

## Cognitive-Behavioral and Psychodynamic Group Psychotherapy in Treatment of Geriatric Depression

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The purpose of the study was to assess whether depressed geriatric patients would respond to group psychotherapy and, if so, would they respond differently to cognitive-behavioral and psychodynamic group psychotherapy. Thirty-three persons entered the study and 20 completed the 9-month course of treatment. Patients in both types of groups showed statistically and clinically significant reductions on observer-rated measures of depression and anxiety, as well as on self-report measures of depression. There were no clinically significant differences, but a statistically significant difference between the types of groups was found for the Beck Depression Inventory and this favored the cognitive-behavioral treatment. Limitations on interpretation of these results because of the lack of a control condition are discussed.

Approximately 7% to 11% of the American population age 65 and older suffer from depression (Gurland, 1976), making the treatment of depression in the elderly an important concern of both research and practice. Yet, few psychologists (Dorken & Webb, 1979) or psychiatrists (Marmor, 1975) in private practice see elderly patients, and the preferred mode of treatment for this age group appears to be pharmacological (Ford & Sbordone, 1980). However, the use of antidepressants may be contraindicated for a large number of el-

derly persons (i.e., those taking medication for chronic physical disease that may interact with the psychotropic drugs).

For this reason alone, it is important to be able to provide alternative treatments such as psychotherapy. Yet, despite a vast literature suggesting the utility of psychotherapy with the elderly (cf. reviews by Blum & Tross, 1980; Gotestam, 1980; Steuer, 1982), there are few empirical studies assessing treatment efficacy. Group therapy rather than individual therapy has been advocated for elderly patients (Grotjahn, 1978; Hartford, 1980; Wolff, 1967), both for its cost-effectiveness and to counteract the isolation and loneliness presumed to be common in old age. As mentioned earlier, empirical data on the efficacy of group psychotherapy as a treatment for depression in geriatric outpatients are generally lacking. Outcome data from group therapy investigations are from analogue studies with nonpatient samples (Ingersoll & Silverman, 1978) or from studies with institutionalized patients in groups of diverse diagnostic composition, including "organicity," schizophrenia, and depression (Nevruz & Hrushka, 1969; Wolff, 1962, 1967; Wolk & Goldfarb, 1967). One of the very few studies of depressed geriatric outpatients in the literature reports that 5 weeks of behavioral and supportive group psychotherapy were equally effective in reducing self-reports of depression (Gallagher, 1981).

The present study was designed to inves-

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tigate whether elderly depressed outpatients could respond to group psychotherapy and, if so, would older persons respond differently to cognitive-behavioral group therapy when compared with psychodynamic group therapy. The two treatment types were chosen for the following reasons: (a) Cognitive-behavioral therapy has been shown to be extremely effective in younger age groups and therefore information on its effectiveness with older persons was considered important, and (b) psychodynamic treatment is among the oldest and most frequently used forms of therapy. Therefore, it seemed an appropriate comparison condition.

The issue of an appropriate control condition for psychotherapy research was carefully considered and bears some discussion here.

An experimental study of psychotherapeutic effectiveness must compare two or more treatments. It is impossible to conceive of a true (i.e., untreated) control group which can be precisely implemented in such research. A group not explicitly treated (in some way) as part of the study is likely to suffer serious attrition or to seek treatment elsewhere. Also, withholding therapy is itself a treatment. . . . Hence, the comparison must be . . . between qualitatively different treatments. (Fiske et al., 1970, p. 24)

Traditional types of control groups, including no treatment, wait list/assessment, and attention/placebo conditions, seemed for the following reasons to be either impractical, unethical, or a combination of the two. A no-treatment control of 9-months duration is probably impossible when moderately-to-severely depressed elderly persons are being considered. It would seem likely that if persons actively seeking treatment cannot get it from one source they will try another. Moreover, it was considered unethical to withhold treatment from such distressed people. To provide an inactive psychosocial control condition such as wait list/assessment or attention/placebo that replicates the nonspecific factors of the psychotherapy treatment without in itself becoming an active treatment is technically impossible given the length of this study. Moreover, we do not know, even were it possible to develop such a control condition, if "inactive" conditions are truly benign or if they contribute to an increase in suffering through continuation of the depression. Not taking action may, through prolonging the depression, also decrease responsiveness to treatment when it

is finally delivered (O'Leary & Borkovec, 1978). Thus for practical and ethical reasons no control group was used in this present study, but rather we followed the suggestions of Fiske et al. (1970) and designed the study as a comparison between two treatments.

