

The Systematic Activation Method (SAM) in Depressed Elderly: A Case Report

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PURPOSE: The study aims to describe the implementation of Activity Scheduling (AS) as a nursing intervention in an inpatient population of older adults with a major depressive disorder.

DESIGN AND METHODS: In a single case report, the implementation of the intervention was described.

FINDINGS: This case report shows that AS, when adapted into a brief and prescriptive course, can be beneficial for depressed elderly in an inpatient care setting.

PRACTICE IMPLICATIONS: Although previous research shows promising results, there is a need for additional research on the effectiveness of the intervention when AS is executed by nurses.

One of the major consequences of a major depressive disorder (MDD) is a decrease in activity level, because of a diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (American Psychiatric Association, 2000). When patients with MDD are admitted to a clinical ward, (re)activation is an important intervention carried out by nurses (Kurlowicz, 1997; Kurlowicz & Harvath, 2008). In (re)activation, nursing care is focused on encouraging patients to engage in everyday activities, social activities, and leisure activities. Although most nursing guidelines prescribe (re)activation as a nursing intervention, little is known about the procedures and effects of this intervention. Nurses tend to rely on self-reports by the patients (Parrish, Peden, & Staten, 2008) or are guided by their intuition (Hassall & Gill, 2008). Especially for depressed elderly, it is difficult for them to engage in activities because of reduced physical capabilities and a decrease in social contacts. It is therefore vital to focus on an increase in activity level within the possibilities of the depressed elderly.

We developed (re)activation as a brief systematic course for depressed elderly, which we called the Systematic Activation Method (SAM; Clignet, van Meijel, van Straten, Lampe, & Cuijpers, 2008). The SAM is based on Activity Scheduling (AS), a behavioral treatment for depression, which is also often

referred to as behavioral activation treatment. Recent studies show that AS is an effective treatment for depressed patients (Cuijpers, van Straten, & Warmerdam, 2007; Dimidjian et al., 2006; Hopko, Lejuez, Lepage, Hopko, & McNeil, 2003). AS is an accessible intervention, is easy to understand, and focuses explicitly on an important consequence of MDD.

This case report describes the implementation of the SAM by the first author (FC) to Susan, a 77-year-old woman suffering from MDD. Susan was admitted to an inpatient health-care facility for elderly with psychiatric disorders. Although her depressive symptoms decreased, she still felt no pleasure in life. She was afraid to go home for the weekends because of her feelings of loneliness and grief. She was indicated for the SAM because of her inability to engage in pleasant activities because of her depression. The purpose of this case report is to illustrate the use of the SAM as a nursing intervention in depressed elderly inpatients.

The Systematic Activation Method as a Nursing Intervention

AS was developed in the early 1970s by Peter M. Lewinsohn (a psychologist) and his colleagues (Lewinsohn, Biglan, & Zeiss,

1976), as a treatment modality in depressed patients. A key assumption of AS is that a decrease in positive reinforcers can be responsible for an increase in depressive symptoms (Lewinsohn & Libet, 1972). The initial AS protocol was focused on increasing pleasant activities in combination with relaxation, social skills training, and cognitive restructuring. In the late 1970s, Beck and colleagues (Beck, Rush, Shaw, & Emery, 1979) incorporated AS into cognitive therapy (CT). In CT, the focus of treatment is to explore and modify the automatic thoughts and their underlying assumptions that are responsible for depressive behavior. AS, within CT, is used as a modifier for dysfunctional automatic thoughts. A study by Jacobson et al. (1996), in which the behavioral components and the cognitive components of CT were divided, showed that behavioral activation (AS) was as effective as CT. These findings focused renewed attention on AS as a stand-alone treatment with promising results (e.g., Dimidjian et al., 2006; Hopko et al., 2003). In a recent meta-analysis by Cuijpers et al. (2007), the effectiveness of AS was estimated from 16 studies. In these studies, AS was compared with CT, cognitive behavioral therapy (CBT), supportive therapy, and waiting-list conditions. The overall effect of AS was .87, indicating a strong effect. AS is considered an effective and easy-to-understand intervention for depressed patients. Hopko et al. (2003) conducted an experimental pilot study with 25 depressed inpatients. In this study, AS was compared with supportive group therapy. The results show an effect size of .73 in favor of AS, indicating a large effect. To our knowledge this is the only AS study with an inpatient population.

