PRACTICE GUIDELINES IN THE USE OF COGNITIVE-BEHAVIORAL STRATEGIES WITH DEPRESSED ELDERLY IN PRIMARY CARE

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Abstract

Practice Guidelines in the Use of Cognitive-Behavioral Strategies with Depressed Elderly in Primary Care

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Depression is the leading psychiatric disorder in old age. Although it is one of the most frequent diagnoses made in outpatient practice, late-life depression is underrecognized, misdiagnosed and undertreated. The management of major depression in the elderly is affected by several factors, including the presence of multiple medical conditions, polypharmacy, increased sensitivity to medication, atypical presentations of depression, and age-specific psycho-social issues such as the stigma elderly attach to mental disorders, social isolation and lack of financial resources. Since aged persons tend to refuse referral to mental health specialists and psychosocial interventions are often an important aspect in the treatment plan for depression, the integration of strategies based on brief, time-limited psychotherapies such as cognitive-behavioral therapy into primary care visits can provide significant benefits for the depressed elderly client. Due to advanced practice nursing's holistic approach and comfort level applying nonpharmacologic modalities in the treatment of clients in primary care, cognitive-behavioral strategies lend themselves well to their practice style. The focus of this project is the development of practice guidelines in the use of select cognitive-behavioral strategies with depressed elderly in primary care.

Practice Guidelines in the Use of Cognitive-Behavioral Strategies for Depressed Elderly in Primary Care

The Problem

Introduction

Major depression is estimated to affect up to 4 % of older adults, while self-reports of depressive symptoms in community surveys indicate a 15 - 65 % prevalence (Blixen & Wilkinson, 1994; Miranda & Munoz, 1994; Thompson, Futterman & Gallagher, 1988). Depression is the most common psychiatric disorder in old age (Hendrie & Crossett, 1990) and is among the most common diagnoses made in outpatient practice (Richter, Barsky & Hupp, 1983). Major and minor depression in primary care clinics are found to affect 5 % of the elderly population (NIH Consensus Development Panel on Depression in Late Life, 1992). Although 90 % of people with major depression are treated in primary care, it is estimated that only about 10 % of elderly in need of psychiatric service receive it. In spite of its prevalence, depression in the elderly is underrecognized, misdiagnosed, and undertreated causing much unnecessary suffering for the elderly (Badger et al., 1994; Banazak, 1996; Callahan, Dittus & Tierney, 1996; NIH Consensus Development Panel on Depression in Late Life, 1992; Pierre, Craven & Bruno, 1986; Ruegg, Zisook & Swerlow, 1988; Scott, Tacchi, Jones & Scott, 1997; Steiner & Marcopulous, 1991).

The management of major depression in the elderly is affected by several factors including the presence of multiple medical conditions, polypharmacy, increased sensitivity to medications, masked or atypical presentations of depression, and age-specific psycho-social issues such as the stigma elderly attach to mental disorders, social isolation, and lack of financial resources (Flint, 1996). The NIH Consensus Development Panel on Depression in Late Life (1992) determined that goals of treatment for geriatric depression should include symptom reduction, decreased risk of relapse and recurrence, enhanced quality of life, amelioration of overall health, cost-effectiveness and mortality reduction. The two major categories for the treatment of depression include biological therapy, such as pharmaco-therapy, and psycho-therapy, such as cognitive-behavioral therapy (CBT) (NIH Consensus Development Panel on Depression in Late Life, 1992), which can either be used alone or in combination. The efficacy of these therapies will be discussed in the literature review.

With primary care providers prescribing 80 % of all antidepressant medications used in the United States (Robinson et al., 1995), it is important to recall that many of these medications have significant side effects especially in the geriatric population. Despite improved antidepressant medications being available and appropriate for the elderly, many older persons cannot or will not take them (Callahan, Dittus & Tierney, 1996; NIH Consensus Development Panel on Depression in Late Life, 1992; Oxman, 1996). Because growing data is becoming available regarding the efficacy of brief psychotherapies in the treatment of late-life depression, and the population is increasingly exposed to its principles through media and self-help books, there is a growing trend to use cognitive-behavioral strategies (CBS) in the primary care setting (Robinson et al., 1995). Since aged persons tend to refuse referral to mental health specialists and psychosocial interventions are often an important aspect in the

treatment plan for depression, the integration of interventions based on brief, time-limited psychotherapies such as the application of CBS into primary care visits can provide significant benefits for the depressed client. Due to advanced practice nursing's (APN) holistic approach and comfort level applying nonpharmacologic modalities in the assessment and treatment of clients in primary care, CBS lend themselves well to their practice style.

Purpose of the Project

The purpose of this paper is to develop clinical guidelines for the use of cognitive-behavioral strategies with depressed elderly in primary care to be used alone or in conjunction with other treatment modalities. The unique needs of the depressed geriatric client will be taken into consideration and the goal of therapy will be to enhance the quality of life and improve the rate of recovery.

Conceptual Definitions

Depression

Although geriatric patients often present with the classic symptoms in the DSM-IV (1994), atypical presentations are equally common. The concept depression can be used to refer to a "subclinical problem: a 'blue' mood state and general feelings of hopelessness and demoralization" (Thompson, Futterman & Gallagaher, 1988, p. 557). Depression can also refer to an acute or chronic disorder as specified in the DSM-IV (1994). Beck et al. (1979) state that non-psychotic, unipolar depression is especially responsive to cognitive-behavioral therapy.

For the purpose of this project depression will be defined as a mild to moderate, unipolar, non-psychotic (without hallucinations or delusions) major depressive disorder which may present many or all of the following symptoms of depression. The classic symptoms of unipolar affective disorder as listed in the DSM-IV (1994) include: depressed mood, diminished interest or pleasure in activities, weight changes, insomnia/hypersomnia, psychomotor change, fatigue/energy loss, low self-esteem/guilt, concentration problems/indecision, and thoughts of death or suicide. McCullough (1991) makes additional mention of the atypical presentations of depression in the elderly: cognitive deficit/pseudo-dementia, pain syndromes, somatization, anxiety/irritability, and alcohol abuse. The DSM-IV (1994) further differentiates the severity of depression (mild, moderate or severe) which is determined by the number of symptoms, severity, level of functional disability and distress.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) is a form of brief, time-limited psychotherapy made up of cognitive and behavioral strategies that focus on the here and now rather than exploring the distant past (Grant & Casey, 1995). Cognitive-behavioral therapy is among the only structured therapeutic approaches created specifically to treat depression. It focuses on eliminating distorted thought systems while striving to increase the number of pleasant events in a client's daily life (Moberg & Lazarus, 1990).

Cognitive-behavioral therapy is based on Beck's theory of the cognitive contribution to depression and focuses on eliminating the following types of abnormal thinking: the cognitive triad (the patient's negative concept of him/herself as useless, a pessimistic view of the future and the outside world as threatening); schemas (in which automatic negative thought patterns

result in occurrences being interpreted in an exclusively negative way); and faulty information processing (in which dysfunctional thought processes, such as overgeneralization and misattribution, result in further negative interpretations of occurrences) (Beck et al., 1979). Cognitive-behavioral therapy seeks to aid in recognizing the connection between negative patterns of thought and depressed mood, and reversing these through the following five steps: " Monitoring negative thoughts; recognizing the connections between negative thoughts and feelings of depression; examining the evidence for and against specific automatic negative thoughts; learning to identify and alter the dysfunctional beliefs that sustain negative cognitions, and developing more reality-oriented or adaptive views of the self, the world, and the future" (Moberg & Lazarus, 1990, p. 94).

It is explained to the clients that this therapy can help them adjust to issues currently occurring in their life, requires active participation, encourages the use of a therapy journal and the practicing of techniques at home (Moberg & Lazarus, 1990). Beck et al. (1979) view the integration of behavioral techniques as an important factor in obtaining cognitive change. Through the change of cognitive processes and behavior (increasing the occurrence of pleasant activities) the client is shown that negative and overgeneralized thought patterns (i.e. "I'm useless", "this will never get any better", "things just never seem to work out for me") are not accurate. The thoughts of helplessness, hopelessness or pessimism which had previously seriously restricted the level of motivation and resulting behaviors are replaced by positive thoughts and a positive mood. The client is taught to become aware of the relationship between thought, activity and mood. Cognitive-behavioral therapy is very structured, and teaches the client new skills through in-session exercises and homework assignments like reading assignments or the utilization of imagery or relaxation techniques. It is a pragmatic

approach that focuses on problem solving using clear, measurable goals and reduces symptoms in a collaborative relationship between the client and the facilitator (Grant & Casey, 1995).

Cognitive-behavioral therapy is indicated in the treatment of mild to moderate major depression in the elderly and is especially effective with a specific problem or precipitating event (although this is not essential). Clients with severe cognitive limitations, very severe psychomotor agitation or depression, extreme medical frailty or instability, and severe sensory loss may be too impaired to benefit from CBT (Casey & Grant, 1995). Yet Rybarczyk et al. (1992) stress that CBT can be adapted to special needs.