## Method

### *Subject Selection*

Patients were recruited through local newspapers, radio programs, senior citizen organizations, and by referral from community physicians and mental health professionals. After an initial phone contact with the project, patients underwent a 3-stage screening process: (a) a phone screen, (b) a clinical interview with either a psychiatrist or psychologist, and (c) a psychometric evaluation. Specific criteria for admission were as follows: age of 55 years or more, a diagnosis of major depressive disorder according to the criteria of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association, 1980), and a score of 16 or greater on the 21-item version of the Hamilton Depression Scale (HAMD; Hamilton, 1967). Patients were not to be receiving treatment elsewhere. Exclusionary criteria were as follows: (a) recent history of alcoholism; (b) presence or history of schizophrenic disorder; (c) depression secondary to major physical illness, malnutrition, or medication; (d) active suicidal ideation; and (e) severe cognitive impairment.

### *Subjects*

In conjunction with a concurrent trial of antidepressants (Jarvik, 1979), over 100 persons were screened by phone during each of the 2 years of this present study. Approximately half of this number received a clinical evaluation, and, of these, about 40% entered one of the two studies. The remaining persons were almost equally divided into those who did not meet entrance criteria and those who refused to enter either study. As a general rule, patients' initial inquiries were responded to within 1 week, and, after possible eligibility was assessed by a phone screen, every attempt was made for patients to be clinically evaluated within 1 month. Most patients were able to enter a group during the 6 weeks after their evaluation, but a few persons did wait from 8 weeks to 5 months for treatment to begin.

Patients for the current study were 26 women and 9 men (age range = 55 to 78 years; median age = 66) who volunteered and met the entrance criteria for the study. All were community residents who were able and willing to travel to the project offices. The majority of patients were married (69%) and living with a spouse, and the remainder (31%) were divorced. One person was widowed during the course of treatment. Patients were generally well-educated, though the education level varied widely; 36% had attained at least a college degree, and 41% of those had continued to graduate school. Another 39% had some college education; 15% had finished high school; and 9% had not completed grade school.

Most patients had some form of chronic physical disease, with 9 patients having four or more health problems and

only 3 patients having no current diagnosed condition. The most common medical disorders were hypertension, circulatory problems, heart disease, and arthritis. Duration of the current depression ranged from 2 months to 15 years ( $M = 3.7$  years). Onset of the first episode of depression covered a wide range from early childhood to age 70.

Thus, the typical group member was a married, Caucasian woman who was native born, relatively well-educated, and middle class with at least one chronic illness that was not severely incapacitating. The gender composition of this sample is representative of older Americans as is perhaps the general health status. Less representative, however, may be the high level of education of persons in this study.

Data from 2 persons are not listed here. One man died shortly after beginning treatment and 1 woman dropped out after four sessions and refused to return for a second evaluation. Table 1 summarizes patient characteristics.

### Treatments

Four groups, two with each type of treatment, were conducted. Therapist availability determined that the first group was cognitive behavioral. Therefore, the second group was psychodynamic. As patients on the waiting list for the third group were most similar on HAMD scores to those in the cognitive-behavioral group, the third group was designated as psychodynamic.

Each group had two female co-leaders, one of whom was considered an expert and the other was considered a trainee in the specific type of treatment. Each leader-expert had at least 1 year of supervised clinic experience as well as another year of didactic training in the type of therapy. One leader was a Ph.D., two were M.S.W.s, and the other five were clinical psychology graduate students at the internship level.

