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Competitive Memory Training for treating depression and rumination in depressed older adults: A randomized controlled trial

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ABSTRACT

Although rumination is an important mediator of depressive symptoms, there is insufficient proof that an intervention that specifically targets rumination ameliorates the clinical condition of, depressed patients. This study investigates whether a time-limited cognitive behavioral intervention (Competitive Memory Training, or COMET for depressive rumination) is an effective treatment for depression and rumination. This intervention was tested in older adult depressed outpatients. A total of 93 patients (aged ≥65 years with major depression and suffering from rumination) were treated in small groups according to the COMET protocol in addition to their regular treatment. Patients were randomized to two treatment conditions: 7 weeks of COMET + treatment-as-usual (TAU) versus TAU only. COMET + TAU showed a significant improvement in depression and rumination compared with TAU alone. This study shows that the transdiagnostic COMET protocol for depressive rumination might also be successful in treating depression and rumination in older adults.

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Introduction

Depression is a highly prevalent psychiatric disorder in later life (Beekman, Copeland, & Prince, 1999) that is associated with substantial costs and burden (Murray & Lopez, 1997), and excess mortality rate (Cuijpers & Smit, 2002). The prevalence of depression is expected to increase, especially in older adults (Heo, Murphy, Fontaine, Bruce, & Alexopoulos, 2008). Rumination is one of the key cognitive aspects of depression (Papageorgiou & Wells, 2004). Rumination is defined as the tendency to experience intrusive, repetitive and negative cognitions about symptoms of depression, and the possible causes and consequences of these symptoms (Alloy, Ambramson, Metalsky, & Hartlage, 1988; Martin & Tesser, 1989, 1996; Nolen-Hoeksema, Morrow, & Fredrickson, 1993). Rumination predicts the onset, duration, relapse and severity of depression (Just & Alloy, 1997; Kuehner & Weber, 1999; Lyubomirski & Nolen-Hoeksema, 1995; Nolen-Hoeksema, 2000). Furthermore, rumination has a negative impact on thought content (Lyubomirski, Tucker, Caldwell, & Berg, 1999), impedes problem-solving skills (Watkins & Baracaia, 2002) and mediates the predictive effect of other known risk factors of relapse (e.g., attributional style) (Alloy et al., 1988). Rumination is an important factor in late life depression (Erskine, Kvavilashvili, & Kornbrot, 2007; Von Hippel, Vasey, Gonda, & Stern, 2006) as well as in adult patients (see, for example, Smith & Alloy, 2009).

Several treatments have been developed that target rumination, including meditation (Segal, Williams, & Teasdale, 2002), attention training techniques (Wells, 1990), acceptance and commitment therapy (Hayes, Luoma, Bond, Masuda, & Lillis, 2006), and rumination-focused cognitive behavior therapy (RFCBT) for residual depression (Watkins et al., 2007). Watkins, Bayens, and Read (2009) also developed concreteness training (CNT). Purdon (2004) reports that treating rumination is difficult, e.g. whereas meditation and attention training seem promising interventions, both have only moderate effects. Wells (2007) states that there appears to be a consistent positive effect of attention training for a range of disorders, but these data are preliminary.

In the present study the effectiveness of a new, time-limited transdiagnostic training was adapted to treat depression by focusing on rumination in older patients. The supposed mechanism of change is by inhibiting access to dominant dysfunctional attitudinal styles and meanings by facilitating access to more functional attitudes and meanings. According to Brewin (2006), cognitive therapy does not directly modify negative information in memory but rather influences the relative retrievability of the different meanings that emotional

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concepts are associated with. Strengthening the retrievability of functional representations that are in *retrieval competition* with dysfunctional negative representations is considered to be the core activity of all effective psychological treatments.

The transdiagnostic training for worrying and rumination is described as Competitive Memory Training (COMET) (Korrelboom, Visser, & Ten Broeke, 2004). During the last decade several specific COMET protocols have been developed and have been (or are being) put to the test. Apart from many similarities, these COMET protocols have mutual divergences, due to the specific problems they are meant to treat (for an overview of COMET protocols and studies, see: Van der Gaag & Korrelboom, 2010). The current COMET for depressive rumination intervention targets underlying cognitive processes instead of the content of dysfunctional cognitions. Its aim is not to change the negative emotions and thoughts themselves but rather the amount of involvement the patient has with these thoughts and emotions. This might be crucial, since focusing on content may sometimes worsen rather than decrease rumination (Nolen-Hoeksema et al., 1993). The COMET protocol builds on Lang's work on cognitive emotional networks (Lang, 1985, 1994) in order to strengthen an emotional network. According to Lang, cognitive emotional networks in long-term memory consist of auditory-visual stimulus representations, motor and visceral response representations, and symbolic representations. Activation of an emotional network is a function of the number of matches between perceptions of the real world, the information already stored in these emotional networks, and the priming of specific elements therein. In COMET for depressive rumination, the counter themes of being indifferent or adopting an attitude of acceptance are trained to become more emotionally salient. This is accomplished by selecting memories of the counter theme (personalized scenes in which patients are able to detach from worrisome or emotionally-charged situations by being indifferent, or by adopting an attitude of acceptance) and relive the memory by simultaneously activating stimulus, response and symbolic representations. In this way a credible and incompatible emotional network is supposed to be installed and strengthened. By overlearning through repetitive activation the counter-theme network moves up in the retrieval hierarchy and can then be used to inhibit the dominant ruminative network. It should be stressed that patients are not encouraged to avoid or deny but learn to be less involved in their emotions and negative thoughts; patients have shown their ability to do this in earlier situations. Less involvement can be accomplished by accepting certain facts of life, or by learning to be indifferent to certain situations (i.e. they are not worth worrying about). In COMET both of these aspects are dealt with. Depending on the specific rumination theme of each patient, it is determined whether a patient should learn to accept, or to be more indifferent.

