DOCUMENT RESUME

ED 189 492 CG 014 517

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TITLE Conceptual and Clinical Issues in the Psychotherapy of Elderly Depressed Persons.
PUB DATE Jun 78
NOTE 18p.; Paper presented at the Society for Psychotherapy Research (Toronto, Canada, June 1978). Best copy available.

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Behavior Modification; Case Studies; Cognitive Processes; Counseling Techniques; *Counselor Attitudes; Counselor Role; *Depression (Psychology); *Intervention; *Older Adults; *Psychotherapy; State of the Art Reviews; Therapists

ABSTRACT

Numerous studies report that depression is the most common psychiatric disorder of the elderly. According to the behavioral view, depression results from inadequate, ineffective or insufficient positive reinforcement. In contrast, the cognitive position sees depression as a result of negative thinking about oneself, one's experience, and the future. Both behavioral therapy and cognitive therapy can successfully be used as effective therapeutic tools with depressed elderly persons. However, it is unlikely that either of these treatments is adequate or sufficient to treat all depressions of old age. Great variability is a consistent finding in research on the aging, which makes it necessary to remain flexible in determining the problem and selecting an intervention appropriate for the client. Additionally, it is necessary that the therapist feel that older persons can learn new behaviors and cognitions, and that they can respond to the same therapeutic principles as younger persons. (Author)

CONCEPTUAL AND CLINICAL ISSUES IN THE PSYCHOTHERAPY OF ELDERLY DEPRESSED PERSONS

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Paper prepared for inclusion in the Symposium chaired by Allen Raskin, Ph.D., National Institute of Mental Health, entitled: Psychotherapeutic Approaches with the Elderly. Presented at the Society for Psychotherapy Research, Toronto, Canada: June, 1978.

The aim of this paper is to integrate knowledge about the aging process with current developments in the psychological treatment of depression. The first section will present several theoretical issues derived from both the gerontological and depression literatures. The second section consists of observations of some problems and issues the clinical researcher is likely to encounter when attempting to study psychotherapy with depressed elderly persons.

To begin with, numerous studies have reported that depression is the most common functional psychiatric disorder of the elderly. Peak (1973) estimated that between 21 and 45% of persons over 65 seen in outpatient clinics are depressed. Lowenthal & Berkman (1967) found that the majority of respondents in their San Francisco community survey reported depression as a significant problem in their lives. Despite this fact, the elderly make up a very small proportion of outpatient users of mental health facilities. This may be due to two complementary factors: reluctance on the part of the present generation of older persons to seek mental health treatment, and resistance on the part of professionals to treating the aged with psychological kinds of interventions. Thus, it may be difficult for the elderly person to appropriately self-label his subjective experience as depression. It is equally difficult for the professional to accurately diagnose this condition. In addition, the aging literature indicates wide inter-subject variability on virtually all behaviors measured, and depression is no exception.

Clinicians working in this area will be struck by the great differences in both causes and manifestations of depression

in the elderly. For example, depression resulting from psychosocial losses such as a job or death of a spouse is qualitatively not the same as depression experienced concomitant with physical illness such as cancer. Therefore, they cannot be classified under one umbrella label, nor can they be treated with one kind of therapy. Depression in the old is not a unitary phenomenon, and this point must be appreciated by the clinician attempting to work with this problem.

Related to this is the problem of reliably diagnosing depression in the elderly, which is a difficult procedure because of the lack of normative information for this age group. Typically, the elderly are evaluated in terms of criteria developed for the young, yet the comparative research has not been done which compares the structural properties of depression across the life span. The elderly are also more often viewed as having an organic brain syndrome than the young with comparable symptoms, as Gurland (1976) observed from data obtained during the cross-national diagnostic study of practices in this country and the United Kingdom. Gurland (1976) found that psychiatrists doing blind ratings on symptoms more frequently diagnosed depression in persons under 65 and OBS in those over 65, despite the fact that the symptoms were identical. Thus age bias interacts with the lack of normative data to provide a confusing picture on this issue. In addition, Epstein (1976) has pointed out that no single schema has been found to be truly satisfactory for the classification of older depressed persons. It is often not clear what the precipitants are, and whether there are significant differences between depressions that appear for the first time in the sixth or seventh decade as compar d to

those that are probable recurrences of affective disorders from earlier life. There is also real confusion among practicioners and researchers alike as to how to distinguish between complaints due to normal aging and those which truly reflect a clinical depression (cf. Gaitz, 1977). For example, sleep disturbances, low energy level, reduced activities, and feelings of loneliness are often regarded as normal concomitants of aging, and it is difficult to determine in what instances their presence and/or intensity should be regarded as "clinical" symptoms of an underlying psychological disturbance. Since these same symptoms may also reflect any of a number of physiological problems common to the old, their significance can only be evaluated within the context of the person's overall physical and mental status.

