Psychotherapy and Behavioral Health Interventions with Older Adults

Ann M. Steffen, Ph.D., ABPP
Nicholas Schmidt, MS, MA

Missouri DMH Spring Training Institute 2019

UMSL Psychological Sciences
University of Missouri–St. Louis

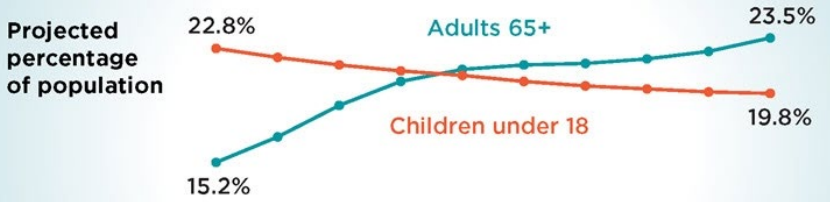
Objectives

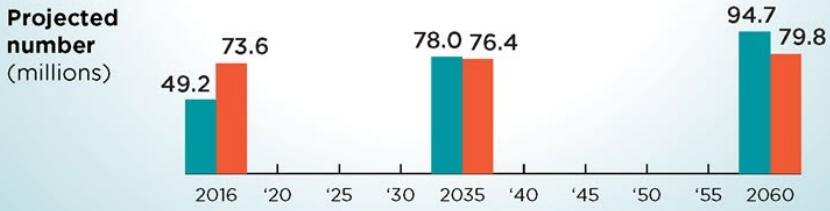
1. Identify attitude, knowledge and skill competencies for evidence-based assessment and treatment of older adults
2. Describe key considerations in the assessment and treatment of older adults with co-morbid physical and mental health concerns
3. Discuss in-session strategies for overcoming challenges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

An Aging Nation

Projected Number of Children and Older Adults

For the First Time in U.S. History Older Adults Are Projected to Outnumber Children by 2035





Note: 2016 data are estimates not projections.

