COGNITIVE-BEHAVIOUR THERAPY FOR OLDER ADULTS WITH COGNITIVE IMPAIRMENT

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WHY CONSIDER PSYCHOTHERAPY?

- High incidence of co-morbid anxiety and depression in dementia (Depression: Up to 50% of residents in residential care settings = 3 times the community rate, -Snowdon, 2009). BEHAVE-AD contains 4 anxiety-related items, anxiety is 1 of 10 items in NPI (Mintzer et al, 2000). 19.5% clinical levels of anxiety mild dementia, additional 22.5% subclinical anxiety (Hynninen et al, 2012)

- Co-morbidity between anxiety and depression: anxiety affects outcome of treating depression and increases relapse (Cheok et al, 1996).

- Increased use of restraint (psychotropic and physical) when anxiety and depression remain untreated in dementia (reported in Orgeta, Spector & Orrell, 2011)

- Definition of “agitation” – common presentation of BPSD - overlap with anxiety, poor consensus (Nordus & Hynninen, 2010)
CLINICAL RELEVANCE OF CBT IN RESIDENTIAL SETTINGS

- Consistent with person-centred care: collaborative exploration and gathering information, knowledge of the person’s needs are paramount.
- Adapting to loss and change congruent with CBT paradigm of developing and utilizing new skills (e.g., coping with eating in a communal dining room, using an elevator).
- Active coping strategies (rather than health status) predict positive psychosocial functioning in long term care (Schanowitz & Nicassio, 2006).
SUPPORT FOR COGNITIVE BEHAVIOUR THERAPY IN COGNITIVE IMPAIRMENT

- Increased research support for the use of CBT in dementia in treating anxiety and depression (behaviour therapy: Verkaik et al review, 2005; Protocol for Cochrane review Ortega et al, 2011).
- Much evidence to support behavioural activation therapy/pleasant events in treating depression in Alzheimer’s Disease (eg Teri, 1997).
- Support for more structured forms of CBT such as problem solving therapy (Gellis et al, 2007; Alexopoulos et al, 2011), relaxation therapy (Ayers et al, 2007). Eg BE-ACTIV program in nursing homes (Meeks et al, 2008), focusing on problem solving and pleasant events.
SUPPORT EVIDENCE CON’T

- Modified/augmented CBT for anxiety disorders (e.g., Mohlman, 2008; Kraus, 2008)
- Interpersonal psychotherapy for depression in dementia: integration of care providers when examining role transitions. IPT-CI developed (Miller & Reynolds, 2007)
- GIST program (Hyer et al., 2009): repetition, via staff, of single sessions containing key coping skills
- Group psychotherapy: Cheston et al. (2003) improved depression scores following 10 week gp, maintained at f/u
- Review of psychotherapy in long term care found improvements reported in 9 out of 18 studies (Bharucha et al., 2006)
BARRIERS TO CBT ACCESS IN THOSE WITH COGNITIVE IMPAIRMENT

- Professional ageism: Freud (“Old people are no longer educable”)
- Therapeutic bias, “therapeutic nihilism”, particularly in dementia
- Depression seen as part of “normal” ageing; basis for referral is often “behavioural” rather than affective (ie people with dementia not recognized as having psychological needs)
- Mental illness not being screened, recognized or acted on when identified (eg Cornell: Davison, Snowdon et al 2012).
- Excessive task focus of staff
- Specific cognitive deficits: language
CBT IN DEMENTIA: TREATMENT RECOMMENDATIONS

- Relaxation training (O’Connor et al, 2008 review; Ayers et al 2007) in addressing agitation and anxiety (”What is old is new again”)

- Carer support (“Collaterals”) in delivering Rx: eg Kraus et al, 2008 (2 case studies: CBT-AD). Also direct work with carer stress (Teri, Gallagher-Thompson, James)

