Webinar Tips for Attendees

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Our webinar presentation (and audio) will begin promptly at 2pm ET.
For today's presentation, you will not see the presenter—you will only see the slides.

NATIONAL REGISTER OF HEALTH SERVICE PSYCHOLOGISTS

CLINICAL WEBINARS

FOR HEALTH SERVICE PSYCHOLOGISTS

TRANSLATING RESEARCH TO PRACTICE

Persistent Depressive Disorders

J. Kim Penberthy, PhD, ABPP

Chester F. Carlson Professor
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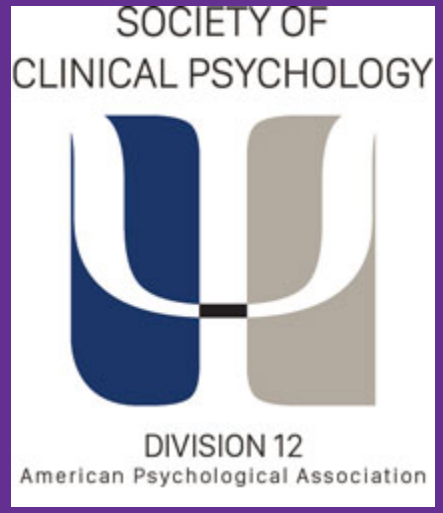
University of Virginia School of Medicine
Charlottesville, VA, USA

Presented in Collaboration With APA Division 12



Attendees Earn One Continuing Education Credit

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J. Kim Penberthy, PhD, ABPP

Jennifer “Kim” Penberthy, PhD, ABPP is the Chester F. Carlson Professor of Psychiatry and Neurobehavioral Sciences at the University of Virginia School of Medicine. She obtained her Ph.D. in clinical psychology from Virginia Commonwealth University, where she was a student of Dr. Jim McCullough, Jr. and her fellowship at the University of Virginia School of Medicine. She is on the American Psychological Association Council of Representatives and past chair of APA Society of Clinical Psychology Diversity Committee, past chair of the American Psychological Association Continuing Education Committee and International CBASP Society and current Marketing Chair for the American Board of Clinical Psychology.

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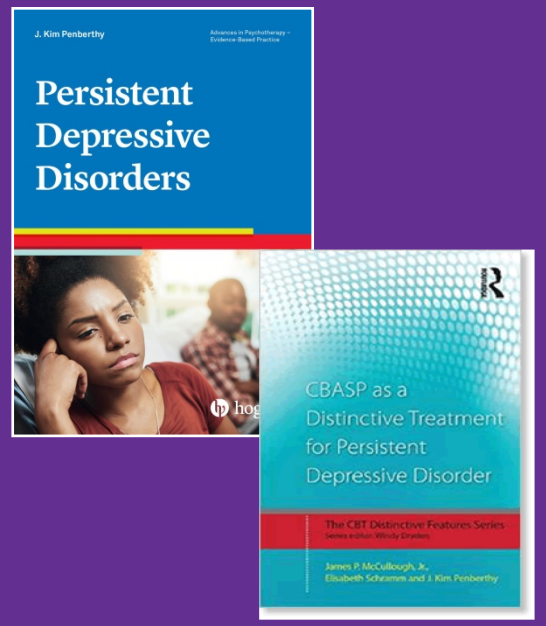
Disclosures/Conflicts of Interest



Dr. Penberthy is the author and co-author of books about persistent depressive disorder including:

- Penberthy, J.K. (2019). Persistent Depressive Disorders. Hogrefe, Germany.
- Sayegh, L., Penberthy, J.K., McCullough, Jr., J.P. (2016). Cognitive Behavioral Analysis System of Psychotherapy: A Group-CBASP Manual for Persistent Depression - Therapist's Guide. Routledge /Informa, NY.
- Sayegh, L., Penberthy, J.K., McCullough, Jr., J.P. (2016). Cognitive Behavioral Analysis System of Psychotherapy: A Group-CBASP Workbook for surviving persistent depression. Routledge/Informa, NY.
- McCullough, Jr., J.P., Schramm, E., Penberthy, J.K. (2015). CBASP as A Specific Treatment for Persistent Depressive Disorder: Distinctive Features Series. New York: Routledge Press: Taylor & Francis Group.