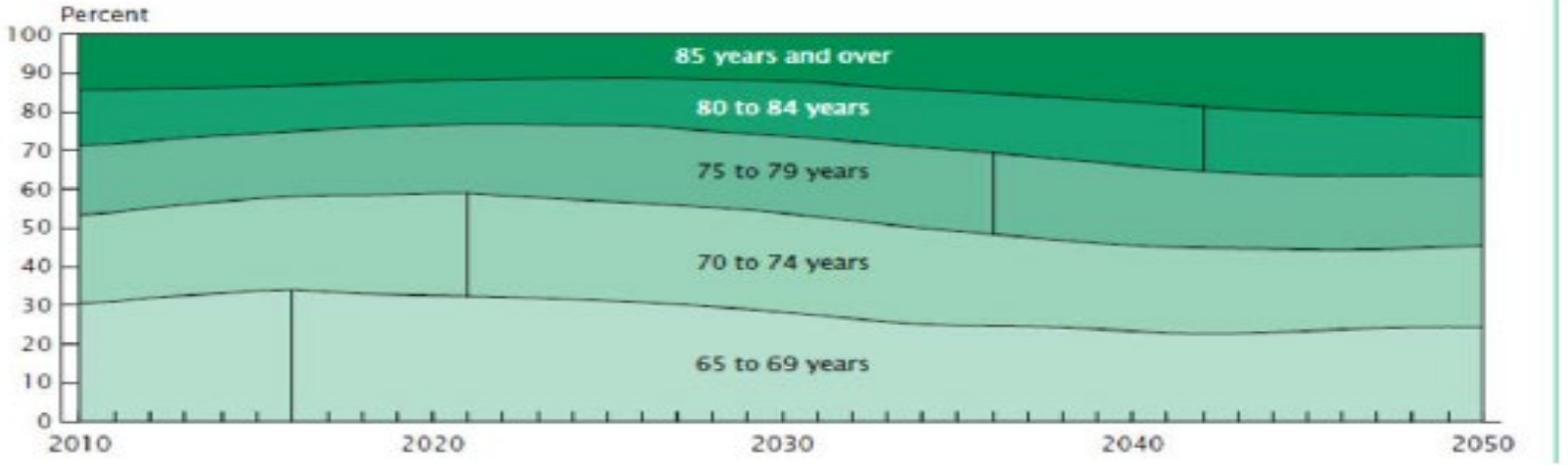
United States Census Bureau

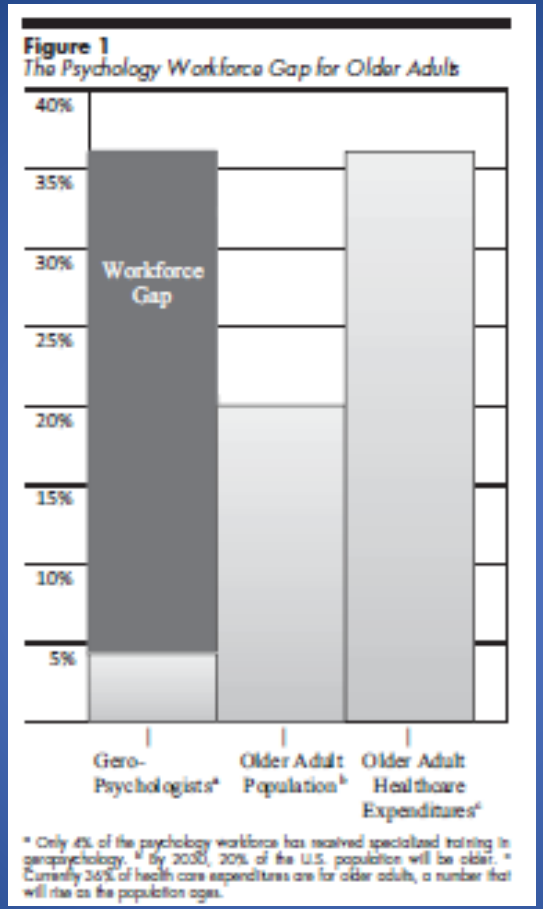
U.S. Department of Commerce
Economics and Statistics Administration
U.S. CENSUS BUREAU
census.gov

Source: National Population Projections, 2017
www.census.gov/programs-surveys/popproj.html

US Older population by age 2010-2050

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





(Hoge et al., 2015)

Example: Clinical Psychology

(Hinrichsen et al. 2018)

"Exposure" to geropsychology - 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)

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.

Subgroups of older adults are at higher risk for mental health concerns:

- Multiple chronic physical health conditions
- Cognitively impaired
- Nursing home residents

Later-life depression is among the conditions with highest prevalence and impact.

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, adaptation
  - Greater self-acceptance

As we age...

We become more different from each other

This is due to variability in:

-life experiences

-health status, physical and cognitive functioning

-exposure to risk factors

-areas of strength and resiliency

-multiple identities salient for an individual

Assessment

- Cognitive Concerns
- Suicide risk
- Alcohol
- Depression

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

THE GERONTOLOGICAL SOCIETY OF AMERICA®

Join | Career Center | Online Store

AAA

Search Site

ABOUT US | PROGRAMS & SERVICES | MEMBERSHIP | PUBLICATIONS | MEETINGS & EVENTS | STAY CONNECTED | PRESS ROOM | SUPPORT GSA

Home > Programs & Services > Alliances and Multi-Stakeholder Collaborations > Cognitive Impairment Detection and Earlier Diagnosis

- Policy Center
- Alliances and Multi-Stakeholder Collaborations
  - Clinical Trials and Older Adults
  - 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

