



"ASSESSMENT FOR MAJOR DEPRESSION - USING THE N.D.I."

This .pdf document contains the course materials you must read.
Simply keep scrolling down and read every page. To receive CEU credit after reading this file,
please follow the directions at the end of the course.

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ASSESSMENT FOR MAJOR DEPRESSION - USING THE N.D.I. 3 CEU Credit Hours

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Course Description:

There are distinct differences between 'feeling blue' and clinical major depression - both in diagnosis and treatment protocol. Misdiagnosis can result in ineffective treatment - and perhaps even suicide - and no one wants that liability.

Course Objectives:

At the conclusion of this course the professional will be able to:

- 1.) Understand the diagnostic criteria from the DSM-IV for major depression
- 2.) Explore potential diagnostic Rule Outs and other diagnoses
- 3.) Utilize the Nongard Depression Index concepts for assessing major depression

Purpose of this course:

The purpose of this Continuing Education course is to provide discussion of issues relevant to the mental health counselor concerning assessing and utilizing client strengths and resources, rather than simply focusing on their deficits. Information is provided to assist counselors in understanding client condition, treating clients, and providing patient education.

Course Outline:

Part 1: Course organization, Documentation and Introduction.

Part 2: Reading of the course materials (this document)

Part 3: Administration and Completion of the Evaluation of Learning Quiz

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3 Clock Hours / CE Credits

If you ever have any questions concerning this course, please do not hesitate to contact **PeachTree at (800) 390-9536.**



Your instructor is **Richard K. Nongard**,
a Licensed Marriage and Family Therapist,
Certified Clinical Hypnotherapist
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SECTION I

ASSESSMENT OF MAJOR DEPRESSION

This is one of the most important courses that a clinician can take. Why? Because whether the clinician is working in inpatient or outpatient settings, major depression is one of the most frequently seen diagnoses affecting adults, adolescents and children.

Those working with addicts often have to determine: Is the person drunk because they are depressed, or are they depressed because they are drunk?

Those working in criminal justice settings see major depression affecting motivation, attitude, and the ability to function within societal norms.

Those who are treating women and children often find that situations related to social experiences complicate and exacerbate major depression.

The psychiatric patient presenting with a diagnosis ranging from schizophrenia to impulse disorders often presents with a simultaneous diagnosis of major depression.

The assessment of depression is not simple; it's actually quite complex. Many things look like major depression or present as major depression, but are not. I have done a lot of addiction counseling, and as I tell my clients: If you put a 12-pack of depressant in your body every day, you will become depressed.

The diagnosis of depression is also complicated by the difficulty in determining the difference between normal depressions that people experience as a result of normal human emotions, and pathological depressions stemming from psychiatric and psychological difficulties.

This is also an important course because we have experienced depression in the course of our normal lives, and we often assess client depression from a therapist-centered perspective, rather than from our client's frame of reference.

Every clinician taking this course for continuing education credit has been depressed to some level, at one time or another. Some clinicians taking this course have perhaps even met the criteria for dysthymia, or have themselves experienced major depression.

Since we have all been depressed at one time or another, we all believe we know what major depression is like. I know it sounds cynical, but it's almost as if we assess clinical depression this way in our profession: *If my client's depression is more severe than my own depression, then it's pathological. If they are only as depressed as me, or less depressed than me, then it's situational and a normal emotion.*

The DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, from the APA, American Psychiatric Association) gives us a detailed specific set of criteria for the diagnosis of major depression. The reason for this is that not all people manifest depression in the same manner. When some clients are depressed, they over-eat. Some quit eating. Some will sleep 18 hours a day, others sleep just a few hours a night.

The criteria outlined in the DSM-IV takes into consideration the various manifestations of depression that different people have. This makes it a useful guide for understanding major depression because it helps us to see our client's condition apart from our own experiences.

I speak to groups who see and treat major depression on a daily basis. I have given the following pop-quiz to literally thousands of mental health professionals at seminars and workshops. The quiz is very simple; it's fill-in-the-blank.

"In order to meet the diagnostic criteria for major depression - the most frequent psychiatric condition we treat in either inpatient or outpatient settings, the condition we see more than anything else regardless of the type of work that we do, whether treating adults, adolescents or children - a person must meet _____ out of _____ number of criteria, more often than not, for a period of 2 weeks or longer".

I recently conducted a seminar for school psychometrists, and I gave them this quiz. The essential job description of a psychometrist is the evaluation and diagnosis of mental health conditions, including major depression. Their job is to assess, and to diagnose. There was only one person at the workshop who was able to fill in the blanks.

Of the thousands of mental health professionals I've asked, probably less than 50 have been able to fill in the blanks.

I don't expect that the average clinician has memorized all of the criteria for all of the psychiatric conditions in the DSM-IV. That would be an unreasonable expectation. And I honestly don't even expect clinicians to have memorized all of the specific criteria for major depression. However, it does amaze me that of those who serve in the capacity of assessment and diagnosis, and of those who treat major depression on a daily basis, less than 5% have been able to pass my pop-quiz.

Again, I think this is reflective not of poor psychotherapy or even poor assessment, but of our own familiarity with depression as a human emotion. We rely on our own beliefs and experiences, and therefore our assessment practices come from a therapist-centered vantage point, rather than from a set of clinical criteria.

The correct answer is 5 out 9.

The DSM IV requires 5 out of 9 of these symptoms to occur - and the key phrase here is "more often than not" - for a period of two weeks or longer. The 'two weeks' criteria is also significant.

The DSM-IV prefaces the individual specific criteria for the diagnosis of major depression with this key descriptive phrase to help us distinguish major depression as a clinical syndrome from the normal human emotion of depression.

Anyone reading the diagnostic criteria for depression will see that they may meet some of the criteria at any given time. This is normal life. This is not psychiatric illness.

For example:

One of the criteria for the diagnosis of major depression is essentially fatigue; tiredness and a loss of concentration. As I am dictating this course material, I am actually traveling down an interstate on a long trip from one city to another. I am fatigued; I am tired; I am having a difficult time concentrating, and I have probably rewound and restarted the tape several times in order to make sure the material I want to present is accurately recorded.

This does not mean that Richard meets the diagnostic criteria for major depression. It means that in normal life, sometimes we experience some of the symptoms of major depression.

It is significant that at least half of the defined criteria, 5 out of 9, must be met for a diagnosis of major depression to be made. It is also significant to note that the DSM-IV requires the symptoms which measure major depression to occur 'more often than not'. Again, this is to help us distinguish between major depression and the normal human emotion of depression.