Prior to the first group psychotherapy meeting, patients were seen for an individual session by one of their two group leaders. At this interview patients were informed as to which type of group they were assigned, and fears and expectations the patients had concerning group therapy were explored. Patients were asked at this time to make a 12-week commitment to attend the group meetings. It was explained that we would not coerce them to attend but that we would like this promise because it would take a while for us to know them and for them to know us. Moreover, it takes time for treatment to be effective, and we would like them to have the opportunity of benefiting from the treatment if it were effective. Group rules about such topics as punctuality, confidentiality, subgrouping, and attendance were discussed.

A manual was prepared for each treatment type (Emery, 1979; McCarley, 1980), and the group leaders were trained in the use of the manual by consultants to the project. Leaders received a minimum of 1 hour of supervision for every four sessions from a consultant expert in the specific therapy. This expert was also responsible for verifying that treatment was consistent with type of therapy. Moreover, videotapes from the first cognitive-behavioral group were reviewed by personnel at the Center for Cognitive Therapy in Philadelphia who verified that cognitive-behavioral treatment was being done, and project observers viewing the videotapes were able to differentiate correctly the two types of therapy.

Table 1  
*Patient Characteristics*

Characteristic	<i>n</i>	%
Sex		
Male	8	24
Female	25	76
Age		
55-64	12	36
65-74	17	52
75+	4	12
Education		
Finished college	12	36
Some college	13	39
Finished high school	5	15
Some grade school	3	9
Marital status		
Married	22	67
Divorced	11	33
RDC		
Agitated	11	33
Retarded	10	30
Neither	8	24
Mixed	4	12

*Note.* RDC = research diagnostic criteria.

The cognitive-behavioral groups were treated by methods proposed by Beck, Rush, Shaw, and Emery (1979) and adapted by Emery (1979) to the group format. Cognitive-behavioral therapy is characterized as an "active directive, time-limited, structured approach" to the treatment of depression (Beck et al., 1979). It uses both behavioral techniques and cognitive strategies to change behavior and modes of thinking. Examples of behavioral interventions used in the present study were weekly activity schedules, mastery and pleasure log, and graded task assignments. Cognitive techniques included recording of negative cognitions (automatic thoughts), empirical reality testing of these cognitions, examining distortions (e.g., overgeneralizations, catastrophizing, dichotomous thinking), and generating new ways of viewing one's life.

The psychodynamic approach was based on the work of Alexander (1946), Grotjahn (1977), and Yalom (1975) as modified for a manual for group therapy by McCarley (1980). Psychodynamic group therapy is not psychoanalysis but is based on psychoanalytic concepts. Concepts, such as the dynamic unconscious, insight, transference, and resistance, guide but do not limit the leaders' choice of interventions. Interventions used in the psychodynamic groups included leader behaviors of the following types: support, direction, confrontation, facilitation of corrective emotional experiences, as well as interpretation. For the most part, the leaders of the psychodynamic groups focused on (a) the development of group cohesion, as defined by Yalom (1975), to relieve the acute symptoms of depression and forge a working group, and (b) the redevelopment of insight into patterns of socially maladaptive behavior (e.g., inadequate assertiveness, overaggressiveness, etc.) in order to help patients avoid recurrence of depression. The main principle guiding leader interventions was that the leader

did for the group only what the group was unable to do for itself.

Groups met twice a week for 10 weeks and once a week for the following 26 weeks for a total of 46 sessions over a 9-month period. Each meeting lasted 1.5 hours.

### *Procedure*

The nature of the study was explained during the clinical interview. After the person expressed willingness to participate in the study, that person was asked to sign an informed consent form.

Patients were assigned to groups on the basis of time entering the study. Reflecting the preponderance of women in the upper age groups, the ratio of men to women at the beginning of treatment was 2:6 and 1:8 in the cognitive-behavioral groups and 3:5 and 3:7 in the two psychodynamic groups.