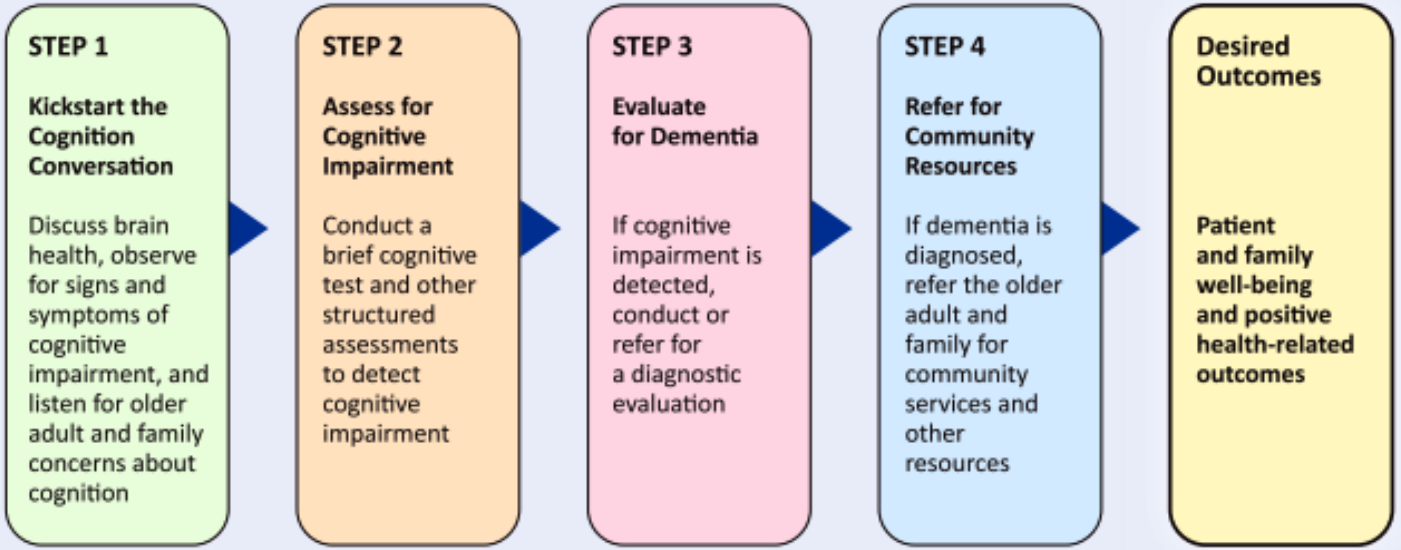
This comprehensive toolkit is focused on the KAER model developed by the GSA Workgroup on Cognitive Impairment Detection and Earlier Diagnosis. The workgroup identified valuable tools and resources to implement the four steps in the KAER model. The resulting toolkit provides options for each of the steps 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:

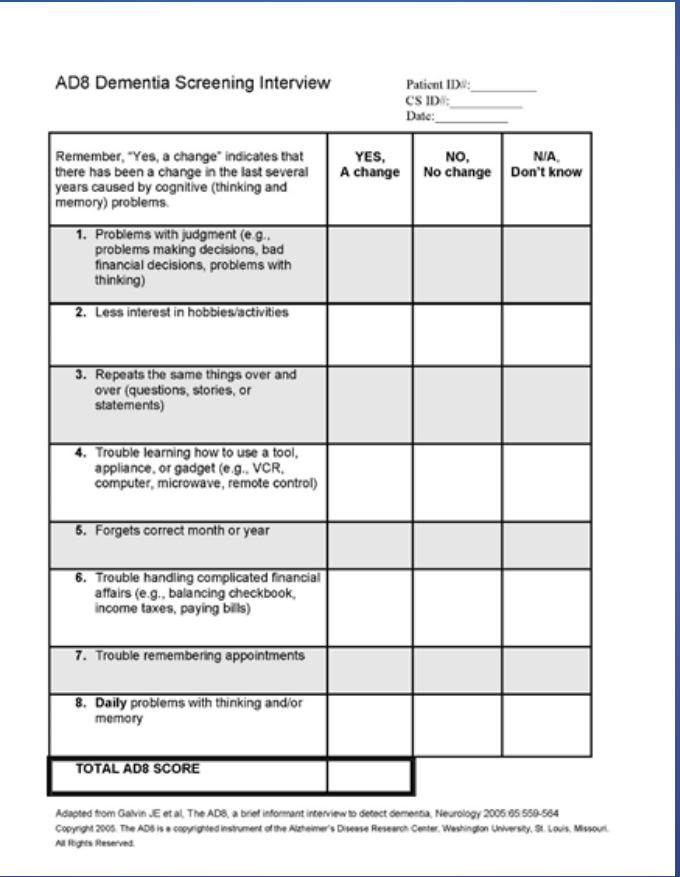
- **Kickstart** the cognition conversation
- **Assess** for cognitive impairment

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

Copyright 2005. The AD8 is a copyrighted instrument of the Alzheimer's Disease Research Center, Washington University, St. Louis, Missouri. All Rights Reserved.