I have surely manifested 5 or more of these symptoms simultaneously during periods of stress or difficulty. However, my depression did not become clinical, in that even though I experienced many of these symptoms, I experienced them intermittently or fleetingly during the course of a day, rather than more often than not over a long period of time. Although I may have been emotionally depressed, I still considered myself grounded and happy. 'For a period of two weeks or longer' is a specific measure of time that helps us to determine the difference between situational or normal depressions, and pathology.

I'm a dog lover. If you have taken some of my other courses, you may have heard about the power struggles between my dogs and I, and how these situations relate to power struggles between therapists and clients. My three German shepherds are Zelda, Jet and Angel. I love them all, but Zelda is the most special to me. She's my oldest dog, almost 9. Zelda and I have been through a lot together, I love her dearly.

Unfortunately, dogs and people have different life spans, and I know that one day when I come home from out of town, the dog bowl will still be filled with food and the water bowl will be untouched because Zelda will have passed away. When my faithful companion Zelda dies, I will no doubt be depressed. As a matter of fact, I would venture to say I would probably experience 5 or more of the symptoms of major depression for several days, because she has been so important to me.

But even though I will miss Zelda when she goes, and even though no other dog can replace her, my guess is that within a week or two after Zelda's passing I will probably begin to consider acquiring a new puppy. And although periodically throughout the rest of my life I will remember Zelda and how special she was to me, and on occasion I may even be blue when I think of my departed faithful companion, I will not remain significantly depressed for any more than a week or two.

The time prohibition in the DSM-IV (more often than not, for a period of two weeks or longer) is there for a specific reason. It is to keep us from mistaking the natural stages of grief for major depression, or symptoms of stress for major depression, or specific situational difficulties for major depression, or self-inflicted motivational deficits for major depression.

SECTION II

THE IMPORTANCE OF ACCURATELY DIAGNOSING MAJOR DEPRESSION.

When we use the label ‘major depression’, we are actually calling somebody ‘diseased’; we are calling them ‘sick’.

It is essential to assess depression accurately, because many clients who present in therapy do need professional assistance or help, but yet they don’t fully meet the criteria for psychiatric disease.

Without a doubt, many people in couples counseling, many people in addiction counseling, and many adolescents come to us with difficulties and problems and they feel depressed. This is far different than disease.

When we diagnose an individual with a psychiatric illness, there can be life-long ramifications of that diagnosis. Focusing on accurate assessment is an essential tool when working with a depressed client, because if we mistake situational depressions for clinical depressions, we will prescribe the wrong treatment interventions.

In addition to the potential for prescribing the wrong treatment intervention and therefore wasting our client’s time in therapy, we also run the risk of damaging our clients in the long run.

I teach a lot of ethics classes. One moral principle that should underlie any ethical therapist’s practice is the rule of non-maleficence, meaning doing no harm to our clients. Sometimes in our zeal to assist our clients in the short-term by helping them seek third party reimbursement, we create a pathological diagnosis that suits our client at the moment, but can have long-term consequences.

Perhaps the best example I can think of comes not from my professional experiences, but from my personal life. I was talking to a friend who owns a small business. We’ll call him Justin. Justin had been a consultant for an optical company for a number of years and had been quite successful. He was now opening up his own manufacturing company and retail shop.

He needed to build a new building, and he approached the government about a small business loan. He believed they would meet his needs, so the contracts were signed and construction began. However, for some bureaucratic reason, Justin was unable to secure the Small Business Administration’s Loan. With construction halfway through and a substantial change in financial arrangements, he now faced eminent bankruptcy at the height success, if he was unable to secure an additional loan.

While expanding a business, raising a building, and changing his position in life from

an employee to an employer, Justin felt many of the stressful challenges anyone might feel in this situation. During this time, he went to his family doctor for a routine annual examination, and his doctor asked him about depression.

Justin, of course, jumped at the opportunity to talk to his doctor about some of the difficulties and scenarios that he was experiencing with his life changes.

The doctor, of course, diagnosed him with major depression and suggested that a medication would be in order, as it would certainly assist him with being able to manage some of the uncomfortable emotions he was experiencing during this time of change in his life.

The business owner, not being a physician, trusted his doctor's advice, filled the prescription for the anti-depressant, and began taking them.

Anti-depressants are effective medications for the depressed person, but this business owner was not a depressed person. He was a stressed person, experiencing significant life changes. And so, after a few weeks of taking the expensive anti-depressant, Justin felt no changes, and he stopped taking the medication.

On with his life, he applied to various private lending institutions, and a bank finally agreed to provide him the loan to finish his construction project. One of the conditions of the loan was that Justin would procure a life insurance policy equal to the mortgage on the building, with the bank as the beneficiary.

Being in good health and having no difficulties, my friend started applying to life insurance companies for a term policy to meet the bank's requirements. He was told by the first insurance company that his medical history indicated prior treatment for major depression. As a result, he was a high-risk, and they would be unable to insure him.

My friend then applied at 12 different insurance companies before he was finally accepted by one who sold him a policy at roughly four times the amount he would have paid, had he not had a pre-existing condition: a diagnosis of major depression.

There is no doubt that Justin's physician was well intentioned. He was simply trying to use one of the available tools of his profession, and believed a psychotropic medication would benefit this patient who was experiencing situational difficulties.

But you know what they say about good intentions. The physician's failure to diagnose using a defined set of clinical criteria subsequently led to a long-term consequence in the life of this patient, which was far more harmful than beneficial.

As clinicians, we have a responsibility to know and use the criteria in the DSM-IV responsibly and ethically. The assessment of major depression appears to be one of those areas where the criteria are often not followed, and as you can see, this can have destructive consequences.

We are going to stray off course for a moment. I want to offer the concept of P.I.E. as a tool for understanding client condition from a non-medical approach. P.I.E. is the *Person-in-Environment Classification System for Social Functioning Problems*, by James M. Karls and Karin E. Wandrei. It's based on a social work model for understanding client conditions and presenting problems, and it differs from the pathological model offered by the DSM-IV.

It is outside the scope of this CEU workshop to get into all of the issues and intricacies related to the P.I.E., but situations like the one above could probably be avoided if we begin to expand our understanding of client condition apart from simply a model of disease, and also begin to look at a psychosocial model of human condition.

Those who are interested in the subject of the P.I.E., its development and use in diagnosis and assessment, should contact the National Association of Social Work, who publishes a manual available online at:

<http://www.naswpress.org/publications/books/clinical/pie/2405A.html>

Until other non-pathological models are developed and accepted by our professions, the DSM-IV is the best tool we have for understanding client condition. I developed the *Nongard Depression Inventory* to assist me in understanding client condition from my client's unique frame of reference, using the DSM-IV criteria in its interpretation to assess the level of depression. The NDI is actually a preliminary screening; a self-report best used with the client who is compliant, the client who is honest, and the client who is motivated.

