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Depressive Disorders

□ Description of Disorders

The predominant feature of mood disorders is the experience of dysphoric and/or euphoric states that deviate markedly from societal norms and create significant distress or impairment in functioning. The mood disorders encompass a variety of affective problems that include major (or unipolar) depression, bipolar disorder, cyclothymia, dysthymia, and substance-induced mood disorder. Depressive disorders are a subset of the mood disorders and include major depression, dysthymia, and depressive disorder (not otherwise specified [NOS]). The prevalence and functional impact of depressive disorders are substantial, necessitating an implementation of primary and secondary prevention (or assessment) strategies that facilitate efficient and effective recognition of clinical depression, assist in the selection of appropriate target behaviors, and help in designing intervention programs. Accurate detection of depressive symptoms and disorders requires a comprehensive assessment process that is based on awareness of diagnostic criteria, knowledge of risk factors, and utilization of a multimethod assessment strategy. Moreover, application of assessment strategies throughout the intervention process is essential for monitoring patient progress and facilitating clinical decision-making. Given the significance of the assessment process in recognizing and treating

patients with depressive disorders, this chapter highlights characteristic symptoms and risk factors, elucidates a range of assessment strategies, focuses on pragmatic issues associated with assessing depressive disorders in clinical practice, and concludes with a case illustration depicting the use of assessment methods prior to and during psychotherapy.

Depression is in some respect an expression of normal human emotion that periodically may be experienced in the form of "sadness," "disappointment," "grief," or being "down in the dumps." It is not uncommon to periodically exhibit these feelings, particularly if environmental experiences are unrewarding, stressful, negative, or aversive. Indeed, factors such as the frequency and duration of stressful life experiences, attributional style, degree of response-contingent positive reinforcement, and the extent of coping resources may greatly impact whether these normal human experiences become symptomatic and potentially evolve into a depressive disorder (Abramson, Metalsky, & Alloy, 1989; Beck, Rush, Shaw, & Emery, 1979; Cronkite & Moos, 1995; Lewinsohn, 1974). According to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, revised text (DSM-IV-TR; American Psychiatric Association, 2001), the two primary diagnostic criteria for major depressive disorder (MDD) are depressed mood and loss of interest or pleasure in most activities, at least one of which must occur for a duration of at least two weeks. Secondary symptoms include significant appetite change, weight loss, or both, sleep disturbance, psychomotor agitation or retardation, fatigue or energy loss, feelings of worthlessness or guilt, attentional or concentration difficulties, and recurrent thoughts of death or suicide. Of these diagnostic symptoms, dysphoric mood, appetite and sleep change, and thoughts of death are most common, while loss of interest in activities and psychomotor change appear to be less common (Weissman, Bruce, Leaf, Florio, & Holzer, 1991).

In contrast to MDD, dysthymia is a depressive disorder that is chronic in nature and requires that an individual experience a depressed mood on more days than not for at least 2 years. Dysthymia generally is characterized by fewer and less severe symptoms, with researchers indicating that symptoms such as decreased energy, suicidal ideation, concentration problems, and eating and sleeping disturbances are milder and not as prevalent compared with patients diagnosed with MDD (Klein et al., 1996). The term double depression has been used to refer to patients who experience a major depressive episode superimposed on a preexisting diagnosis of dysthymia. Compared with individuals with MDD, individuals with double depression may exhibit greater Axis I and II comorbidity (Pepper et al., 1995) and may be less likely to exhibit long-term treatment gains (Klein et al., 1998). The residual category of depressive disorder (NOS) is reserved for individuals who experience depressive symptoms but do not

meet criteria for either MDD or dysthymia. Researchers recently have indicated that a subset of subsyndromal depressive symptoms may be characteristic of a minor depression, a diagnosis proposed for further study in DSM-IV (American Psychiatric Association, 1994). Although the definition of minor depression varies across studies and the distinction from depressive disorder NOS is somewhat unclear (Pincus, Davis, & McQueen, 1999), generally this label is applied to patients whose depressive symptoms fail to meet diagnostic criteria for a depressive disorder due to limited duration, intensity, or number of symptoms. Research with mixed-age and older adult samples has found that subsyndromal depression is more prevalent than diagnosable depressive disorders (Judd et al., 1998; Oxman, Barrett, Barrett, & Gerber, 1990) and is associated with increased disability, health care use, and risk for developing a formal diagnosable depressive disorder (Angst, Merikangas, & Preisig, 1997; Broadhead, Blazer, George, & Tse, 1990; Lyness, King, Cox, Yoediono, & Caine, 1999; Wagner et al., 2000). In addition, younger and older patients with minor depression typically are more similar to depressed patients than nonclinical groups on variables such as impaired social functioning and decreased quality of life (Koenig, 1997; Lewinsohn et al., 2000; Wagner et al., 2000).

In assessing for depressive disorders and in conducting a differential diagnosis, it also may be useful to consider depressive symptoms within the domains of mood, cognition and perception, behavior, and somatic functioning (Rehm & Tyndall, 1993). Of these symptom domains, negative mood state generally is most stable, with depressed individuals frequently reporting immense sadness or feelings of hopelessness. The experience of anhedonia, or loss of interest in previously rewarding activities, may be reflective of this negative affect but often is exhibited in the form of decreased overt behaviors that may result in decreased exposure to environmental reinforcement and the onset and maintenance of depressive affect (Lewinsohn, 1974; Lejuez, Hopko, & Hopko, 2002). It also is common for depressed individuals to exhibit increased anger and irritability, which among adolescents may manifest as an externalizing problem or disorder (Pozanski, 1982). Impaired cognitive functioning also may be evident in the form of attentional deficits, poor concentration, and memory impairment (Williams et al., 2000), with some data to suggest attentional training procedures may be useful in alleviating depressive symptoms (Papageorgiou & Wells, 2000). Depressed cognitive styles or patterns of thinking may pervade the clinical picture, an assessment of which may assist in evaluating the severity of depressive symptoms (cf. Sacco & Beck, 1995). A subset of patients also may present with psychotic symptoms that are associated with increased depression severity, longer depressive episodes, greater incapacity, and more resistance to treatment (Coryell, 1998). Unlike other depressive subtypes, psychotic depressions

tend to be only weakly associated with significant life events or stressors (Paykel & Cooper, 1992). Somatic symptoms traditionally include the vegetative symptoms of sleep and appetite disturbance as well as decreased energy. Most typically, depressed patients will exhibit decreased appetite and insomnia, although atypical symptoms (increased appetite and hypersomnia) may predominate characteristics linked with an increased likelihood of treatment response (Stewart, Rabkin, Quitkin, McGrath, & Klein, 1993). Appetite and sleeping patterns also are considered behavioral indices of depression, as are psychomotor behaviors, verbal or behavioral expressions of suicidality, and restricted activity patterns in the form of passivity or lethargy (Hopko, Lejuez, Ruggiero, & Eifert, 2002). Associated behaviors of social withdrawal and substance abuse may be considered in the same category, the former of which may represent an emotional avoidance strategy (Hayes, Strosahl, & Wilson, 1999).