Follow-up on cognitive screens

alzheimer's association

About | News | Events | Professionals | E-news

24/7 HELPLINE
800.272.3900

DONATE

Alzheimer's & Dementia | Help & Support | Research | Get Involved | Local Resources | Search

Select a Topic

Medical Tests

From mental status testing to imaging, learn how Alzheimer's is diagnosed.

Why Get Checked?

Read about the benefits of receiving an early diagnosis.

Visiting Your Doctor

Get questions to ask and learn what to expect at a visit for symptoms.

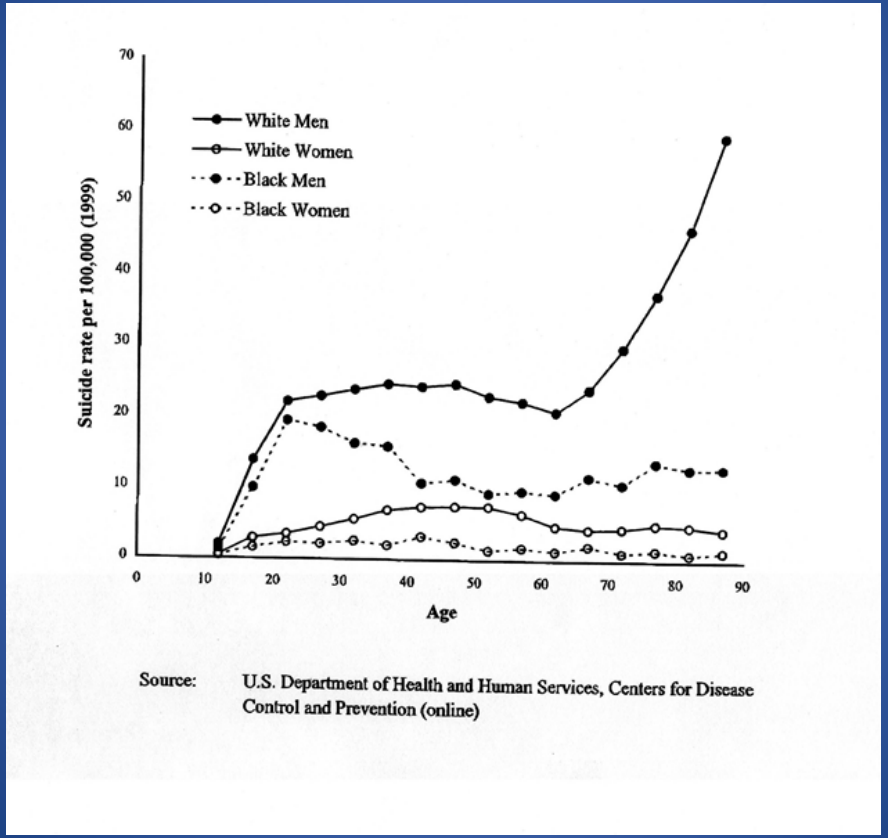
Evaluating Memory and Thinking Problems: What to Expect

Your doctor will likely take multiple steps in order to evaluate your memory and thinking. The evaluation may be divided into several visits, allowing time to gather information to accurately determine the cause of your concerns and rule out other possibilities. Understanding the type and purpose of the tests your doctor(s) may order and knowing what to expect during an evaluation can be empowering and help to ease anxiety.

Click on each icon to learn more.

To view a list of the tests, select the "Download Summary" button below.

Risk for Completed Suicides



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

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/

Treat suicide risk directly!

