developing a pattern of recognizing specific ways to change can lead to general change across situations._

**Interpretation**

_He may struggle to speak only in factual term but I would try to collect as many facts as possible. This would allow the client and to work with me later on in the worksheet. I would encourage him to tell me what happened in the situation, just who said or did what and then, and describe clearly how the situation ended. I would ask him to give me three or four automatic thoughts that he experienced during the course of the specific situation. It is important not to include thoughts prior to or after the situations. This is the interpretation phrase of the situation. I expect to hear that phrases like “why do I always fail?”, “everybody hates me”._

**Behavior**

_I would ask him about what he did in the situation and what stands out as he thinks back on the event. I would encourage him to be thorough. I will also observe his behaviors, i.e. eye contact, tone of voice, delay in responses, body language, and what was said during the course of the interaction._

**Actual and Desired Outcomes**

_I would ask him how the situation came out for him. What was the actual outcome? What did he want to happen in this situation._
Desired outcomes are limited things that he can control. In other words, the desired outcome can not be something that is physically impossible. Even more importantly, the desired outcome can not be something that he wanted somebody else to think, do, or feel even it is natural to desire other people to feel or do things. This can be frustrated to him and he may even believe that he is being blamed for all that goes wrong. This is not the case, however. Instead, he will be taught to simply focus on things over which he has control so that things outside of his control no longer make him feel as though he has done something wrong.

2) Remediation

During the remediation phase of CBASP, he and I will review each interpretation and behavior listed on the worksheet and determine whether it was helpful or hurtful with respect to increasing the likelihood that he would obtain his desired outcome in that situation.

The goal is to self-correct maladaptive interpretations. I will then review each interpretation for 3 qualities- “is it accurate?” “Is it grounded (or is it more global type thinking)?” and “Does it contribute to my getting what I want out of this situation (my desired outcome)”?

For interpretations and behaviors that were helpful towards obtaining the desired outcome, time is spent discussing why it was helpful, what led him to choose an adaptive behavior, and what he might do to increase the likelihood that he will use this same approach in future situations. For interpretations and behaviors that were hurtful towards obtaining the desired outcome, helpful alternative approaches are designed. I will also emphasize the use of “if___, then___” statement to highlight that improved interpretation helps in obtaining situational goals.

3) Generalization

I would then teach the patient to take what is learned and transfer to his greater lifes after pinpointing the specific behavior in the exercise. I would also ask him the question “How does what you learned here apply to other situations?”

Ratings: (R1) ; (R2) ; (R3)

#12D: (not returned/missing data)
“C: What makes you think that I would think you are pathetic?”
Pt: I feel bad about myself...
C: Do you think you are pathetic?
Pt: ------
C: Do you realize by your feeling pathetic, it has an effect on me?
----
C: How would your partner have reacted to you? How did I react?
C: Who taught you to be this way?”

Ratings: (R1) ; (R2) ; (R3)

“C: Why do you think you feel this way?’
Carl: I don’t know (pt is being passive)
I will work with pt to try to get pt to gain some insight. Ask pt to identify a few significant other’s in his life (past or present, positive and negative)
‘What it was like growing up in his family?’
Important to determine the impact left by significant person on pt. Use of transference: to teach pt how to interact empathically with others, to master the required behavioral skills for healthy interpersonal interactions & relationships, conflict resolution.”

Ratings: (R1) ; (R2) ; (R3)

“I first would inform Carl that it is ok to be upset because his situation sounds very difficult. I would acknowledge his feelings at being hurt by his family in having to deny a part of who he really is.
I would ask Carl if he has any suicidal ideation. If he responds that he does not have any suicidal ideation, I would then start asking him what he thinks would help the situation. I would also want to know what he wants to get out of therapy. I would also recommend that he receive medications appropriate to his condition and scheduled weekly sessions.”

Ratings: (R1) ; (R2) ; (R3)

“I would have the client refocus on the here and now not allow him to get distracted and steer the conversation in a different direction. I would tell him that I can understand his being upset and that I am glad he has come to my office for help. Then I would ask him to tell me more about his relationship with his father? Later I would ask about his relationship with his mother. Then I would ask about his relationship with his siblings. Lastly I would ask open ended questions about his relationship with his partner?”

Ratings: (R1) ; (R2) ; (R3)
Table XVII

Evaluation A Individual Participant Responses on Content Items A11 through A18 with Percent Summaries.

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<th>Participant ID#</th>
<th>Item A-11 CD Identification</th>
<th>Item A-12 CD Types</th>
<th>Item A-13 CD Epidemiology</th>
<th>Item A-14 CD Response to Traditional Tx</th>
<th>Item A-15 Identification of EBP for CD</th>
<th>Item A-16 CD areas of Dysfunction</th>
<th>Item A-17 % of CD with Axis II personality disorders</th>
<th>Item A-18 Efficacy of providing hope response to CD patient</th>
<th>Each Participant's Total % Correct Score on Items A-11 through A-17</th>
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Total % Correct for each item

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*Note: ID#1, 4, and 14 did not attend; no responses are entered.
Table XVIII

Evaluation B Individual Participant Responses on Content Items B1 through B-9 with Percent Summaries.