We developed the SAM as a nursing intervention for depressed elderly (Clignet et al., 2008), based on Lewinsohn's model (Lewinsohn et al., 1976). The most important principle is that the SAM focuses on those activities that serve as positive reinforcers from the patient's perspective. This means that the patient's (positive) reaction to that specific activity is leading, and not the activity itself.

Analogue to the "Coping with Depression Course" (Cuijpers, 2000), we developed the SAM as a highly structured and prescriptive intervention. The "Coping with Depression Course" contains several elements of AS. We added the following items to complete the SAM: "Ask for help from others" and "Setting up an Activity Experiment."

The SAM was developed as a brief individual course of 7 weeks and consists of six sequential steps. These steps are (a) monitoring of mood, (b) executing pleasant activities from an existing pleasant activity list, (c) designing and executing a personal pleasant activity plan, (d) the use of external resources, (e) setting up an Activity Experiment (AE), and (f) consolidation. The stepwise approach avoids the patients feeling overwhelmed by the need to engage in activities. Such feelings can be responsible for avoidant behavior. A key component of the course is the monitoring of mood. Throughout the course, the patients are asked to score their

moods every day. The higher the score, the better a patient feels. The scores vary between 0 and 10 in which 0 represents "worst mood ever" and 10 represents "best mood ever." When patients score their moods while performing positive activities, they become aware of the relationship between executing pleasant activities on the one hand, and their moods on the other hand. At the beginning of the course, all patients receive a course book, which contains a brief explanation of the treatment rationale and a description of each step. The course book serves as a guideline for the weekly sessions and helps the patients to monitor their own progress.

For registered nurses, a treatment manual has been developed that contains a theoretical background of the SAM, together with guidelines on how the SAM should be executed and how motivational strategies can be applied (Clignet et al., 2008). A brief training program (two 4-h sessions) is available for these nurses.

Although all components of AS are present, the SAM differs on some points from existing protocols. All of the adjustments are aimed at increasing the accessibility of AS for the elderly population. The most striking differences are:

1. **Goal setting:** In the current AS protocols, treatment goals between patient and therapist are developed at the beginning of therapy. In the SAM, the treatment goals of each individual session are presented in the course book. This is helpful for the patient for it is difficult for depressed elderly to describe feasible overall goals for the complete treatment program.
2. **Therapist:** The current AS protocols are mainly executed by psychologists. The SAM is developed as a treatment program for registered nurses in order to increase the accessibility for depressed elderly.
3. **Use of activity logs:** In current AS protocols, patients describe all their activities per hour. During the execution of SAM, patients describe their activities three times a day (morning, afternoon, and evening). Furthermore, in the SAM, only the "mood scores" are used in logs, without the mastery scores, as used in current AS protocols. These simplifications are necessary to avoid overwhelming patients by the use of logs.
4. **Duration of the treatment program and intensity:** The duration of the current AS protocols varies between 8 and 15 weeks, with an intensity of one session per week. The SAM is a brief course of 7 weeks, with an intensity of at least one session per week with the possibility to increase the intensity of personal contact, depending on the needs of the patient. Based on our clinical experiences, it is difficult for depressed elderly to stay engaged in a treatment program over a long period of time, especially when active involvement from the patient is required. Therefore, it is necessary to develop the SAM as briefly as possible with all of the key components of AS being present. In a period of 7 weeks, both of these aspects are taken into account. Furthermore, the aspect of cost effec-

tiveness was taken into consideration when developing the intervention.

Criteria for Using the SAM

We developed the SAM as a nursing intervention that can be added to the usual treatment. It is recommended that the SAM be used with some reluctance in combination with other psychological therapies, so as to prevent excessive patient overload.

The SAM was developed for depressed patients with mild to severe depressive symptoms (score greater than 20 on the Montgomery Åsberg Depression Rating Scale [MADRS], Montgomery & Åsberg, 1979). Furthermore, the SAM is not suitable for patients with severe cognitive impairments (score less than 23 on the Minimal Mental State Examination [MMSE], Folstein, Folstein, & McHugh, 1975). The SAM can be executed in both inpatient and outpatient care facilities.

Patients may be referred to the SAM when there is a lack of pleasant activities in their lives, and when additional motivational interventions are required for the patient to become engaged in these activities.