Patients completed self-rating forms and were re-interviewed (usually by the same rater—not a group leader—who saw them before treatment began) at 4, 8, 12, 26, and 36 weeks. Patients who failed to complete treatment were, if possible, re-interviewed at the time they dropped out. Patients were evaluated at first contact with the project, and if the waiting period was prolonged, they were re-evaluated prior to starting therapy. Most patients showed some improvement over the waiting period (mean improvement = two points on the HAMD), and 3 persons (2 of those who completed treatment) fell below entrance criteria on the HAMD. The first pretreatment rating was selected as the most appropriate baseline for this report as it was available for all participants. Results were also computed using the second pretreatment rating for those for whom it was available ( $N = 12$ ).

### *Instruments*

Presented here are analyses of data from observer ratings on the Hamilton Depression Scale (HAMD) and the Hamilton Anxiety Scale (HAMA) and self-ratings from the Zung Self-Rating Depression Scale (SDS) and the Beck Depression Inventory (BDI).

The HAMD (Hamilton, 1967) has been used extensively in assessing depressive symptomatology in the elderly. The instrument, which focuses heavily on vegetative symptoms of depression (Kochansky, 1979), is a 21-item scale with items rated 0–2 or 0–4. The possible range for total scores is 0–62. A score of 16 or more has been used in previous studies with the elderly (Gerner, Esterbrook, Steuer, & Jarvik, 1980) to indicate clinical depression of moderate severity, whereas a score of six or less has been used to indicate remissions.

The HAMA (Hamilton, 1959) has 14 items rated on a 5-point scale with a range of 0 to 70. Items focus primarily on somatic symptoms of anxiety, although cognition and behavior are also assessed. No published cutoff scores were found for this scale.

The SDS (Zung, 1965) has been widely used to assess self-rated depression in elderly persons (McNair, 1979). It is a 20-item instrument with each item scored on a 4-point scale. Total scores may range from 20 to 80. According to Zung (1967), persons with a raw score of 40 or greater fall into the depressed range. No cutoff scores are given for mild, moderate, and severe depression.

The 13-item BDI (Beck, 1967) is part of the Early Clinical Drug Evaluation Program (ECDEU) assessment battery (Guy, 1976) and differs from the 21-item-long version primarily by excluding items pertaining to somatic symptoms of depression. Each item is rated from 0 to 3, with the possible range for total scores being 0 to 39. Beck and Beamesderfer (1974) suggested cutoff scores of 0 to 4 as no depression, 4 to 7 as mild, 8 to 15 as moderate, and 16+ as severe depression.

### *Results*

A  $2 \times 2$  (Therapy Type  $\times$  Group) multivariate analysis of variance (MANOVA) comparison of baseline scores for all subjects indicated no differences between types of treatment, but significant within-type differences were obtained for the two psychodynamic groups on the HAMD,  $F(1, 2) = 4.00, p < .05$ . When scores for only those who completed treatment were subjected to the same analyses, no significant differences between or within treatment types were obtained. Group differences at baseline appeared, therefore, to be related to scores of those who dropped out of treatment.

#### *Subjects Who Did Not Complete Treatment*

Of the 33 persons who began the study, 13 (39%) left before the 9-month treatment period ended. Approximately equal numbers dropped out of each group. Three persons left treatment by or at the fourth week, whereas the other 10 left at Week 12 or later. In three of the four groups (the exception being the second cognitive-behavioral group), those who dropped out had higher mean HAMD scores at the beginning of treatment than did those who completed treatment, but this difference did not reach statistically significant levels except for the second psychodynamic group,  $F(1, 2) = 6.54, p = .02$ . Eleven persons who began the study were classified as having agitated depressions, and of these, 7 (64%) dropped out of treatment before the 9-month period ended. Two of the 10 (20%) with retarded depression and 4 of the 12 (33%) others with mixed or unclassified depressions also dropped out of treatment.

Three of the 13 subjects who dropped out either did not improve or deteriorated slightly on the HAMD by the time they left treatment, whereas 10 showed improvements in depres-

sion on this scale, ranging from 21% to 95%, with a mean improvement of 34%.

Treatment Outcome

Data were combined across treatment type yielding two groups for the analyses. Ten patients completed each form of treatment: 4 in the first and 6 in the second cognitive-behavioral group, and 5 in each psychodynamic group. Results only for those who completed treatment are presented before results for endpoint analyses. These subjects attended an average of 37.5 sessions or 81% of the possible 46 sessions (range = 26–46 sessions).