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References/Citations

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- Moore, R. G. & Garland, A. (2003). *Cognitive therapy for chronic and persistent depression.* Chichester, UK: Wiley.
- Markowitz, J.C. (2003). Interpersonal Psychotherapy for chronic depression. *Journal of Clinical Psychology, 59*, 847—58.
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Learning Objectives

- Identify the key differences between acute and chronic forms of depression.
- Explain two empirically supported, theory-driven psychotherapy approaches to treat PDD.
- Describe two primary therapeutic tools of the Cognitive Behavioral Analysis System of Psychotherapy for PDD.

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Defining Depression

- Feeling depressed or having symptoms of depression
- Adjustment Disorder: depressive symptoms within 3 months of stressor & don't persist beyond 6 months of end of stressor
- Major Depressive Disorder (MDD)
- No specific category for chronic depressive disorder in DSM until dysthymia in DSM-III
- Persistent Depressive Disorder (PDD) in DSM-5

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Dysthymia

- Depressed mood most of the day, for more days than not, for 2 years or at least 1 year in children and adolescents.
- While depressed, must have ≥2 of the following:
  - poor appetite or overeating
  - insomnia or hypersomnia
  - low energy or fatigue
  - low self-esteem
  - poor concentration or difficulty making decisions
  - feelings of hopelessness.
- Must not be without symptoms for more than 2 months
- MDD may be present for 2 years (after that it is a separate diagnosis)
- No mania or hypomania
- Symptoms cause functional impairment or distress
- Symptoms not better explained by other psychiatric disorder, medical condition, or effects of substances.

Major Depressive Disorder

- 5 or more symptoms are present for 2 weeks and they are a change from previous functioning. At least one of the symptoms must be depressed mood or lack or loss of interest or pleasure.
- Criteria for MDD may be present continuously for 2 years or more, and would be a separate diagnosis from dysthymia/PDD
- Possible symptoms include all of those in dysthymia as well as:
  - Decreased interest or pleasure in activities or things
  - Physical or psychomotor agitation or slowness
  - Feelings of worthless or guilty which is not warranted
  - Recurrent thoughts of death, suicidal ideation plan or attempt

Persistent Depressive Disorder

Integration of the DSM-IV categories of:

- Chronic Major Depression lasting > 2 years
- Dysthymic Disorder lasting > 2 years with no MDEs
- Double Depression:
  - PDD with intermittent MDEs, where MDE criteria have been met during a 2-year period of dysthymia but did not reach threshold of MDE for 8 weeks
- PDD and Chronic Major Depression; both met and both diagnosed
- *Bereavement not excluded from Major Depressive criteria*

Key Differences in PDD versus Acute or Episodic Depression

- Longer duration of symptoms (more than severity)
  - **Early-onset (before age 21): 75%**
  - **Late-onset (≥ 21 years): 25%**
- Increased rates of trauma and adverse childhood experiences
- Increased comorbidities, especially personality disorders
- Poor social and interpersonal adjustment and functioning
- Prognosis:
  - **<10% spontaneous remission rates for PDD**
  - **77% of acute/episodic adult MDEs will remit within 4-8 months with or without medication**

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Effective Therapies Must Address

- Trauma history and subsequent fear and avoidance behaviors

- Impoverished interpersonal adjustment and functioning

Empirically Supported Treatments

- Interpersonal Psychotherapy (IPT)
- Cognitive Behavioral Therapy or Schema Therapy (CBT)
- Cognitive Behavioral Analysis System of Psychotherapy (CBASP)

- *Effects remain largely unknown for persistently depressed populations of color, distinct racial or ethnic groups, or children, since very few research studies have been conducted in these populations.*

Interpersonal Psychotherapy

- Developed for acute, discrete episodes of depression
- Adapted for chronic depression with a focus on a role transition from chronic illness to nascent health
- Focus on mourning loss of persistently depressed role and gaining mastery over a new healthy role, including interpersonal skills
- Goals: independent functioning, increase sense of competence, get attachment needs met outside of therapy, prevent relapse
- Strategies: support, positive feedback, reflect back progress
- Support: no different than CBT, less effective than CBASP or medications