Case Report: Susan

Susan is a 77-year-old woman with recurrent MDD according to the *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition, text revised) criteria (APA, 2000). She scored 30 on the MADRS (Montgomery & Åsberg, 1979), indicating MDD, and 30 on the MMSE (Folstein et al., 1975), indicating no cognitive problems.

In 1987 and 1995, she had depressive episodes; in 2006, she was admitted to a clinical ward because of a depressive episode. During her depressive episodes, Susan suffers from uncontrollable hand movements (comparable with epileptic seizures). There are no neurological abnormalities. In 2007, her husband died, which led to strong feelings of grief. In 2008, she underwent hip surgery and she got depressed. Although she was treated with antidepressant medication, her depressive symptoms worsened, so clinical admission was necessary. She felt as if she did not have enough time to grieve about the loss of her husband because of her hip surgery.

Susan lives alone and has a housekeeper who helps her clean the house once a week. She has three children who are concerned about their mother but who are also vulnerable to stress, so their practical and emotional support to their mother is limited. Susan is an active member of the Young Women's Christian Association (YWCA), from which she has many friends. Although her social network is broad, it is difficult for her to ask for help because she is convinced that the only reason others help her is that they feel sorry for her.

After admission, Susan adjusted quickly to the regimen of the ward. The support from the staff and the distraction of the

therapy program worked well for her. Because she is sensitive to many antidepressant medications, the possibilities of treatment with medication were limited. During the first weeks after her admission, Susan attended both grief counseling and CT sessions. Although her depressive symptoms decreased, she still felt no pleasure in life. She was afraid to go home for the weekends because of her feelings of loneliness and grief. She was indicated for the SAM because of her inability to engage in pleasant activities because of her depression. Nursing care focused on increasing her activity level during the weekends. Together with the nurse, Susan would schedule her activities for the next weekend, which were evaluated every Monday. Susan carried out only a few of the scheduled activities and tended to postpone all social activities, like going to church on Sunday or visiting relatives and friends. She argued that she would undertake these activities when she felt better. Susan tended to avoid going home on weekends.

Treatment With the SAM

Three days before the first appointment, Susan received the course book. The course book contains an overview of the treatment rationale, an introduction to the SAM, and a description of each session. Except for the first session, all sessions have about the same structure. Each session starts with an evaluation of the homework, followed by an introduction on the objectives of the session, and the central theme. Next, attention is focused on the activities to be executed in the following week (see Table 3). A session ends with a brief evaluation of the session and making appointments for the next week.

First Session

In the first session, mutual expectations were discussed between Susan and the nurse. The nurse explained that the effectiveness of the SAM depends on active involvement by the patient. An active involvement not only includes engaging in activities but also active monitoring of the state of mood and activity level by using the course book. The treatment rationale was also explained, emphasizing the here-and-now focus of the SAM and success rather than failure. Susan had already read the first chapter of the course book and could identify with the principle that a lack of pleasant activities can contribute to a decrease in mood. After the general introduction, the next step was to monitor her mood. Susan had been asked to score her mood at three different times on the previous day (morning, afternoon, and evening) and to describe her activities at these times. This exercise was a prelude to her homework. At the end of the first session, Susan was asked to monitor her mood during the following week, using a scheme that was provided in the course book.

Table 1. Scheme of Random Activities (Session 2)

Activity	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Take a bath	X			X		X	
Go for a stroll	X	X	X	X	X	X	X
Call my daughter				X		X	
Listen to music		X		X	X		
Reading	X	X				X	
Have a conversation with a close friend		X		X			
Smile at a person	X	X					
Sleep well at night						X	X
Feel the presence of God					X		X
Wear clean clothes	X		X			X	
Have a nice meal	X	X		X			
Other							
Mood score	7	7	5.5	7.5	6.5	7	6

Second Session

At the beginning of the second session, the homework was discussed. Susan had monitored her mood after lunch, after dinner, and every evening before she went to bed. This took about 10–15 min of her time each day. A clear pattern emerged from her mood scores. In the morning hours, her mood score was very low but improved as the day progressed. Generally, she felt more energetic in the afternoon and evening. There was a slight increase in her mood score when her son visited her and when she went for a stroll with a friend. When these scores were discussed, she argued that she did not feel 100% yet but she certainly enjoyed these events and activities.