For the purpose of this project cognitive-behavioral strategies (CBS) will be defined as interventions that are based on the idea that distorted thought processes and the absence of pleasurable activities contribute greatly to the development and continuation of affective disorders such as depression. Cognitive-behavioral strategies focus on eliminating distorted thought systems, while striving to increase the number of pleasant experiences in one's daily life. In addition to being highly effective in treating depression, the client learns skills useful in coping with a broad range of stressors (Thompson, 1996). The APN can either use CBS alone or in combination with other modalities.

Conceptual Framework

The issues related to major depression in the elderly and its resulting effects fit well into the framework presented by theorist Dorothea E. Orem (1991) in her general theory of nursing which provides the framework for this project (see Figure 1).

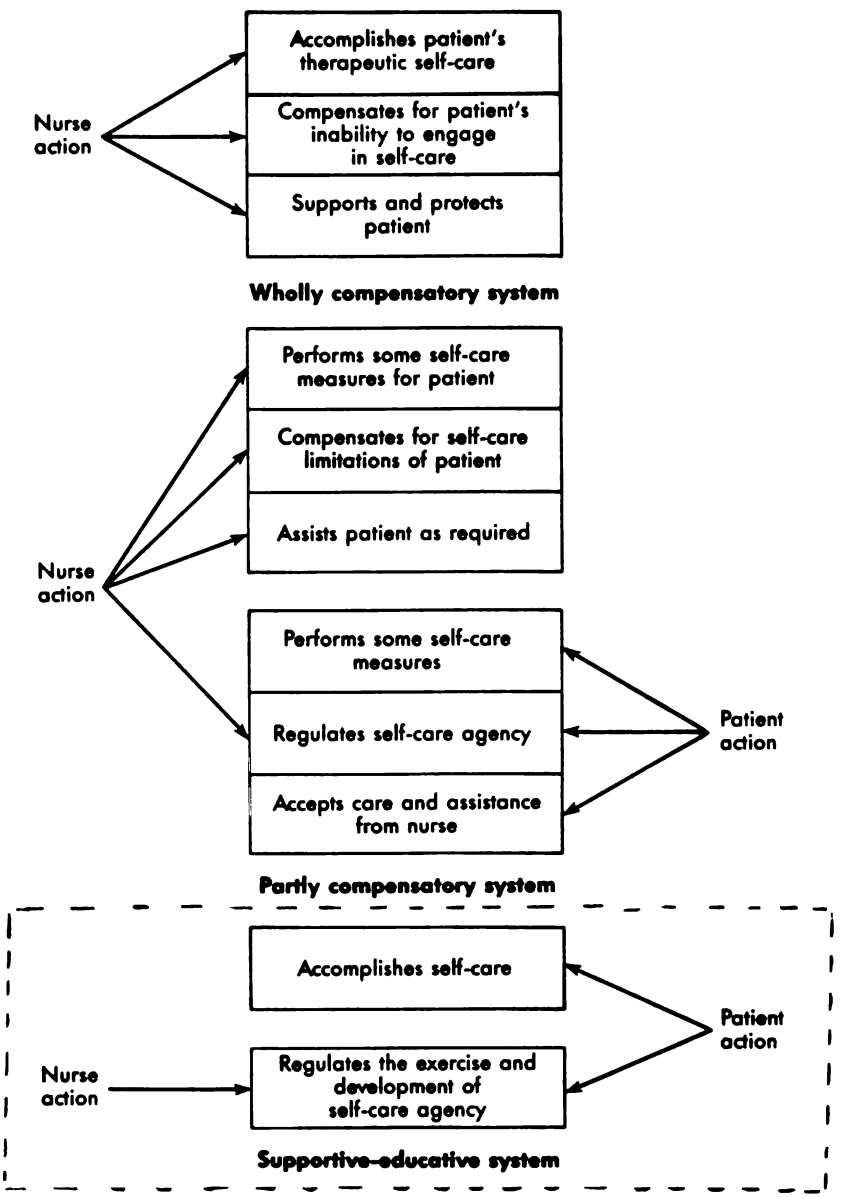

Figure 1. Basic Nursing Systems (Orem, 1991)

Orem's framework consists of three interrelated theories: the theory of self-care, the theory of self-care deficit, and the theory of nursing system.

Theory of Self-Care

Orem (1991) states that 'self-care' is an individual's ability to respond to his/her personal needs which are affected by age, stage of development, state of health, the environment, and the result of medical treatments. She further explains that self-care is a learned behavior and a deliberate action aimed at meeting ever-changing internal and external factors through self-regulation. Self-care, which is learned through an intellectual process, is developed through social interaction where recurring requisites for self-care lead to the development of care habits. These vary from culture to culture and are situation specific.

Theory of Self-Care Deficit

In this context Orem (1991) defines 'deficit' as an individual's inability to respond to his/her personal needs. She stresses that this should not be interpreted as a human disorder, although it may be indicative of a person's functional or structural disorder. When self-care abilities are less than those required to meet a self-care demand, such as frequently occurs in depression, a client may require nursing care. A client's self-care engagement is affected by the (p. 71) "person's limitations in knowing what to do under existent conditions and circumstances or how to do it." As a result the client's therapeutic self-care demand requires a

usually time-limited, situation specific intervention which meets self-care requisites until the ability to resume self-care is attained once again.

Theory of Nursing System

Orem's (1991) theory of nursing system discusses the relationship between client and nurse. The nursing interventions used in response to a therapeutic self-care demand seek either to protect the client or facilitate the ability to once again respond to personal needs. The nurse takes the client's values into consideration while applying the nursing process. Nurse and client mutually determine goals and the roles each are to assume in achieving these, in order to reinstate self-care agency.

Orem (1991, p. 291) describes three types of nursing systems: wholly compensatory, when the client is completely unable to engage in self-care and the nurse performs all necessary care i.e. a comatose person; partly compensatory, when both client and nurse "perform care measures ... involving manipulative tasks or ambulation," i.e. medical rehabilitation nursing; and lastly the supportive-educative nursing system.

Supportive-Educative System

Within this nursing system the client requires assistance to perform therapeutic self-care, such as (Orem, 1991, p.291) "support, guidance, provision of a developmental environment, and teaching." Orem (1991) explains that this is a supportive-developmental system where the nurse assists the client with the making of decisions, controlling behavior and the learning of new knowledge and skills. The nurse's role is primarily consultative, providing periodic guidance and teaching (see Figure 2).

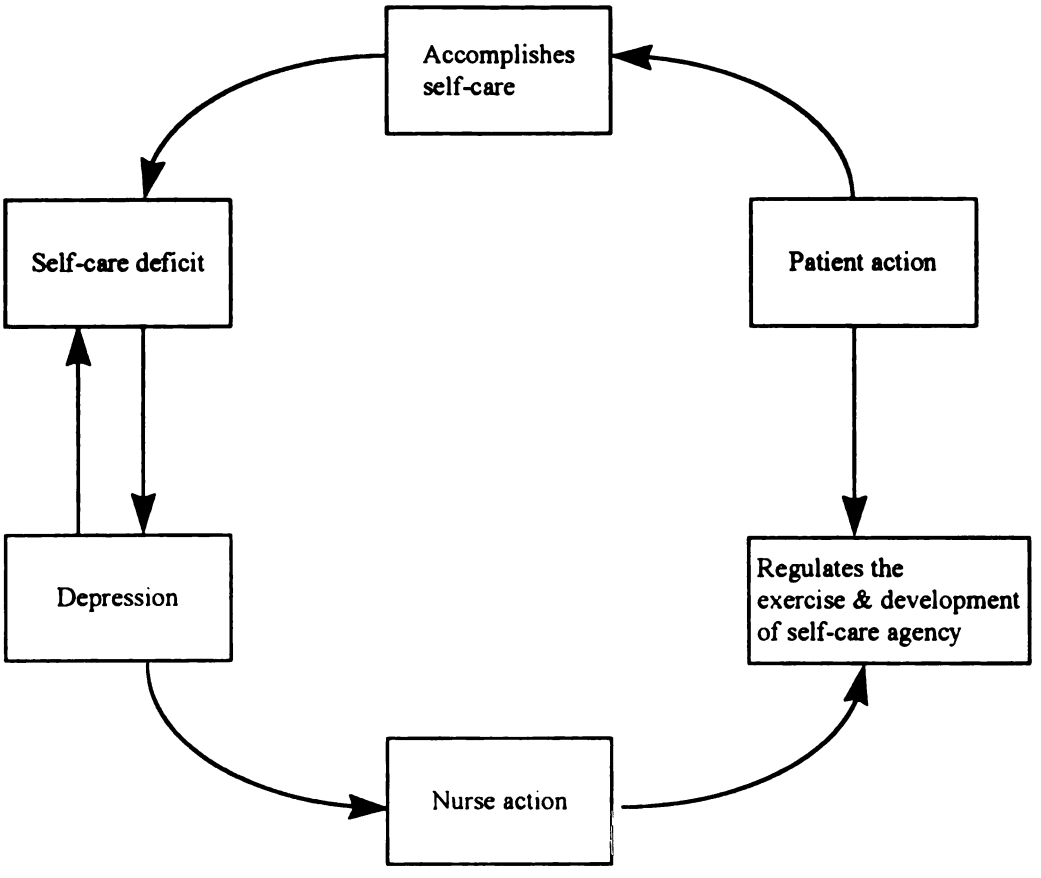

Figure 2. Application of Orem's Supportive-Educative System to Treat Depressed Elderly in Primary Care

