Psychotherapy with Older Adults: A Multimodal Model of Treatment

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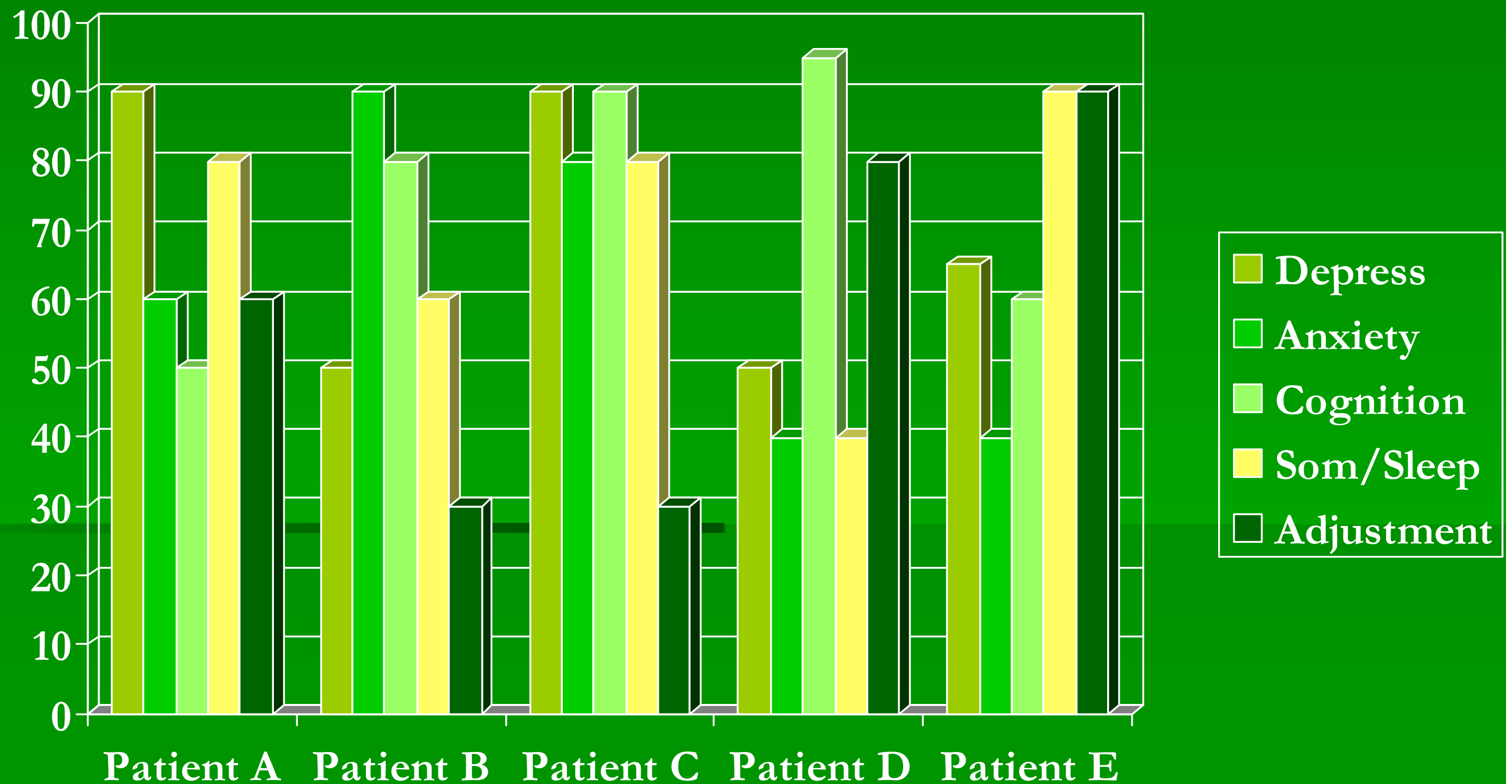
Overview:
Help me in Implementation

- Sensitize you to aging: Heart of Darkness
- Aging is complex: Not good EBP. But….
- Necessary Background
- Principles of Rx
- Depression and Anxiety
- Biases

Case Based Model of Care



Big Picture: "There is no such thing as aging"

- Aging is not a causal variable. Rather it is a marker on a temporal axis along which various exposures and disease processes operate. Aging then is not a meaningful explanation for why one might experience cognitive decline or impairment.
- Dementia also is a non-event. It is an end stage of a process of a "brain at risk," a poor accumulation of health, behaviors, and genetics.

Big Picture: Taxonomy Crisis

- Dementia
- Anxiety/Depression
- Focus should be on identifying items
- that place a person on the continuum,
- not whether he is or is not in the group.
- Additive effect: Risk factors in genes
- and environment accumulate.
- Psychotherapy: Transdiagnostic model

Big Picture: Psychiatry Truisms

- **Over 50 years of research have suggested the following are more true than not:**
- 1. differential effectiveness of competing
- therapeutic approaches only marginally exists (low ESs)
- 2. the superiority of psychopharmacological
- over psychological approaches is untrue
- 3. the utility of psychiatric classification as
- determining the course of Rx is poor
- 4. identification of and treatment of dementias
- and depression/anxiety have only mildly improved

5. psychiatric care is more complicated than medical care
6. the “more’s” apply AND the “sublthresholds” also apply.

Big Picture: Treatment Efficacy

- National Institute of Mental Health cites treatment efficacy rates of at least 80% for patients with major depression (if patients are provided appropriate treatment),
- National Comorbidity Survey Replication found an adequate treatment rate of only 42% among patients.
- Two large-scale studies, IMPACT and PROSPECT, using collaborative care management in primary care, found that less than half of older patients with major depression who underwent intervention experienced a 50% reduction in depressive symptoms. In the IMPACT study, only about one-quarter of patients became completely free of depressive symptoms.
- Public-health relevant approaches to prevent depression in high-risk elderly people are needed.

- WE SUCK AT THIS.

Little View: Psychotherapy

- Antidepressant use doubled from 1996 (5%) to 10.4% in 2006; 2 or > meds increased from 42% in 1997 to 60% in 2006; 3 meds from 16% to 33% (Olfason et al., 2006)
- 40% of older with first LLD suffer recurrence in 3 yrs (Hybels, et al., 2006)
- Over time (9 years) subsyndromal depressive symptoms predict disability (Adams et al., 2009)
- Compliance for anti-depression meds is 44.3% after 6 months (Sawada et al., 2007)
- Placebo effect is here (non-specific factors): Substantive Effect = Real Effect-Placebo: Response yes, remit no… Placebo effect addresses the same brain areas as SSRIs (increases in prefrontal, ACC, posterior insula and decreases in para-hyppocampus and thalamus) (Mayberg et al. 2002)
- Old-old respond and remit less than young old.

Little Big View: Older Adults and Therapy

- Reality constraints on outcome worse for older adults: client's readiness to change; acceptability of the treatment and preferences of the client; caregiver acceptance; availability of desired or needed services; tolerance of incongruous recommendations; prior treatment failures or successes; and side effects.
- Three components of therapy – research, clinical experience, and client characteristics – are less robust at late life and we must borrow from reasonable generic psychotherapy markers. PCC Emphasis: Watch and Wait: Tinker with caution.
- PCC Emphasis
- Use Modules: DO NOT pick one best treatment at the outset: Rather recognize how patients present with and experience depression, choose slowly treatment options but apply objective measures of treatment response. Make changes until the patient improves.
- Components of CBT, including problem solving therapy and IPT, represent modules that are more equal than others.