- Baltes SOC model: “Successful modification of CBT for persons with dementia depends on exploitation of preserved abilities and use of compensatory strategies for impaired abilities” –(Snow, Powers & Liles, 2006 p. 272)

- Reminiscence component: focus on past successes
THE USE OF CBT IN DEMENTIA CASE EXAMPLES: SHIRLEY

- In RACF, high care, bedridden, on oxygen, visual impairment
- Referred for screaming (Note: behavioural focus!)
- On assessment, duration chart showed screaming was severe, prescribed diazepam 5mg
- On assessment, hyperventilation noted!
- Given psychoeducation, structured slow breathing, distraction, spaced retrieval to aid learning and recall (repeating to breathe slowly when she feels anxious)
- “Script” for staff which acted to challenge staffs’ negative self-talk
GORDY

- Referred for severe aggression, legal action threatened by families
- Had been an in-patient in psychiatric hospital for 6 months
- Moderate dementia, some depressive features, themes of loss, stress (war trauma background)
- Highly modified cognitive therapy focusing on differences between his memories and current environment, note all “care” aspect of his present situation (selective abstraction). Needed prompts
J is a 64 year old lady who was referred to the behaviour management service of SMHSOP (BAsIS) for helping her adapt to residential care. Referred by chronic care team where she had been a community client for 8 years.

Known to be resistive to care, had had respite at another Facility which had failed.
BACKGROUND

- spent most of her childhood with grandparents, (parents died) described as very distressing. One sister, no current contact.
- History of alcohol use, unable to furnish any details, history of admission to “mental health clinic” (self report) psychiatric hospital (EMR) in 1990’s, has refused to discuss this. Dx “on paper” of schizophrenia, bipolar. (depending on which document is accessed in EMR!). No details provided.
- Many physical issues: COPD, on continuous oxygen, morbidly obese, unable to mobilize fully, has had falls resulting in fractures of both ankles, OA, pain issues
- Lived with partner (also known to SMHSOP due to vascular dementia) in DOH unit, one daughter.
- Was seeing chronic care team, with one carer to help her remain at home (eg help with meals, cleaning, support, banking etc.)
ASSESSMENT

- Initially assessed whilst still in the community
- Extremely hostile due to mental health background of assessor
- Entered aged care facility one month later and verbally aggressive towards psychologist, refused care.
- Staff requested behavioural intervention, education provided and program of psychosocial suggestions implemented (therefore, work was indirect). Program was centered around increasing her level of control in the Facility (eg forced choice), differential reinforcement of clam behaviour, introduction of structure and routine, predictability
- Hypothesis was that possible executive dysfunction secondary to alcohol (possible hypoxia) may be contributing to irritability and poor co-operation. Depression. Attachment, trauma issues.
ASSESSMENT: SCALES

- Psychologist returned another 3 times and was met with continued hostility that gradually dissipated. Preoccupation with privacy.

- **Formal assessment:**
  - MMSE = 20/27 (bed bound). Poor mental reversal, temporal orientation, slowed mentation (??is she registering information, particularly if its complex?)
  - Geriatric Depression Scale score = 8/15: unsatisfied, empty, fearful, helpless, low energy
  - HONOS: 15; RUG-ADL 13 (dependent+++)
ACTION

- After third visit, requested to nursing home that case manager visit her regularly: wanted to ventilate concerns.
- Supportive psychotherapeutic relationship developed, exposed to highly structured anger management strategies (e.g., recognize triggers, what are the effects of “blowing up”?, etc.)
- Remains on present medications, refuses medication review.
- Functioning at a more independent, engaged level: attending groups, lost weight, able to manage stairs, improved mood (Role of improved nutrition and general care in RACF environment)
GENERAL POTENTIAL PSYCHOLOGICAL MECHANISMS IN THESE CASES:

