Never too old to learn : the effectiveness of the Coping with Depression course for elderly

Haringsma, R.

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Summary - Samenvatting

Summary

It has taken a long time to shake off Freud's legacy, i.e., the thought that older people lack the mental plasticity to change or benefit from psychotherapy or that depression is a natural consequence of the increasing number of losses experienced as we age. In the last twenty years it has been shown many times that treatments effective for younger adults with depression were also effective for seniors (see Cuijpers et al., 2006). In this thesis, the effectiveness of the Coping with Depression (CWD) course for depressed older adults living in the community is investigated. The course was developed in the United States of America by Lewinsohn and Clarke (1984) as a curative outreach program for adults with unipolar depression. Adaptations followed for other populations with unipolar depression known to be hard to reach (Cuipers, 1998a). In the mid nineties of the previous century the course was adapted for the Dutch community living senior and implemented in the prevention arm of the community-based mental health care system. The prevention departments offer the course regularly to seniors with mild depression.

Efficacy studies in which the course was carried out in controlled research settings showed medium size effects (Cuijpers, 1998b). The main objective of this research was to study whether the course was also effective in the usual care setting when given by the typical community staff to consumers of community mental health services. To ensure this objective the study was embedded in the procedures used by the prevention departments of 13 community mental health centers (CMHCs) throughout the Netherlands. A total of 318 participants in 43 courses took part in the study.

First, we studied the criterion validity of the Center for Epidemiologic Studies Depression scale (CES-D; Radloff, 1977), a widely used self-report questionnaire measuring the level of depressive complaints. We looked at the immediate effects and the effects after one year. A second question concerned the prognostic characteristics of the participants of the course for immediate as well as long-term effects. A wide variety of demographic, clinical, psychosocial and treatment factors that may have been relevant for indicated prevention and treatment of major depression were used to examine their contribution to the immediate and maintenance effect. We also investigated whether the specificity of the autobiographical memory was a marker of vulnerability for depression or a factor predicting relapse a year after the conclusion of the course.

Main findings

Characteristics of the participants

The age of the individuals enrolling ranged from 55 – 85. About half of the participants were so called young elderly aged 55 – 64, the oldest old (75 – 85 years of age) formed a minority of 15%. Two thirds were female, 50% was living alone, of which 43% was widowed. In this sample a third had a low level of education: primary school only or lower vocational training. A medium high level of education was achieved by 40%, and 27% had taken tertiary education (college or university).

Compared to the cohort this sample belongs to (Central Bureau of Statistics, 2007), the course attracted higher educated participants. Two thirds reported to suffer from at least one chronic medical condition. The features of this sample are characteristic for individuals vulnerable for depression (Beekman, et al., 1997; Cole & Dendukuri, 2003).

The level of depressive symptoms was high, the mean sum score on the CES-D was 25.9 (SD 9.7), and 85% had a CES-D score ≥ 16 which indicated the presence of a clinically relevant depression. At the time they were enrolled 42% met the criteria for a DSM diagnosis of major depression (MDD), also 42% had an anxiety disorder. The double diagnosis MDD-Anxiety disorder was given in 20%. Only 14% had never experienced a major depression. Half of the participants were treated with antidepressants or tranquilizers for their depression. The mental health status showed that the elders in this study resembled a sample of psychiatric outpatients more than a community sample.

Criterion validity of the CES-D

The Mini International Neuropsychiatric Interview (M.I.N.I.; Sheehan et al., 1998) was used to establish 'gold standard' diagnoses including major and minor depressive disorders. Receiver operating curve (ROC) analysis showed that the scale's operating characteristics were satisfactory. The optimal cut-off score for MDD was 25 (sensitivity 85%, specificity 64%, and positive predicted value 63%). For minor depression (or clinically relevant depression; CRD), the optimal cut-off score was 22 (sensitivity 84%, specificity 60%, and positive predicted value 77%). True positives reported significantly more anxiety symptomatology and more co-morbid anxiety disorders, false positives reported more previous depressive episodes. Subjects scoring ≥ 25 constitute a target group for further diagnostic assessment in order to determine appropriate treatment.