Clients often have a difficult time bringing up emotional and difficult subjects, especially early on in the assessment process. In the era of brief therapy and limited time and resources, the NDI is perhaps a great resource for professionals confronted by these situations and scenarios. As a preliminary diagnostic self-report, the NDI can often be used in the intake and assessment process as a tool for beginning therapeutic dialog.

There are many other tools which also measure depression in a similar manner, however, they are not based on the DSM-IV criteria. Using one or more screening tools as an adjunct to other tools when assessing depression based on the DSM-IV criteria is important, not only for interacting with 3rd party payers and managed care, but also to insure that the recommended treatment interventions are based on the client's true presenting problem.

Like many professionals, I have also used the Beck Depression Inventory, the ASIQ, and the Depression Adjective Checklist. The Beck is probably one of the most widely used. It can be re-administered on an ongoing basis, and its changing score can be used to demonstrate the progress a client makes in treatment.

But there's irony in using the Beck Depression Inventory. It asks a person to choose 1 of 4 choices, 20 different times.

Here are four choices—pick one.

Here are four more choices—pick one.

Here are another four more choices—pick another one.

Only seventeen more times will you have four choices and need to pick one of them.

We are assessing for major depression. One of the criteria for major depression is the inability to concentrate, focus and make decisions. If a person has the inability to concentrate, focus and make decisions, can I really ask them to choose 1 from 4 choices, 20 times? For the catastrophically depressed client, this can actually be quite overwhelming.

As an alternative, the Depression Adjective Checklist is available from Psychological Assessment Resources (www.PARinc.com or (800) 331-TEST). Instead of being multiple choice, it simply asks clients to checkmark the adjectives related to the emotions that they are currently experiencing. Like the Beck Depression Inventory, it too yields a numerical score. However, unlike the Beck Depression Inventory, it takes only moments to complete, and it has also been normed in criminal justice populations.

The ASIQ: Adult Suicidal Ideation Questionnaire and the adolescent version are also available from PAR. I particularly like the ASIQ because it yields not only a measure of a client's level of suicidal ideation, but also gives specific indicators requiring eminent action on the part of the professional. This can be a particularly useful tool for those who are only doing screenings, or those with large case loads such as school counselors or probation officers.

The following pages contain the *Nongard Depression Index* in both the adult and adolescent versions, followed by the professional use manual. The NDI was developed for my use with clients in therapy and in the assessment process - not to replace other tools - but to have an adjunct screening based on DSM-IV criteria. I consider the NDI to be a preliminary screening tool, since it is a self-report.

Also, since it is a self-report, the client who is sandbagging or withholding information from the therapist, particularly the adolescent, will not benefit tremendously from the time spent completing the NDI, nor will it yield meaningful results. However, for the client who is compliant and the client who seeks an end to their misery, it can help us diagnose major depression, and also rule-out major depression, identifying specific dilemmas or situations that the client is experiencing.

The primary value of the NDI is in (1) documenting the diagnosis which I have made, (2) eliciting from the client information that they otherwise would not have felt comfortable talking about or would have waited to talk about, and (3) providing the client with feedback concerning progress.

Much like the Beck or the Depression Adjective Checklist, I can go back weeks, or even months later and re-administer the NDI, and again yield a numerical score which lets us see that although perhaps perfection has not been attained, resolution to some depressions has occurred, as evidenced by the decrease in patient score.

The adult version of the NDI focuses on scenarios, beliefs and experiences typical for the adult, and the adolescent version - which is scored identically - focuses on the situations, experiences and feelings typical for the adolescent.

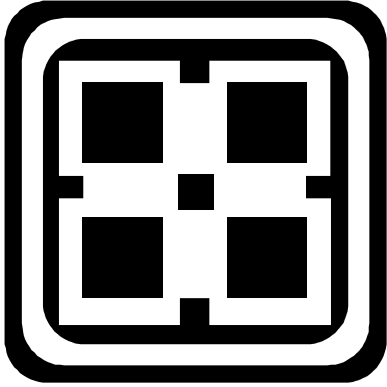
The specific answers, not just the numerical score yielded at the end, can provide valuable information to the clinician in assessing psychological, social and spiritual stressors present in the client's life.

The NDI self-report forms (both adult and adolescent versions) follow this page. To receive continuing education credit, the professional is required to self-administer the NDI.

Following the NDI forms is the instructional use manual. The professional must read the manual, and then score and interpret their self-administered NDI form.

The concluding sections of the course follow the instructional manual, and must also be read.

If you determine that the NDI would be valuable in your clinical practice, an individual or facility "license to copy" agreement can be obtained by contacting our office at 1-800-390-9536 or on the Resources section of our website at www.fastceus.com. Your purchase will include a reproducible copy of both the adult and adolescent forms, and the professional use manual.



NONGARD DEPRESSION INDEX

NDI

Adult and Adolescent Version and Use Manual

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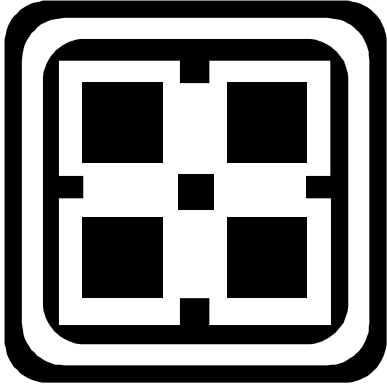
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NDI



 Client

 ID Number

 Date

NONGARD ADULT DEPRESSION INDEX

Instructions:

The following two pages ask questions about your thoughts and feelings. Place an (X) or a check-mark next to any statement that describes your feelings or thoughts, **during the past two weeks**. Answer the questions as they are written, relating to your thoughts or feelings of depression.

Please be honest in your responses. Most individuals will identify with at least some of the statements. Answering honestly will allow your counselor to provide you with important feedback.

This inventory has several sections. You may have nothing checked in some areas and multiple check marks in other areas. When you have finished, your counselor will go over the answers with you.