Repeated-measures analyses of variance (ANOVAS), using data only from those who completed treatment, indicated significant positive linear changes for the two treatments on each of the four dependent variables ( $df = 1, 18$ ): HAMD ( $F = 66.08, p < .01$ ), HAMA ( $F = 31.47, p < .01$ ), SDS ( $F = 14.89, p < .01$ ), and BDI ( $F = 15.68, p < .01$ ). The only statistically significant Linear Group  $\times$  Time interaction was on the BDI ( $F = 5.89, p < .05$ ), with persons in the cognitive-behavioral treatment showing greater gain than those in the psychodynamic treatment over the 36-week time period. The use of second pretreatment scores did not alter the results.

Endpoint analyses use available scores from all subjects. Thus, results from those who

dropped out, as well as from those who completed treatment, are included in the assessment of treatment. Within-groups analyses of different scores for all subjects at endpoint show significant decreases for both treatments in the HAMD cognitive-behavioral ( $t = 5.89$ ) and HAMD psychodynamic ( $t = 6.38$ ), HAMA cognitive-behavioral ( $t = 4.21$ ) and HAMA psychodynamic ( $t = 6.02$ ), SDS cognitive-behavioral ( $t = 3.38$ ) and SDS psychodynamic ( $t = 4.71$ ), and the BDI cognitive-behavioral ( $t = 5.01$ ) and BDI psychodynamic groups ( $t = 3.03$ ; all  $ps < .01$ ).

Analyses of covariance (ANCOVAs) were utilized for between-groups endpoint analyses with pretreatment scores being the covariate. There were no significant differences between treatment types on the HAMD, HAMA, or the SDS. However, treatment differences on the BDI were highly significant,  $F(1, 30) = 7.64, p < .01$ , with the cognitive-behavioral group again showing greater change than the psychodynamic group. Pre- and posttreatment means and standard deviations for those who completed treatment and for all subjects who participated are shown in Table 2.

Average scores used in statistical analyses may hide clinically important information. Therefore, data using cutoff scores to indicate level of depression were examined and are presented in Table 3. Criteria for determining cutoff scores are referenced in the assessment

Table 2  
Pre- and Posttreatment Means and Standard Deviations for Those Who Completed Treatment and All Subjects on Depression Scales

Statistic	Cognitive behavioral <sup>a</sup>						Psychodynamic <sup>b</sup>					
	BDI		Zung		HAMD		BDI		Zung		HAMD	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Those who completed treatment												
<i>M</i>	16.50	8.70	53.20	45.60	18.40	8.30	14.10	11.60	50.90	45.30	18.90	9.50
<i>SD</i>	6.13	4.78	8.59	11.02	1.90	3.65	3.63	5.06	8.94	7.36	2.68	5.62
All subjects												
<i>M</i>	16.38	8.62	53.62	46.44	18.62	10.12	15.41	12.24	52.71	47.71	20.53	11.24
<i>SD</i>	6.12	3.95	7.88	8.71	2.36	6.08	6.65	6.11	8.12	6.72	4.17	5.06

Note. BDI = Beck Depression Inventory; HAMD = Hamilton Depression Scale.  
<sup>a</sup> Sample sizes for the two cognitive-behavioral groups were 10 and 16, respectively.  
<sup>b</sup> Sample sizes for the two psychodynamic groups were 10 and 17, respectively.

section of this article. Differences between treatment types do not unexpectedly appear. However, of the 20 patients who completed treatment, 16 (80%) showed some improvement and 8 (40%) of these went into remission when data from the HAMD, the major screening instrument, were scrutinized. Completion of the treatment program appears to be related to remission as this occurred in only 1 person who did not finish the program. Some amelioration of symptoms did occur for 5 others who dropped out, but more than half of those who dropped out did not appear to benefit greatly. Although statistically significant changes in means were found for the SDS, only 4 persons (all of whom had completed treatment—20%) attained scores outside of the depressed range. These results are shown in Table 3.