After completion of this homework evaluation, Susan chose some day-to-day activities that were perceived as pleasant from the “List of Pleasant Activities,” which consists of 49 daily activities, varying from social activities like “meeting friends” or “having a lively conversation,” to more personal activities like “listening to music” or “taking a bath.” The list is useful as a guideline, with the possibility of adding one’s own personal pleasant activities to the list. The purpose of this step is 2-fold. First, it shows that everyday activities can be pleasurable. Second, by planning these pleasant activities, a patient is able to regain his/her sense of mastery. At first, Susan selected almost all of the activities from the list. She argued that, when she does not feel depressed, most of the activities from the list are pleasant for her. The nurse explained that it would be better to confine oneself to no more than 10–15 activities that are easy to execute and probably pleasant. If she fails to execute all activities, or some activities are not as pleasant as expected, the likelihood is that she will feel disappointed. This can lead to an increase of depressed feelings. After selecting 15 pleasant activities, she filled in these activities in a scheme in the course book.

Her homework was to execute these activities randomly throughout the following week. At the end of each day, Susan

had to mark the activities she had performed and score her mood. At the end of the week, the scheme provided a clear overview of the influence of pleasant activities on her mood (see Table 1).

Third Session

The third session started again with a review of her homework. It was noticeable that she had executed some activities more than once and that she had added some other activities to the list. For example, she enjoyed taking a stroll (alone or with a friend/relative), so she undertook this activity nearly every day. She also added “reading” to her list of activities because she was better able to concentrate on reading than before. It was striking that she scored lower when she had a difficult task to execute, for example, a meeting with her psychiatrist about her vulnerability to a recurrent depressive disorder. Susan explained that such events occupied her entirely so that she was not able to perform any pleasant activities. The nurse pointed out that in these situations, it is very important to distract oneself after a difficult event in order to avoid dwelling on negative thoughts. This was visible on her mood score in which the score was 1 point below her average score.

After the homework had been discussed, the next step was to develop a structured plan for pleasant activities. Such a plan has two functions. First, it reminds Susan to engage in pleasant activities every day, as depressed patients have a tendency to focus excessively on their burden and therefore avoid engaging in pleasant activities. Second, it helps patients to restore their sense of mastery, by assisting them in actively influencing their mood. Great attention is paid to a balanced weekly plan and graded task assignment.

During this session, it became clear that it was difficult for Susan to plan for more than 3 days at a time. The nurse suggested that she confine herself to a 3-day plan. At first, Susan was reluctant to fill in the schedule because of her assumption that the schedule was binding. For example, she was afraid

Table 2. A Weekly Schedule

Name: <u>Susan</u> Week No: _____							
Day/ Period	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	Ambulatory care facility	Help the housekeeper cleaning the house	YWCA meeting	Ambulatory care facility	Going to the fair		Church
Afternoon	Supermarket		Supermarket		— Call Mrs. X to go to the church together	— Taking a stroll — Supermarket	Drinking coffee with a friend
Evening	— Taking a stroll — Taking a bath — Watch TV/reading or writing letters	— Taking a stroll — Watch TV/reading or writing letters	— Having dinner with some friends	— Taking a stroll — Taking a bath — Call my daughter	— Taking a stroll	— Taking a bath	— Taking a stroll — Call my son
Mood score	6.5	7	7.5	7	7.5	5.5	7

The grey areas are recurrent activities.

that she was obliged to go to church when it was scheduled into the plan. She argued that she could not yet judge if she was emotionally ready for church attendance. The nurse explained that she had a tendency to make her activity level dependent on her mood. This is one of the well-known pitfalls of patients with MDD. An activity plan helps patients to avoid this pitfall. The nurse suggested replacing the church visit with a more feasible alternative in order to increase her feelings of success. It would be possible to add a church visit to her plan at a later date. Her initial pleasant activity plan consisted of a daily stroll, a visit from a friend, and a visit to the YWCA.

Fourth Session

During the fourth session, Susan continued with her pleasant activity plan. Meanwhile, she was transferred to the ambulatory care facility. This had no effect on the execution of the SAM despite the fact that the intensity of face-to-face contact was lower in the ambulatory care facility.