Immediate and long term effectiveness

The immediate effect was analyzed with a randomized controlled block design to ensure that participants with and without MDD were divided equally over the course (intervention group; n = 52) and the waitlist (n = 58). To study the long-term effect (limited to the first 14 months after the conclusion of the course) a naturalistic design was used.

Older adults in the intervention group showed a significant decrease in depression symptoms. The overall between effect size (*ES*) was medium (0.49). For people with MDD it was large (ES_{MDD} = 0.92) and for those without a MDD it was small ($ES_{no\text{-}MDD}$ = 0.30). Gains were maintained over 14 months. In the intervention condition 83% had a pretreatment score ≥ 16 on the CES-D, at post treatment 62% still scored ≥ 16. We concluded that the course was beneficial for participants with mild or severe depression. Also treatment acceptability was high. It should be fitted into a stepped

care protocol that varies intervention intensity according to clinical needs, using the post treatment level of functioning as an indication for the next step.

Predictors of immediate and long-term effect

Of the 317 participants (age 55 - 85 years; 69% female) that took part in this study, 232 were reached at the 14-month FU. A variety of demographic, clinical, psychosocial and treatment factors of possible relevance for indicated prevention and treatment was investigated. Random coefficient regression models and logistic regression models were used to examine their contribution to the immediate and maintenance effect.

The course was beneficial for non-MDD and MDD participants, and the level of depression reached at the end of the course was maintained over the next 14-months. Current MDD, high levels of anxiety, less previous depressive episodes and more education predicted a larger benefit. However, the clinical significance of these predictors was too small to justify further triage. Further treatment should be considered for the participants with a post-treatment score ≥ 16. Group-membership was not a significant predictor of the variation in effect.

Autobiographical memory

The first aim of this study was to investigate if reduced autobiographical memory specificity (AMS), is a marker for depression in older adults. Secondly, the separate effect of an induced sad mood on AMS was studied. The Autobiographical Memory Task (AMT; Williams & Broadbent, 1986) was administered twice in a single session to 63 remitted (RD) participants and 58 never depressed controls aged 55 – 85 years. A negative mood was induced in all RD individuals. The controls were randomly assigned to a neutral (n = 26) or a sad mood condition (n = 32). The course of depressive symptoms was assessed in RD individuals over a 14 months follow up period.

All individuals retrieved fewer specific memories than the norm for middle aged individuals. RD and controls did not differ in AMT scores or in their reaction to the mood induction. The mood induction did not affect the AMT. There were no practice effects. Changes in the level of depressive symptoms at the 14-month FU were not predicted by baseline AMT score, changes in AMT scores or mood ratings after mood induction. Our conclusion is that performance on the AMT is not a marker for vulnerability for clinical depression in older adults.

In the general discussion we discussed the findings of the four studies and their clinical implications. We found that, although the CWD course is beneficial for non-MDD and MDD participants and well accepted by them, it is not enough sufficient for the elderly who are having high levels of depression symptomatology. We strongly recommended that before and at the conclusion of the course, the CES-D is administered and that participants scoring ≥ 25 on the CES-D, should be followed up

with a diagnostic interview to specify clinical diagnosis and appropriate treatment. It should be fitted into a stepped care protocol that varies intervention intensity according to clinical needs, using the post-treatment level of functioning as an indication for the next step.

The recruitment strategies failed in attracting the therapy shy, non-white, less educated and the older-old depressed individuals. This is a problem Karel and Hinrichsen (2000) have identified in their article on the treatment of depression in late life. In most of the studies that showed that psychotherapies were effective in the treatment of depression in older people, the participants in were relatively healthy, white, well-educated community living adults in their 60's and 70's. However, studies of effective treatment for the frail elderly have been few, and in the future studies should focus on effective treatment for the frail older-old, or the elderly with mild dementia. Moreover, it is of great necessity to study how the less well educated or the large group of ethnic elderly can be reached and which interventions are effective for these elderly.