Prevalence and Impact of Depressive Disorders

Approximately 30% of adult Americans have reported the experience of “dysphoria” for a duration of greater than 2 weeks at some point during their lifetime (Weissman et al., 1991). The experience of a major depressive episode is relatively less common, with Epidemiological Catchment Area (ECA) data suggesting a lifetime prevalence of 6.3% and a 1-year prevalence of 3.7% (Weissman et al., 1991). Comparatively, results of the National Comorbidity Survey suggested a lifetime prevalence of 17.1% and a 1-year prevalence of 10.3% (Kessler et al., 1994. See Kaelber, Moul, & Farmer [1995] for an explanation of differential rates). The American Psychiatric Association estimates the lifetime risk of MDD between 10–25% for women and 5–12% for men and the lifetime prevalence of dysthymia at about 6%, with females being twice as likely to develop both disorders (APA, 1994). A concerning discovery is that the incidence of depression and suicidal behavior appears to progressively be increasing across generations (Cross-National Collaborative Group, 1992). Interestingly, within primary care, and mindful of data indicating that clinical depression largely is unrecognized in this context, depression is among the most commonly experienced psychiatric problem, with as many as 10–29% of patients presenting with a depressive disorder (McQuaid, Stein, Laffaye, & McCahill, 1999). Depression also is the second most frequent psychiatric disorder among patients admitted to American mental hospitals (Olfson & Mechanic, 1996).

Functional impairment associated with depressive disorders also is quite extensive, including exacerbation of medical illness and negative effects on physical health (Stevens, Merikangas, & Merikangas, 1995),

maladaptive cognitive processes (Beck, Rush, Shaw, & Emory, 1979), decreased engagement in pleasurable or rewarding behaviors (Lewinsohn, 1974), and problems with interpersonal relationships (Klerman, Weissman, Rounsaville, & Chevron, 1984). Compared with nondepressed students, depressed college students miss more classes, perform poorer in the classes they do attend, and have more relationship difficulties (Heiligenstein, Guenther, Hsu, & Herman, 1996). Moreover, the experience of a major depressive episode greatly increases the likelihood of future depressive episodes (Rohde, Lewinsohn, & Seeley, 1990) and is highly comorbid with other psychiatric problems such as anxiety disorders (Mineka, Watson, & Clark, 1998) and alcohol abuse (Regier et al., 1990). The direct (health care, medication) and indirect (lost wages, absenteeism) economic costs of treating depressive disorders are staggering (Booth et al., 1997). For example, Jonsson and Rosenbaum (1993) estimated that between \$300–400 million in direct costs are spent annually on these disorders, and there is ample evidence to suggest that clinical depression is associated with increased use of medical health services (Simon & Katzelnick, 1997; Simon, Ormel, VonKorff, & Barlow, 1995).

Risk Factors

As mentioned previously, gender seems to be associated with development of clinical depression (for further discussion see Just & Alloy [1997] or Nolen-Hoeksema & Girgus [1994]). Other risk factors include Caucasian ethnicity, experiencing a separation or divorce, prior depressive episodes, poor physical health, medical illnesses, or some combination (e.g., hypothyroidism, Cushing's syndrome), low socioeconomic status, adverse life events (e.g., unemployment, loss of loved one), and family history of depression (cf. Kaelber et al., 1995). Although major depression may develop at any age, the average age of onset is 15 to 19 years in females and 25 to 29 years for males (Burke, Burke, Regier, & Rae, 1990), with the average age of onset steadily decreasing over past decades (Weissman, Bruce, Leaf, Florio, & Holzer, 1991). It is important to note that earlier onset is associated with greater chronicity and poorer response to treatment (Akiskal & Cassano, 1997). Contrary to misconceptions, the elderly do not appear more susceptible to depression (Roberts, Kaplan, Shema, & Strawbridge, 1997). Although risk factors such as these should be considered in the assessment process, it is imperative to recognize that they are based on nomothetic data. Thus, it is unclear to what extent particular risk factors are causative, an associated epiphenomenon, or possibly a consequence of a depressive disorder

(Kaelber et al., 1995). As such, we advocate an ideographic approach to assessment in which these generalizations are recognized within the context of a more extensive individualized assessment based on patients' unique clinical presentations and symptoms, severity of symptoms, and proximal and distal factors or events associated with the etiology and maintenance of symptoms (i.e., functional analysis). A broad range of assessment strategies for depression may facilitate this process.

□ Range of Assessment Strategies Available

Numerous assessment strategies have been developed to assess for depression and related constructs such as attributional style, hopelessness, and depressive vulnerability. Approaches for assessing depression generally may be characterized as falling under the rubrics of unstructured or structured interviews, self-report measures, observational methods, and functional analysis (Thorpe & Olson, 1997). Although many resources are available, their appropriateness and clinical utility vary greatly across patient and assessment context (Alexopoulos et al., 2002). The level of skill and training required of the assessor to incorporate these strategies also is quite variable, ranging from minimal skill to administer a self-report measure, moderate skill to conduct a valid structured interview, and extensive skill to perform a comprehensive functional analysis of depressive symptoms. Indeed, a number of other logistical and procedural factors must be taken into account during the process of selecting an appropriate assessment tool or tools (Nezu, Nezu, & Foster, 2000). Prior to exploring these issues in greater detail, the present section outlines the primary methods of diagnosing clinical depression and assessing associated symptoms.

Unstructured and Structured Interviews

The structure of clinical interviews has tremendous variability, ranging from a primarily unstructured and completely flexible approach, to a semistructured approach that provides moderate direction while maintaining a degree of flexibility (e.g., intake form, Brief Psychiatric Rating Scale; Overall & Gorham, 1962), to structured methods that are more restrictive and goal-directed. A number of positive correlates may be associated with unstructured methods that include increased therapist-patient rapport, ability to assess how patients organize

responses, and the potential to explore unique details of a patient's history. Most contemporary practitioners allow for some degree of flexibility, although most also make use of some type of intake form or checklist to facilitate the assessment process. Largely due to concerns about reliability and validity of unstructured interviews and efforts by managed care organizations to improve the efficiency and cost-effectiveness of assessment and treatment as well as the accountability of clinicians, increased focus has been placed on examining the utility of more structured procedures toward accomplishing these goals (cf. Groth-Marnat, 1997). The controversy over whether the use of more structured interviewing and assessment strategies is concomitant with managed care objectives continues, as does discussion over which assessment methods are most optimal. Indeed, managed care companies continue to exhibit marked variability in terms of preference for particular assessment strategies and documentation required to justify treatment for mental illness (Keefe & Hall, 1999). Acknowledging these ongoing issues, we present the most commonly used structured (clinician-rated) interviews.