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1/DEP

- _____ I almost always feel sad
- _____ I usually feel empty
- _____ I often feel as if I am depressed
- _____ Most of the time I feel bored
- _____ Others often ask me if I am O.K.
- _____ Strangers sometimes tell me to smile
- _____ I am frequently am told to cheer-up
- _____ Other people think I am depressed
- _____ Most of the time I feel down
- _____ I probably make others feel depressed

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2/DIM

- _____ I have lost interest in my friends
- _____ Most of the time I'm not interested in going anywhere
- _____ I have stopped doing things I used to enjoy doing
- _____ I don't finish daily tasks (e.g. doing the dishes, making phone calls)
- _____ Others ask me why I don't do anything anymore
- _____ My family is upset that I don't do expected household tasks
- _____ Work is boring
- _____ I feel overwhelmed and unable to do things I used to do
- _____ I am less interested in sex than usual
- _____ I recently stopped attending religious services
- _____ I don't do much other than sit around the house

3/WGL

- _____ I'm not on any special diet to gain or loose weight, but I have
- _____ Although I have not been trying to gain weight, I have gained 5 or more pounds
- _____ Although I have not been trying to loose weight, I have lost 5 or more pounds
- _____ I have recently been eating more snacks
- _____ I have been gaining weight, but my diet has not changed
- _____ I have been loosing weight, but my diet has not changed
- _____ I have been not been eating lately
- _____ Nothing tastes good anymore
- _____ I have recently been eating the same thing over and over with little variety

4/IHF

- _____ It's been harder than usual for me to wake up almost every morning
- _____ It's been harder than usual for me to fall asleep almost every night
- _____ I wake up several times during the night
- _____ I am tired during the day
- _____ I have been napping almost every day
- _____ I am tired but have too much on my mind to sleep
- _____ I wake up too early and can't get back to sleep

5/PMA

- _____ I have been very restless and can't sit still
- _____ My speech has been slow or slurred for no reason
- _____ I find myself pacing or moving from place to place
- _____ It takes me longer than usual to answer a question or complete my thoughts
- _____ I have been shaky or felt "my nerves frazzled" in recent situations
- _____ I am more fidgety than usual
- _____ I feel periodic muscle spasms or twitches for no apparent reason
- _____ I am asked by others to sit still, or I am frequently told to relax

6/FLE

- _____ I have been tired almost every day
- _____ I always feel fatigue
- _____ Even when I sleep I don't feel rested
- _____ I run out of energy easily
- _____ I am too tired or lack enough energy to do things I used to
- _____ My body almost always feels tired
- _____ I am so exhausted I can't think or do anything

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7/FWG

- _____ I feel like my problems will never end
- _____ I do things wrong most of the time
- _____ If anything can go wrong it probably will
- _____ I can't do anything right
- _____ The future looks dim and probably can't be changed
- _____ I have not achieved much in life
- _____ People like me deserve the problems they have
- _____ I often feel like a failure
- _____ I feel responsible for problems at work that probably aren't my fault
- _____ If something goes wrong, it's probably my fault

8/DTC

- _____ I can't seem to focus on my thoughts or tasks lately
- _____ My thoughts are not logical
- _____ I feel like I don't know what to do anymore
- _____ My thoughts are so scattered I forget what I was doing or thinking
- _____ I can't even focus on my job anymore
- _____ At times I think I am loosing my mind

9/TDS

- _____ Lately I have been thinking about death more frequently
- _____ I have recently though about suicide
- _____ I have recently attempted suicide
- _____ I think about sleeping and just never getting up
- _____ I have thought about how or when I would kill myself
- _____ If I don't feel better, I am afraid I might consider suicide
- _____ I think others would be better off or happier if I were dead
- _____ If I died, nobody would even miss me
- _____ I wish I would have a serious accident or be killed

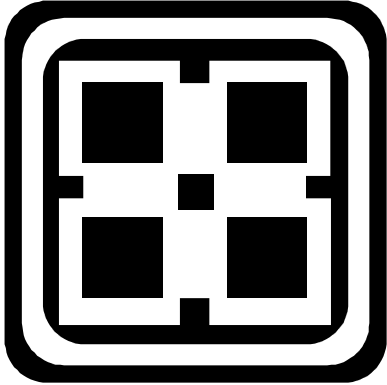
DO NOT
WRITE
IN THIS AREA

1 DEP
4 DIM

____ WGL
2 IHF
____ PMA
2 FLE
____ FWG
____ DTC
3 TDS

TOTAL:
____5____

A-NDI



 Client

 ID Number

 Date

NONGARD ADOLESCENT DEPRESSION INDEX

Instructions:

The following two pages ask questions about your thoughts and feelings. Place an (X) or a check-mark next to any statement that describes your feelings or thoughts, **during the past two weeks**. Answer the questions as they are written, relating to your thoughts or feelings of depression.

Please be honest in your responses. Most individuals will identify with at least some of the statements. Answering honestly will allow your counselor to provide you with important feedback.

This inventory has several sections. You may have nothing checked in some areas and multiple check marks in other areas. When you have finished, your counselor will go over the answers with you.

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1/DEP

- I almost always feel sad
- I usually feel bored with life
- I often feel as if I am depressed
- Most of the time I feel unhappy
- People often ask me if I am O.K. or if something is wrong
- Strangers sometimes tell me to smile
- I am frequently told to cheer-up
- Other people think I am depressed
- I am grumpy or irritated a lot
- I probably make others feel depressed

2/DIM

- I have lost interest in my friends
- Most of the time I'm not interested in going anywhere
- I have stopped doing things I used to enjoy doing
- I do not finish daily tasks (e.g. getting dressed for the day, making phone calls)
- People ask me why I don't do anything anymore
- School activities are boring
- I feel overwhelmed and unable to do things I used to do
- I'm no longer interested in fun things
- I recently stopped attending extra activities or clubs
- I don't do much other than sit around the house

SAMPLE COPY ONLY — NOT LICENSED FOR OFFICIAL USE**3/WGL**

- I'm not on any special diet to gain or loose weight, but I have anyway
- Although I have not been trying to gain weight, I have gained 5 or more pounds
- Although I have not been trying to loose weight, I have lost 5 or more pounds
- I have recently been eating more snacks
- I have been gaining weight, but my diet has not changed
- I have been loosing weight, but my diet has not changed
- I have been not been eating lately
- Nothing tastes good anymore
- I have recently been eating the same thing over and over with little variety

4/IHF

- It's been harder than usual for me to wake up almost every morning
- It's been harder than usual for me to fall asleep almost every night
- I wake up several times during the night
- I am tired during the day
- I have been napping almost every day
- I am tired, but have too much on my mind to sleep
- I wake up too early and can't get back to sleep

5/PMA

- ___ I have been very restless and can't sit still
- ___ My speech has been slow or slurred for no reason
- ___ I find myself pacing or moving from place to place
- ___ It takes me longer than usual to answer a question or complete my thoughts
- ___ I have been shaky or felt "my nerves frazzled" in recent situations
- ___ I am more fidgety than usual
- ___ I feel periodic muscle spasms or twitches for no apparent reason
- ___ I have been asked by others to sit still or told to relax frequently

