Psychotherapy and Behavioral Health Interventions with Older Adults

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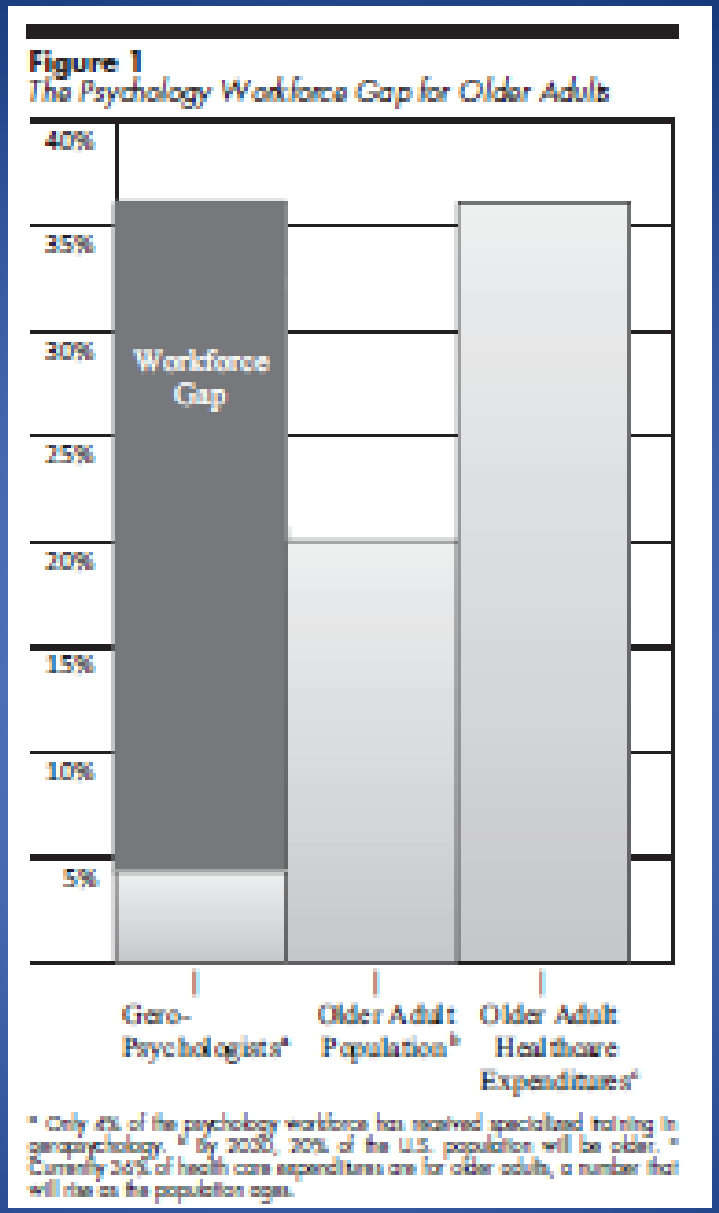
Missouri DMH Spring Training Institute 2019

Objectives

1. Identify attitude, knowledge and skill competencies for evidence-based assessment and treatment of older adults
2. Describe key considerations in the assessment and treatment of older adults with co-morbid physical and mental health concerns
3. Discuss in-session strategies for overcoming challenges in psychotherapy with older adults



(Hoge et al., 2015)