Her mood pattern was similar to the previous sessions: When she was engaged in a pleasant activity, her scores were about .5 point above her average daily score. There was one exception: When her son visited her unexpectedly, her mood scored 1.0 point above average. Susan explained that this day started as an ordinary day and her mood was below average because she felt lonely. Her son's visit came as a pleasant surprise and his visit reduced her feelings of loneliness. When the nurse asked how she evaluated this situation, she admitted that she was fortunate that her son came. The nurse explained to Susan that a pleasant activity plan would prevent an improvement in her mood from depending merely on fortunate circumstances. Planning pleasant activities could help her to gain mood control and could make her less dependent on external (fortunate) circumstances. In cooperation with

the nurse, she filled in her activity plan. First, she started to schedule her weekly appointments with the ambulatory care facility. Second, she filled in recurrent pleasant activities like "taking a stroll" and "going to the YWCA." Third, she planned some new activities like visiting friends. A complete weekly schedule is shown in Table 2.

Fifth Session

The fifth session started with an evaluation on the execution of the weekly plan. Susan had undertaken most of the pleasant activities and enjoyed them.

The central theme in the fifth session was to ask for help from others. Susan argued, like many depressed patients, that others helped her because they pitied her and that she was a burden to others. Together with the nurse, Susan explored the help she had already received since her discharge from the ward and how she had experienced this help. She found that she had already had more help than she actually realized. She was surprised that she was more accepting of help than she imagined. This was an eye opener to her.

After that, Susan defined what kind of help she needed in using her pleasant activity plan. She decided to ask to visit the market as planned on Friday. Normally she liked to go to the fair (alone or with a friend) but now she felt uncertain in public places because she feared that other people would notice that she was depressed, although she knew rationally that this was not true. These thoughts make it difficult to ask for help. On the one hand, she realized that a friend could help her to get over this threshold, but on the other hand, she was convinced that she ought to be able to go to the market alone. Susan explored how she could be helped with this point. For example, she could ask someone to accompany her. She could ask a friend from the YWCA to join her, or she could call her daughter the evening before her intention to visit the market.

Susan was determined to go to the market so she decided to use both possibilities. If she failed to invite a friend, she could call her daughter. Susan filled in the “resource scheme” from the course book. The scheme consists of four rows containing the items (a) Who can help me?, (b) Which activity?, (c) How can he/she help me?, and (d) How can I reach that person? The purpose of this scheme is 2-fold. First, it helps her to ask for help in particular situations only. Second, it encourages her to use these resources.

Sixth Session

During the evaluation of her homework, Susan reported that she had not been able to invite a friend to the market because the friend she had in mind was occupied during the YWCA meeting. She admitted that she was actually relieved that she could not ask this friend because of her idea of being a burden to others. Instead, she called her daughter although she had the same feelings of being a burden. Her daughter suggested that they go together as she had planned to visit anyway. When the nurse asked how Susan reviewed her homework, she told her that she was relieved she went to the market, according to her plan. After the evaluation of her homework, the central theme of this session, namely the execution of an “Activity Experiment,” was discussed. An AE is executed when an activity is perceived as being difficult to perform. There are various reasons for this perceived difficulty: for example, “no belief that it will work,” “no belief that I am able to perform this activity,” “being afraid that I will not succeed,” etc. In an AE, a patient executes one difficult activity once and experiences what happens. The central motto is “I’m not feeling great, but I’ll try it anyway.” In the case of Susan, she chose a dinner date to which she had been invited. She was afraid that a lot of attention would be paid to her recent life events (her psychiatric treatment, becoming a widow), which could lead to feelings of sadness at home afterwards. Susan said that she was not ready for an emotionally charged conversation with her friends, although these friends knew about her problems. Together with the nurse, she explored the possibilities and pitfalls. The first thought that came into her mind was to postpone the dinner date. The nurse said that this could be a good solution if Susan was not ready yet. But the nurse also suggested focusing on other possibilities besides this one. To postpone activities that are difficult can also be one of the pitfalls in depressive patients. Other possibilities mentioned by Susan were going to the dinner and starting conversations herself on more neutral or positive topics like plans for the holidays. Furthermore, she mentioned that she could ask her hosts to avoid dwelling on her life events and explain to them why this was important for her. The nurse asked her what she would do if she felt sad afterwards nevertheless. Susan suggested that she would distract herself by reading a book or watching television. After

she explored these possibilities in more detail, she chose the most suitable solution and wrote it in the “AE form” that is provided in the course book. On this occasion, Susan chose to accept the invitation and to start a conversation herself on more neutral subjects. When the conversation became too emotionally charged, she would ask her hosts to change the subject. Furthermore, she planned to read a chapter of a book if she felt sad afterwards.