The Structured Clinical Interview for DSM-IV — Patient Version (SCID-I/P; First et al., 1996) is a semistructured interview based on operational diagnostic criteria from the DSM-IV. It incorporates a categorical system for rating symptoms, and an algorithm for arriving at a final diagnosis. The SCID-I/P takes approximately 60–90 minutes to administer and requires fairly rigorous training. Administration begins with an open-ended interview that is followed by a systematic series of questions designed to facilitate an accurate differential diagnosis. Adequate interrater reliability and diagnostic accuracy have been demonstrated for the instrument (Ventura et al., 1998). Although this instrument has been utilized extensively in treatment outcome studies and is an invaluable research tool, clinicians in more applied settings may be reluctant to allocate the time required to conduct this more formalized assessment. In cases where a clinician suspects a depressive disorder is evident and wants to be more definitive, it may be feasible to streamline the approach by administering only the mood disorder module.

The Anxiety Disorders Interview Schedule (ADIS-IV; Brown, Di Nardo, & Barlow, 1994) is a semistructured interview designed primarily to provide a differential diagnosis of anxiety disorders. Likely due to the high level of overlap with anxiety disorders, the ADIS-IV also includes comprehensive modules for major depression and dysthymia, as well as screens for mania, somatization disorders, substance abuse, and psychosis. Many symptoms are rated on a (yes/no) nominal scale, several of which also include severity ratings that are established based on an anchored continuum of severity or interference. The ADIS-IV

generally takes approximately 45–60 minutes to administer. A recently conducted reliability analysis using the ADIS-IV suggested that categories such as major depression, panic disorder, specific phobia, and social phobia had good to excellent reliability (i.e., $k > 0.60$), while the category of dysthymia was associated with relatively poor agreement ($k = 0.22$; Brown, Di Nardo, Lehman, & Campbell, 2001).

The Schedule for Affective Disorders and Schizophrenia (SADS; Endicott & Spitzer, 1978) is used to assess for over 20 major diagnoses, including major depressive disorder and the various subtypes. Based on individuals' responses to questions assessing current and past functioning, results can be used to assess the temporal nature (and severity) of psychological disorders. The SADS takes approximately 90–120 minutes to administer and requires extensive training. Spitzer, Endicott, and Robins (1978) reported excellent reliabilities for diagnoses including major ($k = 0.90$) and minor depressive disorder ($k = 0.81$).

The 17-item Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960) was designed as a postdiagnostic measure to assess the severity of depressive symptoms and to measure changes in a patient's functioning over time. The recommendation is that the HRSD be completed (in about 10 minutes) following a clinical interview of at least 30 minutes duration in which the necessary information is obtained to accurately assess the patient (Hamilton, 1967). Inter-rater reliability coefficients of the HRSD generally are excellent (> 0.84) and data suggest moderate convergent validity with several self-report measures of depression (Nezu, Ronan, Meadows, & McClure, 2000). The HRSD is the most widely used and accepted outcome measure for the evaluation of depression and has become the standard outcome measure in clinical trials (Kobak & Reynolds, 1999). An additional benefit of this instrument is its availability at no cost via assessment resources (Nezu et al., 2000) and the Internet (www.glaxowellcome.com).

The Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962) was originally developed to assess 18 psychiatric symptoms and to evaluate change over time. Commonly used in inpatient settings and in treatment outcome research, the BPRS is completed based on observations obtained during a basic 20–30 minute clinical interview. Although the measure is used to assess clinical symptoms among patients with a broad range of problems, several scales are relevant to depression, including somatic concern, anxiety, emotional withdrawal, guilt, depressed mood, motor retardation, and blunted affect. Adequate inter-rater reliability, as well as discriminative and predictive validity of the measure has been documented (Faustman & Overall, 1999).

The Diagnostic Interview Schedule (DIS; Robins, Helzer, Croughan, & Ratcliff, 1981) is a 90–120 minute structured interview initially devel-

oped to estimate the prevalence and incidence of psychiatric disorders within the context of the National Institute of Mental Health's Epidemiological Catchment Area Program. As such, the DIS was designed to be conducted by laypeople who were provided with extensive training. Despite some evidence of instrument reliability and findings suggesting that lay interviewers formulate diagnostic impressions similar to those of psychiatrists (Robins et al., 1981), given the comparable time to administer the measure (90–120 minutes), the suggestion has been made that clinicians who use structured diagnostic interviews use those with more established psychometric properties (Nezu et al., 2000).

Self-Report Measures

Self-report measures of depression have proven useful as screening instruments, as auxiliaries in the diagnostic process, as tools for monitoring progress across treatment sessions, and as outcome measures for assessing the efficacy and effectiveness of various psychosocial and pharmacological interventions. Scales have been designed to assess a tremendous range of content areas, including affective, verbal-cognitive, somatic, behavioral, and social symptoms of depression. At present, there are at least 80 measures designed to assess depression and related constructs. The majority of these instruments have adequate to excellent psychometric properties (see Nezu et al., 2000 for a comprehensive review). A few of the most commonly utilized measures are presented here.

The Beck Depression Inventories (BDI; Beck & Steer, 1987; BDI-II; Beck, Steer, & Brown, 1996) assess the severity of depressive symptoms and each consists of 21 items, rated on a 4-point Likert scale. The instruments have excellent reliability and validity with depressed younger and older adults (Beck & Steer, 1987; Beck et al., 1996; Beck, Steer, & Garbin, 1988; Snyder et al., 2000). Among younger clinical and nonclinical adults, the instruments have substantial internal consistency ($\alpha = 0.73\text{--}0.95$) and adequate test-retest reliability for nonpsychiatric ($r = 0.60\text{--}0.83$) and psychiatric patients ($r = 0.48\text{--}0.93$) (Beck et al., 1988, 1996). Concurrent and construct validity among the Beck inventories and other indices of depression ranges from moderate ($r = 0.33$ with DSM III diagnosis of clinical depression; Hesselbrock et al., 1983) to strong ($r = 0.86$ with the Zung SDS; Turner & Romano, 1984; see Beck et al., 1988, 1996 for comprehensive reviews).

The Hamilton Depression Inventory (HDI; Reynolds & Kobak, 1995) is a 23-item measure designed to assess for the presence and severity of depressive symptoms. A 17-item version also is available that is

consistent with the HRSD in content and scoring. Strong internal consistency ($\alpha = 0.90\text{--}0.93$), 1-week test-retest reliability ($r = 0.95$), and convergent validity with the HRSD ($r = 0.94$) and BDI ($r = 0.93$) have been demonstrated.