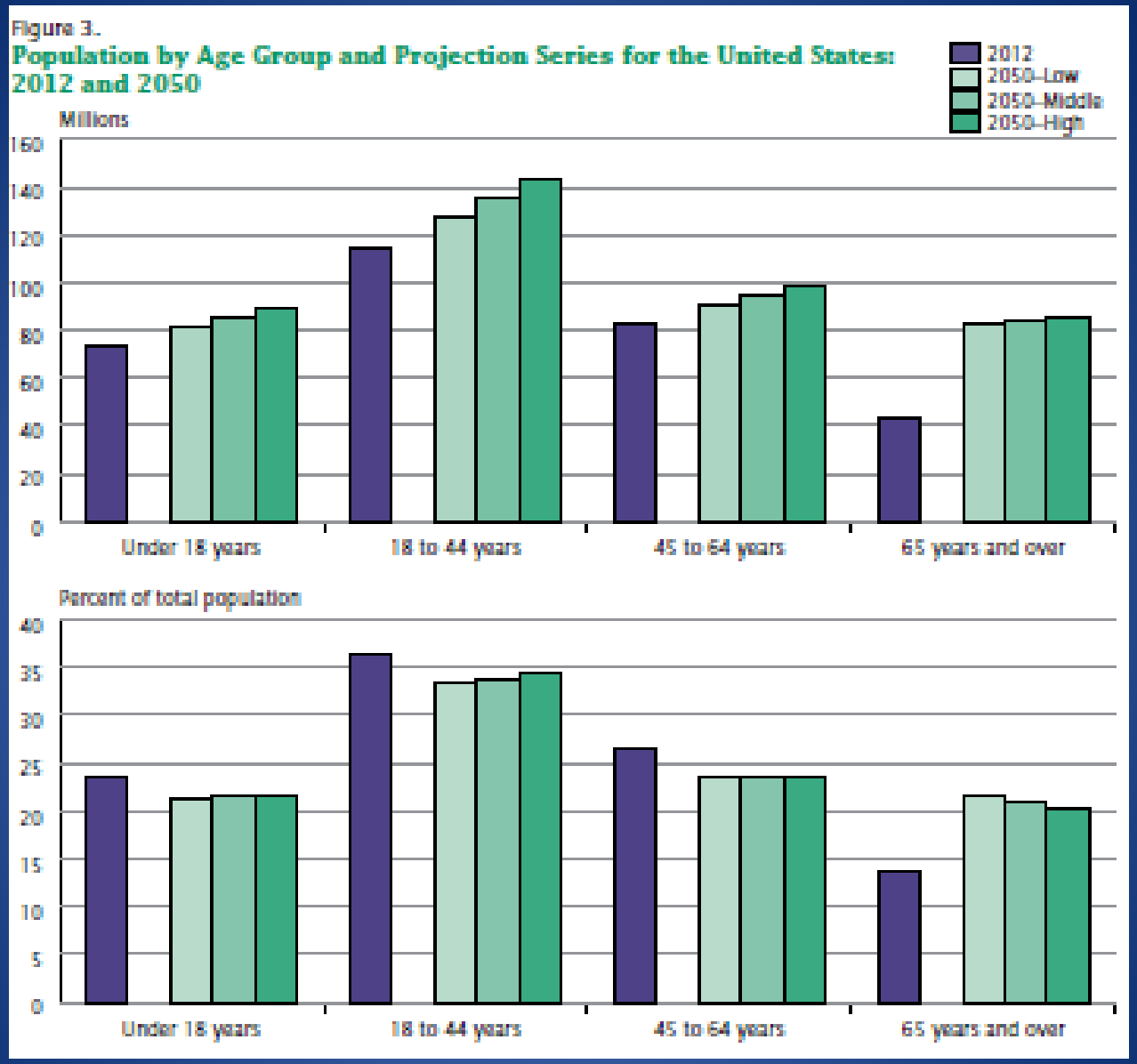
Example: Clinical Psychology

(Hinrichsen et al. 2018)

Post-licensure psychologists interested in "Exposure" to geropsychology should obtain 15 accredited CE hours:

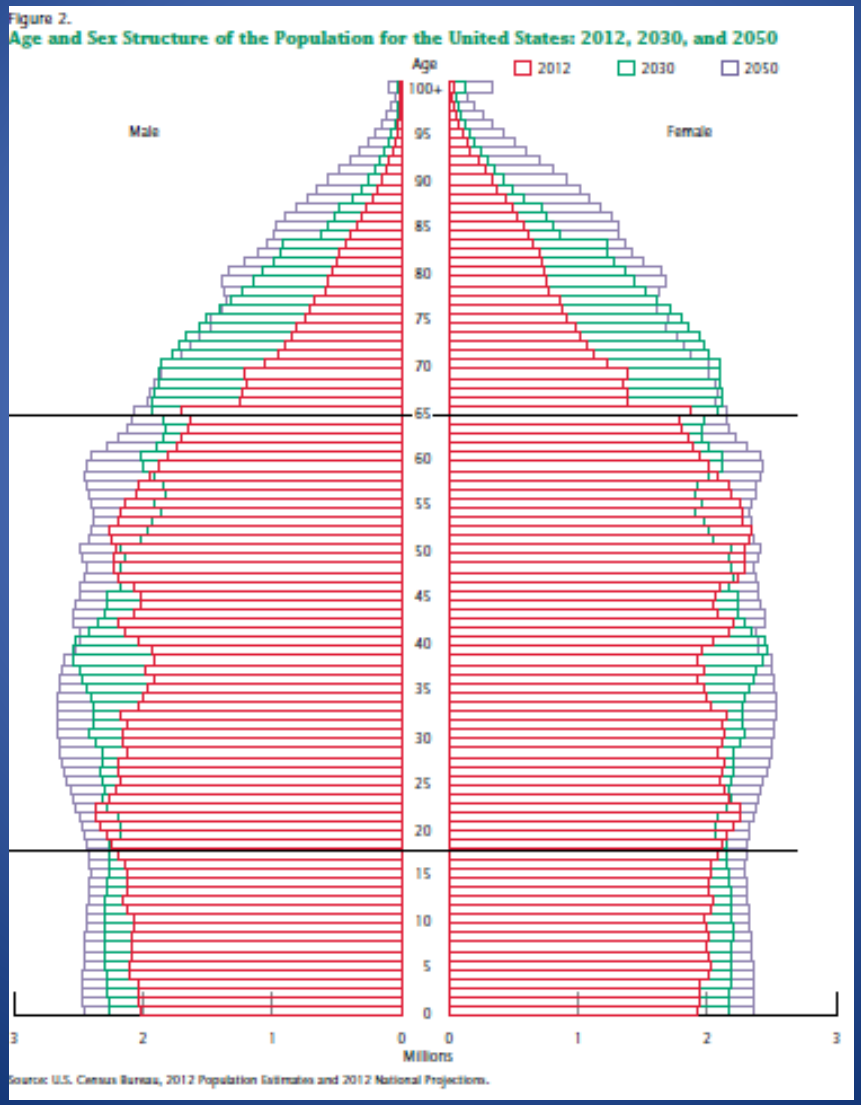
1. Attitudes about older adults & aging (1.5 hr)
2. General knowledge about adult development & aging (2.5 hr)
3. Knowledge of the foundations of clinical practice with older adults (3.0 hr)
4. Knowledge of the foundations of assessment with older adults (3.5 hr)
5. Knowledge of the foundations of intervention, consultation and other service provision (3.5 hr)

Demography & Psychiatric Epidemiology



(U.S. Census Bureau, 2012)

Age and Sex Structure of the Population of the United States 2012, 2020 and 2050 (U.S. Census Bureau, 2012)



Distribution of the projected older population by age for the United States, 2010-2050

(vertical line is year each age group is the largest proportion of the older population)
Vincent & Velkoff, 2010

