Chapter 3. Evidenced-Based Treatment of Depression in the College Population

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SUMMARY. This review explores evidence-based treatment for depression within the college and university population. Treatments for depression in adults are among the most rigorous studied treatment modalities in the psychotherapy literature, providing consistent evidence for the efficacy of at least two treatments, cognitive behavioral therapy and interpersonal psychotherapy for depression, but the evidence for use of these therapies within the college population is sparse and inconclusive. The length of psychotherapy, diagnostic purity, and lack of adherence to specific theoretical models may be important elements contributing to the lack of treatment research on this population. More research should be focused on developing and evaluating specific treatments, which might address some of the unique stresses and dynamics within the college population.*[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com>*

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Depressive disorders may be the most common psychological disorders experienced by college students. A survey of more than 47,000 students on 74 campuses in the spring of 2003 conducted by the American College Health Association reported that 18.9 percent of the students had experienced some symptoms of depression, though perhaps not the full symptom picture of a clinical depression. Voelker (2003) cites a utilization survey conducted at Kansas State University. That survey found that the number of students seeking services to alleviate depression in 1988-1992 compared with 1996-2001 rose from 21 to 41 percent. Voelker's (2003) article suggests that college counseling centers in most other institutions have experienced similar increases in utilization. Kadison and DiGeronimo (2004) echo these findings stating that the incidence of depression on college campuses has doubled in the past 15 years. The data from the American College Health Association shows a 4.6 percent increase in the incidence of depression among college students over the four years from 2000 to 2004. In those surveys 14.9 percent of students in the 2004 survey group reported a lifetime incidence of diagnosed depression, whereas only 10.3 percent of the 2000 survey group reported ever having been diagnosed with depression. Given these trends, it is extremely important to consider efficacious ways to treat depression among the college population.

The two most rigorously studied treatments for depression are cognitive behavioral therapy (Beck, Rush, Shaw, & Emory, 1979) and interpersonal therapy for depression (Klerman, Weissman, Rounsaville, & Chevron, 1984). Both the cognitive behavioral and interpersonal therapies have detailed manuals outlining the treatment, and both have been subjected to "clinical trials," similar in nature to medical drug trials, in which the researchers have attempted to control for so-called extraneous variables. "Purity" is sought with respect to diagnostic criteria used for selection of patients, therapist adherence to the therapy, and length of treatment.

Further, in "clinical psychotherapy trials" therapists are specifically trained in the particular model of treatment under evaluation, adherence to the prescribed treatment condition is deemed necessary for an adequate evaluation of the treatment modality, and patient outcomes are assessed systematically and uniformly. Moreover, patients are screened with respect to diagnostic criteria and are excluded if they do not meet all of the criteria for major depression (in fact, in many studies recurrent depressions must be evident). These research studies used criteria similar to the Diagnostic and Statistical Manual-III (1980) definition of depression which require patients to have depressed mood or loss of

interest/pleasure towards most daily activities for at least two weeks, and a cluster of four of seven symptoms including changes in sleep and appetite, psychomotor agitation or retardation, fatigue, feelings of worthlessness or guilt, problems concentrating or making decisions, and thoughts of death or suicide (DSM-III, 1980). Patients are excluded when co-morbid conditions such as panic disorder, substance abuse disorders, and personality disorders (categories A and B) exist. Given the rigid exclusion criteria, a large number of potential clients are excluded from participation. The exclusion rates found in a recent meta-analysis of treatment of depression studies range from 42% to 86% (Weston & Morrison, 2001).

These clinical trial studies have been criticized as not representative of psychological treatment as it is usually practiced. For example, it is hard to imagine excluding 42 to 86 percent of depressed clients in the university counseling center setting because they have co-morbid diagnostic features. Additionally, finding ways to induce adherence to specific treatment modalities would be difficult in many college mental health settings where high proportions of the staff value integrative or eclectic counseling approaches. Though these studies have been criticized as being overly divorced from the "real world" practice of psychology, they remain prototypical of the empirical method to psychotherapy research. And when insurers and health care administrators talk about "empirically validated treatments for depression," these therapies (and various psychopharmacological interventions) and the body of literature surrounding them are generally what they have in mind.

If we were to simply ask the question–"Is there empirical evidence supporting the use of particular types of psychotherapy for the treatment of depression in the college or university setting?"–the answer would probably have to be "No." A few studies that attempt to test particular types of therapy such as cognitive behavioral or interpersonal (Hogg & Deffenbacker, 1988; Pace & Dixon, 1993) have been undertaken, but sustained and systematic efforts to conduct this type of investigation are lacking. The result is a few, very small "n" studies which may appear promising, but which are truly inconclusive about the efficacy of these treatments within the college population. Beyond the problem of small sample size, most of these studies lack sufficient rigor to allow clear demonstrations of the efficacy of the psychotherapies with this population. Additionally, the number of sessions in the typical study with college students is eight, whereas the number of sessions in the main "evidence-based research" investigations on similar psychotherapies

that have received systematic study over the past couple of decades is 12 to 16.