- Reinforcement, enjoyment of activities, behavioural activation
- Improved sense of identity and self esteem: Feeling “validated”, capable
- Feeling “safe”, contained, feeling life is less threatening whilst resolving conflicts
- Having someone listen! (bearing witness)
- Improved sense of control, choice, leading to decrease in agitation, depression
PSYCHOTHERAPY: THEMES

- Multiple losses, role changes (active vs passive recipient of care)
- Explore meaning and impact of cognitive losses (e.g., memory)
- Adjustment to placement (predictors include: recency, previous exposure, psychiatric illness, carer stress).
- Coping: Active coping and positive reappraisal
- Narcissistic injury, expression of the need for control
PSYCHOTHERAPY: PROCESS
(RICHARD CHESTON, 1998; CAROL HAUSMAN, 1992)

- Assessment for suitability (e.g., language, severity of symptoms)
- Therapeutic alliance
- Importance of their “story” (as opposed to “technique”)
- Promote mastery, autonomy, purpose (to account for helplessness and dependency). Predict GDS scores (Davison et al., 2012)
- Transference, counter-transference (age; therapist child-parent relationships!); filling in relationship gaps (e.g., idealized daughter), affects termination
CBT IN DEMENIA: PRACTICAL ISSUES

- Cognitive loss: structure, pace
- Sensory loss: visual, hearing
- Mobility
- Confidentiality
- Treating the “whole” community: who is your client? (family, RACF staff)
- Consent, Guardianship
PROMOTING CBT IN RESIDENTIAL AGED CARE SETTINGS

- Increase training opportunities in geropsychology for psychologists
- Increase positive exposure to aged care settings whilst a student, placements and agreements between Universities and RACF (eg Bhar & Silver, 2014)
- Education for potential referrers (eg GP’s RACF management, “Better Access” conference. Education for staff, demonstrating techniques such as relaxation.
- Ensure staff are collaborators in therapy
- More treatment trials of CBT in residential aged care, consider technological aids (eg Ipad-Leng et al, 2014)
WHAT ABOUT MODERATE DEMENTIA?: MEDIATOR-CENTRED INTERACTIONAL THERAPY Haupt, 1996, Dementia, 7, 207-209

- Blends psychotherapy with management of challenging behaviours
- 4 deficits in dementia “which jeopardize identity, self-reliance, and sense of self worth” (p.208)
<table>
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<th>DEFICITS</th>
<th>AREAS OF DEFICIT</th>
<th>TECHNIQUE TO MINIMIZE DEFICIT</th>
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<td>CONTINUITY</td>
<td>Disorientation: break between present and past</td>
<td>Daily structure&lt;br&gt;Prompt reminiscence through activity (eg festivals, music, photos)&lt;br&gt;Familiarity (eg photos, furniture in room)</td>
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<td>COMPETENCE</td>
<td>Increasing dependence, loss of autonomy in ADL’s</td>
<td>Maintain skills&lt;br&gt;Offer useful, meaningful activities&lt;br&gt;Give “jobs”, integration with present community</td>
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<td>CONGRUENCE</td>
<td>Patient’s reality different to that of caregiver</td>
<td>Avoid “correcting”&lt;br&gt;Validation&lt;br&gt;Provide simple explanations</td>
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<td>COMMUNICATION</td>
<td>Ability to express thoughts, wishes and feelings</td>
<td>Short sentences, avoid pronouns etc&lt;br&gt;Use non verbal communication when appropriate&lt;br&gt;Ensure sensory deficits have been addressed</td>
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IN CONCLUSION...

- People with cognitive deficits can benefit from psychological therapies (and should not be denied access — depression, anxiety)
- Psychological therapies have been shown to be effective in dementia but more research is needed
- Ageism needs to be addressed
- Losses and adjustment difficulties can be addressed via meaningful activity, ventilation of concerns, adapting communication styles
IS IT “WORTH IT”?

- Berezini (1972):

  When he asked one of his elderly patients why he wanted psychotherapy, the patient replied:

  “Doctor, all I have left is my future”

(Miller, 2011)