Seventh Session

The seventh and final meeting started, as usual, with the homework evaluation. Attention was paid to two aspects. First, the execution of the pleasant activity plan was discussed. Second, the AE was discussed. Although Susan had not engaged in all of the described activities, she was generally satisfied with her activity level. She enjoyed the YWCA meetings and her visits to the church were no longer problematic for her. Her only concern was Saturday. On Saturday she had no particular pleasant activities except taking a stroll. Most of her friends were occupied and she did not want to bother her son or daughters every Saturday when she felt lonely.

Her evaluation concerning the AE was positive. She enjoyed her dinner date. The conversations were pleasant and she brought up some of the conversation topics, according to her plan. Her recent life events were briefly discussed but this did not affect her in a negative way. When she came home, she felt lonely. She described her homecoming as coming into a dark, lifeless house after a pleasant evening. Although Susan had planned to read a chapter of her book, she related that she was not able to read because she felt tired.

The central theme of the last session is the use of (parts of) this course in the future. Susan looked back on the course together with the nurse to explore these possibilities. Although the course could not take away her feelings of loneliness, she had experienced it as a valuable tool to gain control over her activity level and make it less dependent on her mood. The most striking session was the second session where she selected everyday activities that were potentially pleasant. She was surprised that she had forgotten how everyday activities like taking a bath or going out for a stroll could be pleasant. She also learned that undertaking pleasant activities has a positive influence on her mood. She admitted that she selected an activity (a dinner date) for the AE that was not too difficult for her. Although her concerns about the attention to her recent life events were genuine, she was able to cope with this burden. Susan argued that there were no activities that were extremely difficult. More importantly, starting “new” activities in general was difficult because of her diminished self-esteem. This course helped her to engage in (pleasant) activities even when it was difficult.

A summary of the sessions is presented in Table 3.

Table 3. Systematic Activation Method in Seven Sessions

Session	Subject	Result
First session	Monitoring the mood — General introduction to the course — Explanation about the treatment rationale — Instruction on scoring the mood — Exercise on scoring the mood — Explanation of homework assignment: scoring the mood for the coming week	— Susan identified with treatment rationale. — Susan filled in her mood scores.
Second session	Execute pleasant activities randomly — Review of the homework — Selection of 10–15 pleasant activities from “The Pleasant Activity List” — Explanation of homework assignment: execution of the selected pleasant activities and scoring the mood	— Susan chose 15 day-to-day activities and executed them during the following week. — There was an increase in her mood when she executed pleasant activities.
Third session	Designing and executing a pleasant activity plan — Review of the homework — Education on developing a balanced week plan with performable pleasant activities — Drawing up a pleasant activity plan — Explanation of homework assignment: the execution of the pleasant activity plan and scoring the mood	— An initial plan was made for a 3-day period. — Increase of her mood scores when she was engaged in these pleasant activities.
Fourth session	See third session	— Susan executed most of the activities from her plan and enjoyed them.
Fifth session	How to use external resources — Review of the homework — Education about possible external resources (who can help the patient, type of resources) — The selection of a situation in which external help is needed — Completion of the external resources scheme — Explanation of homework assignment: request for help according to the resources scheme	— Susan selected two persons that could help her get to the fair (as described in her plan). — She requested one of these persons to actually help her.
Sixth session	Setting up an Activity Experiment — Review of the homework — Instruction about an Activity Experiment (i.e., performing a difficult task and evaluating the results) — Selection of a difficult (but possibly pleasant) activity — Completion of the Activity Experiment Scheme — Explanation of homework assignment: performing an Activity Experiment	— Susan selected a difficult activity for her Activity Experiment (a dinner date). — She went to the dinner date and enjoyed it.
Seventh session	Consolidation — Review of the homework — Evaluation of the course — Description of helpful elements of the course and how it can be helpful in the future — Description of the prevention of pitfalls that cause relapse	— The course increased the level of pleasant activities and her awareness of the positive influence of pleasant activities on her mood.