BDI scores indicate that although 3 of those who completed treatment (2 in the cognitive-behavioral program) went into self-rated remission (15%) and 2 more (1 from each treatment type) had only mild depressions, 15 of those who completed treatment (75%) still rated themselves as having moderate to severe depressions after 9 months of treatment. Four of those who dropped out gave themselves ratings of mild depression, whereas 9 still thought they were moderately to severely depressed (see Table 3).

### Course of Treatment

Of the 20 persons who finished treatment, 16 had greater positive percentage changes on the HAMD between Weeks 26–36 than between baseline and Week 26. Differences in percentage change between Weeks 0–26 compared with Weeks 26–36 showed a trend ( $t = 2.05$ ,  $p = .06$ ) but did not reach statistical significance (group HAMD means are shown in Figure 1). This phenomenon was not as pervasive on the BDI, with 8 of the 26 persons (3 in the cognitive-behavioral treatment) showing greater gains between Weeks 26–36 than during the preceding 25 weeks. The higher percentage decreases toward the end of the study period, particularly in observer-rated depression, may be due to a “flight into health” or to the “hello/goodbye” phenomenon, for although patients were informed of the length of treatment at the beginning of the study, it

Table 3  
Pre- and Posttest Cutoff Scores on Depression Scales

Cutoff score	Cognitive behavioral <sup>a</sup>						Psychodynamic <sup>b</sup>					
	BDI			Zung			BDI			Zung		
	0-4	5-7	8-15	16+	0-39	40+	0-6	7-12	13+	0-6	7-12	13+
Those who completed treatment												
Pre	1	3	6	10	0	10	0	0	0	1	9	0
Post	2	1	6	1	2	8	5	4	1	2	8	3
All subjects												
Pre	1	1	4	10	0	16	0	0	16	1	16	0
Post	2	3	10	1	2	14	6	6	4	2	15	7

Note. BDI = Beck Depression Inventory.

<sup>a</sup> Sample sizes for the two cognitive-behavioral groups were 10 and 16, respectively.

<sup>b</sup> Sample sizes for the two psychodynamic groups were 10 and 17, respectively.

was only at Week 26 that group leaders began to address the issue of termination.

Discussion

This study was designed to assess (a) whether or not moderately-to-severely depressed geriatric outpatients would respond to group psychotherapy, and (b) whether one form of group psychotherapy studied was more effective than the other. Results indicate statistically significant positive linear changes across time on the HAMD, HAMA, BDI, and SDS for those who completed treatment in both forms of group psychotherapy.

Endpoint analyses using pre-post difference scores also indicate significant within-groups decreases on all four scales. Thus depressed geriatric outpatients in group psychotherapy showed statistically significant reductions in depression and anxiety as measured by observer and self-rating scales. Moreover, 40% of those who completed treatment and 27% of those patients who started treatment went into remission, as measured by the HAMD. However, due to the lack of control group, we cannot clearly attribute these changes to treatment effects.

The lack of control groups in the design of the study was the result of careful deliberation

about the needs of patients and the goals of the research. We felt that ethical considerations prohibited us from withholding treatment for this population of elderly depressed outpatients and that it was technically unfeasible to develop a "placebo" psychotherapy of equivalent duration and believability. Moreover, we felt that the basic goal of the study was not to demonstrate that psychotherapies "work" for older depressed outpatients. Demonstrations of treatment versus no treatment have already established the superiority of treatment across a variety of modalities and populations. Also, both cognitive-behavioral and psychodynamic treatments have an established record of successes. Instead, the goal was to learn whether group-administered treatments could be successful for older depressed patients, especially those for whom medical considerations would preclude antidepressant medications. A related goal was to learn if one form of psychotherapy would be more effective than another.