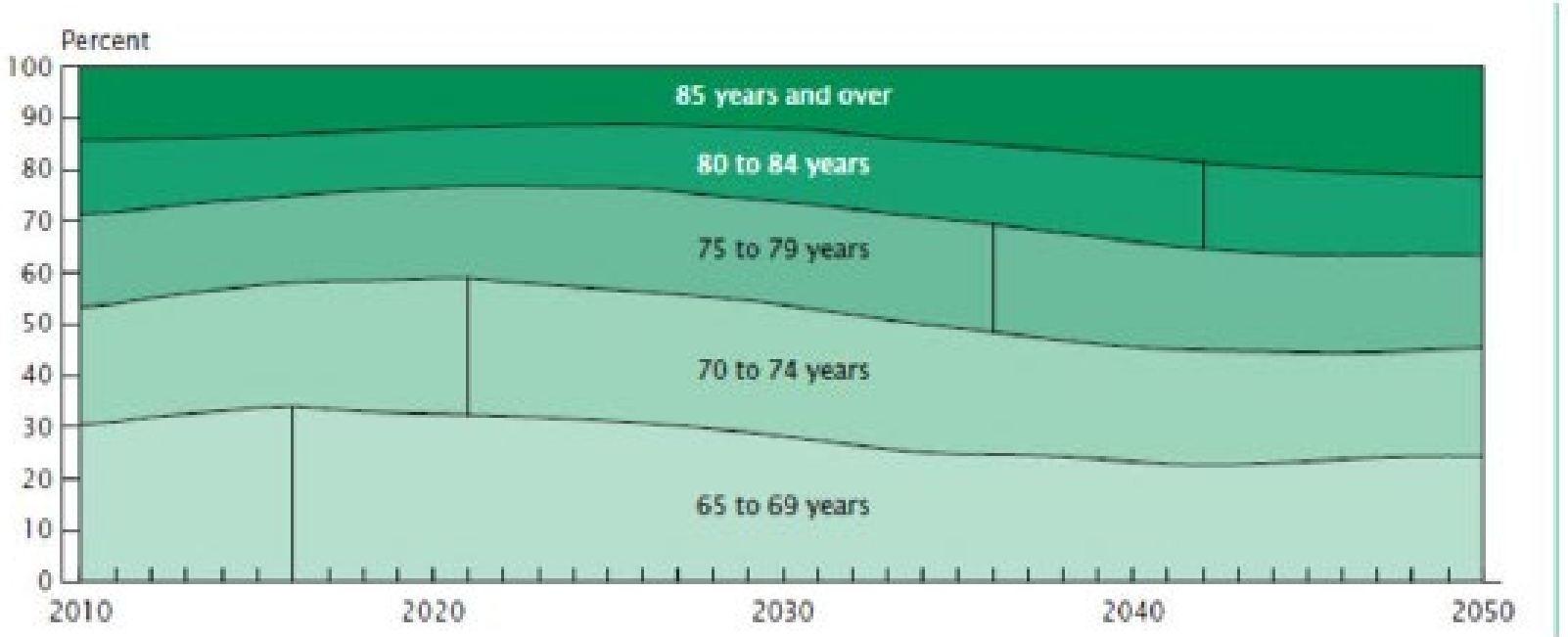


TABLE 2-1 12-Month Prevalence Rates and Estimated Number of Community-Living Adults Age 65 and Older with 10 MH/SU Conditions

Mental Health or Substance Use (MH/SU) Condition	Prevalence Rate[a] %	Estimated Number of Older Adults in 2010[b] (in millions)
Mental health conditions		
Depressive disorders	3.0-4.5	1.2-1.8
Major depressive episode(s)	3.0-4.3	1.2-1.7
Dysthymic disorder	0.6-1.6	0.2-0.6
Panic disorder	0.8-1.1	0.3-0.4
Agoraphobia without panic	*c*-0.3	*d*-0.1
Social phobia	0.9-2.6	0.4-1.0
Generalized anxiety disorder	1.1-2.1	0.4-0.8
Posttraumatic stress disorder (PTSD)[c]	0.6-2.6	0.2-1.0
Substance use conditions		
Alcohol dependence or abuse	*d*-1.9	*e*-0.7
Drug dependence or abuse	*d*-0.2	*e*-0.1
Summary figures		
One or more of the conditions	6.8-10.2	2.6-4.0
One of the conditions	4.8-7.8	1.8-3.0
Two or more of the conditions	2.0-2.4	0.8-0.9
Three or more of the conditions	0.5-0.8	0.2-0.3

(Center for Multicultural Mental Health Research, 2011)

TABLE 2-13 12-Month Prevalence of Selected MH/SU Conditions in Community-Living People in the United States by Age Group

	Age Group				
Mental health conditions	35-44 %	45-54 %	55-64 %	65-74 %	75+ %
Depressive disorders	10.0	8.8	6.4	3.7	2.1
Major depressive episode	9.8	8.4	6.4	3.7	2.0
Dysthymic disorder	2.9	3.5	2.1	0.9	0.7
Panic disorder	3.3	3.2	2.1	0.5	1.8
Agoraphobia without panic	1.0	1.3	0.8	0.4	0.2
Social phobia	8.2	7.0	5.2	3.6	1.1
Generalized anxiety disorder	4.7	4.8	4.2	1.8	1.3
Posttraumatic stress disorder	3.4	4.6	3.7	0.8	0.4
Substance use conditions					
Alcohol dependence or abuse	3.0	1.9	0.7	[a]	[a]
Other drug dependence or abuse	1.1	0.5	[a]	[a]	[a]
Summary figures					
One or more of the disorders	20.4	19.8	14.1	8.2	4.8
Two or more of the disorders	9.4	8.4	5.8	2.5	1.8
Three or more of the disorders	4.7	4.3	3.3	0.8	0.5

[a] The prevalence rate from the CPES is less than 0.2 percent.

SOURCE: Center for Multicultural Mental Health Research, 2011.

(Center for Multicultural Mental Health Research, 2011)

TABLE 2-10 Proportion of Community-Living Primary Care Patients Age 60 and Older with Depressive Disorders and Particular Physical Health Conditions, N=1,801

Physical Health Conditions	Prevalence Rate %
Chronic lung disease	23
Hypertension	58
Diabetes	23
Arthritis	56
Loss of hearing or vision	55
Cancer, excluding skin cancer	11
Neurological conditions, e.g., epilepsy, seizures, Parkinson's disease, stroke	8
Heart disease	28
Gastrointestinal disease	21
Urinary tract and prostate disease	39
Chronic pain	57

SOURCE: Noel et al., 2004.

TABLE 2-3 Proportion of Community-Living Adults and Nursing Home Residents Age 71 and Older with Normal Cognition or Dementia Who Had Associated Behavioral and Psychiatric Symptoms in the Previous Month[a]

Symptom[b]	Older Adults with Normal Cognition n = 303 %	Older Adults with Dementia n = 299 %
Delusions	0.6	18.2
Hallucinations	0.0	14.7
Agitation/aggression	3.6	22.5
Depression/dysphoria	11.9	28.0
Anxiety	6.5	15.2
Irritability or lability	5.9	13.4
Disinhibition	0.5	11.2
Elation/euphoria	1.5	1.6
Apathy/indifference	3.0	22.9
Aberrant motor behavior	0.0	16.5
Summary figures		
One or more symptoms	17.7	57.2
One or two symptoms	13.3	30.5
Three or more symptoms	4.3	26.7