The Center for Epidemiological Studies' Depression Scale (CES-D; Radloff, 1977) is a 20-item self-report questionnaire of depressive symptoms (rated on a 0–3 anchored scale) that was designed as a survey instrument for assessing depressive affect in the general population. Although it was not intended for use as a diagnostic measure, CES-D totals have been shown to be moderately related to a diagnosis of clinical depression (Myers & Weissman, 1980) and some have argued for its utility as an initial depression screening measure (Roberts & Vernon, 1983). When used for screening, scores greater than 16 indicate that a patient may have clinical depression (Radloff, 1977). The CES-D has adequate psychometric properties in psychiatric and medical samples and is available at no cost (Nezu et al., 2000).

The Harvard Department of Psychiatry/National Depression Screening Day Scale (HANDS; Baer et al., 2000) is a 10-item screening measure that was derived using items from well-established instruments including the BDI (Beck & Steer, 1987) and the Zung SDS (Zung, 1965). Preliminary data indicate that the instrument has good psychometric properties, including adequate internal consistency ($\alpha = 0.87$). The instrument also appears highly sensitive, with research indicating that over 90% of individuals who score 9 or higher on the instrument meet diagnostic criteria for major depression.

The Reynolds Depression Screening Inventory (RDSI; Reynolds & Kobak, 1998) is a 19-item measure (score range = 0–63) that assesses depressive symptom severity and is based on DSM-IV diagnostic criteria for major depression. Although scores greater than 24 indicate severe clinical depression, a cutoff score of 16 has been associated with sensitivity and specificity rates of 95% in identifying individuals with major depression. Internal consistency ($\alpha = 0.93$) and test-retest reliability ($r = 0.94$) are strong. The instrument correlated strongly with the HRSD ($r = 0.93$) and the BDI ($r = 0.93$).

The Minnesota Multiphasic Personality Inventory 2 Depression Scale (MMPI-2-D; Butcher et al., 1989) is one of the 10 clinical scales on the MMPI-2 and consists of 57 true-false items that assess depressive symptoms (on more of a state level) as well as related personality features. Item responses on the MMPI-2-D are converted to a T-score, with elevations of 65 or greater considered clinically significant. Harris-Lingoes Depression Subscales provide additional information on several dimensions: subjective depression, psychomotor retardation, physical functioning, mental dullness, and brooding. Coefficient alphas on the MMPI-2-D

range from 0.59 (males) to 0.64 (females) and the test-retest reliability is estimated at 0.75 (Nezu et al., 2000). In addition to limitations given the large number of items, caution should be exercised in using the MMPI-D-2 as researchers recently have indicated that the scale may be associated with problems with sensitivity and predictive power and may not be unidimensional as once theorized (Chang, 1996; Elwood, 1993).

The Personality Assessment Inventory (PAI; Morey, 1991) is a 344-item self-administered test of personality and psychopathology. Items are answered on a four-alternative scale, with the anchors "Totally False," "Slightly True," "Mainly True," and "Very True." The measure consists of 4 validity scales, 11 clinical scales, 4 treatment scales, 2 interpersonal scales, and several subscales. The depression clinical scale focuses on symptoms and phenomenology of depressive disorders and is broken down into three subscales that address the cognitive, affective, and physiological components of depression. Internal consistency of the full scales is satisfactory, with median coefficient alphas ranging from 0.81 (normative sample) to 0.86 (clinical sample). The depression scale is strongly convergent with the BDI ($r = 0.81$), HRSD ($r = 0.78$), and somewhat less so with the MMPI-D scale ($r = 0.66$; Morey, 1999).

Observational Methods

Observational methods of assessing depressive symptoms are used to measure the frequency and duration of observable (overt-motor) behaviors. Behaviors may include excesses such as crying, irritable/agitated behaviors, and even suicidal behaviors, or deficits such as minimal eye contact, psychomotor retardation, decreased recreational and occupational activities, as well as disruption in sleep, eating, and sexual behaviors (Rehm, 1988). Although direct behavioral assessment of depression should intuitively be a primary tool of behavioral (or cognitive-behavioral) therapists, remarkably minimal work has been done in this area subsequent to the pioneering research of the 1970s through the early 1980s.

Pertaining to verbal behavior (see Rehm [1988] for a comprehensive discussion), several studies have demonstrated that depressed individuals generally tend to exhibit a slower and more monotonous rate of speech (Gotlib & Robinson, 1982; Libet & Lewinsohn, 1973; Robinson & Lewinsohn, 1973). Individuals with depression also take longer to respond to the verbal behavior of others (Libet & Lewinsohn, 1973) and relative to non-depressed individuals, exhibit an increased frequency of self-focused negative remarks (Blumberg & Hokanson, 1983; Gotlib & Robinson, 1982) and

use fewer “achievement” and “power” words in their speech (Andreasen & Pfohl, 1976). Nonverbal (motoric) differences between depressed and nondepressed individuals also are evident. In a pioneering investigation, Williams, Barlow, and Agras (1972) developed the Ward Behavior Checklist to assess smiling, motoric activities (e.g., reading, grooming), and “time out of the room” among a small group of depressed inpatients. These behavioral indices correlated moderately with scores on depression measures including the HRSD, but perhaps more interestingly, were more predictive of relapse at 1-year posttreatment. Depressed individuals also smile less frequently (Gotlib & Robinson, 1982), make less eye contact during conversation (Gotlib, 1982), hold their head in a downward position more frequently, engage in more self-touching (e.g., rubbing, scratching; Ranelli & Miller, 1981), and are rated as less competent in social situations (Dykman, Horowitz, Abramson, & Usher, 1991). There also is couples research that suggests when one partner is clinically depressed, interactions are more apt to be characterized by conflict and incongruity between verbal and nonverbal behaviors (Hinchliffe, Hooper, & Roberts, 1978). Finally, depressed mothers have been shown to be less active and playful and tend to exhibit shorter eye-gaze durations when interacting with their children (Field, Healy, Goldstein, & Guthertz, 1990; Livingood, Daen, & Smith, 1983).

Although many of these verbal and behavioral indices of depression have been used as pre-post outcome measures (see Rehm, 1988 for a review) and knowledge of these correlates may contribute to a more comprehensive assessment for clinical depression, systematic and structured analysis of these variables in the context of therapy (and/or home visits) may not be the most practical of assessment methods. Perhaps more useful in this regard, behavioral monitoring logs or diaries may be used to provide information about patients’ sources of environmental reinforcement. For example, MacPhillamy and Lewinsohn (1971, 1982) developed the Pleasant Events Schedule to assess, monitor, and modify positive activities among individuals with depression. The measure also has been used as a treatment outcome instrument and appears sensitive to change following therapy. Along these same lines, our research group has used daily diaries to assess the frequency and duration of healthy nondepressive activities to assist in treatment planning and as a measure of treatment outcome (Lejuez, Hopko, & Hopko, 2001). Recent research has indicated that these daily diaries can be useful in assessing both immediate and future reward value of current behaviors, that reward value ratings correlate highly with self-report measures of depressive affect, and that mildly depressed and nondepressed students can be distinguished via response style (Hopko, Armento, Cantu, Chambers, & Lejuez, in press).