Therefore, although it is technically impossible to conclude that the treatments were responsible for the symptom reductions observed, given the lack of control conditions, there are several reasons for concluding that such changes were not merely due to spontaneous remission. First, the majority of patients have had a long history of depression (a mean of nearly 4 years), so that spontaneous

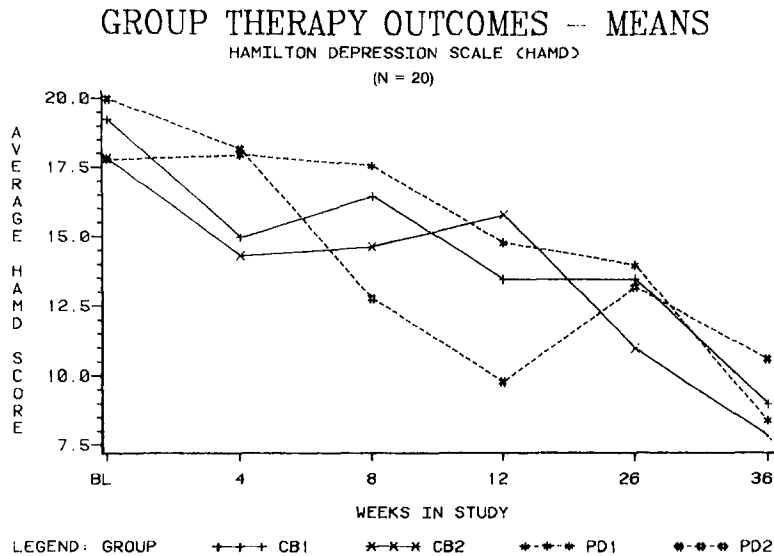


Figure 1. Means for group therapy outcomes on the Hamilton Depression Scale (HAMD; BL = baseline; CB = cognitive behavioral; PD = psychodynamic).

remission following 9 months of psychotherapy was too coincidental to be a likely explanation. Second, our own internal "wait list" period revealed only minor declines in depression level before treatment began. Third, persons who dropped out of treatment showed less improvement than those who completed it. Only 1 of 13 subjects who dropped out showed remission on the HAMD, whereas 40% of treated persons remitted. Together these results add up to a strong, if circumstantial, case for the relative effectiveness of treatment versus no treatment.

Patients in both treatment conditions showed statistically significant decreases in depression on all measures, but there were differences in the levels of change indicated by the various instruments. For example, the SDS showed the fewest clinical remissions as only 4 of those who completed treatment (20%) and none of those who dropped out had scores sufficiently low to fall below the cutoff for the depressed range. For the elderly it may be that scale items measuring depressive symptomatology are unduly influenced by other factors, especially health (Blumenthal, 1975; Steuer, Bank, Olsen & Jarvik, 1980). The scale, apparently sensitive to change induced by psychotropic medication in elderly depressed patients (Kochansky, 1979), may be less sensitive to the type of change that occurs in psychotherapy.

An examination of comparative efficacy of the two types of treatment with only 10 persons for each type can lead to only tentative conclusions. With this caution in mind, we note that the only statistically significant differences were found on the BDI, both only for those who completed treatment and for all subjects at endpoint. These differences favored cognitive-behavioral treatment. Because the BDI is heavily loaded with subjective depressive items such as hopelessness and self-criticism, it may be that cognitive-behavioral therapy that directly confronts such negativistic cognitions would cause significant gains on this measure. Undoubtedly, these are important aspects of depression, but it is also worth considering that cognitive-behavioral therapy may "teach" the scale. The possibility of this type of measurement bias should be borne in mind when the BDI is used as an outcome measure in psychotherapy research comparing cognitive-behavioral therapy with other treatments. The

other measures used in the present study did not show treatment differences.

The superiority of the cognitive-behavioral treatment shown on the BDI in statistical analyses is not supported when one looks at the number of persons who went into either remission or the mild range of depression. For both groups combined, only 25% ( $n = 5$ ) of those who completed treatment and 27% ( $n = 9$ ) of the total group improved sufficiently to score in the mild or no-depression range. And of these, 3 of those who completed treatment and 2 of those who dropped out were in cognitive-behavioral groups, whereas 2 of those who completed treatment and 2 of those who dropped out were in psychodynamic groups.