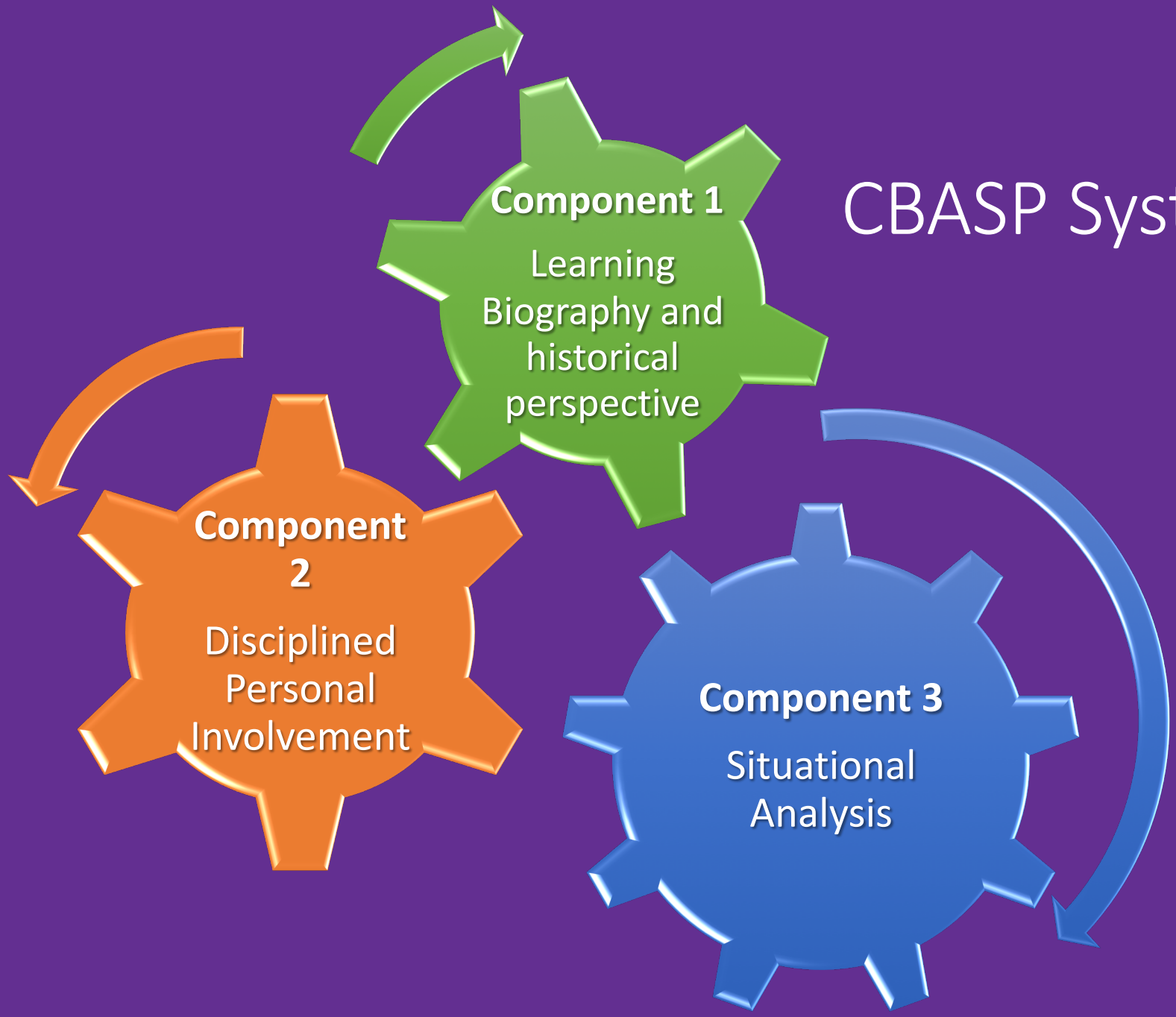
Cognitive Behavioral Therapy

- Developed for acute, discrete episodes of depression
- Adapted for PDD with a focus on modifying early maladaptive schemas (EMSs)
- Focus on identifying and modifying EMSs to improve mood and functioning
- Goals: behavioral goals to increase self-esteem, helplessness, hopelessness
- Strategies: case formulation and modifying EMSs
- Support: no different than IPT (small effect size), more effective than psychodynamic. Research in Hispanics and Chinese Americans demonstrate support

Cognitive Behavioral Analysis System of Psychotherapy (CBASP)

- Developed for chronic or persistent depression
- Focus on learning history, and development of therapeutic role and relationship to facilitate felt safety and foster interpersonal learning
- Goals: increase felt emotional safety, increase perceived functionality *(effective connection with the environment- "what I do counts")*
- Strategies: make explicit learning from significant others; social-emotional problem solving; discrimination learning and emotional retraining exercises
- Support: moderate-high effect size compared to IPT and medications
- Endorsed as 1st line therapy vs. CBT, IPT by Jobst et al. 2016

CBASP System



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Significant Other History

- Ask for list of 3-5 significant others who impacted patient
- “What was it like growing up with/being around this person?”
- “How did this person influence the course of your life?”
- “How did they influence you to be the person you are?”
- “What is the emotional stamp they left on you?”
- Develop causal theory conclusion and transference hypothesis to understand learning and help avoid interpersonal ‘hotspots’ in therapy (promote safety).