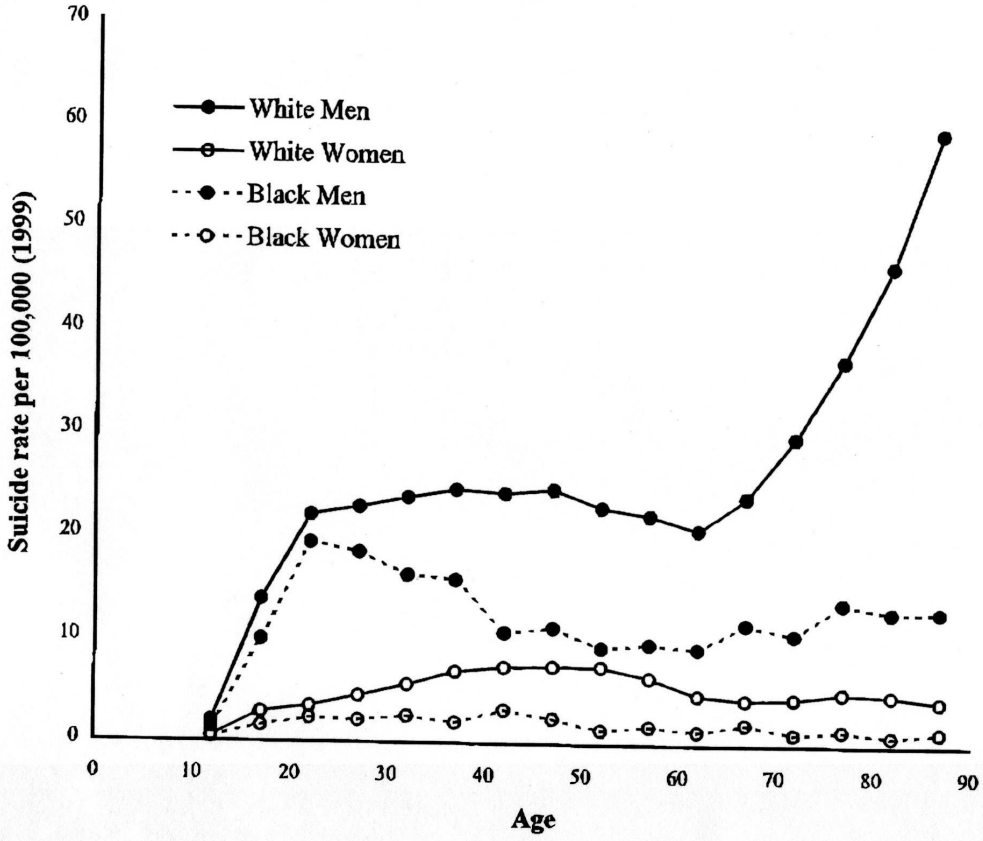
(Okura, 2011)

TABLE 2-4 Prevalence and Estimated Number of Nursing Home Residents Age 65 and Older with Selected Mental Health Conditions, 2009

	Prevalence Rate %	Number of Residents with the Condition
Mental health conditions		
Depression	49.6	590,834
Anxiety disorders	16.1	192,071
Bipolar disorder	2.8	33,416
Schizophrenia	3.6	42,521
Summary figures		
One or more conditions	56.8	675,622

(Shaping Long Term Care in America Project, 2011)

Risk for Completed Suicides



Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (online)

Depressive Symptoms in Older Adults

- Common presentation in older adults
  - Fatigue
  - Sleep disturbance
  - Anxiety/irritability
  - Pain
  - GI complaints
  - Loss of interest in living
- Gender/ethic differences
  - More irritability/agitation in older men
  - Less dysphoria in African Americans
- Compared to younger adults
  - More apathy/withdrawal
  - Less sadness
  - More anhedonia
  - More hopelessness
  - Less guilt, worthlessness
  - More memory/ concentration complaints
  - More passive death wish

For older adults across all racial and ethnic identities, there are increased biological/medical risks:

- Combination of vascular, neuroanatomic, inflammatory risk factors
- Chronic illness
  - Cardiovascular disease, diabetes, hyper and hypo-thyroidism, cancer
- Neurological diorders
  - Stroke, Alzheimer's disease, Parkinson's disease
- Medication side-effects
- Sleep complaints (note insomnia often precedes depression onset)
- Chronic Pain

(Reminder: Genes/genetic risk less important for late vs early onset mental health conditions)

For older adults across racial ethnic identities - decreased psychological risks/ improved resiliency

- Psychological factors more protective in late life
- Adult developmental maturity:
  - Increased emotional and conceptual complexity
  - Improved ability to regulate emotional experience
  - Better at coping with stress/loss
  - Greater self-acceptance
  - “Selective optimization with compensation”

Cognitive Screening

- Clinicians play an important role in early detection of dementia
  - Mental health concerns like depression and anxiety are risk factors for dementia
  - Early diagnosis can lead to early intervention with drug treatment or behavioral intervention
- Clinical judgement is unreliable
  - Subject to our own and our clients' biases on "normal aging"
  - Objective performance is a better indicator than subjective complaints

Cognitive Screening Choices

Do not screen

- Unequipped or unprepared
- No clear reason

Screen

- Suspected impairment
- Potential therapeutic benefit

Refer out

- Formal diagnosis following brief screening
- Medicare annual wellness visit approaching
- Contact primary care physician

Screening Recommendations: KAER toolkit from GSA

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Policy Center

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- Communicating with Older Adults
- Corporate Advisory Panel
- Cognitive Impairment Detection and Earlier Diagnosis
- Family Caregiving
- Human-Animal Interaction and Healthy Aging
- Longevity Economics
- Malnutrition
- National Adult Vaccination Program (NAVP)
- Oral Health: An Essential Element

Cognitive Impairment Detection and Earlier Diagnosis

KAER Toolkit: 4-Step Process to Detecting Cognitive Impairment and Earlier Diagnosis of Dementia