Little View: Older Adults and Therapy

- Watch and wait → Reflect and Prepare
- Establishing rapport, an alliance, is critical.
- Be Believable/Likeable as a Therapist: Placebo rocks!!!!
- Monitor: Outcome targets for many problems, practical and psychological.
- Change treatment to suit the person, often in mid-stream.
- Problems recur….So, you are in for the long haul.
- Use brain: Reregulation of neuronal networks parallels symptomatic changes in psychotherapy
- Use a team - Patient, family, provider, mental health consultant, care manager.

Little View:
Older Adults and Therapy

- Always Remoralization, a sense of a passionate reaction to the possibility of change. Then enter remediation or rehabilitation
- Cognitive Training: CBT exercises were substituted for APT-II content. Such exercises are performed in cognitive rehabilitation (CR) or with defined learning tasks, not usually with CBT.
- Booster sessions: chronic disease model fits best for this population -- a model in which symptom amelioration or suppression but not complete resolution applies. Concomitantly, it follows that a partial response is a frustrating but frequent outcome leading to a recommendation of multimodal interventions and treatment over time.

Summary of Medication and Psychotherapy for Older Adults

- 1. Antidepressants and CBT are effective but CBT sustained better than meds over time
- 2. If effective, anti-depressants work faster than CBT until about 8-10 weeks.
- 3. Data suggest that Medication may be applied first for anxiety, then psychotherapy;
- 4. Med side effects are robust: Interactive effects worse.

I. Recurrence

- Relapse rules (Barlow, 2007)
- "Advances in knowledge in the psychopathology of mood disorders seem to make it clear that the wrong target has been addressed… major depressive episodes will respond to most reasonable treatments in the short term or will remit on their own, but they will **almost always recur**. To be truly effective, treatments, whether psychological or pharmacological, must prevent recurrence of future depressive episodes."
- Barlow, American Psychologist 2004 (p.873)

- **Aging Challenge: Best fit, SOC, Assimilation and Accommodation;**

II. Primary Care

Primary Care: 79% integrated mental health care in 2006.

The GOOD

Case management, step care, and planned interventions (cognitive/behavioral/interpersonal)

The BAD

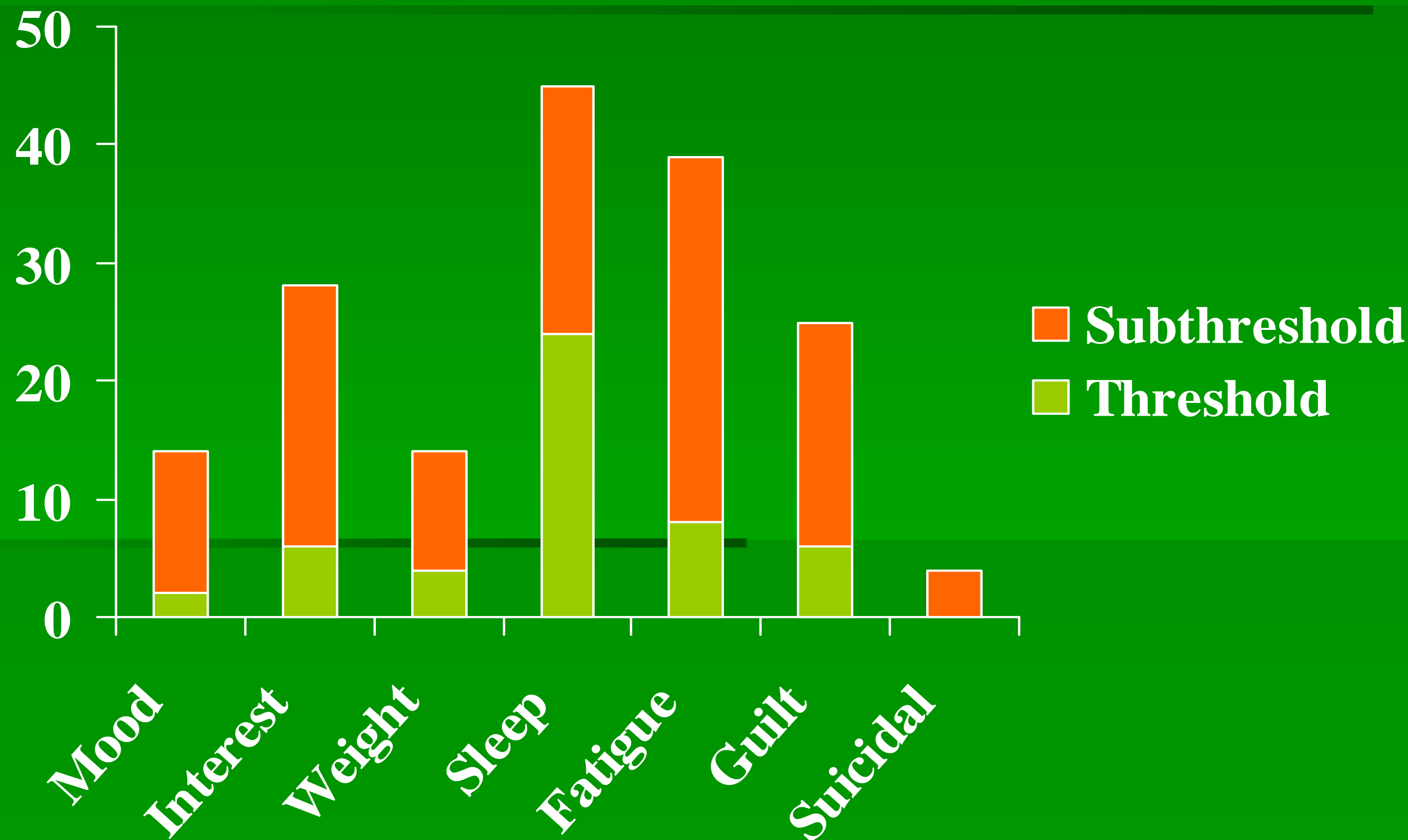
Mitchell et al. (2009) study, Lancet

Anxiety/Depression: Med utilization increases with # of diagnoses (Kroenke et al,., 2007)

If Pt says problem is somatic, PCP miss Psy Dx (85%) (Kessler et al.,1999)