Examples:

Causal Theory Conclusion/Stamp:

If I express need, there will be no help, but only humiliation and rejection.

Transference Hypothesis:

If I let Dr. Penberthy know my needs, I will be rejected and humiliated.

Causal Theory Conclusion/Stamp:

If I get close to someone I will get hurt.

Transference Hypothesis:

If I get close to Dr. Penberthy, she will hurt me.

Interpersonal Impact

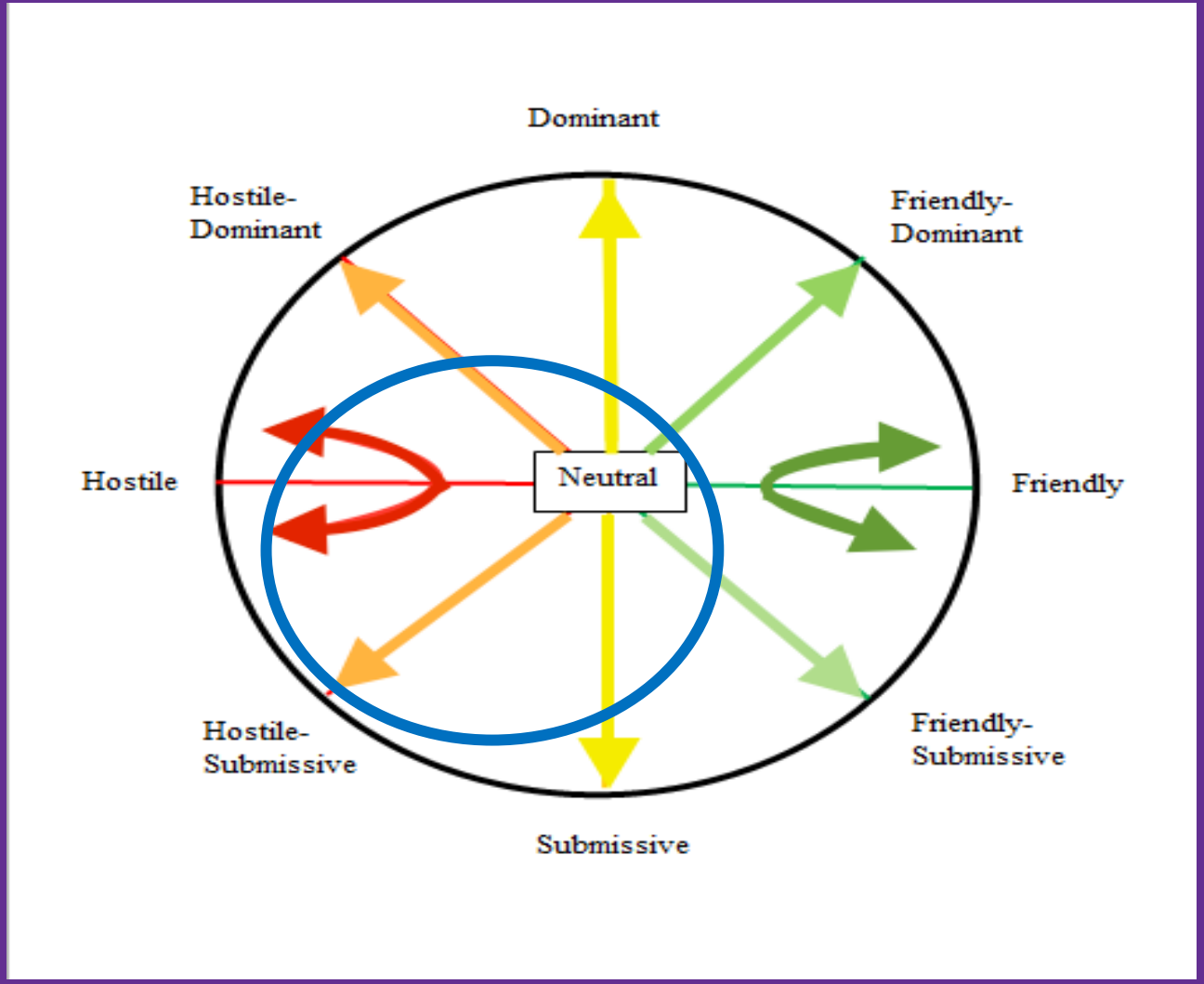
Significant Other History

- Early developmental learning about self and others
- Learned interpersonal style