Approaches and tools for primary care providers

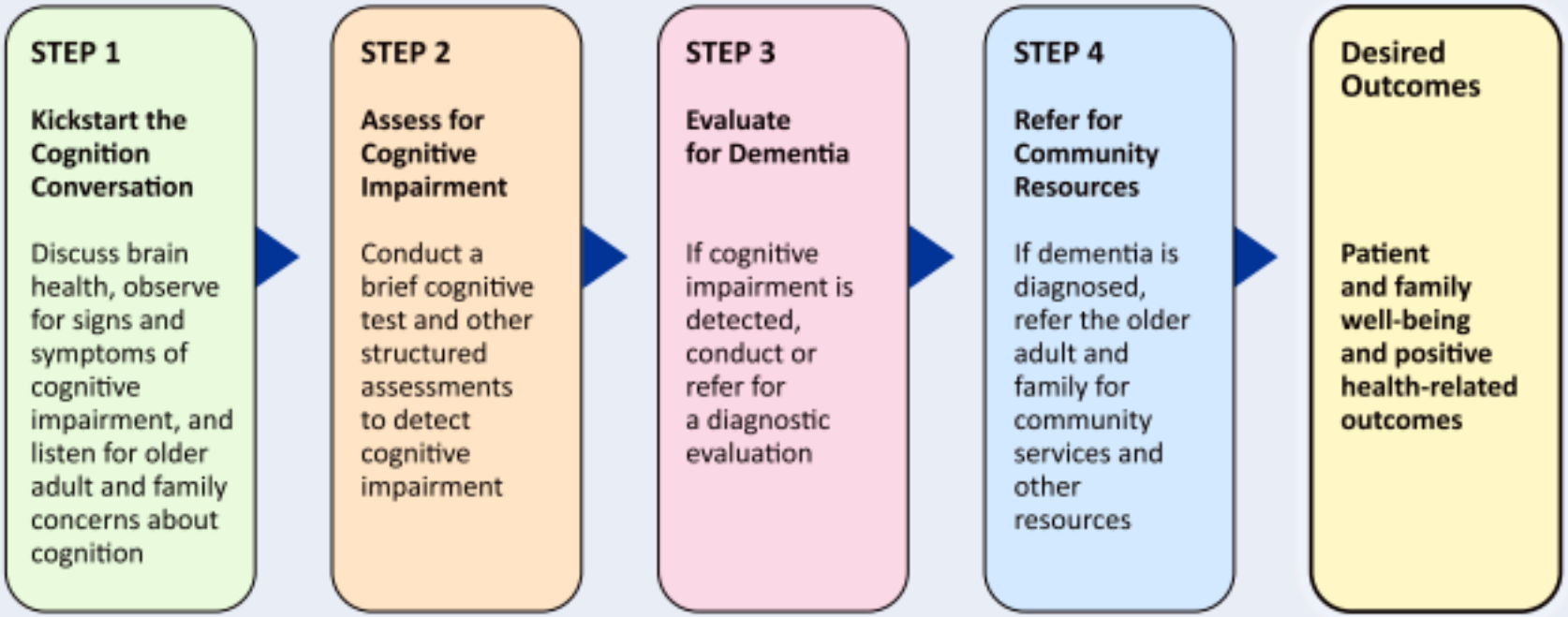
This comprehensive toolkit is focused on the KAER model developed by the GSA Workgroup on Cognitive Impairment Detection and Earlier Diagnosis. The workgroup identified valuable tools and resources to implement the four steps in the KAER model. The resulting toolkit provides options for each of the steps so that PCPs, health plans and health care systems can select the approaches and tools that fit best with their existing primary care structure, organization, and procedures.

The toolkit is broken down by each section of the KAER model to allow quick and easy access:

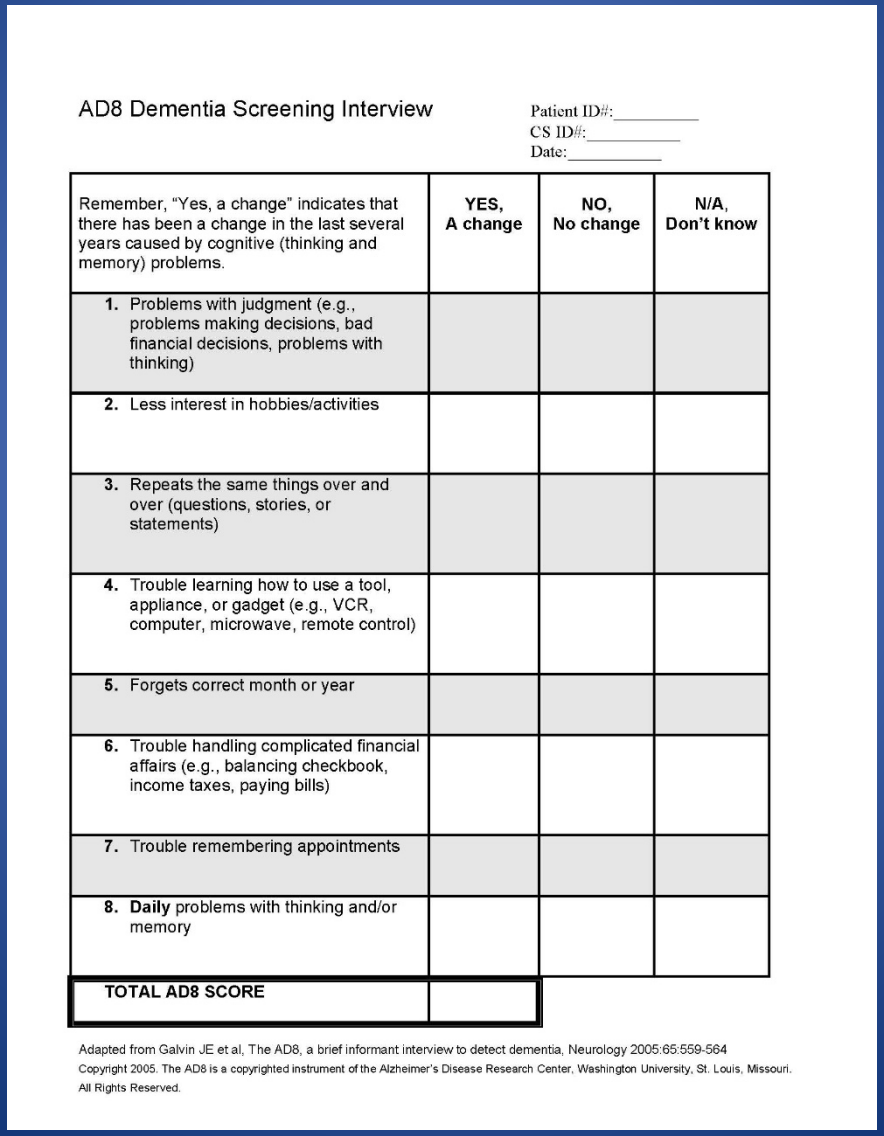
- **Kickstart** the cognition conversation
- **Assess** for cognitive impairment