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6/FLE

- ___ I have been tired almost every day
- ___ I always feel fatigue
- ___ Even when I sleep I don't feel rested
- ___ I run out of energy easily
- ___ I am too tired or lack enough energy to do things I used to
- ___ My body almost always feels tired
- ___ I am so exhausted I can't think or do anything

7/FWG

- ___ I feel like my problems will never end
- ___ I do things wrong most of the time
- ___ If anything can go wrong it probably will
- ___ I can't do anything right
- ___ The future looks dim and probably can't be changed
- ___ I have probably won't achieve much in life
- ___ People like me deserve the problems they have
- ___ I feel like a failure often
- ___ I feel responsible for problems at school that probably aren't my fault
- ___ If something goes wrong it's probably my fault

8/DTC

- ___ I can't seem to focus on my thoughts or school lately
- ___ My thoughts are not logical
- ___ I feel like I don't know what to do anymore
- ___ My thoughts are so scattered I forget what I was doing or thinking
- ___ I can't even focus on my classwork anymore
- ___ At times I think I am losing my mind

9/TDS

- ___ Lately I have been thinking about death more frequently
- ___ I have recently thought about suicide
- ___ I have recently attempted suicide
- ___ I think about sleeping and just never getting up
- ___ I have thought about how or when I would kill myself
- ___ If I don't feel better I am afraid I might consider suicide
- ___ I think others would be better off or happier I were dead
- ___ If I died nobody would even miss me
- ___ I wish I would have a serious accident or be killed

**DO NOT
WRITE
IN THIS AREA**

__1__ DEP
__4__ DIM

__2__ WGL
___ IHF
___ PMA
__2__ FLE
___ FWG
___ DTC
___ TDS

TOTAL:
__4__

Examples of Scoring and Interpretation

It is important that scoring is not based on the quantity of responses within each area, but on the total number of divisions where responses were recorded.

The following samples should help you with the scoring and interpretation of both the NDI and the A-NDI.

Remember, the TOTAL is the total number of areas that have responses, NOT the total number of responses. Although most clinicians record the number of responses in each area, this is only to assist in developing opinions on the severity of condition, and for determining specific life areas which need intervention.

<u>DO NOT WRITE IN THIS AREA</u>		
2 DEP	_1_ PMA	_1_ TDS
3 DIM	___ FLE	
___ WGL	_3_ FWG	TOTAL: _5_
___ IHF	___ DTC	

Responses were recorded in areas DEP, PMA, TDS, DIM, and FWG.

Because responses were recorded in five or more areas, this indicates that the client identifies himself with symptoms meeting the DSM-IV criteria for depression.

Note the high levels of emotional symptoms, with few physical symptoms.

<u>DO NOT WRITE IN THIS AREA</u>		
___ DEP	_3_ PMA	___ TDS
___ DIM	___ FLE	
2 WGL	___ FWG	TOTAL: _2_
___ IHF	___ DTC	

This client responded positively to responses in less than five areas.

Even though several responses were noted in WGL and PMA, the criteria for Major Depression are not met.

Continue to explore other causes of these symptoms and use additional methods to confirm a rule-out of depression.

<u>DO NOT WRITE IN THIS AREA</u>		
___ DEP	___ PMA	_4_ TDS
2 DIM	_1_ FLE	
1 WGL	_3_ FWG	TOTAL: _8_
2 IHF	_4_ DTC	

In this example, high levels of thoughts related to death and suicide are noted (TDS), along with many other areas of depressive symptoms.

Because the NDI is not a suicide evaluation tool, additional screening beyond depression levels specifically looking at suicide should be undertaken.

The NDI: Nongard Depression Index Adult and Adolescent Versions *A Preliminary Screening for Depression*

About the Author's Intent

The Nongard's intent behind the **NDI** is to help provide professionals with an economical, practical, simple and accurate preliminary screening of depression, for both adults and adolescents.

It is true that many other quality depression screening tools are available to professionals. However, very few have been designed as simply and effectively as the **NDI** for ease in administration, completion, scoring and interpretation, in a format that follows the DSM-IV diagnostic criteria for Major Depressive Episode.

Author's Note Regarding the Use of the NDI

While the concepts regarding the use of the **NDI** should be quickly and easily understood by virtue of its design, it is essential that the facilitating clinician thoroughly read through the entire instruction manual.

This is to insure proper performance in administration, completion, scoring and interpretation of the **NDI**, and to yield more accurate and useful testing results.

About Using the Nongard Depression Index (NDI)

The screening and interpretation of the **NDI** should provide the clinician with knowledge regarding the presence of Major Depressive Episode, as clinically defined by the American Psychiatric Association's (API's) reference *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV), and should also reveal basic knowledge related to the current severity of the client's condition.

As a screening tool, the **NDI** was not designed to make an independent definitive diagnosis of Major Depression without use of additional data collection methods, such as clinical interviews and further assessment practices.

The function of the **NDI** is to serve as an effective preliminary screening tool for initial impressions, which upon careful interpretation, may or may not indicate the need for additional client evaluation and assessment in the area of Major Depression.

Unlike other commonly used self-reports, the scoring of the **NDI** carefully follows the APA's DSM-IV criteria for Major Depressive Episode it's clinical interpretation. This qualification elevates the usefulness of the **NDI** to a highly practical and valuable assessment tool for those professionals needing clinical data specifically related to DSM-IV criteria, such as those engaged in diagnostic practices and those providing data to managed care and third-party payers.

The **NDI** is available in two standard formats: an Adult Version and an Adolescent Version.

In some instances the professional administering the **NDI** may appropriately choose to present the adolescent version to younger adults who may be at a younger level socially or developmentally, or vice-versa for higher functioning adolescents, as determined by relevant individual assessment factors.

The DSM-IV makes no differentiation in the determining criteria for Major Depressive Episode based on age, and thus the scoring and interpretations of both forms are conveniently identical.

The overall content and concepts of the questions are the same in both the **NDI-Adult** and **NDI-Adolescent** versions. The adolescent questionnaire differs only slightly by containing similar questions that have been modified for age appropriateness, in order to assist this specific population in identifying characteristics that are found to be typical of adolescent depressive symptoms.

Another characteristic of the **NDI** that makes it a practical preliminary assessment tool, is its dual capability of screening both the symptoms of depression and providing information regarding suicidal ideation, plans and intent, without the need for multiple or variable forms.