Joint Commission Sentinel Alert

https://www.jointcommission.org/sea_issue_56/

-Cognitive Therapy for Suicide Prevention

(CBT-SP; Brown et al., 2004; Stanley et al., 2009)

-Collaborative Assessment and Management of Suicide

(CAMS; Jobes 2016 – 2nd edition)

-Dialectical Behavior Therapy

(DBT; Linehan et al., 2006)

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?

Depression Assessment

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 (GDS)

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

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

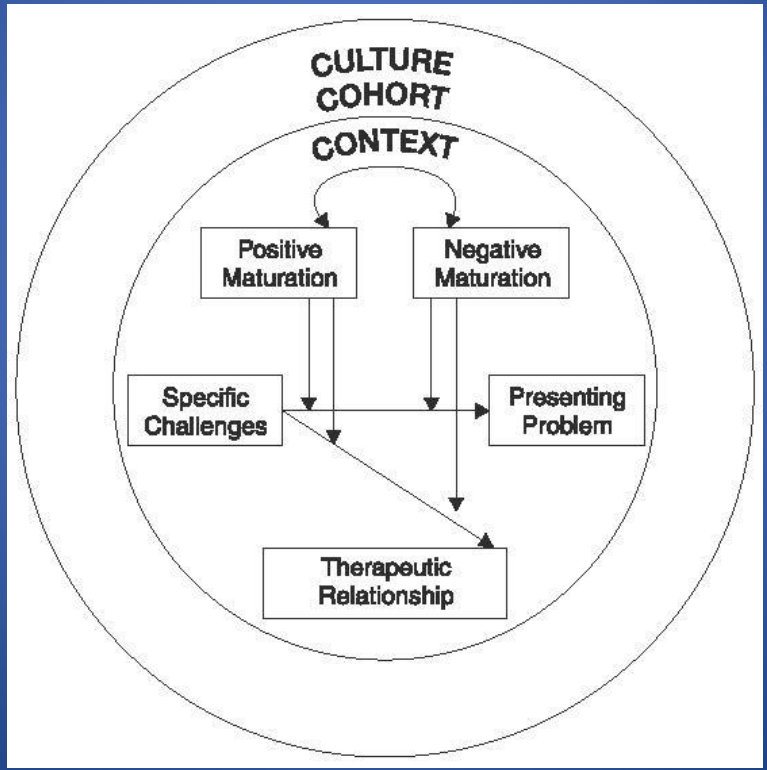
Assessment Resources

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

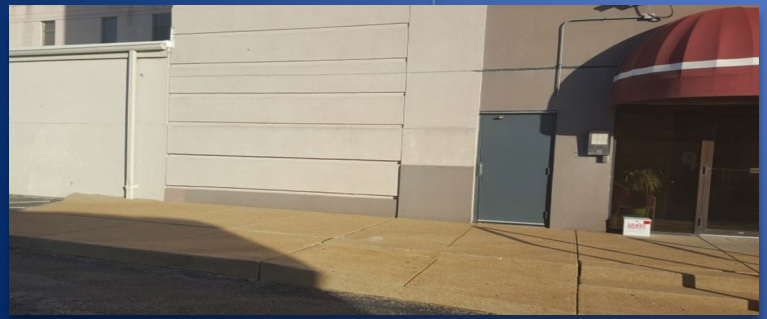
Hartford Institute's assessment tools and e-learning resources: https://consultgeri.org/

Psychotherapy Modifications

(Knight & Pachana, 2015)



Increasing physical access



Setting up your space for older adults

Themes within therapy

- Common Mental Health concerns
- Physical concerns (illnesses, chronic conditions, medical treatments, pain, sleep)
- Losses (due to death, relocation, social roles)
- Family concerns

Modifications of therapy could include….

- More time/repetition orientating 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

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….

- 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 therapy...

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 solely related to loneliness, personality or relationship needs
  - How to interrupt?
- Changing language on forms

Session Pacing/Redirecting

“Before you tell me the entire story, help me understand a little about what makes this important to you….What should I be listening for, to help you?”