Functional Analysis

Although many different definitions have appeared in the literature (Haynes & O'Brien, 1990), functional analysis generally refers to the process of identifying important, controllable, and causal environmental factors that may be related to the etiology and maintenance of depressive symptoms. Rooted in behavioral theory, functional analysis is a strategy fundamental to initiating an appropriate behavioral intervention. Applied to clinical depression, functional analysis involves the operational definition of undesirable (nonhealthy) depressive behavior(s) such as lethargy, social withdrawal, crying, alcohol abuse, and suicidality. Strategies for conducting functional analyses include interviews with the patient and significant others, naturalistic observation, the manipulation of specific situations that result in an increase or decrease of target behaviors, or some combination (O'Neill, Horner, Albin, Storey, & Sprague, 1990). Often incorporating some form of daily monitoring, depressed patients may be asked to record depressive (target) behaviors, the context (time, place, surroundings) in which they occur, and the consequences that follow. With all functional analytic strategies, the therapist is concerned with identifying the function (or maintaining reinforcers) that depressed behavior produces for an individual, or put more simply, why the depressed behavior occurs. According to behavioral theory, depressive behavior occurs because reinforcement for healthy behavior is minimal, because positive and negative reinforcement for depressive behavior is excessive, or both (Lewinsohn, 1974). In other words, depressed behavior may develop following extinction of "healthy" behaviors consequent to a decrease in response contingent positive reinforcement and may be maintained via the experience of pleasant consequences (e.g., other people completing responsibilities, attention, and sympathy), as a result of the removal of aversive experiences (e.g., unpleasant or stressful activities), or both.

In addition to using functional analysis techniques to understand more overt behavior, these strategies also may be useful for understanding maladaptive thought processes that more cognitively oriented therapists believe to be a critical feature in eliciting depressive affect (Beck, Shaw, Rush, & Emery, 1979). Indeed, through strategies that include the use of thought-monitoring logs or various thought sampling methods (Csikszentmihalyi & Larson, 1987; Hurlburt, 1997), functional analysis strategies can be used to identify specific thought patterns elicited by certain environmental events and how these cognitions may correspond with depressive mood states. These same methods also may be utilized to assess change during and following therapeutic strategies that focus on challenging and restructuring the maladaptive or irrational

cognitions. Functional analysis methods may be useful in integrating assessment data, developing hypotheses about factors maintaining depressive behaviors, and may greatly assist in the formulation of a treatment plan. It also should be noted that from a pragmatic standpoint, the practice of conducting functional analyses requires extensive training and skill, is largely based on complex causal models of behavior disorders, and the compatibility of this strategy with the policies of managed care is at this stage undetermined. Because of these factors, it is unsurprising that the literature suggests that pretreatment functional analyses are only infrequently conducted (cf. Haynes & O'Brien, 1990). It also is evident, however, that functional analytic strategies may be quite useful in generating specific treatment goals and as a method of intervention (Haynes, 1998). More traditional (Ferster, 1973) and contemporary behavioral theories and interventions for depression (Lejuez, Hopko, & Hopko, 2002; Martell, Addis, & Jacobson, 2001; McCullough, 2000), as well as treatments for other psychiatric conditions (Hopko & Hopko, 1999; Linehan, 1993) to a greater or lesser degree incorporate functional analytic techniques.

Pragmatic Issues Encountered in Clinical Practice with These Disorders

Various pragmatic issues are associated with assessing depressive disorders in clinical practice, which generally can be conceptualized in the broader context of assessment procedures and financial considerations. Some of the more fundamental issues surrounding the choice and implementation of assessment strategies include determining the goal(s) of assessment, conducting an ideographic multimethod approach to assessing behavioral problems, identifying and problem solving around obstacles to assessment, and evaluating whether assessment procedures are generating useful, reliable, and valid information (Nezu, Nezu, & Foster, 2000). These practical issues have nicely been summarized previously and thus only are briefly reviewed in the present context. The specific goals of assessment are quite diverse, and may include primary prevention screening strategies such as those provided during National Depression Screening Day (www.mentalhealth-screening.org/depression.htm), a program with documented effectiveness in identifying individuals with clinical depression and facilitating their access to the mental health care system (Greenfield et al., 1997). Several screening instruments (reviewed in the previous section) have demonstrated utility in expediting this process. A second goal of

assessment might include the need to accurately diagnose patients, so as to facilitate appropriate patient-treatment matching, to generate confidence in research findings and generalizability of results, or both. Third, assessment may be necessary to better qualify and quantify problems and symptoms as well as maintaining contextual factors so as to assist in a clinician's case conceptualization (Goldfried & Sprafkin, 1976). Finally, assessment may greatly assist in the formulation of a treatment plan as well as comparative evaluations of the efficacy and effectiveness of various treatment modalities.

Regardless of the specific assessment goal, a multimethod, ideographic assessment will help to establish confidence in the validity of conclusions and recommendations. This means assessing across multiple response systems (i.e., behavioral, cognitive, physiological) using various methods (e.g., self-report, direct observation), and always with attention to unique environmental factors that may be involved in the etiology and maintenance of symptoms. Indeed, considering the numerous assessment strategies that may be beneficial in assessing and treating patients with clinical depression, clinicians will vary markedly in their knowledge and administration of these procedures. Without sufficient training and knowledge, clinicians may be unsuccessful in conducting a comprehensive psychological assessment and subsequently may provide ineffective treatment for their patients (Higgitt & Fonagy, 2002). In addition to skill level, many other factors may affect the reliability and validity of assessment results and clinical decision-making (Kaheman & Tversky, 1973; Arkes, 1981; Nezu & Nezu, 1989). Researchers have demonstrated, for example, that clinical decisions often are made out of habit rather than through systematically gathered information (Higgitt & Fonagy, 2002). Safeguards should be utilized to minimize the negative impact of such factors. Nezu and Nezu (1993) have forwarded a continuous and reciprocal problem-solving model that may assist the assessment process as it pertains to problem definition and formulation, generation of alternatives, decision making, and solution implementation and verification.