The advanced practice nurse (APN) in the primary care setting assists the client within this last nursing system. The elderly client experiencing depression displays a range of symptoms which indicate that self-care demands exceed self-care abilities. The client seeks help from the primary care provider (APN), who applies a personalized nursing process (nurse action) to help regulate the exercise and development of self-care agency. The APN utilizes the nursing process to assess self-care requisites, determine self-care demands and self-care abilities of the client. This information is used in the process of making a diagnosis of the self-care deficit and developing an individualized plan. The supportive-educative system provides

information and support to help achieve self-care agency once again. The implementation of this system allows the APN to apply CBS either alone or in conjunction with medication. As the client learns to adopt new coping techniques learned from CBS in his or her repertoire, s/he once again resumes the independent management of self-care.

Review of Literature

Depression and the Elderly

Depression in old age is a major costly public health problem, burdening not only the affected patient, but also their families and ultimately the whole community. It leads to increased morbidity, decreased functional status, over-utilization of health care resources, and possible occurrence of death (Badger et al., 1994; Jarret & Rush, 1994; Miranda & Munoz, 1994; NIH Consensus Development Panel on Depression in Late Life, 1992; Rothshild, 1996).

While depression can be precipitated by various general medical disorders (i.e. endocrine disorders, cancers, infections, nutritional deficiencies, cardiovascular disease, metabolic disorders, collagen disorders, alcoholism and neurologic disorders), it may also be brought on by the use of certain medications (antihypertensives: clonidine, reserpine, methyldopa, propranolol, guanethidine; diuretics; oral contraceptives; steroids/ACTH; cimetidine; digitalis; disulfiram; barbiturates; benzodiazepines) (Steiner & Marcopulos, 1991). One study cited by Rybarczyk et al. (1992) shows that older adults with a significant chronic disease process are at double the risk of depression than someone without medical problems. High rates of depression have been linked with patients with arthritis, stroke, Parkinson's disease, multiple sclerosis, and COPD (Rybarczyk et al., 1992). Risk factors for depression in the elderly include a personal or family history of depression, other medical illnesses,

caregiving, being single (especially widowed), financial burden, loss of independence, social isolation and being female (Hendrie & Crossett, 1990; Katona, 1994; Richter, Barsky & Hupp, 1983; Rothschild, 1996; Steiner & Marcopolous, 1991).

Due to the stigma the elderly attach to mental disorders, they frequently deny symptoms of depression or present with masked depression, characterized by "a condition in which the mood component seems absent or inaccessible to the patient, although other symptoms characteristic of (depression) are present" (Thompson, Futterman, & Gallagher, 1988, p. 578). This is particularly common in men. Elderly typically have a significantly lower rate of seeking referrral for psychiatric care and of being referred by their primary care provider (Hendrie & Crossett, 1996). One study by Richter et al. (1983) cites that less than 25 % of all geriatric depressed patients were referred to mental health professionals. Of these twenty-five percent, 5 % were seen by social services to confirm the diagnosis, 10 % were referred specifically for counseling, 6 % were followed by nurse practitioners for supportive care, while only 3 % regularly met a mental health professional for treatment of depression. All other patients (75 %) were usually treated by their primary care physician with supportive counseling during a 20 minute office visit while addressing issues of general medical care, and follow-up visits were scheduled 8 weeks later.

Atypical symptoms of depression in the elderly complicate appropriate diagnosis of affective illness. Therefore careful history taking is necessary (McCullough, 1991), possibly including near family to aid in the process of gathering information for reliable diagnosis (Hendrie & Crossett, 1990) such as obtaining the medical history, a current list of medications, precipitating events (losses), and recent affective or behavioral changes for reliable diagnosis. The family can also be invaluable in the treatment phase by facilitating accurate medication

intake, providing the client with emotional support, being supportive of the assigned homework, and providing the health care provider with pertinent feedback regarding the client's progress.

Usually depression is time-limited, resolving within 3-6 months if left untreated, although relapse is frequent and 15 - 20 % result in chronic depression. Therefore the aim of treatment is to accelerate recovery and reduce recurrence through learning depression management skills (Fennell, 1995).

Depression in the elderly can be assessed by using the Beck Depression Inventory (Beck et al., 1961) or the Geriatric Depression Scale (Yesavage et al., 1983). Both are self-report questionnaires and can be used for initial screening, to determine the level of depression, and later to assess the effectiveness of interventions used (Thompson, Futterman & Gallagher, 1988).

Mortality rates by suicide in this age group are higher than any other, and careful assessment of suicide potential is essential. Particularly for elderly white men suicide potential increases steadily with growing age (Pierre, Craven & Bruno, 1986; NIH Consensus Development Panel on Depression in Late Life, 1992). Men's suicide rate peaks after age 75, while women are at highest risk after age 45 (McCullough, 1991). The risk of suicide is greatly enhanced when elderly are lonely and isolated (widowed, divorced or unmarried), experiencing physical illness, or when facing the cumulative effect of a range of losses, especially a recent relocation (Katona, 1994). Over 75 % of clients who complete suicide are seen by their primary care provider within 30 days prior to their suicide, generally while experiencing a first episode of major depression, the symptoms of which were not recognized or treated

appropriately (NIH Consensus Development Panel on Depression in Late Life, 1992), or the diagnostic criteria for depression not appropriately applied.

Issues that appear to contribute to up to 50 % underrecognition of depression in primary care include age bias, also known as 'ageism'. Both terms refer to all prejudices and negative views held about the elderly which lead to stereotyping the process of aging (Collins, Katona and Orrell, 1995). Further factors that can lead to misdiagnosis and atypical presentation of geriatric depression include lack of adequate office time, underutilization of screening instruments, and the complexity of the diagnostic process in patients with psychiatric and medical co-morbidity (Banazak, 1996; Hendrie & Crossett, 1990; Kalayam & Shamoian, 1990; McCullough, 1991). Also, the health care system adds to the problem of underrecognition with poor or lack of reimbursement for mental health services overall (Badger et al., 1994).

There is growing evidence that primary care providers recognize symptoms of late-life depression more often than they document or treat them. Callahan, Dittus & Tierney (1996) suggest that this may be due to inadequate knowledge regarding available treatments, client refusal or deferral of therapy, and providers' pessimism regarding the elderly client's potential to respond to therapy. The literature also mentions the 'silent conspiracy' between elderly patients and their health care providers to deny symptoms related to mental illness from fear of potential treatment consequences (Collins, Katona & Orrell, 1995).

Banazak's (1996) study reports that 41 % of primary care clinicians were unaware of federally developed guidelines for detection, diagnosis and treatment of depression in primary care (Depression Guideline Panel, 1993). This may play a key role in the high percentage of antidepressant scripts written and the high rate of patient noncompliance to treatment. Her

study (1996) further supports the earlier finding that patient noncompliance is an important barrier to treatment. Although health care providers in general lay more emphasis on using antidepressant medication rather than psychotherapies, male providers are more prone to use biological treatments, while female providers are more comfortable with their counseling and activity therapy skills. Banazak's (1996) recommendations include the need for primary care providers to become more comfortable with using non-pharmacological treatment modalities.

Primary care providers prescribe the majority of all the antidepressant medication used in the United States (Robinson et al., 1995). In the elderly population of those who take pharmacotherapy for the treatment of acute depression approximately 60 % improve clinically although significant response often takes 6-12 weeks to manifest (unlike younger patients) (NIH Consensus Development Panel on Depression in Late Life, 1992). It is therefore not surprising that there are compliance difficulties with pharmacotherapy. The high rate of adverse drug reactions in the elderly also contributes to non-compliance. Examples of adverse drug reactions include cognitive impairments such as delirium, toxic antidepressant psychoses, and memory impairment (Oxman, 1996), and cardiovascular problems. All of these drug reactions ultimately increase the risk for resulting morbidity, such as the association of falls and hip fractures in the elderly client from the use of antidepressant medication (Steiner & Marcopulos, 1991). Many side effects in the elderly are due to "age-related pharmacokinetic changes in absorption, distribution, biotransformation and elimination of drugs" (Oxman, 1996, p. 39). The single most important cause of adverse drug reactions in the elderly is polypharmacy. The average geriatric client takes between six to eight different medications daily. With medications being metabolized and excreted less optimally in the geriatric client, s/he remains at increased risk for side effects the longer the drugs remain in the body (Rothschild, 1996).