The structure of the **NDI** is self-report, via an "anonymous survey" format. A series of statements are made and these are divided into 9 categories based on DSM-IV Major Depressive Episode diagnostic criteria. The client is asked to respond by marking only those statements which may describe their thoughts and feelings within a two-week period.

NDI scoring and interpretation is then performed by the clinician, based on the statements identified by the client.

Thorough clinical interviewing should always follow scoring and interpretation of the **NDI** and all other screening materials, to ensure clarity and accuracy of testing results.

Administration of the NDI

The interviewer or client should complete the client information section in the top right corner of the front cover of the **NDI**. This information is placed in this position for ease when indexing and retrieving completed **NDI** forms.

Testing instructions are conveniently printed on the front cover page of the **NDI** and can either be read by the client, or read to the client.

The **NDI** can be either administered with the interviewer reading each individual statement to the client and marking the affirmative responses, or by the client reading each statement and placing a mark next to those statements describing their thoughts, feelings and behavior in the past two weeks.

The **NDI** statements are divided into 9 sections. This is for ease in interpretation and scoring. Clients may mark one or several statements in each section, or they may not mark any statements within a section.

Administration of the **NDI** should be completed within a short period of time, with the clients responding to the statements simply as they appear. Individual statement interpretation should only be discussed during a clinical interview, after the **NDI** has been scored and interpreted.

Because of the design of the **NDI**, it is possible that a significant other, such as a spouse or parent, could provide **NDI** screening information based on their observations of a client. Although this would not produce clinically definitive results, for the non-compliant client it could possibly provide useful screening information that otherwise can not be easily obtained by the client themselves.

Additionally, many clients who have not yet had the opportunity to develop a relationship with an interviewer may be inclined to respond to the statements on the **NDI** with a greater level of honesty and openness than they would in an initial interview, due to the "anonymous survey" format.

Diagnostic Criteria of the NDI

The **NDI** is divided into nine sections, based on DSM-IV Major Depressive Episode diagnostic criteria.

- | | |
|--------------|---|
| 1/DEP | Depressed Mood |
| 2/DIM | Diminished Interest or Pleasure |
| 3/WGL | Weight Gain or Loss |
| 4/IHF | Insomnia or Hyperinsomnia |
| 5/PMA | Psychomotor Agitation |
| 6/FLE | Fatigue or Loss of Energy |
| 7/FWG | Feelings of Worthlessness |
| 8/DTC | Diminished Ability to Think or Concentrate |
| 9/TDS | Thoughts of Death or Suicide |

Explanation of Diagnostic Criteria

The NDI contains nine corresponding criteria sections of common statements that are found to be typical of the depressed person experiencing depressive symptoms.

The DSM-IV defines Major Depression when an affirmative presence of five or more of the above listed criteria exists.

The presented statements in each **NDI** section do not comprise an exhaustive list of symptoms or problems.

Those who fail to identify with the presented statements on the **NDI** may be non-compliant, lack insight or may truly not identify with these common statements and may be better served by completion of other screening and testing tools.

And, it is always possible that they simply may not identify with the statements because they are not depressed.

1/DEP *Criteria:* **Depressed mood most of the day, every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). *Note:* In adolescents, can be irritable mood.**

This set of questions will identify feelings of depressed mood occurring most of the day. Although many individuals feel situational depression, the key here is a pervasive feeling of depressed mood. Emptiness (or irritability in children), or sadness through most of the day.

The questions ask the client for self-observation of emotions, and to identify situations that might indicate they are frequently or usually depressed.

Adolescents and children may not readily identify the feelings of depression or sadness, and may instead frequently report feelings of boredom or irritability. Irritability is different than aggressiveness, and is often characterized by restlessness and feelings of anger.

2/DIM **Criteria:** **Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by subjective account or observation by others).**

This set of **NDI** statements is used to help identify those who begin to lose interest in experiencing usually pleasurable activities, or in completing routines tasks. This is a condition that is nearly always present, at least to some degree, with the Depressed person.

Individuals may report a decrease in social interaction and expression of communication, may stop completing necessary tasks or may fail to complete projects that had previously been of interest.

Religious expression, interest in sexual activity, school or work related activities and many areas of healthy functioning are often impacted by depression.

3/WGL **Criteria:** **Significant weight loss when not dieting, or weight gain (e.g., +/- 5% change in body weight in a month), or decrease or increase in appetite nearly every day.**

This set of questions is used to identify those who are experiencing symptoms of depression as manifested by significant appetite and/or weight changes.

The focus of these questions is on recent *unintended* weight gain or loss. This is a frequent symptom of depression, as physical health and needs are often neglected. Additionally, many clients find food to be a source of psychological comfort; bringing a feeling of fullness or satisfaction among the depression.

Weight gain or loss, even when pathological, is not necessarily a symptom of depression. Those with responses checked in this area should be screened for eating disorders and other problems if a definitive diagnosis of depression is not made.

4/IHF *Criteria:* Insomnia or hyperinsomnia, nearly every day.

This set of **NDI** statements is used to identify the person experiencing symptoms of depression as manifested by a disruption in normal sleeping patterns.

Insomnia is the most common sleep disturbance associated with depression. Less frequent is hypersomnia (oversleeping), manifested by prolonged sleep episodes at night, or increased daytime sleep.

Like the preceding criteria, sleep disturbances can be a physical manifestation of depressive symptoms, as self-care and physical well being are neglected as the depression progresses.

**5/PMA *Criteria:* Psychomotor agitation or retardation nearly every day
(observable by others, not nearly subjective feelings of
restlessness or being slowed down.**

These **NDI** statements are designed to help identify behavior indicating the physical, or psychomotor symptoms of depression.

Characteristic psychomotor changes may include agitation (e.g., inability to sit still, pacing, hand-wringing, or pulling or rubbing of the skin, clothing or other objects), or retardation, (e.g., slowed speech, thinking and body movements, increased pauses before responding, speech that is decreased in volume, inflection, amount or variety of content, or even muteness).

The psychomotor agitation or retardation must be severe enough to be observable by others, and not represent merely subjective feelings.

6/FLE *Criteria:* Fatigue or loss of energy, nearly every day.

These statements indicate the client's depressive symptoms as manifested by common characteristics such as decreased energy, tiredness, and fatigue.

Fatigue can be characterized as mental exhaustion, physical tiredness and feelings of low energy. Frequently this stems from changes in diet or sleeping associated with depression, and it is another physical manifestation of the illness.

Again, the key here is a pervasive feeling of fatigue, nearly every day. This is important since most individuals feel some fatigue each day, but usually in the evenings, after performing difficult tasks or when dealing with specific situations.

