DOCUMENT RESUME

ED 109 518 CG 014 543

AUTHOR Gallagher, Dolores
TITLE The Behavioral Treatment of Depression in Elderly Outpatients.
PUB DATE 20 Apr 78
NOTE 9p.: Paper presented at the Annual Meeting of the Western Psychological Association (58th, San Francisco, CA, April 19-22, 1978)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Behavior Change; *Behavior Modification; Case Studies; *Change Strategies; Communication (Thought Transfer); *Depression (Psychology); Interpersonal Competence; Interpersonal Relationship; Models; Motivation; *Older Adults; *Positive Reinforcement; *Psychotherapy

ABSTRACT

The behavioral view that depression results from inadequate, ineffective and/or insufficient reinforcers was explored. Since the depressed person does not act in a manner open to positive reinforcement by others, he suffers ongoing and deepening depression. The task of the therapist is to improve behavior, especially social skills, so that the depressed person can obtain greater satisfaction through communication and relationships. Therapist attitude is important in working with the elderly. A case study of therapy with an elderly man illustrates the processes involved in helping the client increase his activity level, reduce dependency and use of medication, and improve communication with his wife. Recommendations for use of a behavioral approach in the treatment of depression in the elderly include: (1) the importance of a clear focus and consistent approach; (2) the necessity of frequent repetition of the connection between adaptive behaviors and depressed feelings to maintain motivation; and (3) the need to set modest goals and anticipate long-term treatment. (NRB)

The Behavioral Treatment

Of

Depression in Elderly Outpatients

Dolores Gallagher, Psychology Fellow

Neuropsychiatric Institute, UCLA Center for the Health Sciences,

Los Angeles, California

Paper presented at 58th Annual Meeting of Western Psychological Association, San Francisco, April 20, 1978

The aims of this paper are to describe how a behaviorist views depression, to point out the possible utility of this model for treating depressed older persons, and to present a detailed case report describing behavioral psychotherapy with a depressed elderly outpatient.

The behavioral model sees depression as resulting from inadequate, ineffective, or insufficient reinforcers. Ferster (1965), Lazarus (1968), Costello (1972) and more recently, Lewinsohn (1974-a,1974-b) have pointed out that the depressed person typically emits few behaviors which are able to be positively reinforced by others in his environment. In effect, the depressed person is on an extinction schedule; according to Lewinsohn (1974-b), this results from the continued absence of response-contingent-positive reinforcement. The total amount of the latter seems to be a function of several factors, such as the number of events which have reinforcing properties (which differs across individuals); the number of events actually available for the person to participate in (which may be age related, especially in our culture), and finally, the individual's ability to engage in instrumental behaviors which can elicit positive response from others. Lewinsohn (1974-a) presents an operational definition of positive reinforcement based on frequency and enjoyment of engagement in pleasant activities. His empirical work has found significant covariance between depressed mood and response contingent positive reinforcement, and has led to a number of treatment interventions aimed at increasing activity level, especially engagement in pleasant activities. Additionally, Lewinsohn, Biglan & Zeiss (1976), have discussed the need to improve instrumental behaviors, especially social skills, so that the depressed person can obtain greater interpersonal satisfaction. For example, his research has found that depressives in group situations typically speak less, have a narrow interpersonal range, and a longer latency of response to the behavior of others, than either psychiatric controls or non-depressed persons.

This dual emphasis in Lewinsohn's model on both activity level and improvement in social skills seems to have relevance to the depressions of older persons, which frequently appear following specific losses, such as spouse, friends, job or income. In these cases, significant reinforcers are lost and quite possibly, social skills diminish as the person withdraws and has less interaction with others. This may set up a vicious cycle leading to a significant experience of depression which the person is unable to break on his own. Rebok and Hoyer (1977) recently reviewed a number of studies in which everyday activities, such as walking and grooming, have been successfully modified (in inpatient studies) using behavioral techniques.

However, there are few reports of therapists utilizing behavioral strategies with depressed elderly outpatients. In order to do this kind of work, one must first believe that older persons are capable of learning new behaviors. Then one should consistently follow a model such as Lewinsohn's that has had success with younger depressives, while at the same time feeling free to modify the model to suit the specific needs of the elderly.