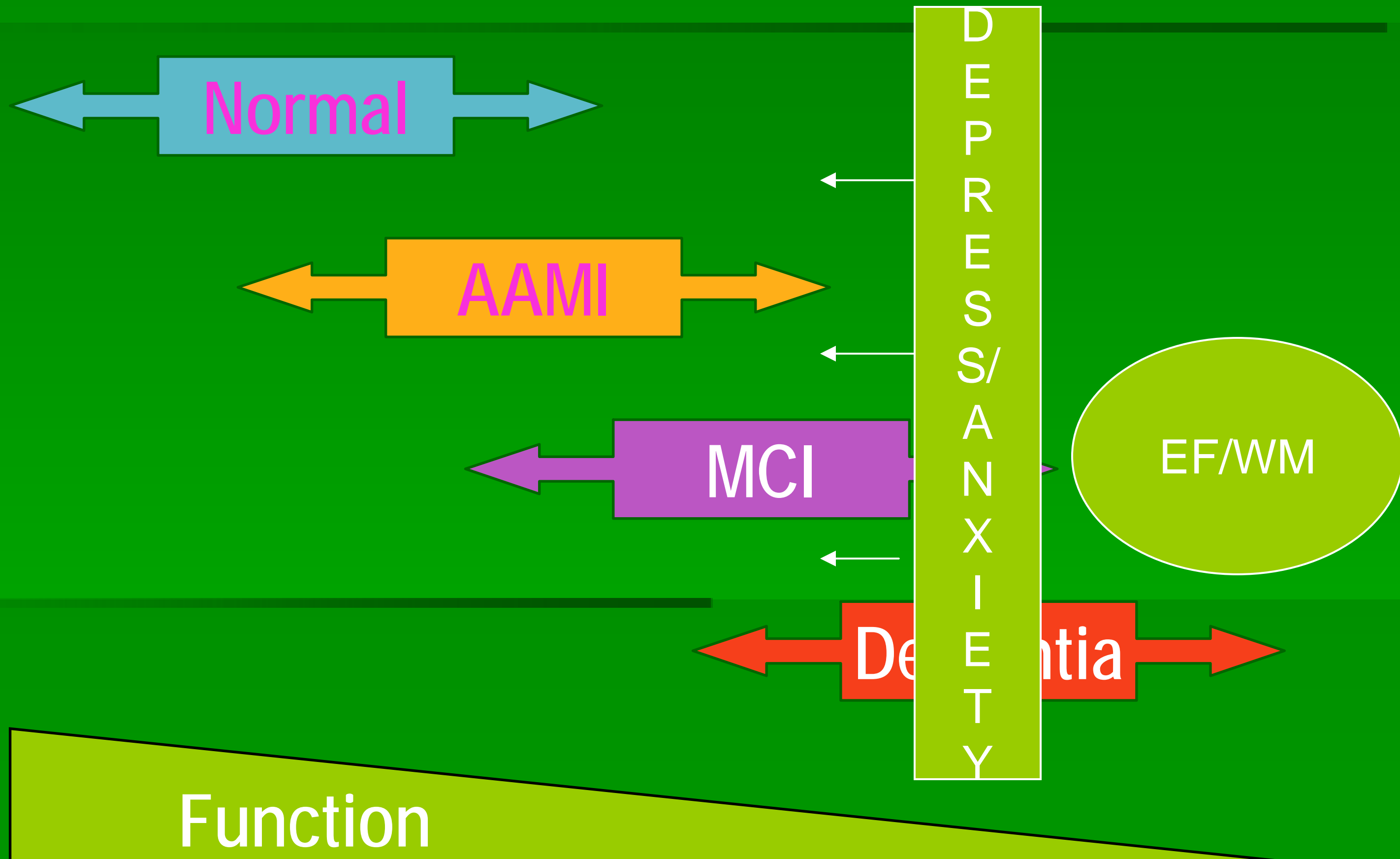
Medications: the optimal duration of acute psychopharmocology at late life is unknown; type and timing of switches of therapies is unclear; the best augmentation strategies of any treatment remains a mystery; predictors of treatment response are not settled; indications for and duration of maintenance therapies are also in doubt; and what constitutes the best mediators and moderators of therapy are cloudy (Reynolds, 2007).