Cognitive-Behavioral Therapy and the Elderly

The elderly have been undertreated with psychotherapy in part due to a view influenced by Freud who believed that clients over the age of 50 didn't exhibit the necessary "elasticity of mental processes" for psychoanalysis. He also feared that older adults' life review would result in never-ending analysis. As a result little research has been done studying psychotherapy with older adults (Grant & Casey, 1995).

Another theory leading directly to age bias and the resulting undertreatment of the elderly client is the misunderstanding of disengagement theory used to help explain the aging process. This theory states that aging is a process of mutual withdrawal or disengagement which results in reduced interaction between the aging person and others in the social systems he belongs to. The theory continues by stating that disengagement results in the severing of many relationships between the elderly person and other members of society, and the alteration in the nature of those which remain (Henthorn, 1979). In her article Henthorn (1979) further explains that this theory has been used by some (i.e. policy makers and health care administrators) to accept 'negligent practices' and the lack of interventions and opportunities to enhance the elders' quality of life. However, in recent years several types of psychotherapies have been proven successful with the elderly patient. This review will focus on the efficacy of CBT in the treatment of the depressed elderly person.

Gallagher and Thompson (1982) report a study where the effects of cognitive or behavioral therapy were compared to the efficacy of relational/insight therapy in the outpatient treatment of depressed older adults. Cognitive and behavioral therapy proved superior not only with regard to the outcomes achieved, but also with regard to the longer maintenance of treatment gains. Almost two-thirds of subjects expressed regularly using specific skills they had

acquired in cognitive or behavioral therapy in a one year follow-up (such as the use of mood monitoring and recording dysfunctional thoughts).

Fry (1984) discusses a further study using CBT in the depressed elderly, comparing the effects of immediate treatment versus delayed treatment. The outcome shows that CBT alleviated depression in both groups. He notes that specific changes observed include "increase in positive cognitions, decrease in irrational thoughts, reduction in beliefs of dependency, self-criticism and inefficacy". However, Fry points out that improvements in depression cannot be attributed to any specific cognitive-behavioral strategy employed.

Morris & Morris (1991) evaluated six controlled trials (between 1982 and 1987) using outpatient CBT with the depressed elderly and concur that CBT is an effective treatment for this population. They question the cost-effectiveness of CBT versus pharmacotherapy (the latter traditionally being considered especially useful because the elderly have more so-called vegetative or physical signs of depression), and point out that more research is needed to determine this. They caution that the results are limited in the generalizability and advocate a treatment approach which provides equal attention to psychological and physical care. Further, they note that issues related to rates of relapse and compliance still need more research.

Blackburn et al. (1981) compared the efficacy of cognitive therapy and pharmaco-therapy, each alone and in combination, both in hospital out-patient clinics and general practice. The subjects' age ranged from 18 to 65 and were diagnosed with primary major depression. Combination treatment was superior to drug treatment in both sites, while cognitive therapy in general practice yielded better results than drug treatment alone. Similar results were obtained in a study by Teasdale et al. (1984) comparing the effect of cognitive therapy (in addition to treatment-as-usual) for major depressive disorder with treatment-as-

usual in primary care. The results indicate that patients receiving the addition of cognitive therapy were significantly less depressed than the control group.

One factor that all the studies reviewed have in common is that the treatment sessions lasted 60 to 90 minutes, for a period of 12 to 37 weeks, and were all facilitated by experienced therapists such as clinical psychologists. Although the outcomes were positive, the fact that patients were referred outside of the primary care setting will need to be taken into consideration when developing the clinical guidelines, by adapting the contents of the sessions to a format acceptable in primary care.

In contrast to the rather lengthy treatments mentioned above, Scott et al. (1997) performed an acute and one-year randomized controlled trial of brief cognitive therapy for major depressive disorder in primary care in a population aged 18-65. The intervention group received six sessions, the first of which lasted 60 minutes and the subsequent ones were about 30 minutes duration along with written material and homework. The results imply that brief cognitive therapy is useful in addition to treatment-as-usual and that patients in the intervention group recovered earlier, with improvements remaining sustained at one-year follow-up. Yet the researchers point out that brief therapy requires trained facilitators with a high level of expertise. The same article discusses the results of three other studies using brief cognitive therapy. Fennell & Teasdale (1987) show that some depressed subjects display a significant improvement within only four sessions of cognitive therapy. While Barkham et al. (1992) and Mynors-Wallis et al. (1995) demonstrated that two cognitive therapy sessions plus a brief problem-solving therapy for depression were beneficial in treating depression.

Mynors-Wallis et al. (1995) presented the randomized controlled trial comparing problem solving treatment with amitriptyline and placebo for major depression in primary care.

They offered six treatment sessions over three months (weeks 1, 2, 3, 5, 7, and 11) to all three treatment groups. Their study utilized three therapists: a psychiatrist and two general practitioners who had been trained in the techniques used. The problem solving technique used has several stages: "(a) identifying and clarifying the problem; (b) setting clear achievable goals; (c) brain-storming to generate solutions; (d) selecting a preferred solution; (e) clarifying the necessary steps to implement the solution; and (f) evaluating progress." Problem solving was significantly superior to placebo at weeks six and twelve. There was no significant difference between problem solving and amitriptyline treatment.

The Leung and Orrel study (1993) looked at the outcome of brief cognitive behavioral group therapy for depressed elderly. The seven sessions focused on helping participants identify automatic negative thoughts and identify goals. This pilot study suggests that this form of therapy can reestablish independence and enhance recovery from major depressive disorders in older adults.

The last five studies mentioned are important in that they contrast the previous research reviewed for this project and show that brief cognitive therapy is effective. The Mynors-Wallis et al. (1995) study is significant in demonstrating that trained practitioners can effectively provide treatments when instructed properly.

Robinson et al. (1995) describe a study of primary care physicians' use of cognitive-behavioral techniques with depressed patients. Patients reported that on average their primary care physician recommended between 2 to 5 cognitive-behavioral techniques in the antidepression prescription visit, although more younger than older patients reported mention of the use of cognitive behavioral techniques. The psychological coping techniques identified were (p. 354): "planning regular participation in activities that (1) are pleasurable, (2) boost

confidence, (3) help with relaxation, and (4) are with other people; (5) using problem-solving techniques for problems in life ...; and (6) recognizing negative thoughts and replacing them with more positive thoughts". One possible reason the researchers mention for this result is the greater difficulty elderly have in accepting the diagnosis of depression and of less interest and familiarity in psychological treatments of depression. Also, older physicians are less likely to discuss counseling as a treatment option (which may be reflective of their training) and also tend to have older patients. It also may reflect older physicians not being familiar with the newer and briefer psychotherapeutic approaches and belief that psychotherapy is equal to psychoanalysis. This may confirm the stigma earlier mentioned which elderly attach to mental disorders, and possibly be a reflection of client and provider age bias affecting treatment options for the depressed elderly. Significantly, higher rates of utilizing cognitive-behavioral techniques resulted in higher adherence to pharmacotherapy.

Scogin et al.'s (1989) study recommends the use of select cognitive-behavioral bibliotherapy in the treatment of mildly and moderately depressed older adults as an alternative or adjunct to traditional treatments. The authors mention that its cost-effectiveness and non-invasive nature make it attractive to older adults. Participants in the one treatment group obtained a copy of Control Your Depression (Lewinsohn et al., 1986), a 241-page presentation of behavioral therapy for depression, while the second treatment group received a copy of Feeling Good (Burns, 1980), a 398-page presentation of cognitive therapy for depression. The participants were given 4 weeks to complete the book and the researchers made weekly 5-minute phone calls to the participants. The control consisted of a delayed treatment group. The results indicate that both cognitive and behavioral bibliotherapies are effective self-help

depression treatments yet require active monitoring (p. 407) "because of the risks to emotional and physical health that can result from a deepening affective disorder".

These findings are confirmed by Robinson et al. (1997) whose study of behavioral bibliotherapy concludes that older depressed primary care patients benefit from written information in addition to psychological treatments during primary care visits, which has also been found to help patients adhere to antidepressant treatment in the period until the results can be observed. The authors conclude that older depressed patients benefit from brief, interactive, age- and need-specific, written information on medication and behavioral strategies, coupled with either longer office visits or ancillary phone contacts from the primary care provider. Written information/ booklets are also useful in providing structure for interactions between physician and client during office visits. This study is supported by the findings of Brown & Lewinsohn (1984).

Although there is relatively little research specifically adapting psychotherapy to primary care, Salazar (1996) mentions a national survey of family practitioners treating mental health illnesses which shows that over 80 % regularly provided advice, reassurance, or supportive problem solving, while 25 % regularly provided insight-oriented verbal therapy; and over 15 % regularly provided behavior modification. The survey estimates that more than 25 % of the total amount of time devoted to psychotherapy in the United States occurs in general medical settings. That is promising yet surprisingly low considering that 90 % of depression is treated in primary care. Salazar (1996) and Shearer & Kaplin Adams (1993) both mention CBT for use in primary care, while the latter extensively mention bibliotherapy to supplement the treatment of depression.