On the other hand, these therapies as practiced in university mental health settings may bear enough similarity to those "evidence-based" psychotherapies evaluated with the general adult population (ages 18-60) that we can reasonably apply them to the college population. Or perhaps, we should say that given the lack of convincing evidence against their use, they are the best "evidence-based" treatments we have to offer at this time.

It should be noted, however, that there might also be reasons that cognitive-behavioral and interpersonal therapies might not be the best choices for the treatment of college students. Specifically, students may be particularly at risk for depression because of the lifestyle that seems inherent to the college experience, including adapting to a new environment, substance use, and chronic sleep deprivation (Voelker, 2004). In support of this, Furr, Westerfield, McConnell and Jenkins' (2001) survey of students at four different college and universities (1455 students in the combined sample) found that 53% had experienced what they would term depression since beginning college. The top four "causes" of their depression were grade problems, loneliness, money problems, and boyfriend/girlfriend relationship problems. Bonner and Rush (1988) suggest that the prevalence of depression among college samples is twice that of age-peers who are not in college. Thus, the collective stresses and experiences of college students may be unique to them, and treatments with utility for the general populations, even those including college-aged people, might not generalize well to college settings. At the present time, no research is available to answer this question.

THE REAL MEANING OF BRIEF THERAPY IN COLLEGE POPULATIONS

Largely stemming from utilization/resources disparity, many university and college counseling centers have been put under pressure to utilize very short-term or brief treatment methods. This often translates into specific session limits or subtle pressure to be brief because of the continual influx of clients. Thus, one question is how the specific treatments advocated by the clinical trials research might translate into usage in the university setting.

It is difficult to do tightly-controlled research in the college population with "naturally occurring" clientele. Most clinical trials of psy-

chotherapy have used some type of manual-driven, duration specific treatment in an effort to ensure consistency amongst clinicians providing the treatment. The prototype of this research is the NIMH Treatment of Depression Collaborative Research Project (Elkins, Shea, Watkins, Imber, Sotsky, Collins, Glass, Pilkonis, Leber, Dockerty, Fiester, & Parloff, 1989). This study examined the use of cognitive behavioral therapy (CBT), interpersonal psychotherapy for depression (IPT), and psychopharmacology, both alone and combined with the psychotherapies. The length of treatment in this study was 16 weeks. While there is some variation among studies, treatment episodes in the typical research design last from 12 or 16 weeks. The research designs required adherence to a particular treatment modality plus a minimum length of treatment to be sufficiently tested. A common outcome measure is the percent of "completers," i.e., those who improved under a specific treatment and time condition.

The number of sessions is of particular interest in this discussion of psychotherapy in the college counseling center setting. Draper, Jennings, Baron, Erdur, and Shankar (2002) provide information from surveying 42 member universities in the Research Consortium of Counseling and Psychological Services in Higher Education. These universities were mostly state-supported ranging in size from 2,000 to 48,000 students with most schools within the range of 15,000 to 25,000. They report on a pool of 4,679 clients who sought services during the 1997-1998 academic year. Thirty-four percent of clients either failed to return after intake or to respond to intake or the Outcome Questionnaire-45 (OQ45). Moreover, 1,336 students declined to follow through with the study or failed to complete sufficient questionnaire information. Thus, they end up reporting on only 1,761 participants or 38% of the potential client sample. In this subsample, the modal number of sessions was 1 and the average number of sessions 3.3 (SD 2.4). These facts begin to illuminate the difficulty of doing evidence-based psychotherapy research within the university setting with its "naturally-occurring" population. It seems that the typical college student client does not stay in therapy long enough to benefit from the types of evidence-based psychotherapies investigated in the literature.

Draper et al. (2002), in their introduction section, note that most of the counseling centers involved in their research employed a brief treatment model. They commented in their discussion section that since they did not have "session limits" (an assigned number of session), they had no groupings large enough (20 or more participants) for clients who attended more than 10 sessions to generate meaningful data, somehow

implying that had they had a defined number of sessions that they could have enticed more students to stay in treatment. This may be so, although the attrition rates in most clinical trials, which explicitly specify the number of psychotherapy sessions, is also quite high (Westen et al., 2001). Moreover, it seems important to address the typical population of clients under study.