7/FWG **Criteria:** **Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional), nearly every day, (not nearly self-reproach or guilt about being sick).**

This sense of worthlessness or guilt (e.g., "I can't do anything right") may include unrealistic negative evaluations of one's worth or guilty preoccupations or ruminations over minor past feelings.

When clients believe that they can not do anything right, are the cause of other problems, or that they are responsible for situations beyond their control, guilt can consume much energy. These misbeliefs, coupled with fatigue, often bridge into feeling of hopelessness and worthlessness.

8/DTC **Criteria:** **Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).**

Many depressed individuals report impaired ability to think, concentrate or make decisions. This may also include brief periods of memory loss, difficulty completing tasks or failure to meet responsibilities that have been met in the past.

Often depression is coupled with feelings of anxiety or of making situations even worse, and as a result, indecisiveness becomes an issue as decision making capabilities are impaired.

Poor work performance, lower school grades and other irritation at these symptoms can cause problems for the depressed individual.

9/TDS **Criteria:** **Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation with out a specific plan, or a suicide attempt, or a specific plan for committing suicide.**

This set of **NDI** statements is designed to identify those persons who have thoughts about death or suicide in a manner inconsistent with an otherwise healthy individual.

The **NDI** is not designed to specifically diagnose a client's risk for suicide. The purpose of these sections is to fulfill the DSM-IV's criteria for major depression, and to provide a preliminary subjective assessment of the client's thoughts in this area.

If a client is depressed, and especially if they do mark that they identify with any statements in this area of the **NDI**, a complete thorough clinical interview should accompany this screening to evaluate the client's suicidal thoughts, plans, means and intentions.

Scoring and Interpretation of the NDI

At the end of the **NDI**, a boxed area ‘for clinician use’ is displayed. The clinician will count each affirmative response made in each section, and then place that total on the line next to the appropriately corresponding section code.

The presence of multiple checks in a division should provide the interviewer with an idea as to the types of problems that the client has experienced as a result of their depression, and should also indicate the potential level of severity of the client's condition. It can also provide information valuable in further assessment relating to suicidal ideation.

However, for scoring purposes, any area that has at least one mark will be considered a positive response to that division.

Count the total number of divisions that have received affirmative responses. These affirmatively marked sections are the problem areas that the client has identified for himself as being symptomatic of the DSM-IV Major Depressive Episode criteria.

If *five or more* of the nine divisions are affirmatively marked, even if by only one identified statement in a division, the client has identified himself as experiencing symptoms typical of those with a diagnosis of Major Depressive Episode.

Important NDI Scoring and Interpretation Note:

Because the **NDI** is a preliminary screening tool for the diagnostic criteria of depression it is not inclusive of all of the symptoms a depressed person might experience.

Non-depressed persons may also occasionally be able to affirmatively respond to one or more statements in any number of sections. These persons could include those who have other problems with symptoms similar to Major Depression. Consult the DSM-IV sections of differential diagnosis.

Through clinical interviews encompassing all potential symptomatic problem or conflictual areas of a person's life should always accompany any screening or assessment tool, as they play an important role in the accurate diagnosis of any condition.

Additional screenings and evaluations should be completed if depression is suspected but not readily identified through use of the **NDI**.

A-NDI Adolescent Version

This manual contains both the **Adult-NDI** and the *Adolescent-NDI* versions.

The adolescent form is differentiated as the **A-NDI**.

Because no difference exists in the scoring or interpretation of the **A-NDI** from the adult version, the preceding instructions should be followed for both versions.

You may notice, however, that the language of the adolescent version has been only slightly modified, to present a more accurate reflection of the feelings and experiences of adolescents.

SECTION III

INTERVENTIONS AND TREATMENT FOR MAJOR DEPRESSION:

The focus of this continuing education course has been on the assessment of major depression, not on the treatment of major depression. However, I want to mention some issues related to the treatment of major depression from my observations.

My first observation is simple: when I take care of myself, I feel emotionally healthier. Many clients who are depressed fail to adequately provide themselves with necessary sleep, self-care and nutrition. I have found that even when life is difficult, if I eat 3 nutritious meals a day (including those veggies) and if I get 8 hours of sleep, I feel a lot healthier emotionally. Addressing the physical aspects of our client's major depression is important.

In the world of psychiatry, psychotropics are often the tool used to help a person overcome depression from a physical perspective. I am firm believer that while psychotropics can be beneficial to many clients who are clinically depressed, we are all actually comprised of much more than the sum total of our serotonin and dopamine receptors. Therefore, it is essential to look at basic self-care, and perhaps create interventions that can assist our clients in developing healthy patterns of sleeping, eating, and just taking care of themselves in general.

In treating our client's major depression, it is important to address the spiritual aspects of wellness, as well as the physical aspects of wellness. From a spiritual perspective, many clients who are depressed seem to be without meaning. Probably at one time or another we have all felt that life was meaningless. Certainly the writer of the book of Ecclesiastes found this to be true, as he proclaimed, "Vanity, vanity, all is vanity." But those who do not have their spiritual needs met are those individuals who often feel incomplete, unfulfilled and dissatisfied, and this is therefore an important area to address in treatment.

No psychotropic medication can address these issues. Although religion can be a way for many clients meet their spiritual needs, in this context, I am talking about something much broader. I am not talking about something that can get a client into heaven or out of hell, but rather something that can met their deepest needs for security, significance, belonging, and as William Glasser said, "To love other people and receive love in return". A client who is without hope is a client whose spiritual needs are not being met.

Addressing the social issues of our clients depression is equally important. People who are isolated find they only have themselves to talk to, and the person who is depressed often says self-defeating things. Cognitive-behavioral therapy can be particularly useful with the person whose isolation has become a complicating factor in their major depression.

Additionally, I have found that teaching the remedial skills of developing healthy interpersonal relationships are equally as important in the treatment major depression as cognitive-behavioral strategies.

Teaching clients assertiveness training, helping them to understand positive communication patterns and to take risks in developing interpersonal relationships through communication strategies, can all be tools for assisting the client in meeting their social needs. Also, challenging clients to become not just an observer of life, but a part of something by actually joining or starting various clubs, can be a tremendous asset.

I had a depressed client who always wanted to be a writer. She dreamed about being on the best-seller list, and she was depressed because her novel had not yet been written. She had many ideas for stories and books, but nothing had been published, mostly because she just didn't know what to do. She didn't know anyone else who wrote, or who had ever been published. I encouraged her to meet other writers, to join a writer's group and to become a part of something. Amazingly, not only did she do this, but she did it in spades. She found that the only writer's group in town wouldn't meet her needs, so she started her own. She became friends with the members, and made a point to call at least one of them every day. Eventually, she discovered that not only was she becoming successful in her writing career, but that the friendships she made were lifelong healthy relationships, able to assist her during times of difficulty.