Salazar (1996) states that the standard of care with less severe depression recommends beginning with psychotherapy alone and only if required adding medication later. He also recommends adding psychotherapy to severely depressed patients once pharmacologic treatment has improved the patient's condition.

In reviewing the available literature on depression in the elderly and the use of cognitive-behavioral strategies in primary care, it is striking to note that nursing generated data is conspicuous by its absence. This is surprising since the holistic perspective nurse practitioners apply in their approach to client assessment and treatment would lead one to expect the APN to study further nonpharmacological approaches in primary care. This author hopes that in the future nurse researchers will focus on this population and its unique treatment issues and thereby enrich the literature with its contributions.

Adapting CBT to the Special Needs of the Elderly

Gallagher and Thompson (1981) have adapted CBT to the treatment of depression in the elderly. Thompson (1996) makes specific recommendations for adapting CBT to optimize the effects in treating late-life depression. He recommends administering the Mini-Mental State Examination (Folstein, Folstein & McHugh, 1975) to assess the level of cognitive function, in addition to a brief assessment of depression (using the Beck Depression Inventory and the Geriatric Depression Scale). He further suggests adapting material for reduced cognitive processing if necessary, presenting new ideas slowly and in a variety of ways, asking the patient to summarize materials frequently, and maintaining a notebook.

Grant and Casey (1995) adapt CBT to the frail depressed elderly by stressing the importance of socializing the client to therapy using simple, commonsense terms, mutually

agreeing on modest therapy goals to allow the client to have an early sense of accomplishment, while creatively individualizing the process. They further suggest using a family system context in approaching the elderly patient's problems, and recommend utilizing family members as a resource in compliance with homework assignments whenever possible. They also stress the importance of the provider being aware of and confronting his/her own beliefs and biases about the ability of elderly to function effectively.

Rybarczyk et al. (1992) specify the use of CBT to treat chronically ill clients with late life depression. They stress the importance of helping the client understand that s/he is indeed depressed and that a chronic medical illness is a problem separate from depression which is reversible. The client may need help understanding what depression is, its symptom profile, and that it is not merely a "side effect" of a medical condition (as is commonly believed). Also, any feelings about being stigmatized by a psychological label should be addressed. The authors also indicate the importance of dealing with issues of loss of social roles and autonomy as a result of chronic illness, and challenging the perception of being a "burden" by addressing three commonly used forms of distorted thinking (p. 134): negative filtering ("I'm nothing but trouble for my family"), mindreading ("my wife is getting tired of taking care of me"), and negative forecasting ("before long, my daughter will have to transport me everywhere and will end up resenting me").

Project Development

Methodology

The structure of the practice guidelines in the use of CBS with depressed elderly in primary care will be evolved from the conceptual framework, while the content of the guidelines will be drawn from the review of literature. The goal of the practice guidelines is to allow the depressed elderly client to accomplish self-care once again. The practice guidelines include a self-care deficit assessment, recommendations for diagnosis of depression and how to develop a personalized treatment plan, educational intervention modules, and a section on how to evaluate outcomes.

The self-care deficit assessment (see Appendix A) addresses the client's bio-psycho-social spheres. It includes a bio-medical and medication history, a psycho-social history assessing for typical and atypical signs of depression, as well as risk factors for depression, suicide and the assessment of suicidal ideation and social support systems. These assessment guidelines further assess specific potential issues relevant to CBS and include relaxation, pleasant activities, problems with people (social skills), troublesome thoughts, problem solving skills and self-control problems, the need for a personalized problem list, an assessment of barriers to participating in CBS and lastly the ability to perform ADL/IADLs. The purpose of this assessment is to determine the level of self-care deficit in the client and is used as a foundation for choosing appropriate treatment interventions for the individual client.

The section on diagnosis (see Appendix B) recommends the instruments the literature discusses for diagnosing depression in the elderly (the Beck Depression Inventory and the Geriatric Depression Scale) and the level of cognitive functioning (the Mini-Mental State

Examination). The plan section (see Appendix C) guides the APN through the process of personalizing the treatment plan and explaining the principles of CBS to the client. Based on the literature review and the research results on the use of bibliotherapy with depressed elderly the book Control Your Depression (1992) by Lewinsohn, P.M. et al. was chosen as a tool to apply the proposed practice guidelines for CBS in primary care. It is a readily available and relatively inexpensive paperback book written by four psychologists, providing self-help techniques to people with depression using principles of cognitive-behavioral therapy. Their approach reflects the content of research reviewed for this project. The book is written at about a high school education level.

The section on interventions (see Appendix D) provides educational modules on medication teaching, relaxation, pleasant activities, problems with people (social skills) regarding assertiveness, personal style and isolation, controlling thoughts, problem solving skills, self-control problems, and relapse prevention.

And finally, the practice guidelines propose a means of evaluating outcomes (see Appendix E). The NIH Consensus Development Panel on Depression in Late Life (1992) determined that the goals of treatment for geriatric depression should include symptom reduction, decreased risk of relapse and recurrence, enhanced quality of life, amelioration of overall health, cost-effectiveness, and mortality reduction.

Utilization of the Practice Guidelines for CBS

The practitioner working with a depressed client needs to make an in-depth assessment of the numerous factors that can lead to depression or present depressive symptoms. Therefore a thorough medical history and physical examination are critical, as well as a review

of the medications taken including prescription and non-prescription agents (see Section A). Further, an assessment of the client's psychosocial history (see Section B) regarding typical and atypical signs and symptoms of depression, risk factors for depression and suicide, as well as an assessment of current suicidal ideation will all help determine the level of acuity and crisis a client is experiencing. A client displaying active suicidal ideation with a plan needs to be hospitalized immediately to regain personal stability. Cognitive-Behavioral Strategies can be applied subsequently as indicated. An assessment of social support systems including family and friends, professional agencies, counselors and therapists, gives the practitioner insight into the social network of a client (or the lack thereof). With the client's written permission key persons may be contacted for further information or to ask for ongoing support.

What follows is an assessment of specific issues (see Section C) which all can contribute to depression and gives the practitioner a basis for the personalized CBS and relevant educational modules which are to follow. The practitioner is advised to be familiar with the content of Control Your Depression (1992) by Lewinsohn, P.M. et al. and can refer to chapter four for further guidance on this section. Section D allows the APN to develop a problem list for CBS based on the assessment done in Section C (for which subsequent educational modules have been developed).

An assessment of potential barriers or challenges (see Section E) to participating in CBS looks at various issues which either require adapting CBS to the special needs of the elderly (i.e. loss of hearing or vision, weakness or pain) or may even prevent a client from benefiting from CBS such as the literacy level or education. Special adaptations used to overcome barriers might include using large print, audio-taping the contents of select chapters, recommending the use of tape recorders for journaling, or working with family members,

friends or volunteers on homework assignments. The client's cultural background and perceived needs can give the practitioner an idea about how to further personalize the guidelines to obtain greater efficacy and improved compliance with the proposed process.

The last section (see Section F) allows the practitioner to ask questions about the current level of Activities of Daily Living (ADL) and Independent Activities of Daily Living (IADL) which may have been impacted by the depression (or the decline thereof which may have contributed to depression). Questions can include ability to wash self, dress, do laundry, prepare food, do groceries, transportation (does s/he still drive), ability to do house work and take medications.

The next section (see Appendix B) instructs the practitioner to either use the Beck Depression Inventory or the Geriatric Depression Scale to make the final diagnosis of major depression in the elderly client. The level of depression should not exceed mild to moderate, and the client should not be psychotic (the APN should rule out visual or auditory hallucinations or delusions) or bipolar (by ruling out previous episodes of manic-depressive occurrences or diagnosis) to optimally benefit from CBS. The Mini-Mental State Examination is used to assess the level of cognitive status (and can indicate the existence of dementia or pseudodementia).

After the self-care deficit assessment (see Appendix A) and the diagnosis (see Appendix B) have been completed, the practitioner reviews the findings of the assessment with the client and explains the diagnosis of depression (see Appendix C). It is important to assess the client's fear of stigma or level of denial regarding a mental health diagnosis, and allow for feedback or verbalization of feelings. The problem list for CBS is also discussed and priorities are mutually established. What follows is an explanation of the principles of CBS, the need to commit to

homework assignments and practicing of exercise techniques learned using the book Control Your Depression (1992) by Lewinsohn, P. M. et al. Once the client agrees to learn CBS the homework assignment is discussed and a follow-up appointment is determined based on the client's level of acuity. The practitioner may periodically follow-up with a brief phone conversation as deemed appropriate.

The interventions (see Appendix D) are made up of ten educational modules: Medication Teaching, Relaxation, Pleasant Activities, Problems with People (Social Skills) and includes Assertiveness, Personal Style, and Isolation, Controlling Thoughts, Problem Solving Skills, Self-Control Problems and Relapse Prevention. The individual modules are only initiated if indicated and in the order that appears appropriate for the respective client (with recommendations made by the APN and by mutual consent). For example the module for Medication Teaching is only used if the practitioner chooses to prescribe psychotropic medications. The client goal is that s/he verbalizes understanding of the proper medication purpose and use. The practitioner documents whether or not the goal was met and documents relevant responses and issues in the comment section.