Follow up

A follow-up meeting was planned 6 weeks after the last session, at which Susan's progress was evaluated. She reported that she felt depressed again. At first, her depressive feelings decreased after finishing the course and when performing the pleasant activities by herself. She enjoyed the activities she performed although she still had difficulties starting them. A few weeks after the last session, she got sick twice (colds). As a

consequence, the depressive feelings increased as well as her feelings of grief. During this period, her activity level declined. She said that she felt too sick to engage in pleasant activities. For example, she skipped the YWCA meetings. Susan related that it was difficult for her to execute pleasant activities again, even when she felt physically better. In order to restore her activity level, she used a contact from her resource scheme (see fifth session) to assist her in going to a YWCA meeting again. Although she still felt depressed at

times, she followed most of the pleasant activities from her activity plan, which she enjoyed performing. The expectation is that her depressive feelings will decrease when the pleasant activities are better integrated in her daily life.

Discussion

The purpose of this case report was to illustrate the systematic and goal-directed use of activity scheduling in inpatient nursing practice.

Advantages of the SAM

As shown, the SAM provided a number of advantages in the treatment of a depressed patient. The SAM intervenes directly in one of the major symptoms of depressive disorder (i.e., loss of interest and pleasure). It is an intervention that is easy for patients to understand, and it shows quick results on mood and activity level. These results are important in guiding and encouraging the patient. Furthermore, its protocolized nature makes it possible to continue the SAM when patients are transferred from a clinical facility to an outpatient care facility.

By using activation as a goal-directed intervention, there is a sufficient balance between “forced activities” and “no activities.” If patients are forced to engage in activities, they are often resistant or avoidant. If there is no activation, depressed patients tend to decline into more and more inactivity. By using the SAM, the patients are encouraged to increase their activities gradually and at their own pace. If it is too difficult to perform an activity, the patient is encouraged to execute a more feasible activity. Furthermore, the SAM enables the patient to monitor his/her mood more adequately and to relate mood state at some point to his/her activity level.

Considerations When Implementing the SAM

Although the SAM provides a number of advantages, there are several considerations regarding the implementation. One concern is that execution of the SAM requires some cognitive skills and, therefore, is not suitable for all depressed patients. We expect that patients with serious cognitive problems will not be able to fully profit from the SAM in its current form. For this group of patients, the intensity of supervision should be increased. Also, for patients with bipolar disorder (depressive episode), some restrictions apply because of their vulnerability to sudden changes in mood.

Furthermore the effect of the SAM depends on the personal efforts of the patient. In order to motivate patients to perform their homework, specific therapeutic techniques are necessary because of the avoidant tendencies of depressed patients.

When patients are admitted to a clinical ward, the possibilities for engaging in pleasant activities are limited. This implies that, when a patient is treated with the SAM, the conditions required to engage in individual pleasant activities should be provided.

Limitations of the Case Report

Although this case report shows the usefulness of the SAM as a nursing intervention, there are some limitations. The case of Susan shows how the SAM is executed in a patient who was recovering from a depressive episode. It is important to notice that we used a motivated patient to describe the execution of the SAM properly. In order to execute the SAM as effectively as possible, it is necessary to adjust it to the personal state of the patient with regard to their possibilities.

Implications for Nursing Practice

By using the SAM, behavioral therapy is added as a treatment modality into the nursing domain. Together, with other treatments like Problem Solving Therapy (Haverkamp, Areán, Hegel, & Unützer, 2004), CBT, or Interpersonal Therapy (Parrish et al., 2008), mental health nurses can use psychological techniques in their own practices. The SAM, as a nursing intervention, contains four major elements: (a) it is theory based; (b) it is a structured intervention; (c) it is from a patient perspective; and (d) it describes the patient/therapist relationship.

Although the SAM is heralded as an easy intervention, guiding the patients in executing the SAM (as with any other behavioral treatment) requires specialized skills in behavioral therapy. Depressed elderly tend to be resistant or avoidant in engaging in activities. Nurses who are experienced with depressed elderly are generally prepared to use these techniques. In order to use the SAM adequately, a training program for registered nurses has been developed in which these skills are educated.

Although the SAM is a promising intervention, there is a need for further research. Until now, AS has been tested only as a psychological intervention executed by psychologists. It is unknown if the results of previous research are transferable to nursing practice because of the differences in the professional perspectives and competencies between psychologists and nurses. As pointed out by Parrish et al. (2008), nurses generally use a holistic approach in their treatment of depressed patients, whereas previous research is mainly focused on a reduction of depressive symptoms. Nursing outcome is not only measured by the decrease in depressive symptoms but also by quality of life, level of mastery, and activation level in depressed patients. Therefore, we are currently preparing a randomized clinical trial in which the effects of the SAM will be tested on depressive symptoms, quality of life, mastery, and activity level.

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