III. Residual symptoms Rule!

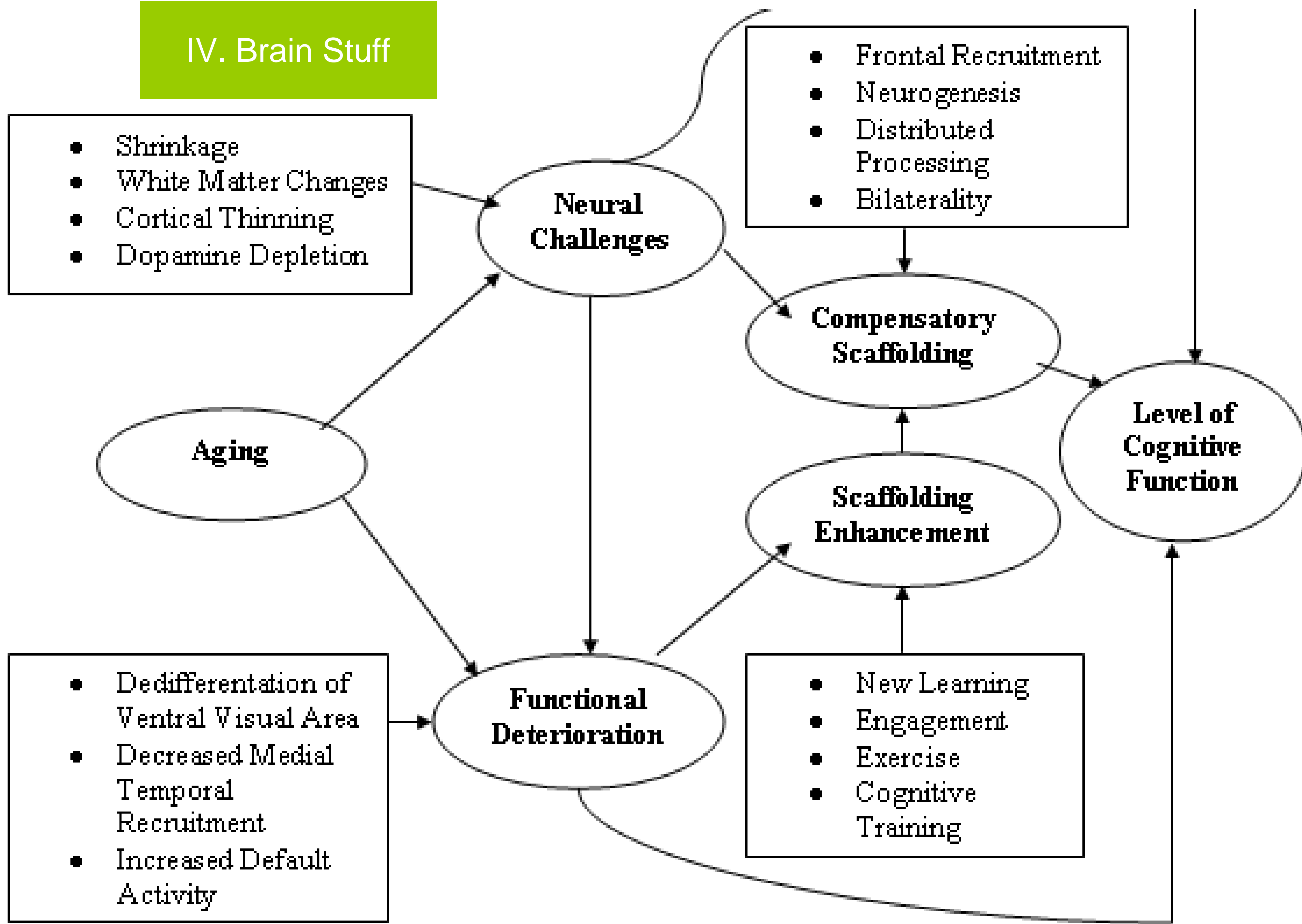


Nierenberg et al,1999

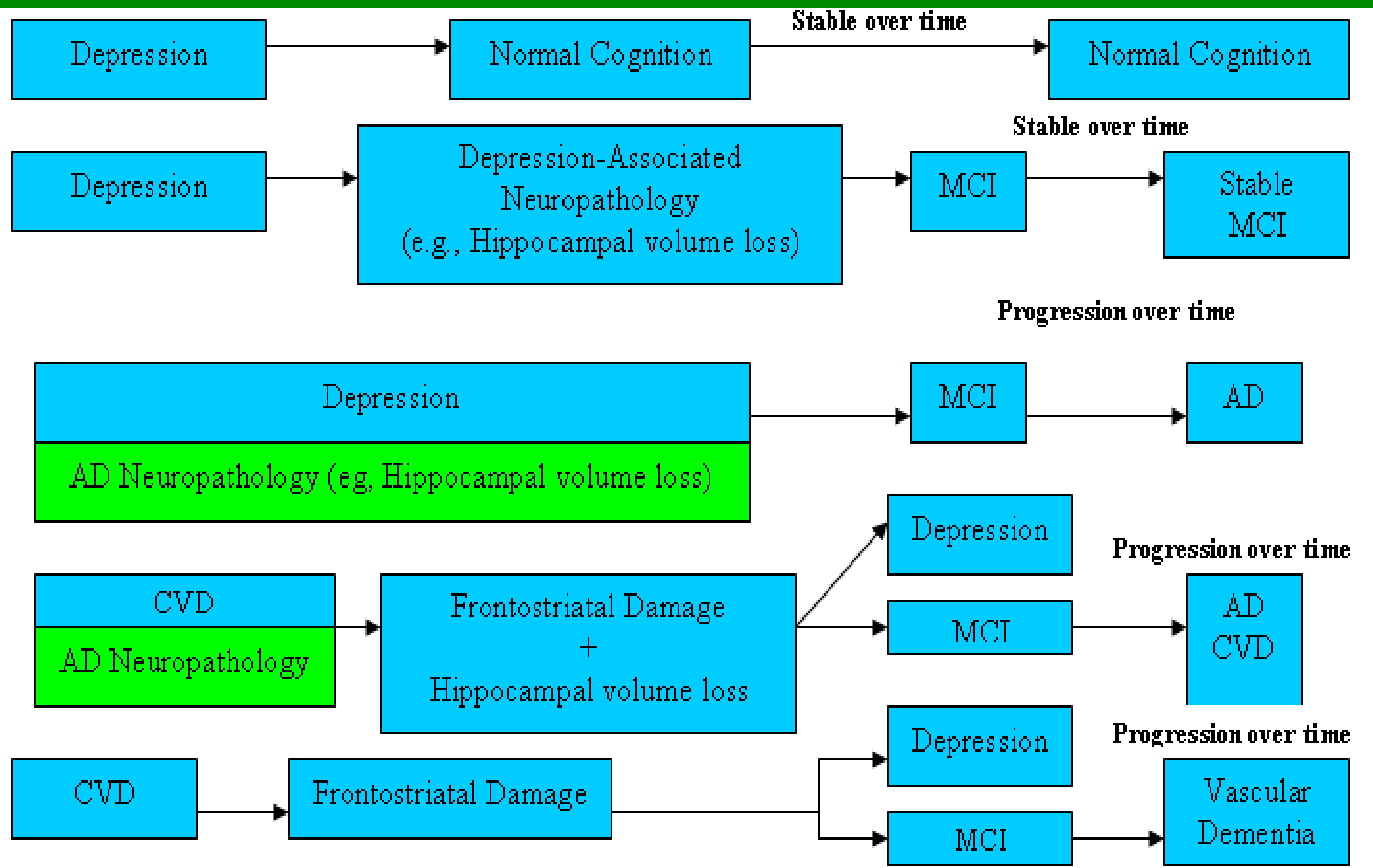
IV. Cognition



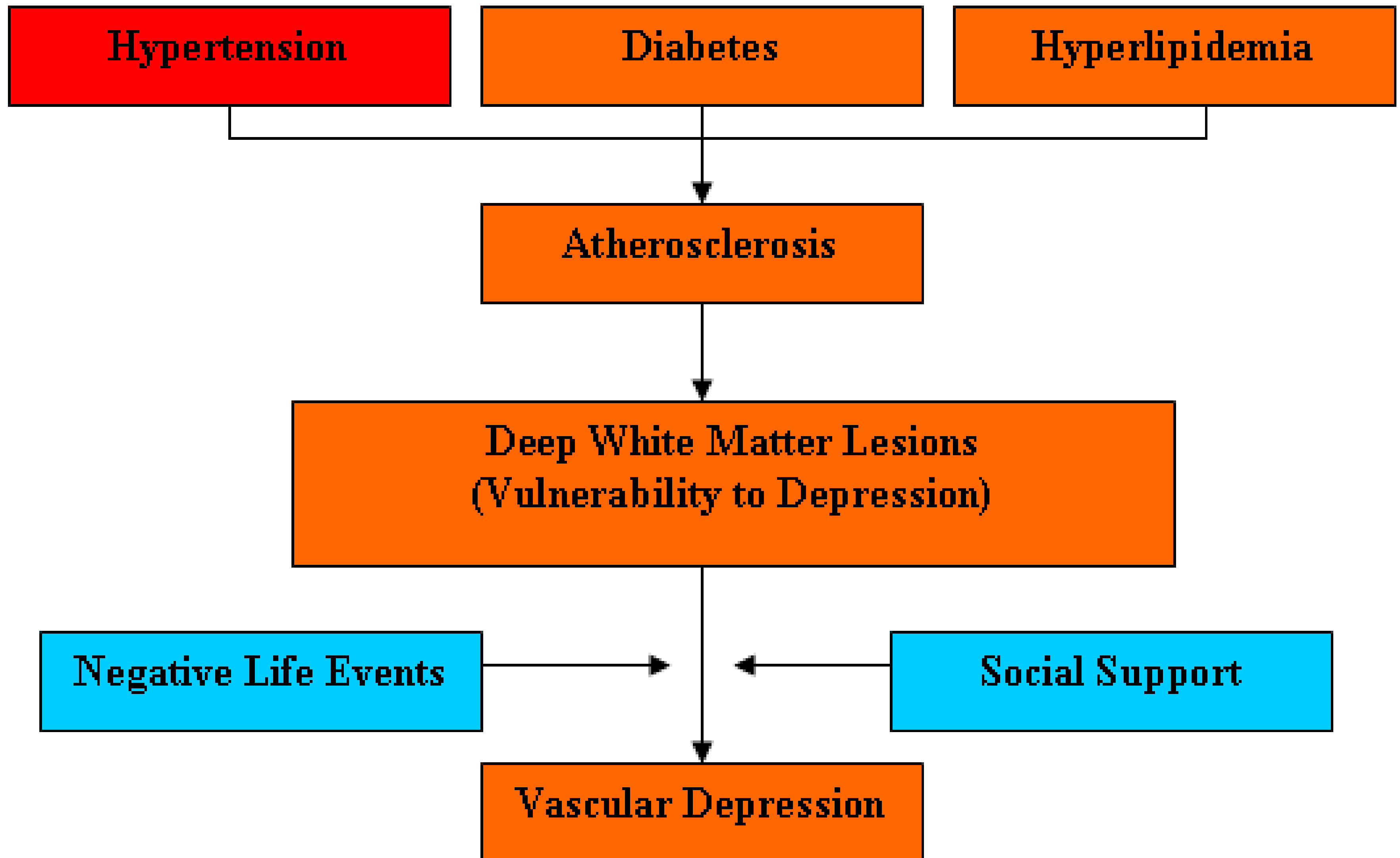
IV. Brain Stuff



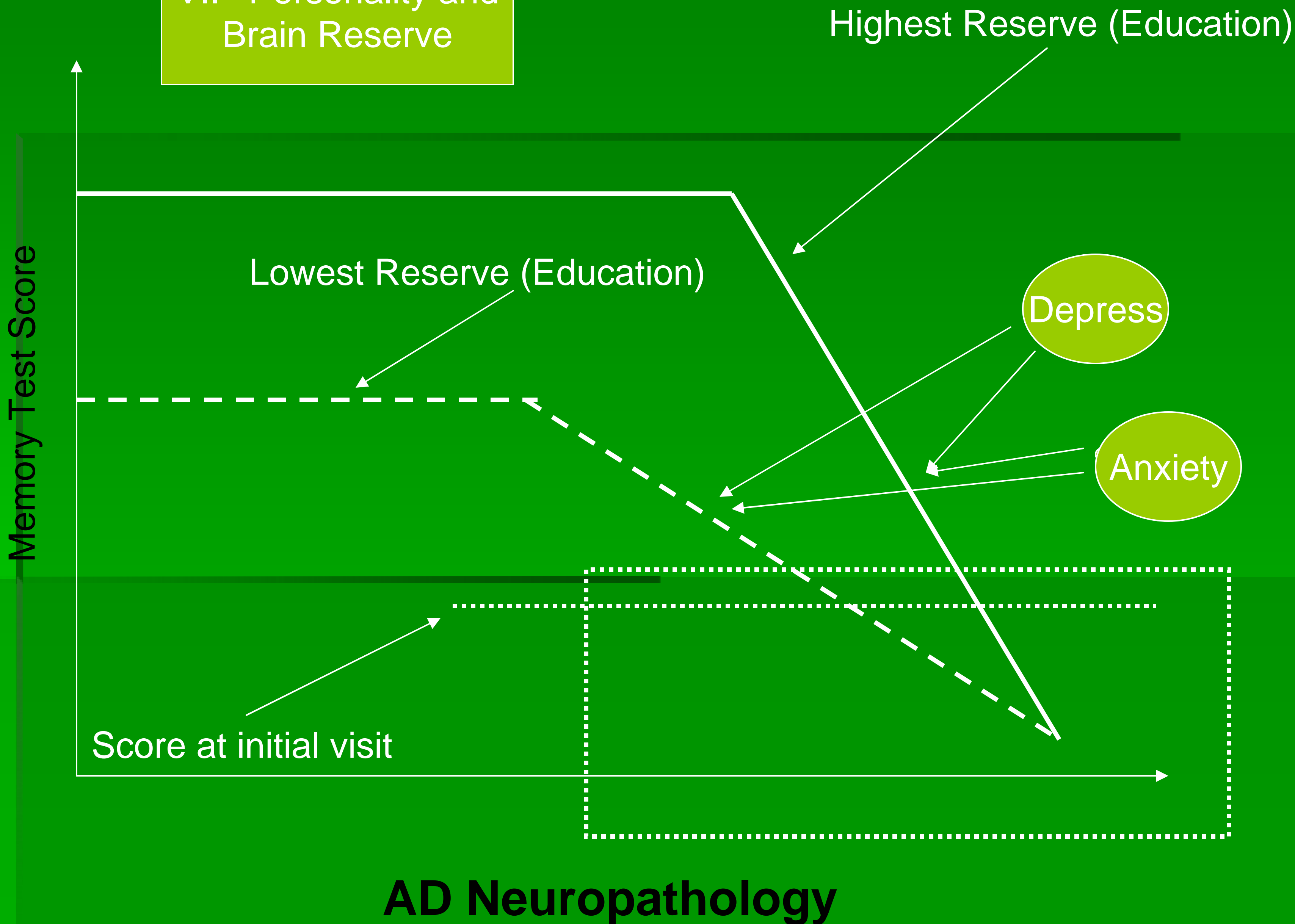
V. Interaction: Depression/Anxiety, Dementia, & MCI



Vascular Depression Hypothesis



VI. Personality and Brain Reserve



VII. Moderating/Mediating Stuff

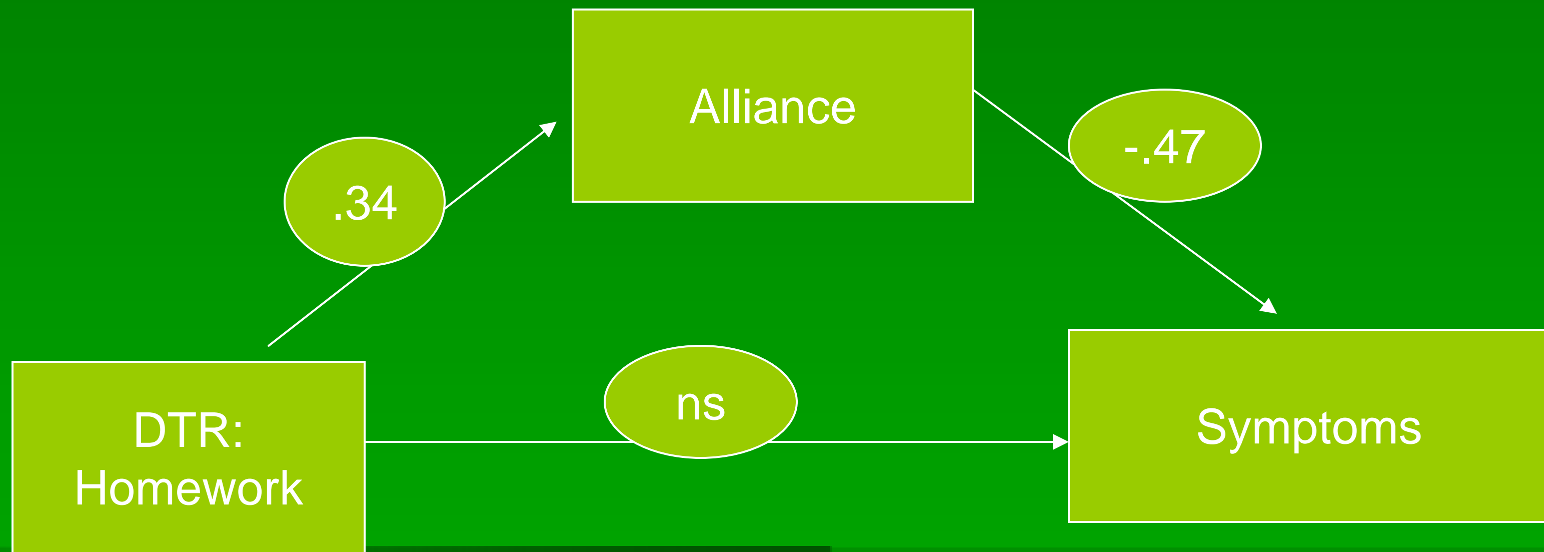
- Pain: Baseline pain problems account for less response in psychotherapies
- Sleep: Roughly 65% of outpatients and 90% of inpatients have insomnia
- Health/Medical comorbidities: Charlson Index and psychotherapy outcomes.
- Medicines: Average = 4.7; 13% >10 meds
- Older old: Less remission on all outcomes
- Socialization/Ethnicity/Marriage
- Stress: Watch for stressors: Orthogonal to CVRF predicting depression (Holley & Mast, 2007)

VIII. Alliance

Treatment with meds is a
PSYCHOLOGICAL INTERVENTION

- No specific effects of SSRIs and SNRIs; No
- relationship between dosage and plasma levels
- of antidepressant and outcome.
- **Successful doctors** get better results with placebo
- or SSRIs or whatever.
- It is the Doctor! Create a context and a relationship.
- 89 studies TA and outcome R =.21 (ES=.4)

Treatment Alliance (52%)



IX. Exercise Rules!

- Meta-analysis of **40** English-language articles publishes 1995 to 2008 involving **sedentary adults with chronic illness.**
- **2914 patients**: also extracted information regarding potential moderating variables.
- Compared with no treatment conditions, exercise training significantly reduced anxiety symptoms by a mean **Delta effect of 0.29**
- Largest anxiety improvements resulted from exercise lasting no more than **12 weeks**, using session durations of at least **30 minutes**.
- Exercise training reduces anxiety symptoms among sedentary patients who have a chronic illness.
- Herring MP, O'Connor PJ, Dishman RK.