Screening Recommendations: Our roles are step 1 and 2

Figure 1. Steps in the KAER Model to Increase Cognitive Awareness, Detection of Cognitive Impairment, Diagnosis, and Post-Diagnostic Referrals and Medical Care



Ask Directly: Cognitive changes



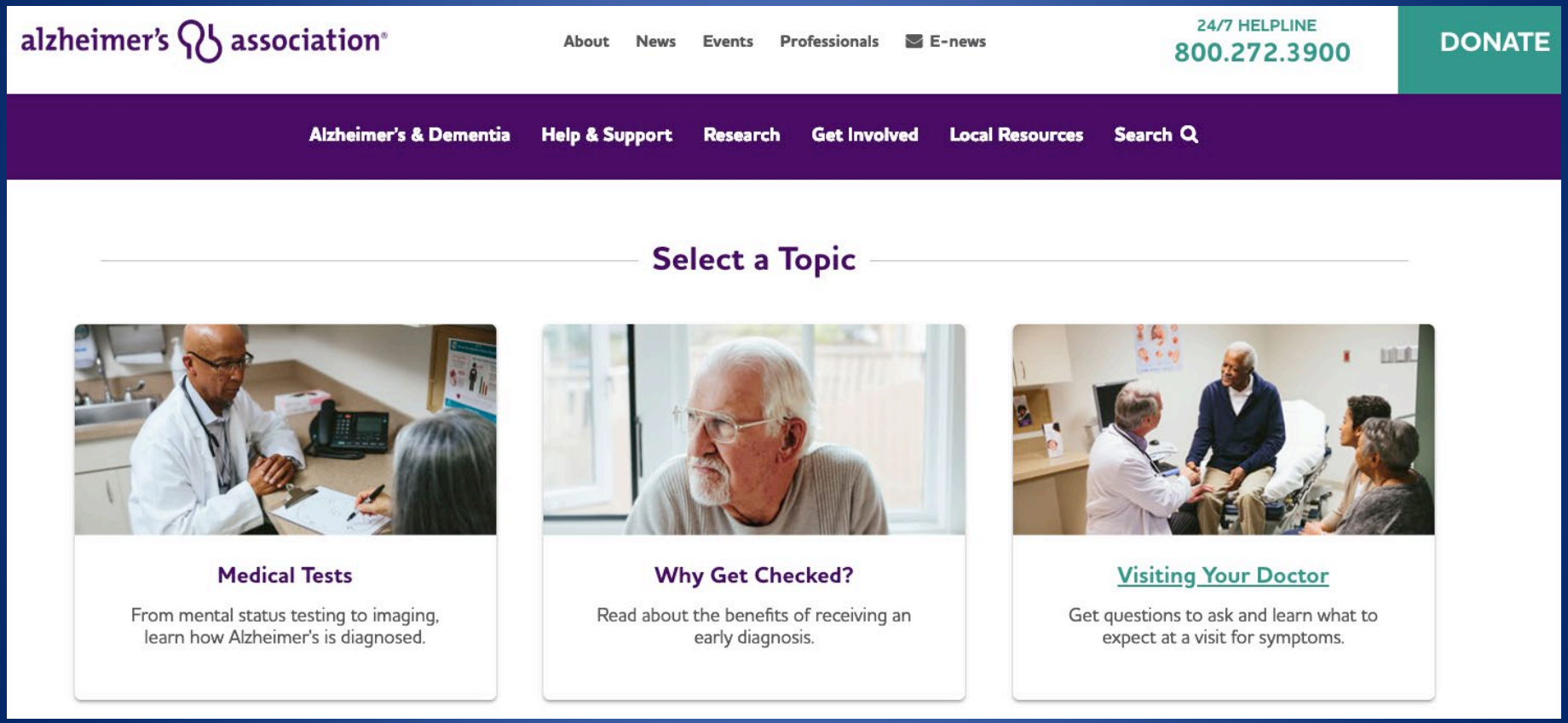
AD8 Dementia Screening Interview

Patient ID#:_____
CS ID#:_____
Date:_____

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	YES, A change	NO, No change	N/A, Don't know
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. **Daily** problems with thinking and/or memory			
TOTAL AD8 SCORE			

Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005:65:559-564

Follow-up on cognitive screens



alz.org/alzheimers-dementia/diagnosis

Assessment Considerations

Ask Directly: Suicide Risk

Columbia-Suicide Severity Rating Scale (C-SSRS)

http://www.cssrs.columbia.edu/

- Range of settings, populations (including with cognitive impairments), languages, administrative options (interview, self-report, electronic)
- Resources provided for free online training:

http://cssrs.columbia.edu/training/training-options/

Ask Directly: Alcohol Use

Short Michigan Alcohol Screening Test – Geriatric (SMAST-G)
https://consultgeri.org/try-this/general-assessment/issue-17.pdf

1. When talking with others, do you ever underestimate how much you drink?
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?
3. Does having a few drinks help decrease your shakiness or tremors?
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?
5. Do you usually take a drink to calm your nerves?
6. Do you drink to take your mind off your problems?
7. Have you ever increased your drinking after experiencing a loss in your life?
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?
9. Have you ever made rules to manage your drinking?
10. When you feel lonely, does having a drink help?

Diagnosing depression in older adults and family caregivers

For clinicians with limited experience with older adults, common errors are related to societal ageism:

- Under diagnosing depression because it seems to be an understandable response to a difficult life situation.

In fact, even in same difficult situation, most older adults are not clinically depressed. And, depression is as responsive to treatment in older adults as in younger.