Addressing obstacles that may sabotage an otherwise informative clinical assessment also will be critical. Patient obstacles that may include logistical and motivational problems (particularly among depressed patients), therapist obstacles that may include lack of expertise, resources, or time, and common obstacles such as limited financial resources will be key problems to consider. Obstacles may necessitate the need for modification of assessment procedures, increasing clinician skill level (perhaps through continuing education), choosing other techniques that can be more effectively used, or both (Nezu, Nezu & Foster, 2000; Maruish, 1999). Finally, although assessment is most prominent at the outset of therapy, it also is a continuous process that begins with the initial patient visit and

extends toward the maintenance phase at post-treatment, with periodic evaluation necessary to establish whether assessment strategies are accomplishing the goals for which they were designed.

Financial Considerations, Managed Care, and Assessment of Clinical Depression

A Substance Abuse and Mental Health Services Administration (SAMHSA) report estimated that approximately 22.3 million adults received mental health treatment in 2001, representing 11% of the population 18 years of age or older. The majority of these patients are treated within the context of primary care, in which major depression is one of the most common mental health problems (Spitzer et al., 1994; Ustun & Sartorius 1995). Intervention costs are staggering. The American Psychological Association (2000) reported, for example, that mental disorders collectively accounted for approximately 15% of the nation's health care costs, with intervention costing in excess of \$100 billion annually. Compounding this problem, indirect costs in the form of absenteeism, lost productivity, and employee turnover are significant, with estimates of depression-related costs exceeding \$30 billion annually (Greenberg, Kessler, Nells, Finkelstein, & Berndt, 1996).

A further pragmatic consideration of assessing for clinical depression evolving out of this current zeitgeist is the necessity that clinicians be effective and efficient in assessment and intervention to meet the demands of managed care companies (Bieber et al., 1999; Johnson, 1995). Consistent with policies surrounding the cost-effectiveness of psychotherapy, managed care organizations (MCOs) have limited the reimbursement and subsequent use of psychological assessment procedures (Ficken, 1995; Werthman, 1995). Clinicians are consequently engaging in fewer testing procedures and are more restricted in their use of assessment instruments (Piotrowski, 1999).

So what does this mean for practitioners and the assessment of clinical depression? First, the impact of MCOs on various assessment strategies will be quite differential. In most cases, for example, clinicians will continue to receive monetary compensation for unstructured clinical interviews at the initiation of therapy. In community practice, the use of more timely structured interviews might be less feasible, as would the administration, scoring, and interpretation of lengthy personality assessment instruments (Piotrowski, 1999). Given the brevity of other self-report measures (such as the BDI or CES-D) and the feasibility of assessment occurring outside of the context of clinical practice (e.g., daily monitoring logs, self-report), there is no reason to suspect such strategies

greatly would be affected by MCOs. Similarly, the process of conducting a functional analysis of depressive behavior generally is ongoing and is enmeshed within the context of psychotherapy. As long as therapeutic services are being reimbursed, so should this type of assessment.

Second, practitioners may have to learn to become more flexible and creative (Mays & Croake, 1997). This may involve assessment of depression via the training of nontraditional personnel such as nurses (Wells, 1999), using assessment instruments for multiple purposes (Hopko, Averill, Small, Greenlee, & Varner, 2001), incorporating family members into the assessment process (Lejuez, Hopko, & Hopko, 2001), writing briefer reports, and learning how to administer specific assessment instruments as required of MCOs. Third, as part of the need to increase efficiency, generation of educational opportunities to enhance understanding of clinical depression is warranted. A significant proportion of patients with clinical depression who present to primary care settings, for example, often are undiagnosed or misdiagnosed (McQuaid, Stein, Laffaye, & McCahill, 1999; Schuyler, 2000). Dissemination of effective and efficient assessment strategies to practitioners in this environment as well as utilization of technologically advanced assessment strategies (Sturges, 1998) therefore is exceedingly necessary. Fourth, managed care has necessitated that clinicians show increased accountability throughout the assessment and therapy process. Systems that monitor practitioner performance therefore will be critical toward meeting this demand and ensuring patient progress and improvement (Callaghan, 2001; Donabedian, 1985). Finally, it will become increasingly important for practitioners and managed care personnel to collaboratively work toward streamlining assessment processes and maximizing quality of care. For practitioners, this means learning about the philosophy and goals of MCOs, educating MCOs about the value of testing, and being conservative and discriminatory when requesting authorization and reimbursement for testing (Dorfman, 2000). These practices may ultimately result in more limited use of physician services and decreased medical costs, a phenomenon referred to as “medical cost offset” (Bieber et al., 1999; Simon et al., 2002).

Case Illustration

Client Description

The patient (Anne) was a 38-year-old married Hispanic female. She had been married for 19 years and had three daughters, ages 5, 9, and 18. At the time of assessment Anne was a homemaker, but was previously

employed in various secretarial positions. Anne had a tenth grade education. At intake she was oriented in all spheres, with adequate grooming and hygiene. Her mood was dysthymic and psychomotor retardation was evident. Anne's thought process was logical and goal-directed and there was no evidence of perceptual abnormalities. Her speech volume, rate, and tone were within normal limits. Anne presented with depressive symptoms that included depressed mood, decreased sleep and appetite, anhedonia, concentration difficulties, and feelings of guilt and low self-worth. She also reported several obsessive-compulsive symptoms that were related to a core fear of acquiring head lice.

History of the Disorder

Anne indicated that she had felt depressed for as long as she could remember, with the most severe symptoms manifesting over the past decade. Her history was unremarkable as far as significant psychosocial stressors. She had always resided in the same community, had positive peer and parental relationships, had no recollection of childhood abuse or neglect, and no significant medical history; however, she did report a family history of (maternal) depression. Anne reported that the last 2 years had been particularly difficult, following the loss of her job and subsequent financial problems. Anne's family moved into a low-income housing project that had deplorable living conditions, including rat and mice infestation as well as significant sewage problems. During their time at this residence, Anne indicated that her 9-year-old contracted lice from one of her schoolmates, which then quickly spread to other family members. When Anne first discovered lice in her daughter's hair she experienced her first panic attack and a marked worsening of depressive symptoms.

Anne reported no history of inpatient or outpatient psychological (or pharmacological) treatment. With the exception of her mother and aunt, Anne denied a family history of depression, anxiety, and psychosis. She did report a family history of polysubstance abuse, particularly with her brother and grandfather. Anne reported that she drinks wine infrequently (i.e., twice per month), smokes 1 pack of cigarettes per day, and drinks between 2–3 cups of coffee per day. She denied use of other psychoactive substances.