Impact Message Inventory
(Kiesler & Schmidt, 2006)

- Where is the patient on the interpersonal circle now?

Both help increase felt emotional safety along with disciplined personal involvement.



COPING SURVEY QUESTIONNAIRE (CSQ) (Situational Analysis)

J.P. McCullough, Jr. (2000).

Instructions: **Select one stressful interpersonal event that you have confronted during the past week and describe it using the format below. Please try to fill out all parts of the questionnaire. Your therapist will assist you in reviewing this situational analysis during your next therapy session.**

Step 1. Describe what happened: (Write who said or did what, then describe clearly how the event ended – the final point)

Step 2. How did you interpret what happened:

a. _____

b. _____

c. _____

Step 3. Describe what you did during the situation: (How did you say what you said? What were some of your behaviors, tone of voice, eye contact, etc?)

Step 4. Describe how the event came out for you (Actual Outcome): (What *actually* happened? Describe in such a way that an observer would have seen.

Step 5. Describe how you wanted the event to come out for you (Desired Outcome):

(How would you have *wanted* the event to come out for you? What *goal* would you have wanted to achieve, that is realistic and attainable. Describe it in behavioral terms.

Did you get what you wanted? YES_____ NO_____ Why or why not?

SITUATIONAL ANALYIS OF THE
COPING SURVEY QUESTIONNAIRE (CSQ)

1. **Describe <u>what</u> happened, with a beginning, middle and end point.** (SHAPING & FOCUSING BEHAVIOR AND FORMAL OPERATIONAL THINKING)

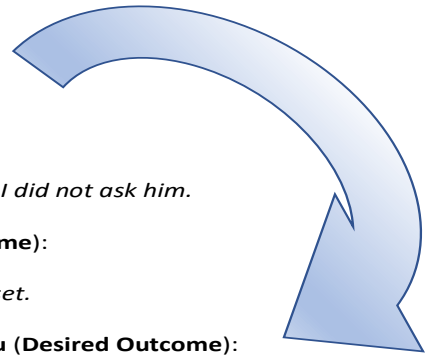
Attended company picnic. Photographer was taking pictures of everyone. He took everyone else's picture, but not mine.

2. **How did you <u>interpret</u> what happened, in other words, what did it mean to you? How did you read it?**

a. *The photographer doesn't like me.*

b. *I am not worth being photographed*

c. *I never get what I want.*



3. **Describe what you <u>did</u> during the situation:**

I said nothing. I hoped he would take my picture, but I did not ask him.

4. **Describe <u>how</u> the event came out for you (Actual Outcome):**

I never got my picture taken, and felt left out and upset.

5. **Describe how you <u>wanted</u> the event to come out for you (Desired Outcome):**

I wanted to have my picture taken at the company picnic.

GOAL = REALISTIC & ATTAINABLE

THIS WILL NEED TO BE REVISED TO BE SOMETHING UNDER PTS CONTROL

I wanted to ask the photographer to take my picture.

6. RATE: **Did you get what you wanted? In other words, did your Actual Outcome = Desired Outcome (AO=DO)?**

YES ____ NO _*X*_

7. **Why?** (THIS IS ASKED TO INCREASE DISSONANCE OR CONSOLIDATE LEARNING)

Nothing works out for me.

What have you learned from this? (USED TO HELP CONSOLIDATE AND GENERALIZE LEARNING)

Social-Emotional Problem Solving

- Increase felt emotional safety which can facilitate learning
- Learn to set realistic and attainable goals that involve other people and are in line with values
- Develop skills of gearing interpretations/thoughts and behaviors towards facilitation of achievement of goals
- Develop understanding of own interpersonal impact on others and the role of such on goal achievement

Q&A

- Dr. Sammons will ask Dr. Penberthy select questions that were submitted via the Q&A feature throughout the presentation.
- Due to time constraints, we will not be able to address every question asked.

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