

Functioning Focused Rehabilitation (FFR): a multi-dimensional approach to individual behavioral activation for the treatment of depression¹

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Introduction

The current organization of depressive disorders is rather arbitrary: the diagnostic categories are descriptive on the level of symptoms and not based on underlying causal processes. The number of diagnostic categories is increasing over the years which evidences that depression is a phenomenon of complex heterogeneity. For therapists the treatment effects of the two mainstream models for the treatment of depression: cognitive therapy and pharmacotherapy are often confused with causal effects. Cognitive therapists emphasize the primacy of logical errors and underlying convictions as the cause of depressive patterns of behavior (Reus, 1997) and the effects of antidepressants are often erroneously used to explain depression as a defect of the neuronal system. Recent research in neurobiology however has revealed the plasticity of the brain at an advanced age and the continuously changing connectivity of neural networks as a result of the interaction of the individual and the environment (Boer & Glas, 2004). These scientific findings urge the need for more contextual causal explanations of depressive patterns of behavior instead of explanations in terms of functional defects of the organism. Modern biological psychiatry is interested in the origin, development, structure and function of the brain in the adaptation of the individual to the environment.

Adaptation and Conditioning Theory

Conditioning theory reveals the processes of how organisms learn to look after themselves in an ever changing world (Bakker-de Pree, 2002). The outcome of these continuous conditioning processes

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results in an individual specific repertoire of behavior. This personal functioning is successful when it is adaptive and contributes to survival, self maintenance and a better personal state: emotional well being. Personal Successful Functioning (PSF) concerns the behavioral activity by which the person is safeguarding his emotional well being. If the person is able to respond to discriminative stimuli for successful functioning in his personal living conditions his emotional state will improve. The absence of discriminative stimuli or restrictions in responding to them makes the person vulnerable in safeguarding his emotional well being. Protracted circumstances in where the person is restricted in his successful functioning are leading to behavioral inactivity, demoralization and finally to depression. The primacy of adaptive active avoidance in individual repertoires of successful behavior is originated from the fact that adaptive active avoidance produces the existentially most important state of safety (Bruins, 2008). Particularly restriction of adaptive active avoidance responses can lead to maladaptive conditioning. The onset and persistence of depressive symptoms are the result of these response restrictions. Depression is seen as chronic diminished Personal Successful Functioning in combination with increased disfunctioning.

Maladaptive Conditioning

Disfunctioning concerns disordered behavior labeled as anxiety, agitation, psychotic delusions, etc and maladaptive behaviors like increasing withdrawal, passivity (maladaptive escape and passive avoidance), binge eating (maladaptive approach) and rumination, suicidal ideation, etc (maladaptive active avoidance or respondent reactions). The aversive stimuli which control these maladaptive behaviors are becoming more and more powerful and originally neutral stimuli are getting an aversive character due to respondent conditioning: salient aspects in the current environment of a person who is in a state of discomfort, dysphoria become negatively associated. Finally a state of complete disorder can be the result. This can manifest itself as total lethargy, agitation, anxiety, insomnia, concentration problems, decreased or increased appetite and all other symptoms from the checklist for Major Depressive Disorder in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). Notice that some of these symptoms

are each other's counterpart. We view the diversity of symptoms as consistent with the diversity in individual conditioning history due to a unique ongoing individual process of conditioning and its underlying physiology. Protracted states of disorder can lead to temporary or permanent damage to structure and function of our brains. Behavioral Analysis can pre-eminently provide an integrative view of depression taking into consideration genetics, biology, individual overall prevailing patterns of behavior labeled 'personality' and external and private events.

Central Role of Conditioning Processes

In this presentation we will elaborate the central role of conditioning processes in the treatment of depression of elderly persons. For elderly people the uniqueness of their functioning repertoire is a result of a long history of conditioning. They are also more vulnerable for confrontation with all kinds of experiences of loss (loss of physical health, work, important others etc). These losses can lead to response restriction of personal successful behavior. So a Mental Health Care setting for elderly people is an appropriate environment for the development of an integrative multi-dimensional approach of depression and other disordered behavior.

Treatment Strategies

Functioning Focused Rehabilitation (FFR) is providing a wide range of strategies to activate Personal Successful Functioning of individuals with maladaptive patterns of behavior (Andreoli, 2000). Interventions are focused on the recovery and extension of the individual specific repertoire of successful functioning. They all have in common that their general goal is to bring the person suffering from depressive (and other) symptoms back in contact with discriminative stimuli for his successful functioning. They vary in the extent of professional involvement in activating Personal Successful Functioning in daily life situations. Interventions may consist of Functioning Focused Behavior Therapy (FFBT) as well as sustaining interventions outside the consultation room in the personal habitat and other relevant environments. FFBT is the most important in-therapy intervention within the FFR paradigm and is targeting on recent Personal Successful Functioning. In general FFBT starts by discrimination-