Example

Paolo is a 73-year-old man who, like many other immigrants, came to the Netherlands in the 1960s. He left high school in Italy without a diploma, even though he had the intellectual ability to graduate. In the Netherlands he had several jobs but because he lacked diplomas never achieved the career level he had hoped for. After his retirement he became depressed and constantly ruminated on the theme that he should have finished high school. During COMET for depression and rumination, he recognized that this problem could not be changed or treated as a solvable problem. He realized that he led a reasonably comfortable life (although he was not wealthy), that there was no need to go to school again, and that constantly ruminating on this theme was not going to make him better. Therefore, he should let it go. The counter theme he chose was one of 'indifference' because he regarded the rumination theme as no longer important. One thing he was certainly indifferent about was the Dutch 'carnival'. Paolo could visualize this theme as other people being strangely dressed and behaving in an outrageous way, whereas he was totally unaffected by the carnival. His posture was to sit indifferently in a chair and shrug his shoulders while saying: "… they can do whatever they want, I don't care." When activating the counter theme in this way, he could feel indifferent. When being able to activate indifference in connection with the carnival he easily learned to combine this indifferent feeling while imagining his rumination theme, i.e. of being without a diploma and not having had a satisfying career. After several sessions and practice at home Paolo managed to be significantly less involved in the rumination theme. Having had this positive experience, Paolo went on to use his 'letting go' skills to deal with other rumination themes.

Although having been developed independently (Korrelboom, 2000; Korrelboom et al., 2004), COMET for depressive rumination shares a lot with other recent interventions, such as RFCBT (Watkins et al., 2007) and CNT (Watkins et al., 2009). All three use imagery of emotionally-salient autobiographical memories and focus on strengthening alternative ways of response by repeated practice. Main differences are that CNT aims at the process of being specific as opposed to being general – which is the case in many dysphorics. In RFCBT the focus of the memories to be generated is of absorption and compassion. In COMET the focus of the memories is aimed at memories of earlier successes in letting go, by means of accepting or being indifferent. These may be seen as more specific counter themes to the problem of rumination. Another difference is the duration of the imagination exercise. In COMET, the participants perform the imagination exercise for about 5 min several times a day, whereas in CNT the imagination exercise lasts 25 min. Furthermore, in both CNT and RFCBT a relaxation component is added which is not the case in COMET. However, this latter difference is debatable since COMET instructions to imagine e.g., an earlier success, will probably implicitly have a relaxing effect.

To date, different COMET protocols have been tested in various forms of psychopathology. Three non-randomized studies with the COMET protocol for low self-esteem in groups have been completed. First, in an outpatient sample with mixed diagnoses, self-esteem was enhanced and depression was reduced (Olij et al., 2006). In a sample with hospitalized and day-treatment patients with personality and/or eating disorders, similar results were obtained (Korrelboom, Van der Weele, Gjaltema, & Hoogstraten, 2009). Finally, these findings were corroborated in a group of 86 patients with mood disorders (e.g. major depression) (Maarsingh, Korrelboom, & Huijbrechts, 2010). Moreover COMET for low self-esteem was found to be effective in treating low self-esteem and depression in two randomized controlled trials (RCTs), i.e. in outpatients with eating disorders (Korrelboom, de Jong, Huijbrechts, & Daansen, 2009) and in patients with personality disorders (Korrelboom, Marissen, & Van Assendelft, 2011). In an RCT investigating psychotic patients, another variant of COMET reduced the burden caused by auditory hallucinations (Van der Gaag, Van Oosterhout, Daalman, Sommer, & Korrelboom, 2010).

In the first pilot study with the COMET protocol for worrying and rumination, worry and state anxiety were reduced in patients with generalized anxiety disorder (Martens, Korrelboom, & Huijbrechts, 2009). The present study tests the efficacy of this latter COMET protocol in older patients with depression.

Method

Overview

Patients were recruited from four ambulatory departments of Parnassia, a large mental health institute specialized in the treatment of the elderly (aged ≥65 years). All patients suffered from

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