The case of Mr. S. illustrates this process. Mr. S. is a 71 year old, white married male living with his wife who came to the Neuropsychiatric Institute of UCLA with a 15 year history of depression. He was formerly employed as a salesman and says his depressive episodes started when he began to be less successful in his work, and younger men were surpassing him in sales. He was treated off and on for the past 15 years with a variety of approaches, including 2 brief hospitalizations, a course of shock therapy, and medications to numerous to list, but including major tranquilizers as well as the typical anti-depressants. He was in both individual and group therapy several times for brief periods. Mr. S. reported that he gained only slightly from each of these interventions, and was soon back where he started in terms of severity of depression. He has not worked for the past 10 years and had no hobbies or interests to fill his time. When Mr. S. was first seen for intake, he was reporting severe and chronic depression and his MMPI "D" scale score was in the high 90's. He was also extremely agitated and reported that this too was a chronic condition. Mr. S. was literally homebound, spent most of the day in bed, and had no contact with anyone other than his wife and doctors. He was being treated for hypertension with a medication known to have depressive side effects, as well as being on 300 mg. of mellaril. Mr. S. was initially evaluated by a psychiatrist and psychologist, and it was decided to try behavioral therapy more or less as a last resort, since he had been exposed to every other form of treatment and did not benefit much. He began in weekly therapy sessions in August, 1977 and has been seen for over 40 one hour appointments to date. He was given the Zung Self-Rating Depression Inventory on three occasions. At first his score was above 70, which is quite elevated on this scale; after 6 months of treatment his score was in the mid 50's, which is the normal range for his age group; recent testing indecated that this is remaining stable.

Following Lewinsohn's model, treatment began by acquiring accurate baseline information as to his levels of depression, anxiety and activity. Written ratings were obtained over several weeks in order to select target behaviors for therapy to focus on. Three targets were identified early on; increasing his activity level,

reducing his dependency on medication as much as feasible, and improving communication with his wife. She is employed full time as a secretary and has been inadvertently reinforcing much of Mr. S.'s "sick role" behavior by her tendency to take over and run the household in all respects, as if he were not capable of contributing in any way.

Regarding the first goal of treatment (increasing activities, especially pleasant ones), Mr. S. had to build in new behaviors very slowly because he was starting from such a minimal point and had to deal with high anxiety as well as depression. For example, he woke up each morning in an agitated state and frequently would not get dressed or out of bed until afternoon. We began with relaxation training; this took 6 sessions to accomplish because Mr. S. had difficulty remembering the instructions, and had little impetus to get out of bed and DO the exercises. He was encouraged to turn on an early morning TV show which featured yoga exercises; this got him up and attuned to what he was supposed to do; so that he could then start the progressive muscle-relaxation work.

We also spent a fair amount of time finding the right reinforcers for Mr.S.. Inttially, he was unable to identify any, but it was learned accidentally that he enjoyed small talk and attention from several waitresses at a local coffee shop (when he was able to get there). Therefore, he was encouraged to walk there daily, and to spend time interacting when he got there. This activity got him out of the house and provided some pleasant social contact with persons other than his wife. As time went on, the therapist learned that Mr. S. was a talented artist who had exhibited frequently when living in New York and who won several competitions for his oil paintings. In order to shape the specific behavior of attending a Senior Citizens center where he would have the opportunity to paint and therefore gain positive attention from others, a variety of techniques were used that broke the task down into manageable components and gave him specific rewards as he went along. For example, role-playing, modeling and in-vivo desensitization were used. For about 3 months, therapy focused on building in this pleasant actvity into his repertoire; this activity is continuing now on a regular basis.

Regarding the second treatment goal (reduction of dependence on medication), a gradual approach was used over a six-month period. Under the supervision of our Team psychiatrist, mellaril was reduced from 300 mg. daily to no regular medication but with 50 mg. tablets available if needed. Mr. S. had been using Valium as well to sleep at night, and this has been discontinued. In addition, he was on aldamet for years (as suggested previously) for his hypertension. His primary physician was cooperative in discontinuing this when the relationship of aldamet to

depression was pointed out. Mr. S. checks his blood pressure every two weeks at the local medical clinic and since January when this change was initiated, his blood pressure has remained within normal limits for his age. This decrease on medication is viewed as essential to the success of the behavioral approach since it reinforces the concept that depression is not a "disease" to be cured, but a style of life capable of being modified. It has taken Mr. S. some months to appreciate this fact and there have been several periods of crisis when temporary setbacks occurred. During these times, Mr. S. seemed to be testing the theory in a sense, in that he needed to know that he had control over his mood changes. By stopping the behavioral program for a few days he saw for himself how his depression increased and just how dependent his moods were on his activity level.

Regarding the third goal of treatment (improved communication with his wife), therapy was done in conjoint sessions for some time. This made it possible to point out the maladaptive patterns of interaction between Mr. and Mrs. S. For example, Mrs. S. clearly maintained much of her husband's "sick role" behavior by giving him a great deal of attention when he complained or was anxious. She was fearful that pushing him into doing things would in some way make him worse. Although she cared about him, she often reacted with anger when he could not follow through on global suggestions she tended to make such as "get out and meet people".