“Do you mind stopping a second...you've given me lots of information already. Just to make sure I have understood completely, let's look at the major points you’ve made so far.”

“We may have strayed off the topic a little, shall we get back and focus on the chief issues you raised?”

“Now we have 20 minutes left before the end of the session. Is there anything else you think we must cover before the end - keeping in mind that we will also need time to discuss what you plan to practice before we meet again?”

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.
- 3 x 5 index cards for key insights/plans

Target Complaints

Problem:

In what situation does this occur?

Why do you think this problem occurs?

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:

Home Practice Between Sessions

- Link to a concrete therapy goal ("We are experimenting with helping you _____. This activity will help us by ___")
- Do one small piece together (based 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 try this and bring this form with you to our next meeting?"
  (if < 80%, ask, "What can we change to meet your needs?")

Some older adults will need more session time than you are used to.

Session Summary Form

Date of Session: _____

Today, we focused on:

I'd like to especially remember:

Before my next appointment, I am going to specifically work on:

My next appointment is:

Preparing for Session Form

Date of Session: _____

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

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

What was I trying to practice at home? Did I have a specific 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?

Common Errors in Session: Behavioral Interventions

-not allowing enough time in session to set up the details of home practice and review in later session

-not providing sufficient repetition in the type of behavioral experiments and practice

-difficulty interrupting to help client focus

Common Errors in Session: Cognitive Interventions

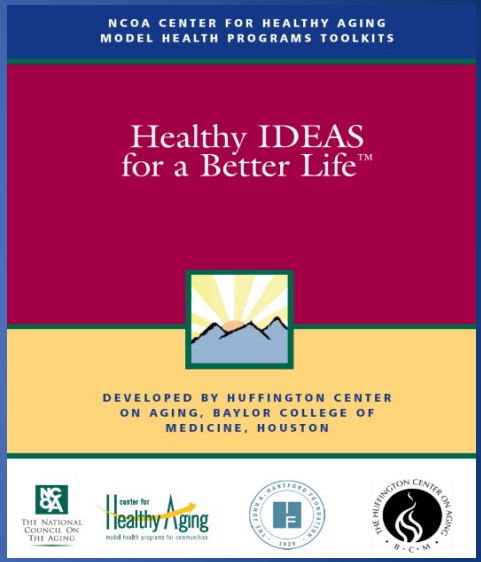
-not recognizing that a thoughts is unhelpful:
(*"I am in pain so I cannot do anything today"*)

-clinician challenges instead of helping client learn to examine and modify their own thoughts

-difficulty interrupting to help client focus

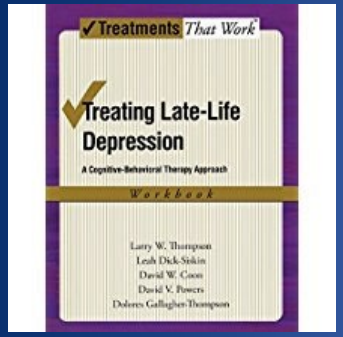
Pursuing Happiness: Case Managers

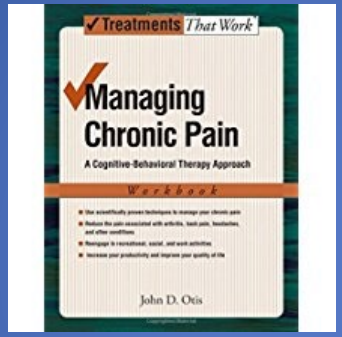
- Healthy IDEAS:
  Identifying
  Depression
  Empowering
  Activities for
  Seniors

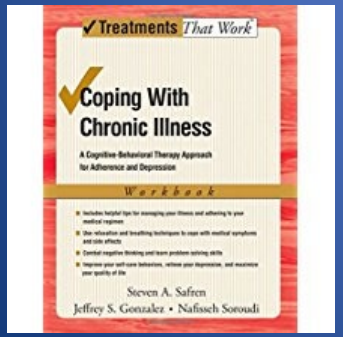


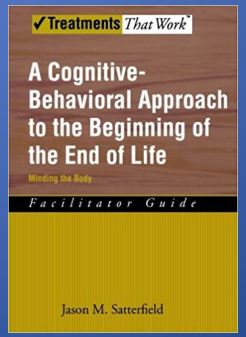
- Based on Chronic Disease Health Management model – National Council on Aging & Administration on Aging