For the depressed person, taking action such as this is usually the exception rather than the rule. But for clients who can be encouraged to take advantage of or even to make opportunities by developing a connection to the community in which they live - through church, professional associations, neighborhoods and family systems - they discover that even though sometimes life situations don't go their way, they are able to function in a healthy and happy way, anyway.

SECTION IV

CONTINUING EDUCATION

We hope that his continuing education course has been useful to you. As stated, the focus of this course has been on assessment rather than treatment. Professionals interested in further continuing education on the treatment of major depression, suicide and bipolar disorder would be well served by taking a look at some of the other courses we offer, including:

- (1) Bipolar Disorders, a 3-hour audio CD course
- (2) Anger, Anxiety and Depression, a 3-hour audio CD course
- (3) Suicide Intervention and Prevention, a 3-hour audio CD course
- (4) Advanced Anger and Depression, an 18-hour Specialty Certification program, focusing on the medical aspects of major depression and a specific set of strategies designed to assist the angry and depressed client.

These courses overview the general diagnostic criteria for proper assessment, but concentrate primarily on developing effective treatment strategies and targeted interventions.

Please contact our office at **(800) 390-9536** for additional information on Specialty Certification, or check out our website at www.FastCEUs.com

THANK YOU FOR YOUR PARTICIPATION IN THIS COURSE

To receive continuing education credit for this course, you must have read this entire text file.

You must also complete and return the Evaluation of Learning Quiz and pay the CEU fee. (Instructions are on the next page.)

We always appreciate constructive input from our customers - even when it's 'negative', so please feel free to fill in the "Additional Comments" section of the Grade This Course evaluation when you submit your quiz and payment.

*Richard K. Nongard, LMFT, CCH, CPFT
Executive Director*

"ASSESSMENT FOR MAJOR DEPRESSION

- USING THE N.D.I."

3 Continuing Education Clock Hours

Procedures to Receive CEU Credit:

- This document contains all of the course materials you needed to read.
- Now you must complete the required True/False Evaluation of Learning Quiz and submit it to our office along with your payment, in order to obtain your CEU certificate.

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Go back to www.FastCEUs.com and click the "QUIZ & PAY" link for this course.

On the page that opens, enter your information and take the T/F Quiz. When you click SUBMIT, the program will instantly grade your quiz, and provided you pass by at least 80%, it will then charge your credit or debit card.

Immediately, a new web page will open containing your Receipt and Certificate info, and a Link will be provided to access a fancy Certificate for you to Print and/or Save to your computer.

You will also receive an Email containing this same information and the link.

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Print the Quiz and Payment forms on the next few pages of this document, and complete the requested information.

Our 24-hour secure Fax number is **(888)-877-6020**.

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We process faxes within approximately 4 business hours after receiving them. Faxes submitted late in the day or after hours will be processed the next business morning. However, all certificates are dated the date we receive your course quiz and payment.

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EVALUATION OF LEARNING QUIZ - PAGE 1 of 3

PRINT & FAX or MAIL THIS PAGE AND THE ANSWERS PAGES TO OUR OFFICE

*** * * * OR * * * ***

You may complete and submit this information **ONLINE** by following this link:

<https://www.fastceus.org/index.php?extension=ndi-depression>

PLEASE NEATLY PRINT THE FOLLOWING INFORMATION:

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ASSESSMENT FOR MAJOR DEPRESSION - USING THE N.D.I.

This **3** Hour CEU Course is **\$49.00**

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EVALUATION OF LEARNING QUIZ - PAGE 2 of 3

Course Title: "ASSESSMENT FOR MAJOR DEPRESSION: Using the NDI"

3 Hours of Approved Continuing Education Credit

☞ PLEASE ANSWER THE FOLLOWING EVALUATION OF LEARNING QUESTIONS.

- T F** 1.) I have read all of the required reading for this course.
- T F** 2.) I have completed a self-administration of the NDI
- T F** 3.) Major depression is one of the most frequently seen diagnoses affecting adults, adolescents and children.
- T F** 4.) The psychiatric patient, with a diagnosis ranging from schizophrenia to impulse disorders, rarely presents with a simultaneous diagnosis of major depression.
- T F** 5.) The assessment of depression is not simple.
- T F** 6.) 5 out of 7 criteria must be met for a diagnosis of Major Depression.
- T F** 7.) If a client is suicidal, a diagnosis of Major Depression can be made without requiring two weeks of symptomology.
- T F** 8.) Anyone reading the diagnostic criteria for depression will see that they meet some of the criteria on a regular basis.
- T F** 9.) The 3 week time prohibition in the DSM-IV is there for a specific reason.
- T F** 10.) When we use the label 'major depression', we are actually calling somebody 'diseased', we are calling them 'sick'.
- T F** 11.) When we diagnose an individual with a psychiatric illness, there can be life-long ramifications of that diagnosis
- T F** 12.) As clinicians, we have a responsibility to know and use the criteria in the DSM-IV responsibly and ethically.
- T F** 13.) One of the most widely used tools to assess client depression is the Beck Depression Inventory.
- T F** 14.) Most effective use of a self-report is with the compliant client, or the client who is motivated to seek treatment.
- T F** 15.) The NDI is designed to replace all other screening tools for depression.
- T F** 16.) One benefit of the NDI is being able to provide the client with feedback concerning their progress.
- T F** 17.) Psychotropics can be beneficial to many clients who are clinically depressed.
- T F** 18.) Religion is a way many that clients can meet their spiritual needs.
- T F** 19.) Many clients who are depressed fail to adequately provide themselves with necessary sleep, self-care and nutrition.
- T F** 20.) Teaching clients assertiveness can be a tool for assisting them in meeting their social needs.

GRADE THIS ONLINE COURSE! – Page 3

It is helpful to us if you return this form via snail mail or fax, along with your Quiz & Payment. Thank-you!

Participant Assessment of Home Study CEU Course

ASSESSMENT FOR MAJOR DEPRESSION
- USING THE N.D.I.

3 Credit Hours

Please Rate the Following Statements from 1-5
(1 being the Lowest, 5 being the Highest.)

- _____ 1. I found the PeachTree Online Home Study Course Instructions simple to follow.
- _____ 2. I found the PeachTree Online Home Study Course materials to be of professional quality, and easy to read.
- _____ 3. I found the PeachTree Online Home Study Course materials to be of educational value, relative, and useful to my counseling practice.
- _____ 4. I completed the 3 Hour PeachTree Online Home Study Course in approximately 3 hours.
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