Presenting Complaints

Anne presented with coexistent depressive and anxiety symptoms. Depressive symptoms included anhedonia, dysthymic mood, insomnia, weight

loss, and frequent crying spells. Physiological symptoms of anxiety included trembling, perspiration, increased heart rate, shortness of breath, nausea, and difficulty swallowing. Cognitive symptoms included a pronounced fear of “either myself or my daughters obtaining lice,” the possibility of which was equated with a core fear of “being a bad and worthless mother.” Behavioral symptoms involved avoidance of several situations that included movie theaters, restaurants, playgrounds, furniture (fabric), and contact with other children. When these situations could not be avoided, intense physiological and cognitive anxiety, as well as increased dysphoria was experienced. Ritualistic behaviors in the form of excessive hand washing, blowing, shaking, and tapping also were apparent. Such behaviors almost invariably resulted in marital conflict, a failure to maintain household responsibilities, and an associated increase in depressive symptoms. When anxiety-eliciting situations could successfully be avoided, Anne reported immense guilt and sadness related to the restrictions she was imposing on her children.

□ Assessment Methods Used

- Clinician ratings
 - Anxiety Disorder Interview Schedule (ADIS-IV; Brown et al., 1994)
 - Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960)
 - Unstructured clinical interview
- Self-report ratings
 - Beck Depression Inventory (BDI; Beck & Steer, 1987)
 - Beck Anxiety Inventory (BAI; Beck & Steer, 1993)
 - PADUA Inventory (PI; Sanavio, 1988)
 - Personality Assessment Inventory (PAI; Morey, 1991)
 - Quality of Life Inventory (QOLI; Frisch, 1994)
- Behavioral observations (Lejuez et al., 2001)
 - Daily diaries, Value Assessment
 - Behavioral Checkout
 - Response Prevention Checklist
- Functional **analysis**.

AU: OK?

Psychological Assessment Protocol

At the initiation of assessment/therapy, the patient underwent a brief unstructured clinical interview followed by administration of the ADIS-IV. Results of this interview suggested that Anne met DSM-IV-TR clinical criteria for major depression and obsessive-compulsive disorder. Further sup-

porting the diagnosis of major depression, Anne received a score of 33 on the HRSD. Several self-report instruments also were completed during the initial assessment. Described in a previous section (see Range of Assessment Strategies) Anne scored a 38 on the BDI (severe depression). Anne also completed the Personality Assessment Inventory (PAI), an objective self-report measure of personality and psychopathological variables. Her profile was valid and interpretable. Significant elevations were noted on the depression ($T = 72$), Anxiety ($T = 78$), and Anxiety-Related Disorders ($T = 82$) clinical scales, as well as on all depression and anxiety subscales (i.e., cognitive, affective, physiological). The ARD-O (Anxiety-Related Disorder: Obsessive-Compulsive) subscale also was significantly elevated ($T = 83$). On the self-report anxiety measures, Anne scored a 34 on a measure of cognitive and somatic anxiety (BAI; Beck & Steer, 1993) and was significantly elevated on three of the four scales of the Padua inventory, which assess severity of obsessive-compulsive symptoms [impaired control of mental activities (24), contamination (33), checking (13), and worries of losing control over motor behaviors (2, ns)]. On the QOLI, which assesses life satisfaction on various life domains (e.g., health, relationships, money), Anne scored in the "low" range of life satisfaction (QOLI total = -4).

As a pretreatment assessment strategy and part of a brief behavioral activation treatment for depression (BATD; Lejuez et al., 2001, 2002), Anne also completed a daily diary for one week (Hopko et al., in press). This assignment was used to: (a) provide a baseline measurement by which to compare progress following treatment, (b) make Anne more cognizant of the quantity and quality of her activities, and (c) provide Anne with some ideas with regard to identifying potential activities to target during treatment. Daily monitoring revealed that Anne was leading a relatively passive lifestyle, characterized by such activities as television viewing, daytime napping, and aimless Internet surfing. When queried about the reward (or reinforcement) value of such activities, Anne indicated that minimal pleasure was being experienced. Her daily ratings of the reward value of activities confirmed this appraisal; On a Likert scale ranging from 1 ("minimally rewarding") to 4 ("extremely rewarding"), her average rating was 2.1 ($SD = 1.3$).

Following this monitoring exercise, the assessment process shifted to identifying Anne's values and goals within a variety of life areas that included family, social, and intimate relationships, education, employment/career, hobbies/recreation, volunteer work/charity, physical/health issues, and spirituality (Hayes et al., 1999). Based on this evaluation, an activity hierarchy was constructed in which 15 activities were rated ranging from "easiest" to "most difficult" to accomplish. These activities were outlined on a master activity log (maintained by the clinician) and a behavioral checkout (maintained by Anne) to monitor progress

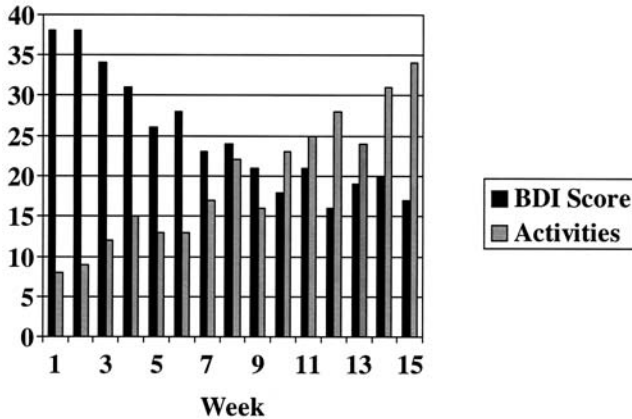


FIGURE 5.1. Weekly BDI scores and activity completion.

throughout each week of treatment. The behavioral checkout is presented in Figure 5.1. As part of the exposure and response prevention procedure that was implemented to treat Anne's obsessive-compulsive behaviors, she also was required to maintain a response prevention checklist. This checklist specified both appropriate and inappropriate behaviors (e.g., washing, checking) and required that Anne indicate on a daily basis whether she succeeded or did not succeed in following each of the recommendations.

Finally, functional analytic procedures were conducted via unstructured interviews with the patient and significant others (i.e., parent, oldest daughter) to identify environmental factors that may be serving to maintain depressive symptoms/behaviors. These interviews revealed that Anne's depressive behaviors were at least partially maintained by positive consequences that followed. For example, when Anne would lie motionless on the couch, which periodically was accompanied by crying, her daughter frequently would provide a significant amount of sympathy and concern and would proceed to complete household tasks such as preparing dinner and washing dishes.