X. Modular intervention Use a menu

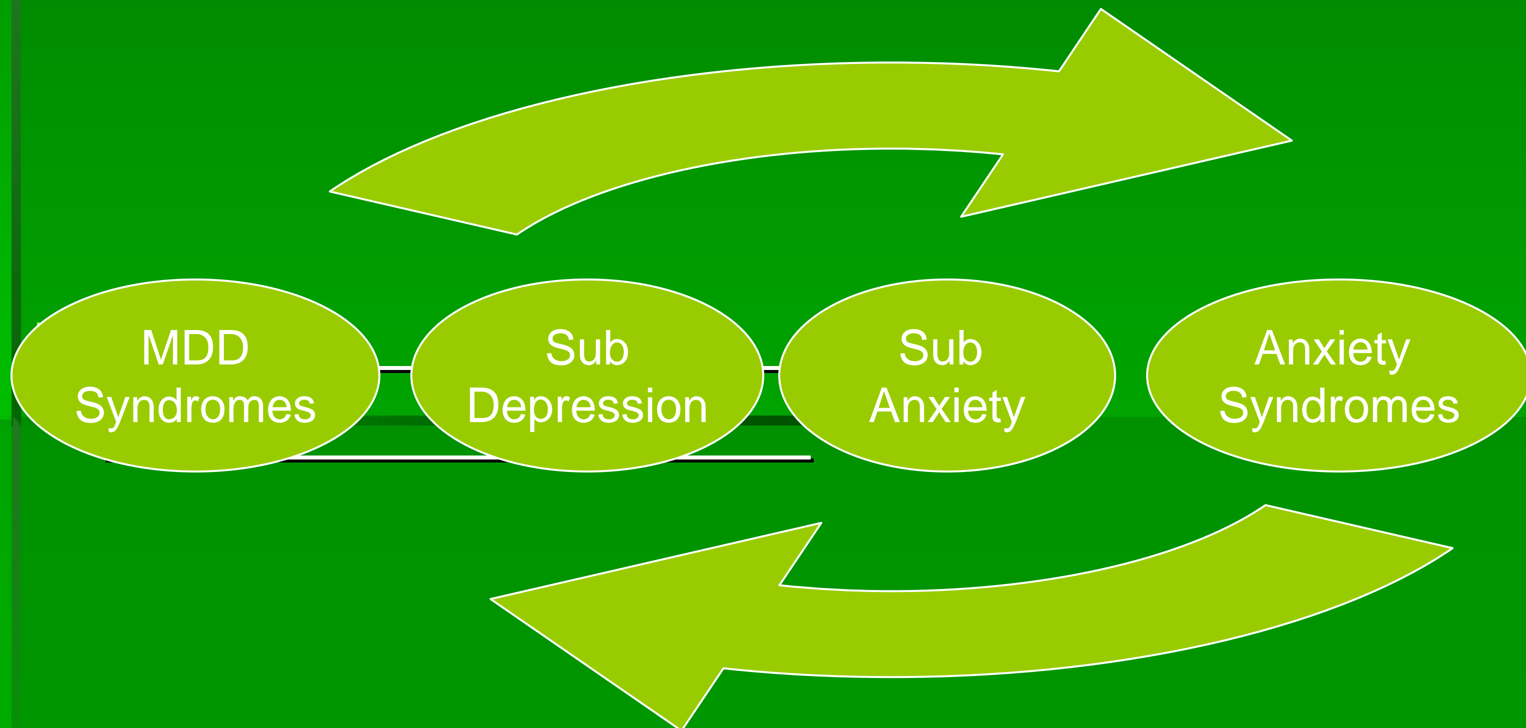
- Relaxation
- Sleep guidelines
- Problem solving skills training
- Worry Control
- Acceptance/Mindful
- Behavioral activation
- Pain management
- Pleasant activities
- Assertiveness training
- Time management
- Cognitive therapy
- Exposure
- Family involvement

- Phone and Home: Mohr et al., 2005: Simon et al., 2004
- Modules: Chorpita et al., 2004; Henin et al., 2001: Patient and therapist choose modules

XI. Get Cute

- Biblio-therapy
- Home –based video (Steffens, 2000)
- REACH (Gallagher-Thompson, 2003)
- Telephone based CB (Glueckauf, 2007)
- Hospice (Demiris, 2007)
- PES- (Cernin & Lichenberg, 2009)
- In home CB (Scoggins et al. 2009)
- New Models: Low Intensity CBT:
- STEPS Model → PCC basis,
- community, self help, lectures,
- Day Care, Screens,
- PRE-psychoeducational
- intervention

XII. Think Transdiagnostic



- Differences among the core depression problems (MDD,
- Mixed Depression and Anxiety, subsyndromal depression)
- are subtle. Think transdiagnostic.

Depression Complexity: Shades of Gray

- Minor depression: 2-4 symptoms, low mood or anhedonia
- Subsyndromal depression: 16 on CES-D
- Mixed Dep and Anx
- Depression without sadness
- Bereavement
- Depressive Executive Dysfunction
- Depression in dementia
- Post Stroke depression
- Suicidal Depression: Fatigue, Hopelessness and Negative Outlook (Joiner, et al., 2001)
- Executive Functioning
-
- AND OLD OLD……

And then there is this…

- “There is increasing evidence that symptoms of elderly depression may be etiologically distinct (e.g, more psychomotor retardation and anhedonia in vascular depression) and that focusing on subclusters of depressive symptoms, rather than relying on general depression assessment tools may help enhance construct validity…” (p.379)
- “It is apparent that the ‘oldest old’ (>75) present different from the ‘young old.’” (p. 379)

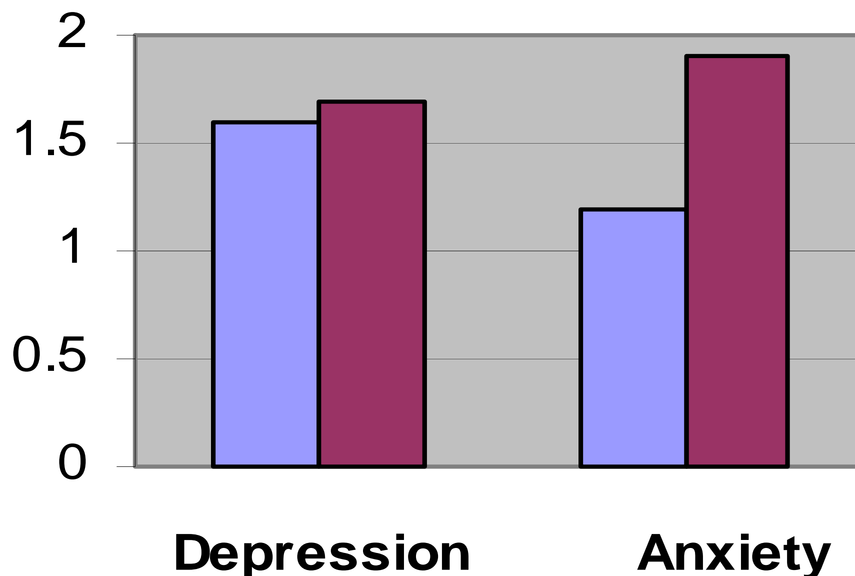
- “The heterogeneity in symptom presentation among older adults diagnosed with MDD can potentially inform the development of the DSM-V.” (p387**)** Hybels et al. (2009)

Anxiety Complexity: Shades of Angst

- GAD levels (e.g., Nuevo et al., 2008) and anxiety in general are lower in older age (e.g., George, Blazer, Winfield-Laird, Leaf, & Fischback, 1988).
- BUT….Research on **subthreshold disorders** with non-clinical older samples indicates that mental health is not better in older age.
- AND… Literature on the **dimensional approach** suggests that this is a better model of psychopathology.
- AND…older individuals provide responses **significantly different** from those of younger adults, potentially requiring special attention in psychiatric care.