Mrs. S. was taught several behavioral principles central to the approach, and proved to be an apt and fairly cooperative pupil. She has learned to differentially reinforce her husband's behavior, and this has proved to be extremely important in their interaction. For example, adaptive behaviors such as cooking the evening meal (which took a relatively short time to shape and insert into the schedule) were rewarded by praise and positive attention from her. On the other hand, maladaptive behaviors such as complaining and depressive talk were dealt with by ignoring them. For Mrs. S. role-playing and rehearsal were necessary in that she had to learn to give praise appropriately, without spoiling it by additional negative comments (e.g., "How nice that you made dinner, but I really didn't like the vegetables we had".) In addition, Mr. S. was supported in his efforts to be more assertive toward his wife, particularly regarding household decisions and leisure time. This had led to increased pleasant time together in evenings, where previously they had little positive contact with each other, as well as some structuring of their weekend time so that they now interact more often with other couples their own age.

Recently, Mr. S. has talked about a long-standing problem with impotency which dates back about 10 years. He has asked for specific sex counseling around

the issue of erectile dysfunction. This component of treatment is being dealt with slowly, since there is massive anxiety for both of them about resuming sexual contact. At this point, exchanges of affection are taking place but no explicit sexual therapy is occurring. It is this therapist's opinion that the S's would benefit from referral to the Human Sexuality Clinic at UCLA, in time, when they are less anxious and a suitable co-therapy team can be found who are interested in working with an elderly couple.

In summary, this case is still active since there are a number of remaining behaviors to be worked on. For example, Mr. S's daily schedule is still slim compared to what he wants to be doing, and there are still a number of negative interactions between him and his wife, so that an additional several months of treatment is anticipated. This is partially because it has been difficult for Mr. S. to generalize what he has learned. He needs quite a bit of direction to formulate a new goal and work through the steps to achieve it, despite the fact that he has been an active participant in the treatment planning all along.

This paper will close with several recommendations for other therapists who wish to use a behavioral approach with elderly persons; first, it has been very important to be clearly focused and to consistently use the approach, not being sidetracked or caught up in the patients resistance - e.g., telephone crisis calls may be a test to see if the therapist is really committed to this approach. Second, frequent repetition must be made of the connections among activity, assertion, adaptive behaviors and so forth, and depressed feelings, in order to maintain the patient's motivation. This may be because older persons have somewhat less cognitive flexibility then younger patients, and therefore take longer to understand and utilize the same constructs. Third, the therapist must set modest goals and expect this to be a fairly long-term process when working with older persons, since the elderly experience multiple problems and these must be appreciated and dealt with as they come to the clinician's attention. It takes a fair amount of time in the beginning to establish the therapeutic relationship, and for the therapist to acquire reinforcing properties for the patient. In addition, patients need some time working with this approach before they develop confidence in it, since it typically is quite different from any previous treatment they have been exposed to.

Finally, the case of Mr. S. is one example among several of elderly depressed persons who have been successfully treated using a behavioral approach at the NPI. Our collective experience suggests that behavior therapy is in fact useful in the treatment of depression in the elderly. Currently, there is a controlled research project to test the effectiveness of behavior therapy (as outlined

above) done in small groups, where reinforcement from other members may prove to be a powerful adjunct and accomplish similar goals in a shorter period of time and with less cost to staff and patient. Results of this work-in-process will be ready to report by August, 1978.

REFERENCES

Costello, C. G. Depression: Loss of reinforcers or loss of reinforcer effectiveness. Behavior Therapy, 1972, 3, 240-248.

Ferster, C.B. Classification of behavioral pathology. In L. Ullman & L. Krasner (Eds.), Research in behavior modification. New York: Holt, Rinehart and Winston, 1965.

Lazarus, A. A. Learning theory and treatment of depression. Behavior Research and Therapy, 1968, 6, 83-89.

Lewinsohn, P. A behavioral approach to depression. In R. Friedman & M. Katz (Eds.), The psychology of depression:Contemporary theory and research. New York: Wiley, 1974. (a)

Lewinsohn, P. Clinical and theoretical aspects of depression. In K. Calhoun, H. Adams, & K. Mitchel (Eds.), Innovative treatment methods of psychopathology. New York: Wiley, 1974. (b)

Lewinsohn, P. , Biglan, A., & Zeiss, A. Behavioral treatment of depression. In P. Davidson (Ed.), The behavioral management of anxiety, depression, and pain. New York: Bruner/Mazel, 1976.

Rebok, G. W., & Hoyer, W. The functional context of elderly behavior. Gerontologist, 1977, 17, 27-34.