The data gathered to support evidence-based treatments is based on studies that specify a particular number of treatment sessions, usually between 8 and 16. Since most of the college students are not meeting those expectations, it is not clear that those treatment modalities would pertain to the "real world population." It seems little wonder that we lack anything approaching consistent "clinical trials" within the university setting.

However, on a more positive note, the Draper et al. (2002) report is consistent with the general psychotherapy literature documenting that psychotherapy, in general, is helpful in reducing psychological distress. No consistent theoretical orientation was specified or identified, yet improvement was noted across sessions within those university samples involved in that study. However, the percent "improved" is still modest at best, though the longer a student stayed in counseling, the more they seemed to improve, at least until the eighth to tenth sessions subsequent to which the increased magnitude of gain was quite small.

WHAT'S A COLLEGE COUNSELING CENTER THERAPIST TO DO?

The American Psychological Association (2002) advanced three criteria for suggesting treatment guidelines: empirical research, clinical judgment and expertise, and acceptability to the patient. As suggested in the preceding discussion, the jury is still out as to whether the CBT and IPT therapies, that have demonstrated efficacy with respect to the treatment of depression in the general population, are applicable to the college setting. Further research is needed in that area. Moreover, the debate about specific treatments (i.e., CBT, and IPT) vs. common factors and empirically-supported (therapy) relationship factors is applicable to this discussion. Each "camp" seems to have support for their position. That is, there is support for the efficacy of specific treatments; there is support for common factors, and there is support for relationship factors (which may be a subcomponent of common factors). "Clinical judgment and expertise" is likely to vary from clinician to clinician

depending on their training and experiences. The same is true for "acceptability to the patient" which will vary with the patient's previous experiences, worldview, and the ways in which treatment issues are presented to the client.

One possibility is that university-based clinicians can utilize the evidence-based treatments, if they have the training to do so, with selected sets of the college-aged population. For example, young people who are mourning the loss of a loved one might be motivated to stay in treatment longer than average (for college students seeking therapy). Those individuals might benefit from interpersonal psychotherapy for depression to address issues of grief, since grief is one of the specific problem foci of that treatment. In other instances, cognitive behavioral techniques might be very helpful for people with strong tendencies to engage in catastrophic thinking, especially about academic or relational matters.

It should be emphasized that common factors are at work in specific treatments, as well as nonspecific and/or untested interventions, and future research needs to find ways to both tease apart these dimensions and discover how they combine, and in what circumstance, for effective treatment (Chwalisz, 2001; Beutler, 2002). These common factors probably account for the improvement seen in the general psychotherapy literature where specific therapies are not manual-driven and tested. Special attention needs to be focused on the college populations. Although there is some research to suggest that the psychotherapeutic services provided by counseling centers are helpful to students (Draper et al., 2001), treatment approaches need to be elucidated and refined, especially in this day of increasing accountability. More research needs to be done to determine what short-term modalities will be most effective, in what time frame, and what will help students stay in treatment long enough to make significant clinical gains.

DISCUSSION

Some of the best efficacy studies have been conducted on treatments for depression with the general adult population (ages 18 to 60), but few studies have been done specifically on the treatment of depression with the college counseling center population. However, the existing studies tend to support the broader findings that behavioral, cognitive behavioral and interpersonal treatments are viable, evidence-supported treatments for depression in the college-aged population. A significant problem in the "real world" of therapy in university settings may be to

find ways of helping students remain in treatment long enough to benefit from them.

Alternately, it might be important to look at developing and evaluating short(er)-term therapies (perhaps six to eight sessions in length), specifically for the college-age population with complaints of major depression. It may be that given the multiple demands on their time combined with the additional affects on availability due to the academic schedule, we need to find ways to efficiently address their concerns by creating a "packaged" treatment of short duration that is more consistent with their naturally-occurring staying power in therapy. Moreover, the unique stresses of the college environment might need to be considered in creating treatments. For example, many students experience an exacerbation of depressive tendencies in the "heat" of academic pressures, and then experience a lessening of depressive symptoms once the "heat is turned down" between semesters or quarters. This type of dynamic is acknowledged clinically, but is seldom addressed in the treatment literature in any rigorous way. This "syndrome" may be quite different than clinical depressions among non-college populations.

There are more questions than answers with respect to treating college students who complain of depression. The pressures to use evidence-based treatments are likely to remain the zeitgeist in the foreseeable future. It may actually intensify as public scrutiny is high with respect to counseling service availability on college campuses. It may also be that the best defense is to develop and test treatments specifically designed for the college population, taking into account some of the unique stresses of that population.

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