Targets Selected for Treatment

The first treatment goal was to systematically increase response contingent positive reinforcement by facilitating increased exposure to pleasant activities that were consistent with Anne's value/goal assessment. To accomplish this objective, Anne engaged in a brief behavioral activation treatment for depression (BATD; Lejuez et al., 2001). Anne moved through a constructed behavioral hierarchy in a progressive

manner, moving from the easier behaviors to the more difficult. For each activity, Anne and the clinician collaboratively determined what the final goal would be in terms of the frequency and duration of activity per week. These goals were recorded on the master activity log that was kept in the possession of the therapist. Weekly goals were recorded on the behavioral checkout form that Anne brought to therapy each week. At the start of each session, the behavioral checkout form was examined and discussed, with the following weekly goals being established as a function of Anne's success or difficulty. Rewards were identified on a weekly basis as incentive for completing the behavioral checkout. A component of this treatment also included addressing rewards for depressive behavior as revealed through functional analysis. Through the use of behavioral contracting procedures, Anne and her daughter clearly specified how much time would be spent discussing Anne's negative affect and when this would occur (i.e., 15 minutes in the morning and 15 minutes before bedtime). Both individuals also agreed that it was better if Anne's daughter did not reward passive behavior by completing Anne's household responsibilities. As such, the agreement stated that her daughter would prepare dinner and wash dishes only twice a week (Monday and Thursday). For successful adherence to this contractual agreement, Anne was rewarded by being able to purchase a small amount of materials for her scrap-booking hobby.

The second treatment goal was to reduce Anne's avoidance behaviors (that resulted from anxiety eliciting stimuli and also increased depressive affect) through exposure and response prevention (ERP) strategies for OCD (Stanley & Averill, 1998). Through imaginal exposure strategies followed by in vivo techniques, Anne was encouraged to confront a variety of feared stimuli that included a pillowcase, comb, daughter's bed, furniture fabric, and her daughter's friends. Evident in the behavioral checkout, behaviors targeted for change were sometimes addressed via multiple treatment strategies. For example, taking the children to a movie or having lunch with a friend both were intended to increase exposure to rewarding activities and to alleviate depressive symptoms but also involved increasing contact with feared stimuli (e.g., fabric, other children) to extinguish anxiety-related responding.

Assessment of Progress

Progress was assessed via pre-post comparisons on the self-report and behavioral observation methods. As presented in [Table 5.1](#), Anne made fairly robust improvement during the 15-week combined BATD-ERP treatment intervention. Anne also completed a BDI on a weekly basis,

TABLE 5.1. Comparison of Pre- and Postassessment Measures

Assessment Measure	Pretest	Post-Test
HRSD	33	22
BDI	38	17
PAI (T-Scores)		
Depression Scale	72	57
Anxiety Scale	78	65
Anxiety-related Disorder Scale	82	64
BAI	34	21
PADUA		
Mental Activities	24	8
Contamination	33	14
Checking	13	6
Control	2	2
QOLI	-4	-2
Daily Diaries	2.1	2.7
Response Prevention Checklist		
Successful Behaviors	14 (week 1)	29 (week 15)

which was plotted against her weekly behavioral checkout data (i.e., the number of activities she successfully completed during the previous week). These data suggested a strong relation between increased activity and alleviation of depressive symptoms (see [Figure 5.2](#)).

□ Summary

Assessment of depressive disorders typically involves the use of interviewing strategies, self-report measures, behavioral observation methods, and functional analysis techniques, including the assessment of potentially maladaptive or irrational cognitions. Interviewing methods vary on the dimension of flexibility, with structured approaches more frequently utilized in research settings. Although the practicality of structured interviewing strategies in community practice is debatable, such methods may be useful in facilitating differential diagnosis and in documenting the need for psychological/psychiatric treatment, important considerations in the era of managed care. Similarly, utilization of self-report measures such as the BDI-II or CES-D may be a time-efficient method to facilitate the assessment process as well as monitor therapy progress and treatment outcome. Considering the outlined pragmatic concerns, increased flexibility of assessment methods may be necessary, such as using clinician-administered measures in non-traditional ways to facilitate differential diagnosis (Hopko et al. 2001). Practitioners and managed care personnel also will have to work

Activity	#	Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Tell daughters she loves them	5	UF	YNG	YNG	YNG	YNG	YNG	YNG	YNG
Wake before 9:00 A.M.	6	UF	YNG	YNG	YNG	YNG	YNG	YNG	YNG
Read chapter from Bible	7	UF	YNG	YNG	YNG	YNG	YNG	YNG	YNG
Hug daughters	5	5-10s	YNG	YNG	YNG	YNG	YNG	YNG	YNG
Groom garden/plants	3	30min	YNG	YNG	YNG	YNG	YNG	YNG	YNG
Make dinner for family	5	UF	YNG	YNG	YNG	YNG	YNG	YNG	YNG
Wash dishes	5	UF	YNG	YNG	YNG	YNG	YNG	YNG	YNG
Telephone friend	2	20min	YNG	YNG	YNG	YNG	YNG	YNG	YNG
Attend church on Sunday	1	UF	YNG	YNG	YNG	YNG	YNG	YNG	YNG
Go for 20 min walk	3	UF	YNG	YNG	YNG	YNG	YNG	YNG	YNG
To lunch with friend	2	1hr	YNG	YNG	YNG	YNG	YNG	YNG	YNG
Attend Bible study	1	UF	YNG	YNG	YNG	YNG	YNG	YNG	YNG
Take children to movie	1	UF	YNG	YNG	YNG	YNG	YNG	YNG	YNG
Take children to Chucky Cheese	1	1hr	YNG	YNG	YNG	YNG	YNG	YNG	YNG
Allow daughter to have friend over	1	2 hrs	YNG	YNG	YNG	YNG	YNG	YNG	YNG

Note: UF = Until Finished, Y = Yes, N = No, G = Goal has been met

FIGURE 5.2. Behavior checklist

collaboratively toward streamlining the assessment processes and maximizing quality of care while simultaneously ensuring that their responsibilities are not compromised. Although underutilized, behavioral observation and functional analysis techniques, including the assessment of dysfunctional cognitions, provide additional information that may be useful in identifying and modifying problematic behaviors or cognitions underlying a depressive disorder.

All of these strategies considered, we strongly advocate the importance of conducting a multimethod, ideographic assessment. However, we also acknowledge that the realities of clinical practice across a variety of settings often limit the feasibility of such a comprehensive approach. Accordingly, practitioners must evaluate potential restrictions and limitations (e.g., time, money, training, patient motivation) on a case-by-case basis and make a conscientious and well-informed decision on how well each of the available options meet both the therapist and patients' goals and needs. It certainly is the case that public and practitioner awareness of depression as a prevalent and treatable condition has grown in the twenty-first century, an understanding that has translated into advances in the development of various assessment alternatives. Given these options and in consideration of patient welfare and competency of care, practitioners have a significant responsibility to educate themselves about available assessment resources and how these methods may assist in the clinical assessment and intervention processes. As health providers have become increasingly more accountable for the services they provide via standards and guidelines imposed by managed care companies, efficient and effective clinical assessment is vital. In response to this need, the primary purpose of this chapter has been to elucidate a variety of methods to assess for depressive disorders, outline important pragmatic issues that must be considered, and to demonstrate how various methods may be applied in the context of clinical practice.

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