At the beginning of each new session the practitioner reviews the homework assignment allowing for feedback and assesses the mood before discussing the goal for the visit. It is important to work at the client's pace, although the practitioner may occasionally need to redirect the client and refocus on the task at hand. The practitioner is advised to prepare for the intended module by reading the relevant chapter(s) in the book Control Your Depression (1992) by Lewinsohn, P. M. et al. Forms may be photocopied from the book and enlarged for the client's homework assignment. The homework assignment might include daily

exercises from a previous module (i.e. relaxation exercise) in addition to the one indicated by the module currently being covered.

Each client should end the program with the module entitled Relapse Prevention. This module acts as a review of the material covered and further emphasizes techniques that can be practiced to help prevent further relapses or to detect a new episode of depression in its early stages and seek help (or utilize the techniques learned).

The educational sessions are intended to be used in the primary care setting and last 20 to 30 minutes each. Thorough documentation is indicated with regard to responses and outcomes obtained, and the practice guideline sheets can become a part of the client's permanent record.

Evaluation of Clinical Guidelines

The goals of the clinical guidelines are (see Appendix E): symptom reduction, decreased risk of relapse and recurrence, enhanced quality of life, amelioration of overall health, cost-effectiveness and mortality reduction and were drawn from the recommendations of the NIH Consensus Development Panel on Depression in Late Life (1992). Symptom reduction may be assessed through the client's use of effective coping skills (as evidenced by the appropriate use of CBS learned under the supervision of the APN) , and the comparison of the initial scores of the Beck Depression Inventory or the Geriatric Depression Scale with those at the end of the program. Also the Mini-Mental State Examination may be applied and the scores compared to the initial ones obtained.

Decreased risk of relapse and recurrence may be evaluated by periodically assessing the client for typical and atypical signs and symptoms of depression, the length of remission of

symptoms, and any precipitation of relapse. In addition, the use of effective coping skills (CBS), the number of relapses and recurrences now as compared to prior to the use of CBS, and the periodic application of the Beck Depression Inventory or Geriatric Depression Scale can be used to monitor the client's well-being emotionally.

Enhanced quality of life can be assessed by applying the Beck Depression Inventory or the Geriatric Depression Scale and the Mini-Mental State Examination. Also the number of pleasant activities engaged in as well as the presence of negative thoughts can be monitored by questioning the client, in addition to assessing the use of effective coping skills.

Amelioration of overall health can be assessed by reviewing the utilization of healthcare resources and by comparing the use prior to the utilization of CBS as opposed to after its use. The goal for a client whose depression is controlled or cured is a decreased use of healthcare resources, whereas a client who is still actively suffering from depression should seek appropriate help (which may represent an increased use of resources but may indicate a positive change as opposed to denial or immobilization). Further, a periodic physical and mental functional status examination can evaluate the overall state of health.

Cost-effectiveness can directly be measured by looking at the utilization of healthcare resources such as number of and reasons for visits to the healthcare provider, hospitalizations, referrals and level of compliance with treatment. Here also, a periodic physical and mental functional status examination can give feedback on the client's overall wellbeing.

And lastly, mortality reduction can be assessed in a twofold way. The practitioner can evaluate the number of suicide attempts or threats after use of CBS, or the occurrence of death by suicide.

Implications for Advanced Nursing Practice

The APN in primary care is at the front line of encountering depressed elderly clients. It is of great importance that s/he be able to assess, diagnose and treat depression effectively in this population. The ability to establish a therapeutic relationship with a client over time will help provide the trust that is helpful and often necessary in overcoming the stigma and denial the elderly frequently attach to mental health illnesses. A long-term therapeutic relationship can also benefit the provider in recognizing depression especially when it presents atypically. Further, it is important that the health care provider confront his/her own biases about aging, grief and loss, and depression so as to more effectively recognize and treat this potentially fatal condition in the elderly client. Due to the APN's holistic approach and tendency to apply non-pharmacologic modalities in the treatment of clients in primary care, CBS lend themselves well to their practice style. Therefore, it is important that the prospective APN become familiar incorporating brief, time-limited psychotherapies such as CBS into his/her practice style.

As the health care arena is changing rapidly it is important that clients learn to assume ever more responsibility in the process of health maintenance and illness prevention. The APN can gently and sensitively guide the elderly population away from the traditional "fix me" attitude to develop more of an equal partnership with the provider. In this partnership the APN functions as a clinician, educator, expert, guide and sounding board offering options and allowing the client to make educated decisions.

The educational setting should help make prospective APNs aware of the practice guidelines (such as the Depression Guideline Panel, 1993) available to treat a complex disease process such as depression. Also, the student should further be instructed and encouraged to use these protocols and learn when it is wise to seek a consultation or to make referrals to a

mental health specialist. The prospective APN greatly benefits from developing research and theory based protocols during the educational process as this author certainly has. S/he thereby becomes sensitized to the complexity of issues impacting treatment, and are helped in applying clinical guidelines or protocols in the future clinical setting. The educational setting is an important arena where age-related biases can be uncovered, challenged, and reality-based information imparted to refine the clinical skills of the prospective APN. With the curriculum of programs for APNs becoming increasingly laden with material needing to be covered, the APN increasingly needs to turn to continuing education to expand the knowledge base. The experience gained in the clinical setting will provide the necessary motivation to learn ever more effective treatment modalities, or simply to have more options for treatment available.

The APN in the primary care setting needs to be aware of the prevalence of depression, its typical and atypical signs and symptoms in the elderly person, methods of diagnosis using appropriate diagnostic criteria mentioned in the DSM-IV (1994), treatment and outcome evaluation, and help the elderly client express feelings about the stigma regarding a mental health problem to enhance compliance with treatment. The APN in his or her role as an educator needs to become comfortable discussing depression in simple and understandable terms for the lay person, emphasizing what depression is, how it affects feelings, as well as mental abilities and physiological functions, how common it is, and the high rate of successful treatment.

When introducing the proposed clinical guidelines for CBS into a practice setting, the APN is advised to hold an orientation meeting with his or her colleagues. The discussion can include a brief review of the literature on depressed elderly in primary care, the use of cognitive-behavioral therapy, bibliotherapy and the elderly depressed client, and an explanation

of the proposed clinical guidelines for CBS. As the APN obtains results and gains new experiences , s/he should keep the colleagues updated while concisely documenting outcomes.

The treatment of depressed elderly with non-pharmacological modalities in the primary care setting certainly requires more research in general, and specifically nursing generated research. This is becoming all the more important as a growing segment of our population is aging, facing specific age-related issues. This scholarly project could be used as a basis for a pilot study collecting pertinent data by using specific evaluation criteria from Appendix E. Possible research questions might include: What is the relationship between the use of CBS with depressed elderly in primary care and cost-effectiveness (as evidenced by utilization of health care resources and compliance with treatments) as compared to using only pharmacological interventions? Or: What is the relationship between the use of CBS with depressed elderly in primary care and the rate of relapse and recurrence of major depression as compared to using only pharmacological interventions? The APN can then publish the results obtained or use the results as a basis for negotiating improved coverage of CBS in primary care with insurance companies.

An other area which this author has found lacking in the literature deals with spiritual and existential issues the aging client faces and how to integrate these in the assessment and treatment phase of cognitive-behavioral therapy. It is interesting that the literature discussing CBS adapted to the depressed elderly client doesn't address this. One can only imagine that as the aging client faces issues of mortality and while reviewing his/her life seeks to impart meaning to especially painful experiences of the past, crises can arise which may contribute to the development of major depression. Although other forms of therapy have been developed to

deal with these issues outside of the primary care setting, perhaps research can indicate a way of integrating a useful approach for the APN to use in the primary care setting.

In order for research to enhance its efforts and utilize limited funds for issues benefiting the elderly population, our society needs to relearn how to honor and value its aging (and aged) members, learn to receive the manifold gifts they have to impart, and in return assist them as they face their challenges and metamorphoses. We will certainly all benefit from this partnership.