Finally, when we look at self-report measures of depression to help us index this problem, we find similar confusion and unreliability. As Schaie & Schaie (1977) have noted, such measures have been developed on younger groups and their validity and reliability with the elderly still need to be demonstrated. For example, although the Zung Self-Rating Depression Inventory (Zung, 1965) is the most widely used self-report measure for this age group, a number of researchers are currently pointing out its limitations with the elderly (cf. Blumenthal, 1975; Steuer & Bank, 1978; Gallagher, Thompson & Zelinski, 1978), and suggesting modifications of procedure that may make it more useful for assessment purposes.

In addition to these real problems with diagnosis, there is a related issue of theoretical concern; namely, the absence of <u>models</u> developed specifically to account for (or even describe)

the depressions of old age. In the literature there are a number of models that have been postulated to account for depressions appearing earlier in the life span, such as the psychoanalytic, behavioral, neurochemical, cognitive and sociological positions, to name a few. Akiskal & McKinney (1975) review these and conclude that depression may best be regarded as a final common pathway, with elements drawn from a number of these views. However, no model has been presented specifically to address the origin and nature of depression in the elderly.

In reviewing the models currently in the field, it is our opinion that there are two which hold promise for understanding and treating this problem in this age group. These are the behavioral and cognitive positions, which are theoretically appealing when viewed in light of current knowledge about the aging process. They will be briefly presented, followed by discussion of their potential apllicability to the diagnosis and treatment of depression in the aged.

According to the behavioral model, depression results from inadequate, ineffective, or insufficient reinforcers. A number of theorists have developed this position (cf. Ferster, 1965; Lazarus, 1968; Costello, 1972 and Lewinsohn, 1974), but Lewinsohn's work is well-articulated and has led to substantial research in terms of treatment outcome. Lewinsohn's basic assumption (cf. Lewinsohn, Weinstein & Shaw, 1969) is that depressive behaviors and associated dysphoric feelings are elicited by a low rate of response-contingent positive reinforcement. He has shown that this is related to two main factors (in the young at least) which are: inadequate social skills (such as narrow interpersonal range, depressive talk, and unassertiveness), and a notable decrease in the frequency

and enjoyability of everyday activities. Either or both of these would reduce the person's ability to obtain positive reinforcement from the environment, thereby inducing depressed feelings. It follows that therapy should be focused on increasing the rate of positive reinforcement obtained from the environment; in fact, Lewinsohn and his colleagues have reported a number of studies in which positive therapeutic benefit obtained from using this approach. These are summarized in Lewinsohn, Biglan & Zeiss (1976).

In contrast, the cognitive position as developed by Beck (1963, 1964, 1967; and Beck & Rush, in press) sees depression as resulting from an interactive negative triad comprised of negative views about oneself, one's experience, and the future. This in turn leads to distortions in the way the individual takes in information and structures his experience. For example, such logical distortions as arbitrary inference, overgeneralization, and exaggeration of negatives with concomitant minimization of positives would typify the depressed person's thinking, and would not be questioned by the individual because of his systematic negative bias against himself. Therefore, Beck, Rush, Shaw & Emery (1978) advocate that therapy for depression should focus on modification of these thinking patterns, which is accomplished by correcting distortions and their underlying attitudes and beliefs. The emphasis is on the hypothesized internal events that mediate depressive behavior, and not on the overt behavior as in Lewinsohn's approach.

These models now need to be related to theoretical knowledge about the aging process in order for their utility to become clear. Lewinsohn's emphasis on interpersonal events and social skills

relates very well to recent theories in social gerontology, especially the activity theory (Maddox, 1970), which emphasizes the importance of maintaining an active life-style as one ages in order to maintain a sense of well-being. This is in contrast to the disengagement view (Cumming & Henry, 1961) which saw normal aging as a process of mutual withdrawal of the individual and the social system. In fact, the nature of our present social system is such that as persons age, they are typically removed from many roles that have been critical to the development and maintenance of their self-esteem. According to activity theory, a healthy older person actively engages in compensatory behaviors to offset these losses, and if successful, he will maintain a positive self-concept. An important determinant of success in this venture may well be the person's level of social skill, so that competence in this area should encourage greater participation in the activities that are available. Therefore, it seems reasonable that treatment that focuses on improving social skill and activity level should be helpful in reducing depression, or perhaps even in preventing its occurrence.