CBT Treatments that Work with Older Adults









pikes peak geropsychology - | GeroCentral — Clearinghouse for

gerocentral.org

Search

Most Visited | Getting Started | Latest Headlines | CDR training

GeroCentral

CONTACT US

HOME | CLINICAL TOOLBOX | RESEARCH | POLICY & ADVOCACY | COMPETENCIES | TRAINING & CAREER

What's New at GeroCentral?

NEW Assessment Database from the University of Alabama! Check out links in the Clinical Toolbox under each disorder!

Check out FREE Continuing Education about Aging from CATCH-ON

Join us for the SCG Student Social at GSA 2016!

PARTNER ORGANIZATIONS

- APA DIVISION 12/II
- APA DIVISION 20
- COPGTP
- PLTC

Welcome to GeroCentral!

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

10:01 PM
6/2/2017

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

Social Service Resources

- Missouri Aging Information Network: moaging.com
- Show Me Long Term Care in Missouri:

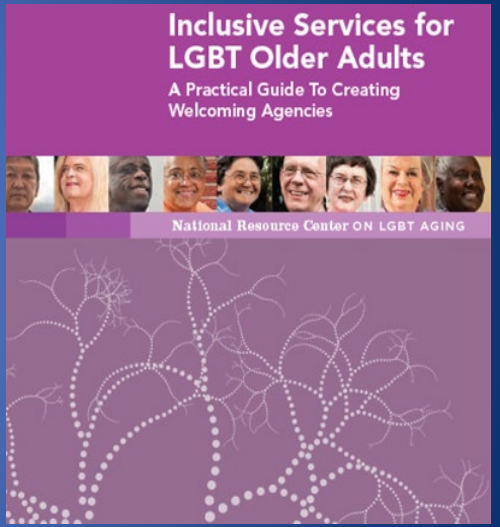
  http://www.dhss.mo.gov/showmelongtermcare/
- US Administration on Aging National Eldercare Locator:

  https://eldercare.acl.gov: 1-800-677-1116
- National Council on Patient Information and Education:

  http://www.bemedwise.org
- AARP Resources for Caregivers: https://www.aarp.org/caregiving/

National Resource Center on LGBT Aging

- https://www.lgbtagingcenter.org
- Technical assistance resource center
- Run by SAGE National
- Provides local and national resources
- Guides:
  - LGBT Programing
  - Asking Inclusive Questions
  - Age-Friendly Inclusive Services
  - Programing for LGBT Caregiving



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.

References

APA (2014). Guidelines for Psychological Practice with Older Adults, *American Psychologist*, *69*(1), 34-65.

Braun, M. M., Karlin, B. E., & Zeiss, A. (2016). Cognitive-behavioral therapies in older adult populations. In C. M. Nezu, A. M. Nezu, C. M. Nezu, A. M. Nezu (Eds.) , *The Oxford handbook of cognitive and behavioral therapies* (pp. 349-362). New York, NY, US: Oxford University Press.

Knight, B. G., & Pachana, N. A. (2015). *Psychological assessment and therapy with older adults*. Oxford University Press, USA.

Laidlaw, K., & Kishita, N. (2015). Age-appropriate augmented cognitive behavior therapy to enhance treatment outcome for late-life depression and anxiety disorders. *Geropsych: The Journal Of Gerontopsychology And Geriatric Psychiatry*, *28*(2), 57-66. doi:10.1024/1662-9647/a000128

Scogin, F. & Shah, A. (Eds.) (2012). Making evidence-based psychological treatments work with older adults. Washington, DC: American Psychological Association.

Steffen, A. M. & McDougall, M. (2016). Psychotherapy and behavioral health interventions with older adults. In S. K. Whitbourne (Ed). *Encyclopedia of Adulthood and Aging.* Wiley-Blackwell.