Geriatric Depression Scale

Find scale and > 30 translations at:
http://www.stanford.edu/~yesavage/GDS.html

- Simple yes/no response format (pros and cons)
- Minimal somatic items (pros and cons)
- Does not ask directly about SI
- 30 item version: cutoff 11 for sensitivity; 14 for higher specificity
- 15 item version: cutoffs ~5-7
- May not be reliable in OA with significant cognitive impairment
- Not intended to be diagnostic: use to inform interview

MOOD SCALE (GDS-15)

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / **NO**
2. Have you dropped many of your activities and interests? **YES** / NO
3. Do you feel that your life is empty? **YES** / NO
4. Do you often get bored? **YES** / NO
5. Are you in good spirits most of the time? YES / **NO**
6. Are you afraid that something bad is going to happen to you? **YES** / NO
7. Do you feel happy most of the time? YES / **NO**
8. Do you often feel helpless? **YES** / NO
9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO
10. Do you feel you have more problems with memory than most? **YES** / NO
11. Do you think it is wonderful to be alive now? YES / **NO**
12. Do you feel pretty worthless the way you are now? **YES** / NO
13. Do you feel full of energy? YES / **NO**
14. Do you feel that your situation is hopeless? **YES** / NO
15. Do you think that most people are better off than you are? **YES** / NO

"Answers in **bold** indicate depression. Although differing sensitivities and specificities have been obtained across studies, for clinical purposes a score > 5 points is suggestive of depression and should warrant a follow-up interview. Scores > 10 are almost always depression."

Cornell Scale for Depression in Dementia
(Alexopoulos et al., 1988)

- Based on interview with patient and with an informant (re: past week); final rating is rater's clinical impression
- 19 items rated as absent (0), mild or intermittent (1) or severe (2)
  - Mood related signs: anxiety, sadness, lack of reactivity to pleasant events, irritability
  - Behavioral disturbance: agitation, retardation, multiple physical complaints, acute loss of interest
  - Physical signs: appetite loss, weight loss, lack of energy
  - Cyclic functions: diurnal variation of mood, difficulty falling asleep, multiple awakenings during sleep, early morning awakenings
  - Ideational disturbance: suicide, self-depreciation, pessimism, mood congruent delusions
- Administration and scoring guidelines:

  http://www.scalesandmeasures.net/files/files/The%20Cornell%20Scale%20for%20Depression%20in%20Dementia.pdf

Assessment Resources

GeroCentral Clearinghouse for Older Adult Mental Health Resources: http://gerocentral.org

Hartford Institute's assessment tools and e-learning resources: https://consultgeri.org/

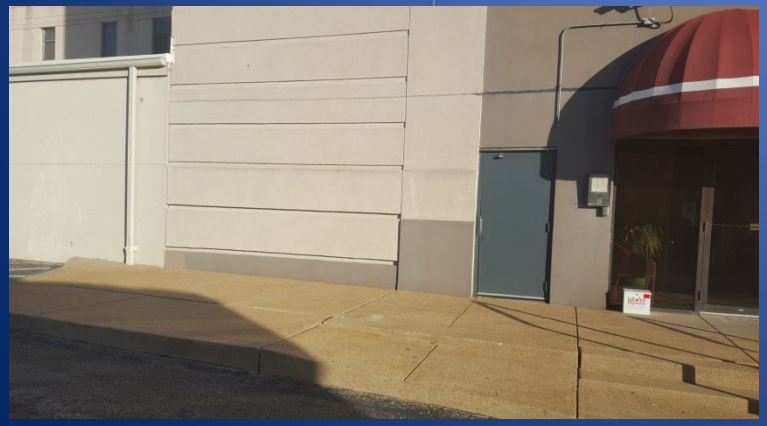
APA Office on Aging: http://www.apa.org/pi/aging/index.aspx

National Center on Caregiving:

https://www.caregiver.org/sites/caregiver.org/files/pdfs/SelCGAssmtMeas_ResInv_FINAL_12.10.12.pdf

Psychotherapy Modifications

Disability access



Setting up your space for older adults

Common elements of therapy with older adults

- Problem identification and goal setting
- Ongoing assessment to guide interventions and evaluate progress
- Between session work (call it “home practice”, not “homework”)
- Session structure (agenda, home practice review, specific skill building using 1-3 areas of client’s life, periodic summaries, developing home practice)

These common elements of CBTs stay consistent for:

- Psychoeducational groups = “classes” (e.g., chronic pain, sleep, stress management, caregiving concerns)
- Brief interventions in healthcare settings
- Individual/family CBT in behavioral health “specialty care”

So what might be different in therapy with older adults?

- Attention to complexity of relationship between physical and mental health
- Consideration of client's potentially decreasing control over some facets of physical and social environment
- Involvement of family (including chosen family)
- Potential age difference between client and provider
- Impacts of societal ageism (on clinician & client)

Modification of the content of therapy could include….

- Spend time providing orientation to therapy
- Agenda items of physical illness, adherence to medical regimens, family relationships
- Increase strengths-based emphasis on life experiences, relationships, & coping repertoire
- With consent, include family partners – traditional and chosen

Modification of the content of therapy could include….

- Slower pace and/or shorter sessions, allowing for repetition of concepts as needed
- Reminders, written or verbal, of key concepts and home practice tasks
- Being cognizant of physical constraints and needs, e.g., bathroom breaks, time to stretch
- Watch use of jargon

Modifications of the content of therapy could include...

Specific to cognitive impairment issues:

- Increased reliance on written forms and whiteboard use
- Interrupting narratives/stories as a form of answering questions
  - This is a factor of change in cognitive style related to changes in frontal lobe, not related to loneliness or personality
  - How to interrupt?
- Changing language on forms

Written summaries promote learning

- Have either workbook or folder with handouts ready at the end of very first meeting, with something to get started.
- Routinely use session preparation sheets before each session.
- Routinely use session summary sheets at the end of each session.
- If using a workbook for clients, embed the cost into fees for first 3 sessions.

Target Complaints

Problem:

a. In what situation does this occur?

b. Why do you think this problem occurs?

c. What have you tried to manage this problem? Did this help in any way?

Specifying Treatment Goals

Positively worded:

- Important to client
- Specific
- Measureable
- Realistic
- Time-limited

If treatment is a success in regards to this goal, I will probably (behaviors/events):

If treatment is partially successful, I will probably:

If this goal is not met at all, I will probably:

When developing and assigning between-sessions work:

- **<u>Always</u>**....
  - Directly link to a concrete therapy goal ("We are experimenting with best ways to help you with your goal to _____. This activity will help us by ....")
  - Do one small piece together (based on day of session, previous day, etc) with client writing it in the appropriate space, as an example
  - Ask, "How likely do you think it is that you will fill this out and bring with you to our next meeting?"

(if < 80%, ask, "What can we change to meet your needs?")

With some older adults, this will take more session time than clinicians may be used to spending.