Now looking at aging from a cognitive perspective, the literature is replete with examples of decline in efficiency of cognitive processing with age (cf. Botwinick, 1973). For example, it is well-known that older persons are less flexible and adaptable in problem-solving laboratory situations than younger persons (Nehrke, 1973). They are less likely to use suitable organizational strategies to form abstract concepts than the young (Rabbitt, 1977) and they also tend to rely on overlearned strategies (even if somewhat inappropriate) if an alternative solution requires

development of complex novel strategies (Nehrke, 1973). Similar age-related trends are seen in personality variables reflecting rigidity, meaning decreased inclination to change familiar habits and to develop new and varied preferences and interest patterns (Kogan, 1973). These changes in cognitive style and processing capabilities may make the elderly more vulnerable to the distortion process which Beck sees as central to the origin and maintenance of depression. If so, then an aggressively cognitive focus in psychotherapy may be very appropriate in treating depression and giving the individual some usable coping skills to ward off future episodes. On the other hand, these same changes may make the elderly less able to participate in and benefit from this kind of approach.

In our opinion, it is unlikely that either of these models are adequate or sufficient to explain or treat all the depressions of old age. As discussed above, great inter-subject variability is a consistent finding in aging research which makes it imperative to be flexible in delineating the problem and in selecting an intervention. Clearly, not all depressed older persons are inactive or are likely to be subject to cognitive distortion. Therefore, while these models provide a rational point of departure for evaluation, treatment and research, it is necessary to evaluate them carefully in controlled studies before conclusions are drawn as to their effectiveness. Such research is currently in progress at two locations in the Los Angeles area and should provide important information when the data are in. It is unfortunately too early to report quantitative results from these studies, but at this point we can describe our collective experience doing psychotherapy with elderly depressives, using these models.

In our experience, behavioral therapy is a powerful intervention technique that can successfully be used with a number of depressed elderly. A case example will illustrate some of the procedures and problems encountered using this model on an outpatient basis. The client is a 72 year old white married male with a 15 year history of depression for which he received a variety of treatments, including several hospitalizations, shock therapy, and numerous psychotropic medications. He reported that he gained only slightly from each of these, and was soon back where he started in terms of severity of his symptoms. When first seen for Intake, he was quite depressed and agitated, was literally homebound in that he had no hobbies or interests to fill his time, and had little contact with anyone other than his wife. He was taking aldamet for hypertension along with 300 mg of mellaril daily. To date, this client has been seen for about 40 sessions and has improved markedly in terms of clinical judgment, his own self-report, and scores on several psychometric measures. Behavioral treatment began by acquiring accurate baseline information which was used to select target behaviors for therapy to focus on. Three targets were identified: increasing his activity level; reducing his dependency on medication; and improving communication with his wife, who had been inadvertently reinforcing much "sick role" behavior by her tendency to expect little positive behavior from her husband. Once the goals were established, each had to be broken down into manageable components, and adequate reinforcers determined. New behaviors were built in slowly in order to ensure success experiences, and to help the client understand the relationship between his behavior and his feelings of depression.

Specific behavioral techniques such as role-playing and

modeling were used to encourage attendance at a senior center and resumption of a specific hobby (oil painting) which he found pleasurable. This seemed to encourage him to gradually decrease medication to the point where he is not now taking any on a regular basis. This was viewed as a major step in the treatment, since it reinforced the notion that depression is not a "disease" to be cured, but a style of life capable of being modified. Eventually, the client's wife was included in counseling sessions designed to improve communication between them. In addition, she was taught to differentially reinforce her husband's adaptive (as compared to maladaptive) behaviors, so that by the time of termination, both had learned and were able to apply relevant behavioral principles.

It should be noted that the length of time involved in this treatment (40 sessions) was longer than what one would typically plan for when using a behavioral approach with younger persons. This seems due to several factors which may be related to the aging process itself, such as the client's apparent difficulty learning new behaviors and then generalizing what he had learned. Also, there were fewer sources of reinforcement available in the environment for him, and these were more intermittent than would usually be the case with a younger client who may have easier access to a potentially positive social network (eg. job, school, interests). Nonetheless, the client's progress was clear and has been sustained for at least a two-month no-treatment follow-up interval.

Cognitive therapy has likewise proven to be an effective intervention with some elderly depressed persons. Again, a case example will illustrate what is involved in the application of this process. The client is a 68 year old white married male who

reported chronic subjective feelings of depression since retirement 5 years previously. He readily acknowledged that he had a number of interests and activities, including purchasing real estate and maintaining properties he owned, as well as frequent socialization in church and recreational groups with his wife. Clearly in his case depression was not due to lack of activity or inadequate social skills. Rather, this seemed to be more an internalized process characterized by severe guilt feelings over early life experiences, much self-blame for presumed failures, and low self-esteem which was not influenced by positive interpersonal experience. In his case, modification of negative cognitions seemed appropriate, along with work on underlying negative attitudes that this client presumably held toward himself. His treatment took approximately 30 sessions, which again is longer than the average length reported for younger depressives.