Meta-Analyses Comparing Psychotherapy and Medication for Geriatric Depression and Anxiety

Not Significant *P<0.05*

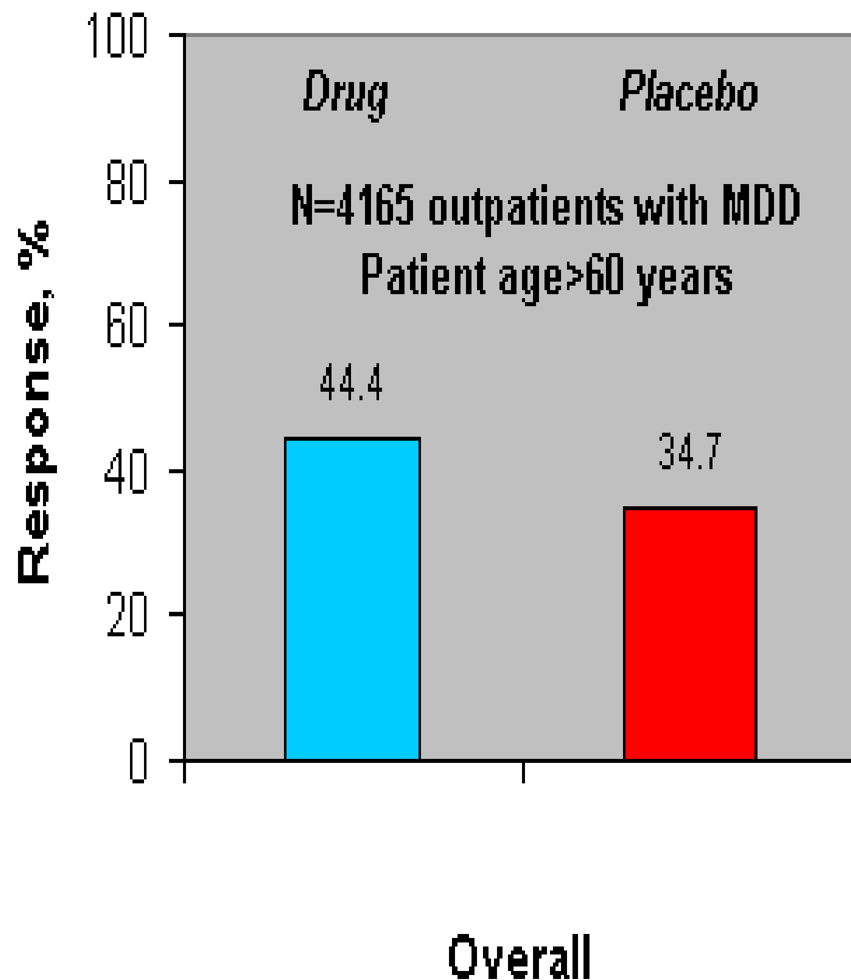


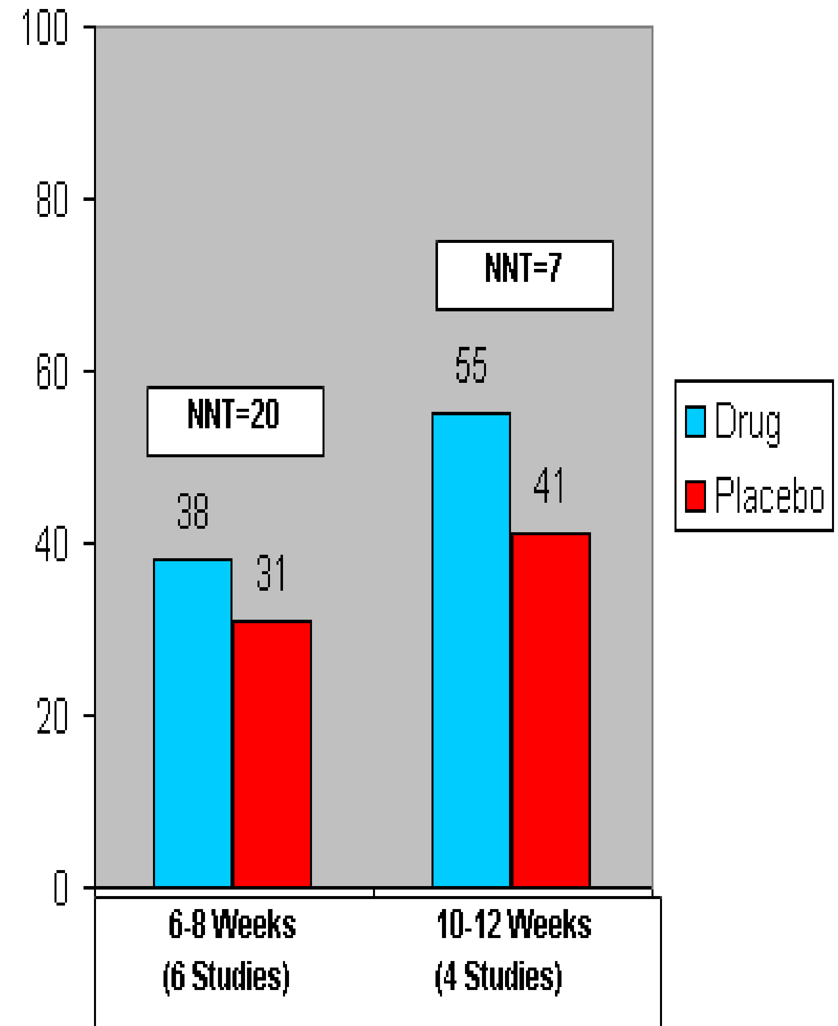
89 studies	32 studies
N=5328	N=2484
Mean=8.3 weeks	Mean=10.3

Pinquart et al. *Am J Psychiatry*. 2006; 163(9): 1493-1501.
Pinquart, Duberstein. *Am J Geriatr Psychiatry*. 2007; 15(8): 639-651.