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<th>Participant ID#</th>
<th>Item B-1 CD Identification</th>
<th>Item B-2 CD Types</th>
<th>Item B-3 CD Epidemiology</th>
<th>Item B-4 CD Response to Traditional Tx</th>
<th>Item B-5 Identification of EBP for CD</th>
<th>Item B-6 % of CD with Axis II personality disorders</th>
<th>Item B-7 CD areas of Dysfunction</th>
<th>Item B-8 Skills needed to wk with CD patients</th>
<th>Item B-9 Use of positive reinforcement in CBASP</th>
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Total % Correct for each item

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Code:

1=Correct Response

2=Incorrect Response

*Note: ID#1, 4, and 14 did not attend; no responses are entered.
Table XIX

Evaluation D Individual Participant Responses on Content Items D-10 through D-15 and Item D-17 with Percent Summaries.

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<th>Participant ID#</th>
<th>Item D-10 CD Identification</th>
<th>Item D-11 CD symptoms</th>
<th>Item D-12 CD Epidemiology</th>
<th>Item D-13 CD Tools</th>
<th>Item D-14 Typical CBASP Response</th>
<th>Item D-15 Optimal CBASP Provider Stance</th>
<th>Item D-17 Planned use of CBASP Tools</th>
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<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>57%</td>
</tr>
<tr>
<td>18</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>43%</td>
</tr>
<tr>
<td>19</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>71%</td>
</tr>
<tr>
<td>20</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Total % Correct for each item</td>
<td>33%</td>
<td>50%</td>
<td>92%</td>
<td>100%</td>
<td>67%</td>
<td>50%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

|       | (4/12) | (6/12) | (11/12) | (12/12) | (8/12) | (6/12) | (11/11) |

Code:

1=Correct

2=Incorrect Response

*Note: ID#1, 4, and 14 did not attend, no responses entered.*
**Chronic Depressive Subtypes**

1. **Recurrent Major Depressive Disorder (rMMD)**

Manic level

<table>
<thead>
<tr>
<th>HYPOMANIC level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Euthymia (Never ≥ 2mos of full recovery; No 2 mos offset or sx-free period &amp; No dysthmia)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DYSTHYMIC level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depressive level</td>
</tr>
<tr>
<td>(Sxs ≥ 2 years, without any interepisode recovery)</td>
</tr>
</tbody>
</table>

Derived from Handout #2-(Cox, CE Workshop Packet Oct, 2, 2010), page 2
2. **Dysthymia**

Manic level

Hypomanic level

<table>
<thead>
<tr>
<th>Euthymia ('Normal')</th>
<th>(Never has a full recovery for ≥ 2mos symptom free)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DYSTHYMIC level</th>
<th>(Sxs ≥ 2 years)</th>
</tr>
</thead>
</table>

| Major Depressive level | (Never meets MDE sxs for 2 weeks or longer). |

Derived from Handout #2-(Cox, CE Workshop Packet Oct, 2, 2010), page 3
3. Chronic Major Depressive Disorder (CMD)

Manic level

Hypomanic level

Euthymia (‘Normal’)

Dysthymic level

Major Depressive level

(Symptoms ≥ 2 years)

Derived from Handout #2-(Cox, CE Workshop Packet Oct, 2, 2010), page 4
Figure 4

4. Double Depression (DD)

Manic level

Hypomanic level

**Euthymia** (‘Normal’)

**DYSTHYMIC level**

>2wk

>2 years

Major Depressive level

The MDE is superimposed on a pre-existing 2yr or longer Dysthymia. The major depression may be a single episode or recurrent episodes. May return to a dysthymic level or to a Major Depressive level but never has a 2 month or longer period of full recovery (symptom-free) during entire episode.

**(Dysthymia ≥ 2 years with subsequent MDE’s and dysthymic level and No 2 month period or longer of full remission)**

According to the DSM-IV (1994) Mood Disorders Field Trial (Keller, et al), ~26% of 349 adults in a current major depressive episode also met criteria for this, Double Depression. (McCullough, 2000).

Derived from Handout #2-(Cox, CE Workshop Packet Oct, 2, 2010), page 5
5. Double Depression/Chronic Major Depression (DD/CMD)

Manic level

Hypomanic level

Euthymia (‘Normal’)  Never has a full recovery during episode.

Dysthymic level

Major Depressive level

(Symptoms $\geq$ 2 years)  Meets Dysthymia $\geq$ 2 years and

(Symptoms $\geq$ 2 years)  Meets MDD sxs for $\geq$ 2yrs

Derived from Handout #2-(Cox, CE Workshop Packet Oct, 2, 2010), page 6
Figure 6

**Major Depressive Disorder/Episode** *(MDD or MDE)*

- **Manic level**
- **Hypomanic level**

---

**Euthymia** (‘Normal’)

---

**Dysthymic level**

---

**Major Depressive level** *(Symptoms > 2wks)*

Derived from Handout #2-(Cox, CE Workshop Packet Oct, 2, 2010), page 1