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Appendix A

Clinical Guidelines in the Use of Cognitive-Behavioral Strategies with Depressed Elderly

I. Self-Care Deficit Assessment (bio-psycho-social)

Objective Assessment	Subjective Findings
A) Bio-Medical History: Evaluate client with complete medical history and physical examination; specifically rule out endocrine disorders, cancers, infections, nutritional deficiencies, cardiovascular disease, metabolic disorders, collagen disorders, alcoholism and neurological disorders. Medication History: Prescription drugs, OTC; specifically antihypertensives, clonidine, reserpine, methyldopa, propanolol, guanethidine, diuretics, oral contraceptives, steroids/ACTH, cimetidine, digitalis, disulfiram, barbiturates, benzodiazepines.	
B) Psycho-Social History: - Assess for typical s/s of depression (as per DSM-IV): depressed mood, anhedonia, weight changes, insomnia/hypersomnia, psychomotor changes, fatigue/energy loss, low self-esteem/guilt, concentration problems/indecision, and thoughts of death or suicide nearly daily, for most of day, for at least 2 weeks and assess severity of depression (mild, moderate or severe). - Assess for atypical s/s of depression: cognitive deficit/pseudodementia, pain syndromes, somatization, anxiety/irritability and alcohol abuse. - Assess for risk factors for depression: personal or family history of depression, other medical illnesses, caregiving, being single (esp. widowed), financial burden, loss of independence, social isolation, gender (esp. female), and recent precipitating events/losses - Assess for suicide risk factors: hopelessness, caucasian race, male gender, advanced age, living alone, prior suicide attempts, family history of suicide attempts, family history of substance abuse. - Assess suicidal ideation, passive or active, plan, frequency of thoughts (note: refer client if you assess suicidal ideation with plan) - Assess Social Support Systems: i.e. level of near family or friend involvement, professional agencies, counselors/therapists, and get permission to contact any of them as needed for further information.	

Objective Assessment	Subjective Findings
C) Assess Specific Issues: 1) **Relaxation**: Assess current level of relaxation, tension, anxiety, muscle tension, headaches, trouble sleeping, stomachaches, jitteriness or shakiness. 2) **Pleasant Activities**: Assess for current involvement in pleasant activities: any changes since depression occurred, doing less compared to peers/friends, list daily or regular pleasant activities involved in. 3) **Problems with People (Social Skills):** a. **Assertiveness:** Assess current style of anger management, level of self-disclosure (thoughts and feelings), ability to say "no". b. **Personal Style**: Assess current interpersonal style: criticism of others, grooming, eye contact, content of speech (negativity), responsiveness to others. c. **Isolation**: Assess current degree of interaction with family and friends, feeling cut off from old friends, ability to initiate conversations or initiate activities, ability to actively interact socially. 4) **Troublesome Thoughts**: Assess for current types of abnormal thinking: - cognitive triad: the client's negative concept of him/herself as useless, a pessimistic view of the future and the outside world as threatening - schemas: assess for automatic negative thought patterns which result in occurrences being interpreted in an exclusively negative way - faulty information processing: in which dysfunctional thought processes (i.e. overgeneralization and misattribution) result in negative interpretations of occurrences. 5) **Problem Solving Skills**: Assess current ability to problem-solve, coping skills, feeling victimized by problems, tendency to overreact. 6) **Self-Control Problems**: Assess current self-control problems, ability to persevere or tendency to procrastinate. D) Develop Problem List for CBS based on above assessment (note: cover **Relapse Prevention** for everyone). E) Barriers to participating in CBS: Assess for physical problems (loss of hearing/vision, weakness, pain), literacy level, education, client's perceived needs, cultural issues, and ability to perform F) Ability to perform ADL/IADL.	

Appendix B

II. Diagnosis

Objective Assessment	Subjective Findings
Note: Appropriate diagnosis for CBS: mild to moderate major depression, non-psychotic (rule out visual or auditory hallucinations or delusions) and unipolar (no previous episodes of manic-depressive symptoms). Apply either BDI or GDS for diagnosis of depression. - Beck Depression Inventory:	
- Geriatric Depression Scale:	
- Mini-Mental State Examination:	

Appendix C

III. Plan

Content	Client Goal	Goal met	Goal not met	Comments
Develop a personalized treatment plan based on assessment of self-care deficits:				
1) Explain results of assessment, diagnosis of depression (assess fear of stigma and denial), and discuss problem list for CBS and prioritize with client.	1) Client will verbalize understanding assessment, diagnosis of depression (incl. verbalize fears of stigma or denial as applicable), and prioritize problem list for CBS			
2) Explain principles of CBS: - explain concepts 'cognitive' and 'behavioral' - explain that the idea upon which CBS is based believes that depression is a learned behavior (social learning theory) and teaches how to change negative thought patterns and enhance pleasant activities in order to minimize depressed mood - explain use of homework assignments (readings and exercise) based on book **Control Your Depression** (1992) by Lewinsohn, P.M. et al.	2) Client will verbalize understanding principles of CBS, understand importance of exercise techniques learned, agree to buy book **Control Your Depression** (1992) by Lewinsohn, P. M. et al., and agree to do homework assignments			
3) Ask if client agrees to learn CBS under guidance and supervision of APN over the next few weeks. If so:	3) Client will agree to learn CBS under guidance and supervision of APN			
4) Homework assignment: - read chapters 1-3	4) Client will verbalize understanding of homework assignment			
5) Set up F/U appointment	5) Client will make new F/U appointment			

Appendix D

IV. Interventions

Content	Client Goal	Goal met	Goal not met	Comments
Medication Teaching (if applicable):				
1) Review homework and mood	1) Client will review homework and give feedback, as well as express feelings/thoughts re: mood			
2) Discuss goal for the visit	2) Client will verbalize understanding goal			
3) Instruct client on new psychotropic medications prescribed: name, dose, frequency, action of medication, potential side effects and ways of coping with them, warn about interactions with Rx drugs, OTC and ETOH, stress importance of adherence to regimen, advise client not to discontinue medications independently, explain that full therapeutic effect may take up to 6-12 weeks, give written info on new meds, explain that side effects are a way to monitor the medication and to know that it is working in his/her body.	3) Client will verbalize understanding purpose and proper medication use			
4) No homework assignment	4) none			
5) Set up F/U appointment	5) Client will make new F/U appointment			

Content	Client Goal	Goal met	Goal not met	Comments
Relaxation:				
1) Review homework and mood	1) Client will review homework and give feedback, as well as express feelings/thoughts re: mood			
2) Discuss goal for the visit	2) Client will verbalize understanding goal			
3) Review personal s/s of tension, inability to relax, techniques used in past	3) Client will verbalize personal s/s of tension and relaxation techniques used in the past			
4) Discuss use of Daily Relaxation Monitoring Form to assess stress	4) Client will verbalize understanding use and purpose of Daily Relaxation Monitoring Form			
5) Discuss "Learning to Relax": - preliminary steps - procedure (have client practice relaxation in office 5-10 minutes) and allow client to give feedback - stress importance of daily practice	5) Client will verbalize and demonstrate understanding relaxation technique and will verbalize understanding importance of daily practice			
6) Discuss common problems relaxing and need to record practice sessions	6) Client will verbalize understanding common problems relaxing and need to record practice sessions			
7) Discuss applying relaxation exercise to specific situations	7) Client will verbalize understanding application of relaxation exercise to specific situations			
8) Discuss homework assignment: - Chapter 5 - other relevant exercises	8) Client will verbalize understanding homework assignment			
9) Set up F/U appointment	9) Client will make new F/U appointment			

Content	Client Goal	Goal met	Goal not met	Comments
Pleasant Activities: 1) Review homework and mood	1) Client will review homework and give feedback, as well as express feelings/thoughts re: mood			
2) Discuss goal for visit	2) Client will verbalize understanding goal			
3) Discuss how number of pleasant activities and level of enjoyment contribute to depression	3) Client will verbalize understanding of how pleasant activities affect mood			
4) Discuss development of self-change plan to increase number of pleasant activities	4) Client will verbalize understanding self-change plan to increase number of pleasant activities			
5) Discuss inverse relationship between pleasant activities and depression	5) Client will verbalize understanding relationship between pleasant activities and depression			
6) Discuss Mood-Related Activities i.e. social interactions, activities allowing us to feel useful/capable, intrinsically pleasant activities	6) Client will verbalize understanding of Mood-Related Activities and how they vary			
7) Discuss Pleasant Events Schedule as an assessment tool	7) Client will verbalize understanding of Pleasant Events Schedule			
8) Discuss writing own Activity Schedule (homework) & use this to self observe your mood & rate of engagement in pleasant activities (give examples)	8) Client will verbalize understanding personal Activity Schedule			
9) Discuss Antecedents (reasons for low numbers of pleasant activities): pressure from activities which must be done; poor choice of activities with high pleasantness potential; anxiety and discomfort during activity	9) Client will verbalize understanding Antecedents			
10) Discuss developing a balanced weekly plan (between 'must' and 'fun' activities)	10) Client will verbalize understanding balanced weekly plan			
11) Discuss homework assignment: - Chapter 6 - other relevant exercises	11) Client will verbalize understanding homework assignment			
12) Set up F/U appointment	12) Client will make F/U appt.			