training of differences in emotional-states and will be followed by response-search of recent Personal Successful Functioning at the moment that the client is reporting improvement of his emotional state by his own action. If this is not possible because the client is so disordered or involved with maladaptive behaviors and there is hardly any Personal Successful Functioning, the client should be brought in circumstances where opportunities for Personal Successful Functioning are available and not restricted in responding to them. This can be done by making the current environment more accessible by structuring and well-ordering or by bringing the client in contact with other, more challenging environments (Andreoli, 2004a). It is important during these interventions to give the client as much as possible control over his activities: too much pressure of the professional distracts the client from potential personal triggers for personal successful behavior (Andreoli, 2004b). At the other hand if stimuli controlling maladaptive behavior are dominating the actual competition of operating stimuli with complete passivity as a result it is the task of the professional to activate the client. Not by convincing him that he should start with a specific activity but by making the environment more challenging for Personal Successful Functioning. As soon as a client is coming into action i.e. operating in the actual environment in order to effectuate a better emotional state the activating interventions can be combined with FFBT. FFBT enhances the effects of activation. Preferably this should be done by a distinct professional at a distinct moment. The only task of the professionals involved with activation is bringing the client in contact with potential discriminative stimuli for Personal Successful Behavior. During this activation it is the client only who can evaluate these stimuli. The professional may not interfere with this evaluation by his comments! So activation of PSF implicates exposure to 'challenging' environments. These environments can be freely accessible (daily life may offer a lot of triggers for PSF!) or only accessible for target groups (e.g. services offered by Welfare or Mental Health Organizations). Activation is executed by professionals with different backgrounds and very often supported by non-professionals like family, neighbors and volunteers. Assessment of personal functioning (successful and unsuccessful) is necessary for a tailor made treatment program.

Other Interventions

Besides FFR and FFBT as basic interventions for the treatment of depression (and other disordered behaviors) other interventions can be necessary to set the conditions for the recovery of Personal Successful Functioning.

Frequently used interventions are:

Psycho-education and skill training

Pharmacotherapy and other Neurobiological Treatment Procedures

Treatment of somatic diseases

Compensation of Impairments and Disabilities

Physical Exercise etc.

Clinical Cases

Now we will elucidate with some clinical cases how FFR is working out as a multi-dimensional approach in the treatment of depression.

Mrs. A 69 years old, she is divorced since 9 years and is living independently. She was looking for help with complaints of insomnia, rumination, depressed mood, feelings of stress and physically unwellness since family problems (a conflict between her daughter and daughter in law). Assessment makes clear that there is still a lot of PSF during the day, but PSF is diminished at empty moments (especially during the evening) or at moment that she is expecting a visit of her family. Mrs. A was decisive in refusing medication which was suggested by her GP. The treatment program agreed on consists of FFBT (discrimination training) and some Psycho Education about conflict management. After 10 sessions there was a complete recovery of PSF and her complaints disappeared for the most part and did not restrict her any longer in her PSF.

Mrs. B 84 years, widow since 18 years, is living independently. She was referred for psychological treatment for depressed mood, agitation, feelings of guilt since the death of her son two years ago. From assessment we got a picture of her functioning. There was restriction of her PSF not only by distraction due to her psychic complaints, but also by physical impairments in her mobility and visual functions. Nevertheless there was some PSF-residue: Mrs. B feels satisfaction when she is involved with household activities and

enjoys the weekly choir repetition (particularly because the director is coming around for her!). Her treatment program consisted of FFBT and Psycho Education (about mobility issues), support of a volunteer and a cataract operation. This resulted finally in extension of PSF and social contacts: life became more meaningful.

Mr. C, 79 years old, has a long term psychiatric history. He is living independently. Current complaints are: depressed mood, withdrawal, isolation and poor housekeeping. Assessment of functioning reveals that Mr. C is surviving: there is hardly any PSF. Mr. C agreed on his treatment program and started with participation in the Part-Time Treatment Program (PTTP) three days a week in a group with six other clients. This program offers a mix of scheduled and incidental activities based on decision making in the group. They prepare their own meal: one of the scheduled activities. He also got Social Psychiatric Support at home. Two weeks after his start at the PTTP, FFBT was introduced. Now one year later, Mr. C still visit the PTTP once a week and there is a clear recovery of PSF: extended social contacts, he makes use of public transport to visit his family or to make tourist trips. He accepted domestic help. Complaints decreased dramatically.

Conclusion

Functioning Focused Rehabilitation offers a lot of treatment strategies which can tune in on the specific demands and needs of the individual and on individual triggers for Personal Successful Functioning. It is an innovative approach with some clear advantages over traditional Behavioral Activation because it influences Personal Successful Functioning directly and enlarges personal commitment with the environment. In Tabel 1 the differences of the two approaches are made clear.

differences	
FFR	BA
➤ One general goal: PSF ➤ Monitoring the environment on opportunities for PSF ➤ Scheduling on opportunities for PSF ➤ Functional Analysis of PSF	➤ Several specified goals ➤ Monitoring specified behavior ➤ Scheduling on specified behavioral targets ➤ Functional Analysis of maladaptive behavior

Tabel 1

Due to its contextual roots and its focus on adaptation of the organism to the environment FFR offers an integrative view of interventions taking genetic, biological, psychological and social processes into consideration.

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