Our current results are not in accord with those studies of younger people reporting cognitive-behavioral group therapy to be a more effective treatment for depression than behavior therapy, attention by assessment (Shaw, 1977), or insight group therapy (Morris, 1975). Our failure to replicate earlier results may be due to several reasons. Perhaps the therapists in our study were too inexperienced to provide an adequate test of cognitive-behavioral therapy. This is of course a possibility, but all therapists were trained by experienced therapists; sessions were carefully supervised; and outside observers considered the therapists competent. A second consideration is that cognitive-behavioral treatment may not be particularly effective with the type of chronic depressions (Fennell & Teasdale, 1982) that we were treating. And finally, the differences in results could be accounted for by the age of subjects (college students vs. elderly patients) and/or length of treatment. The duration of the present study perhaps allowed the psychodynamic treatment sufficient time to demonstrate efficacy equal to the cognitive-behavioral treatment.

If one compares the 40% remission rate for those who completed treatment on the HAMD with the rates of 25% and 20% on the BDI and the SDS, respectively, it appears that observers note greater response in depressed geriatric outpatients to group psychotherapy than do the patients themselves, thus raising the issue of what are observers rating that patients are not seeing, feeling, or thinking.

#### *Subjects Who Did Not Complete Treatment*

The drop-out rate of 39% in this study is slightly higher than that of 30% expected with



younger age groups (Yalom, 1975) and much higher than the 18% previously reported by Rush and Watkins (1981) and by Gallagher (1981). Only 9% of the patients in the present study left treatment before Week 12, a rate lower than any previously published. The lack of subjects who dropped out early may be attributed to the verbal commitment made at the initial interview with the group leader. Perhaps a verbal promise is sufficient to hold people for 12 weeks even when they are specifically told that no one would be coerced into staying. This period was long enough, it should be noted, to manifest some decrease in depression.

The change in number of sessions per week, and thus a decrease in intensity of treatment, may also have contributed to persons leaving treatment. Subjects who dropped out tended to have higher depression scores at baseline than those who completed treatment, and, perhaps, the decrease in the number of sessions combined with relative severity of their depression caused those who quit treatment early to think they were not getting enough help fast enough. Reasons patients stated for dropping out of treatment were primarily dissatisfaction with the group ( $n = 8$ ), with other reasons related to problems with family ( $n = 2$ ), work ( $n = 2$ ), and health ( $n = 1$ ).

Five persons could be considered casualties, or, at the least, nonimprovers. These are defined here as persons who finished treatment without a positive change in HAMD score or whose HAMD remained above entrance criteria. Nonimprovers were equally likely to be in either type of treatment with 2 in the cognitive-behavioral and 3 in the psychodynamic groups. Four of the 5 were subjects who dropped out, whereas 1 completed the 36-week treatment period. The rate of 15% is slightly higher than that of 10% reported by Lieberman, Yalom, and Miles (1973), but whether this difference is meaningful or due to sampling error is unknown. None of the pretest depression measures distinguished nonimprovers from other group members. Clinically they can be described as angry and inclined to reject any shared association or identification with other group members or leaders, an observation in accord with conclusions from the Lieberman et al. (1973) study of encounter groups. Nonimprovers are a very im-

portant and often neglected subgroup (Bergin & Lambert, 1978), and in future data analyses we shall seek ways of making an early identification of such persons.

When treatment types were compared, it was only on the BDI that differences appear. There were no other statistically significant differences between treatment types in outcome or in the timing of symptom reduction. Our current results appear to support the observations of Luborsky and colleagues (Luborsky, Singer, & Luborsky, 1975) who, after reviewing more than 100 psychotherapy outcome studies, concluded that most comparative studies did not show substantial differences between treatment types.

In the absence of a control group, we cannot conclude that the significant statistical and clinical reductions in depression that occurred over the 9 months of treatment are attributable to the treatment. However, we must note that, given the chronic and enduring course of the patients' depression prior to entering therapy, it might be reasonable to suspect that the therapy experience was beneficial and may provide an intervention option for older persons who are physically ill and unable to take antidepressant medications.

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