Session Summary Form

- Today, we focused on:
- I'd like to especially remember:
- Before my next appointment, I am going to work on:
- My next appointment is:

Preparing for Session Form

Either at home or in the waiting room before your session, spend no more than 5-10 minutes to jot down a few phrases in each section….

What did we talk about/work on in last session?

What was my between-sessions assignment? Did I have any difficulties with this? Learn anything new?

What do I want my therapist to know about the past week? Have there been any major changes in my condition or life?

What would I like to be sure to talk about in today's session?

Cognitive interventions with older adults

Most common errors by clinicians with limited experience with older adults:

-not recognizing unhelpful thoughts (“I am in pain so I cannot do anything today”)

-difficulty interrupting to help client focus

Consultation with clinicians trained in geriatrics will help.

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This website is a collaborative effort between the American Psychological Association's (APA) Division 12,

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What Mental Health Providers Should Know About Working with Older Adults

Introduction

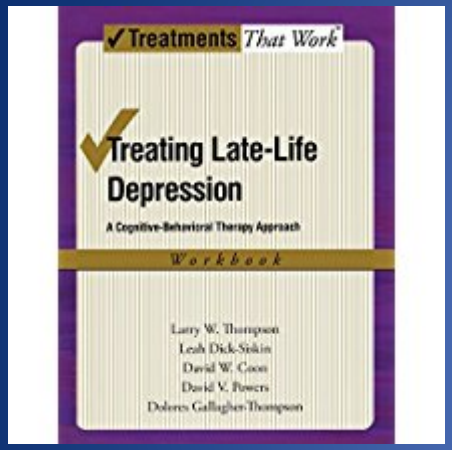
The aging population continues growing in number, diversity and mental health needs. Estimating the current mental health workforce serving older adults remains challenging. Nonetheless, a common consensus is the current workforce is insufficient to meet current and anticipated future demand.

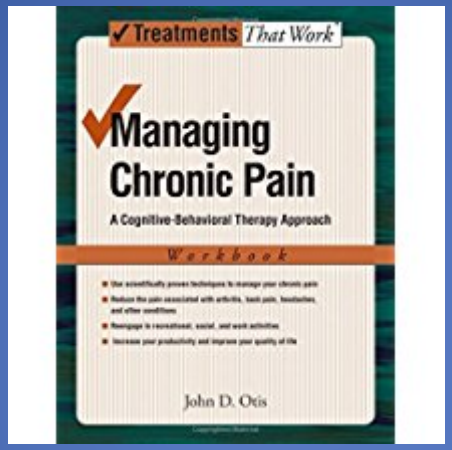
This publication is designed to provide psychologists and other health care practitioners with resources, tools and information to enhance their work with older adults (defined as persons 65 years of age and older). It is intended to serve as a resource in response to the Institute on Medicine's 2011 report, "The Geriatric Mental Health and Substance Use Workforce: In Whose Hands?" that highlights the necessity of increasing the geriatric workforce to address mental health and substance use needs of older adults.

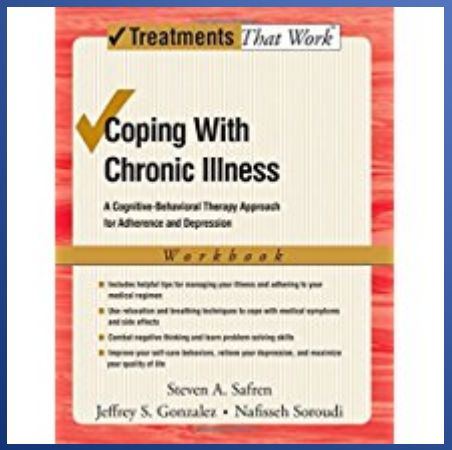
Additional APA Resources

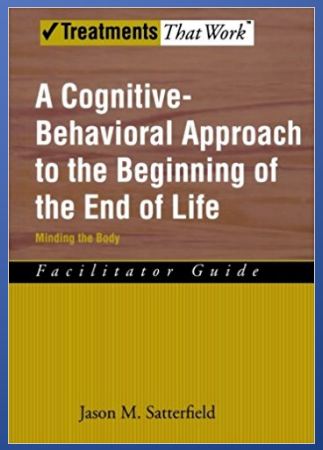
- Programs & Projects
- Resources & Publications
- Committee on Aging
- Other Aging Organizations

CBT Treatments that Work with Older Adults



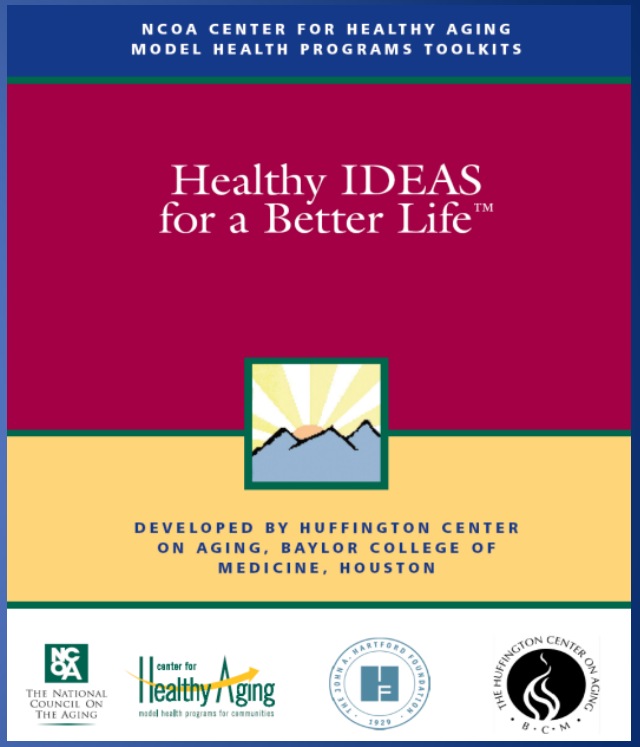






Pursuing Happiness: Case Managers

- Healthy IDEAS:
  Identifying
  Depression
  Empowering
  Activities for
  Seniors



- Based on Chronic Disease Health Management model – National Council on Aging & Administration on Aging

- Baylor College of Medicine

Your own next steps….

Within the next month, I plan to:

1.

2.

3.

I will share this plan with _____ and discuss how they can hold me accountable.