Content	Client Goal	Goal met	Goal not met	Comments
Problems with People (Social Skills)				
I. Assertiveness:				
1) Review homework and mood	1) Client will review homework and give feedback, as well as express feelings/thoughts re: mood			
2) Discuss goal for the visit	2) Client will verbalize understanding goal			
3) Discuss that many mood-related pleasant activities involve social interaction, and that depression affects how we interact socially: decreased social activity, increased difficulty initiating contact, giving/receiving fewer positive statements, less socially skillful and comfortable etc.	3) Client will verbalize understanding the relationship between depression and altered social behavior			
4) Discuss what assertiveness is: ability to express one's thoughts openly, sharing hopes and fears, is of central importance for close and fulfilling relationships, helps avoid unpleasant encounters with others, decreases isolation and exploitation by others	4) Client will verbalize understanding assertiveness and its importance in fulfilling relationships and enhancing mood			
5) Discuss use of Assertion Questionnaire which rates frequency of assertion	5) Client will verbalize understanding use and purpose of Assertion Questionnaire			
6) Discuss learning how to develop assertiveness: creating a personal problem list, plan and reward	6) Client will verbalize understanding of how to develop assertiveness by creating a personal problem list complete with plan and reward			
7) Discuss using Self Monitoring of Assertion Form to monitor progress in asserting self	7) Client will verbalize understanding use and purpose of Self Monitoring of Assertion Form			
8) Discuss practicing assertiveness imagery to explore numerous responses and refine personal style	8) Client will verbalize understanding use and purpose of assertiveness imagery			
9) Discuss homework assignment: - Chapter 7 (p.107-119) - other relevant exercises	9) Client will verbalize understanding homework assignment			
10) Set up F/U appointment	10) Client will make new F/U appointment			

Content	Client Goal	Goal met	Goal not met	Comments
Problems with People **(Social Skills)** **II. Personal Style:** 1) Review homework and mood	1) Client will review homework and give feedback, as well as express feelings/thoughts re: mood			
2) Discuss goal for the visit	2) Client will verbalize understanding goal			
3) Do and discuss Personal Style Assessment (p. 120) with client and explain the impact our style has on others	3) Client will assess personal style and verbalize understanding its impact on others			
4) Discuss making personal problem list, setting specific goals and keeping track of targeted behavior (monitor progress) and rewarding success	4) Client will verbalize understanding the process of making a personal plan to change desired personal habits			
5) Discuss homework assignment: - Chapter 7 (p. 119+) - other relevant exercises	5) Client will verbalize understanding homework assignment			
6) Set up F/U appointment	6) Client will make new F/U appointment			

Content	Client Goal	Goal met	Goal not met	Comments
Problems with People (Social Skills)				
III. Isolation:				
1) Review homework and mood	1) Client will review homework and give feedback, as well as express feelings/thoughts re: mood			
2) Discuss goal for the visit	2) Client will verbalize understanding goal			
3) Discuss how depression can cause us not to use our social skills or causes us to be socially anxious	3) Client will verbalize understanding how depression affects use of social skills and causes social anxiety			
4) Discuss Social Activities Questionnaire to evaluate level of social participation	4) Client will verbalize understanding use and purpose of Social Activities Questionnaire			
5) Discuss problems interfering with social participation: - inadequate stimulation and how to develop plan to overcome this (Social Activities to Increase form, and Interferences: Activities to Decrease form) - inadequate reward and appropriate ways to reward oneself for positive outcomes	5) Client will verbalize understanding problems interfering with social participation and how to develop personal plan to overcome these			
6) Discuss homework assignment: - Chapter 8 - other relevant exercises	6) Client will verbalize understanding homework assignment			
7) Set up F/U appointment	7) Client will make new F/U appointment			

Content	Client Goal	Goal met	Goal not met	Comments
Controlling Thoughts:				
1) Review homework and mood	1) Client will review homework and give feedback, as well as express feelings/thoughts re: mood			
2) Discuss goal for the visit	2) Client will verbalize understanding goal			
3) Discuss how thoughts affect feelings and actions, and how we can use thoughts to improve mood (and number of pleasant activities)	3) Client will verbalize understanding relationship between thoughts, feelings and actions			
4) Discuss use of Self-Assessment of Thinking Patterns questionnaire to enhance awareness of thought patterns	4) Client will verbalize understanding Self-Assessment of Thinking Patterns questionnaire and its purpose			
5) Discuss daily use of Inventory of Thoughts inventory to identify positive and negative personal thoughts	5) Client will verbalize understanding use and purpose of Inventory of Thoughts			
6) Discuss techniques to manage thoughts and decrease negative thinking (thereby enhancing mood): - thought interruption (3 techniques) - worrying time - the blow-up technique	6) Client will verbalize understanding techniques to decrease negative thoughts			
7) Discuss techniques to manage thoughts and increase positive thinking: - priming - using cues - noticing what you accomplish - positive self-rewarding thoughts - time projection	7) Client will verbalize understanding techniques to increase positive thinking			
8) Discuss homework assignment: - Chapter 9 - other relevant exercises	8) Client will verbalize understanding homework assignment			
9) Set up F/U appointment	9) Client will make new F/U appointment			

Content	Client Goal	Goal met	Goal not met	Comments
Problem Solving Skills:				
1) Review homework and mood	1) Client will review homework and give feedback, as well as express feelings/thoughts re: mood			
2) Discuss goal for the visit	2) Client will verbalize understanding goal			
3) Discuss how the way we think about problems (overreact) affects how we deal with them and ultimately affects our mood	3) Client will verbalize understanding how overreacting to problems affects how we deal with them and how we feel			
4) Discuss nonconstructive self-talk: - using highly evaluative words - catastrophizing - overgeneralizing	4) Client will verbalize understanding nonconstructive self-talk			
5) Discuss use of The A-B-C Method (Activating event, Belief or self-talk about A, emotional Consequences) to help develop constructive thinking	5) Client will verbalize understanding The A-B-C Method and its purpose			
6) Discuss use of Daily Monitoring Form to recognize non-constructive self-talk and enhance problem solving skills	6) Client will verbalize understanding the use of the Daily Monitoring Form and its purpose			
7) Discuss homework assignment: - Chapter 10 - other relevant exercises	7) Client will verbalize understanding homework assignment			
8) Set up F/U appointment	8) Client will make new F/U appointment			

Content	Client Goal	Goal met	Goal not met	Comments
Self-Control Problems: (Self-Instructional Techniques)				
1) Review homework and mood	1) Client will review homework and give feedback, as well as express feelings/thoughts re: mood			
2) Discuss goal for the visit	2) Client will verbalize understanding goal			
3) Discuss self-talk and its benefits: - anticipating accomplishments, situations and actions - keeps you on track - helps you handle good or bad situations - motivates	3) Client will verbalize understanding self-talk and its benefits			
4) Discuss Using Self-Instruction to help achieve goals: - understand your objective - develop your plan - write down steps - use your plan - change plan as necessary - integrate plan into routine - reward yourself	4) Client will verbalize understanding Using Self-Instruction to help achieve goals			
5) Discuss homework assignment: - Chapter 11 - other relevant exercises	5) Client will verbalize understanding homework assignment			
6) Set up F/U appointment	6) Client will make new F/U appointment			

Content	Client Goal	Goal met	Goal not met	Comments
Relapse Prevention:				
1) Review homework and mood	1) Client will review homework and give feedback, as well as express feelings/thoughts re: mood			
2) Discuss goal for the visit	2) Client will verbalize understanding goal			
3) Review with client what has been done so far: enhanced knowledge about personal signs and symptoms of depression; ability to recognize depression; ability to understand causes of depression; ability to know situations, behaviors and thoughts contributing to depression; ability to apply self-change plan; ability to recognize reduction of s/s of depression ; ability to understand psychotropic medications; other (as relevant to individual client)	3) Client will verbalize recognizing accomplishments made			
4) Discuss importance of early recognition of depression and regular reassessment of mood	4) Client will verbalize understanding importance of early recognition of depression and regular reassessment of mood			
5) Discuss importance of prevention by preparing for stressful life events that could lead to depression	5) Client will verbalize importance of prevention by preparing for stressful life events that could lead to depression			
6) Discuss importance of using coping techniques learned and seeking support system for depression prevention or symptom reduction	6) Client will verbalize understanding importance of using coping techniques learned and support system for depression prevention or symptom reduction			
7) Discuss homework assignment: - Chapter 12 - other relevant exercises	7) Client will verbalize understanding homework assignment			
8) Set up F/U appointment	8) Client will make new F/U appointment			

Appendix E

V. Depression Evaluation

Expected Outcomes	**Evaluation Criteria**
1. Symptom reduction	- Effective coping skills - Beck Depression Inventory and Geriatric Depression Scale - Mini-Mental State Examination
2. Decreased risk of relapse and recurrence	- Typical and atypical s/s of depression - Effective coping skills - Number of relapses and recurrences - Beck Depression Inventory and Geriatric Depression Scale
3. Enhanced quality of life	- Beck Depression Inventory and Geriatric Depression Scale - Mini-Mental State Examination - Number of pleasant activities and negative thoughts - Effective coping skills
4. Amelioration of overall health	- Utilization of health care resources - Physical and mental functional status
5. Cost-effectiveness	- Utilization of health care resources - Compliance to treatments
6. Mortality reduction	- Suicide attempts - Death