Treatment began with explicit and detailed identification of his particular cognitive distortions. For example, a frequent one was rumination about past inadequacies (such as not visiting his mother for several Christmas holidays about 20 years ago). This kind of thinking elicited the further cognition that this client was a "bad person" who did not appreciate all his mother had tried to do for him in life, which in turn made him quite tearful and depressed. Alternative ways to appraise the situation were developed with him, with focus on the sequence of thought processes that led him to his negative conclusions about himself. His crying spells diminished as he became adept at identifying the repetitive distortions, and along with this, his self-esteem increased.

However, as was suggested previously with respect to behavioral therapy, certain aspects of the aging process seem to interact with cognitive therapy as well and effect the client's ability to respond adequately. In the case reported, the client found it difficult to be cognitively flexible; it seemed to require a great deal of motivation on his part to cooperate with this kind of treatment and not dismiss it as mere appeal to the "power of positive thinking". Fortunately, he became committed to the process, and was successful at remaining relatively symptom-free when evaluated after a two-month no-treatment follow-up interval. However, a less intelligent or motivated individual may have been unable to benefit from this kind of approach. This issue of cognitive rigidity may be less relevant in the behavioral modality, where treatment occurs on a more concrete level and cognitive processing is not the focus of attention. These case examples suggest that the two models we are discussing are likely to be differentially effective in reducing depression, in the sense that their effectiveness may be attenuated by specific subject variables (such as social skill level and cognitive flexibility at the start of treatment).

Some additional observations can be reported from our experience conducting group psychotherapy with elderly depressives. These groups have been behaviorally oriented and short-term in nature. Following participation in 10 structured sessions, clients' self-reports of depression have gone down significantly, and trained observers perceive a number of behavioral changes in predicted directions. Attendance rates have been high, attrition low, and fairly positive interaction has been noted in

this clinically depressed sample. However, several difficulties are also noteworthy, including clients' reluctance to become involved in techniques such as role-playing in the group; their tendency to be uncooperative in completing homework assignments; and their disappointment that requests for one-to-one sessions were not met. The gerontological literature suggests that group therapy should be highly effective because it offers some degree of solidarity and cohesiveness to persons who typically do not participate in other naturally-occuring groups (Rosow, 1973). Yet despite fairly high levels of cohesion in our groups, the group format was perceived as less desirable than individual treatment and clients complained about it, while at the same time not missing sessions and frequently initiating social contact with each other between sessions. Consistent with this were reports at follow-up, where most clients maintained their post-treatment level of improvement, but subjectively do not attribute this progress to the group therapy experience. Over two-thirds of clients interviewed in our most recent follow-up reported they were more active doing things they had not done before coming into treatment; yet the majority saw no relationship between these changes (e.g., part-time employment or a move to better living conditions) and their involvement in the group. It may be that group psychotherapy helped to set a change process into motion that then continued on its own momentum, so that once the subjective feelings of depression lifted, proactive behaviors may have been more "natural" for these clients. In order to determine the specific effectiveness of the behavioral approach (if any) as done in small group format, controlled research is necessary, however, so no conclusions can be drawn at this point.

The concluding section of this paper deals with a number of factors in the therapist ("therapist variables" if you will) which are basic to the success of either of these models with elderly depressives, but which receive little attention in the literature. To begin with, it is necessary that the therapist be committed to the idea that older persons can in fact learn new behaviors and cognitions, and that they are likely to respond to the same therapeutic principles as younger persons. The therapist must be persistent in following the model and not be sidetracked by temporary lack of progress. This implies that modest goals should be set and that a fairly long-term process may be necessary. The elderly present with multiple problems and these can only be dealt with one at a time. Related to this is the recommendation that therapists learn to appreciate the increased cautiousness operating in many elderly, which makes it necessary for them to feel very comfortable before trying new things, both in and out of therapy. Thus, what might look like excessive and exasperating resistance on the part of the client might be due to increased difficulty in risk-taking. Therapists need to be prepared to tolerate the frustration of having to repeat points and suggestions frequently before noticeable effects are observed in the psychotherapy.

On a more general level, some elderly clients are psychologically sophisticated and enter into the therapeutic alliance with apparent ease, while others may go through an extensive course of therapy showing positive behavioral changes; and yet have little awareness of the therapy process. This limits the generality of standard therapeutic tactics, and taxes the creativity

of the therapist to develop unique strategies to use with a variety of specific problems. Yet it is also true that since many problems of the elderly are situational, alleviation of the situation may provide for immediate changes in mood with little need for extended therapy; therapists working with this age group need to be sensitized to this possibility. Thus on the one hand, the therapist working with elderly depressed persons faces the undeniably complex problems highlighted above and needs the willingness to try uncharted courses in his work, while on the other hand, the opportunity to work with those who have the perspective of time and who dwell in history makes therapy with this group an extremely rewarding experience.

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