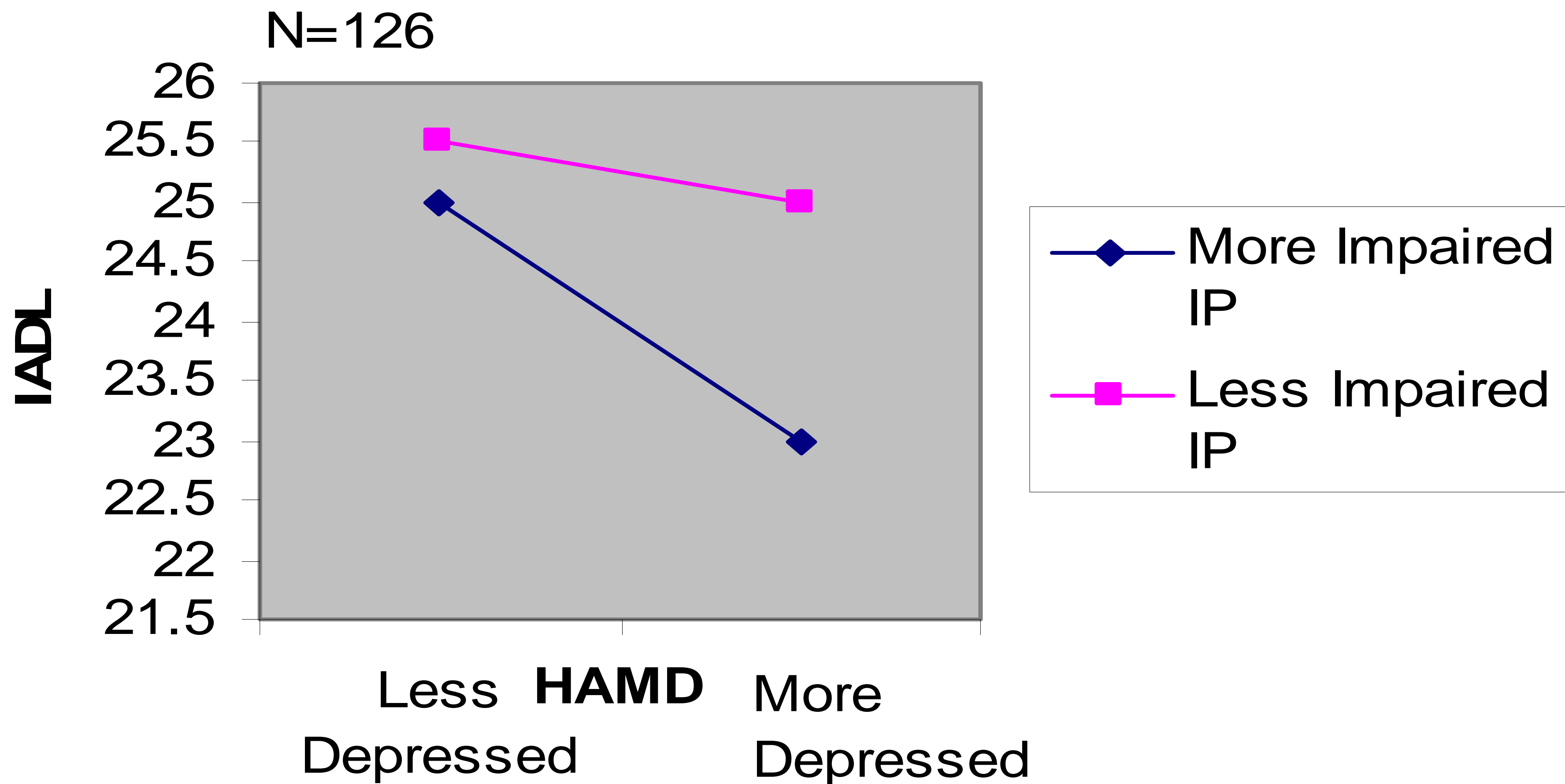
Depression Studies: Second-Generation Antidepressant Trials

Mean Pooled Response Rates from 10 RCTs





Depression and Disability in Elders With Executive Dysfunction



Alexopoulos GS, et al. *Am J Geriatr Psychiatry*. 2002; 10:98-102.

Best Depression Psychotherapies

- Behavioral Therapy – 5 studies > controls; depressive syms lower
- CBT– 11 studies; manual by Laidlaw et al., 2003; emphasize behaviors first
- Cognitive bibliotherapy – 4 studies all support self help. As evidence based.
- Problem Solving Therapy – 4 studies in PPC; Mini-PST in PCC
- IPT – 2 studies; focus on role or transition changes
- Combination therapies work – Meds + Psycohoscial Rx
- Some support for Brief Psychodynamic Therapy, Supportive Rx, and Reminiscence. ACT works.
- **ES = .73**

Anxiety Therapies

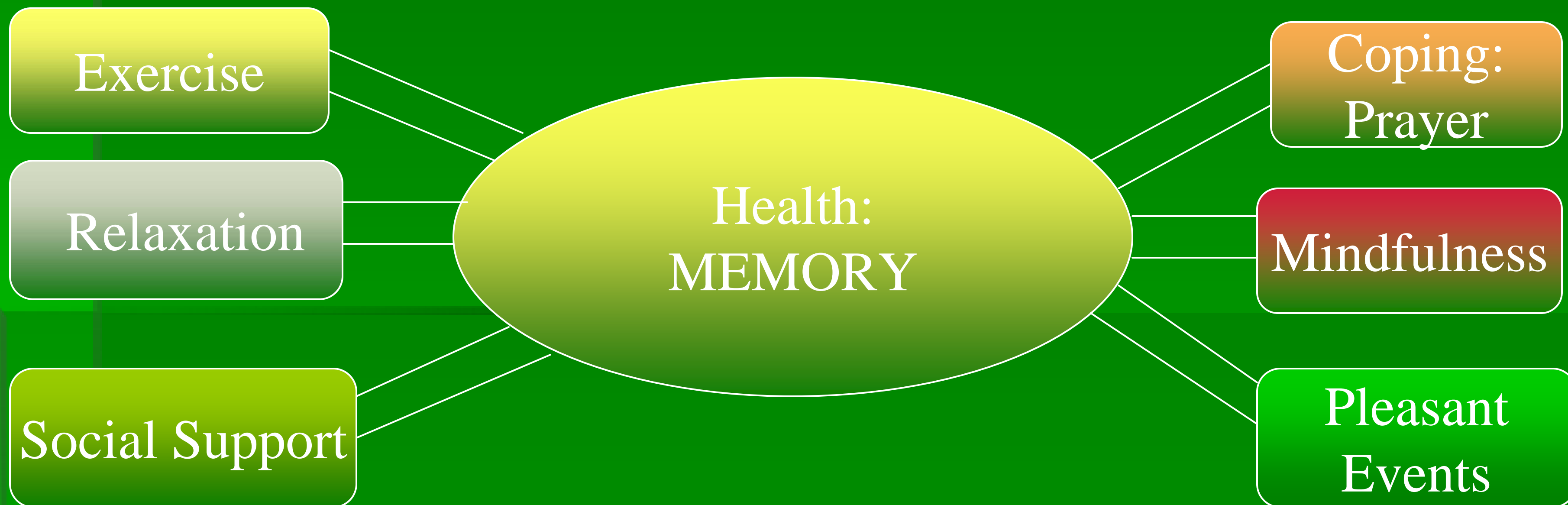
- Meds both anxiolytic and SSRI (e.g., Lenze, et al., 2009; Pinquart & Duberstein, 2007)
- CBT (Stanley et al., 2009)
- PST (Arean, 2010)
- Integration of CBT and IPT (Newman et al., 2004)
- ACT (Roemer & Orsillo, 2007)
- Attention Training (Mohlman, 2007; Papageorgiou & Wells, 1998)
- Intolerance of uncertainty (Ladouceur et al., 2004)
- Emotional dysregulation (Mennin, 2006)
- Metacognition (Wells & King, 2006).

Recommendations for Depression Intervention

- Usual assessment but also assess for EF
- Watch and Wait. Step Care.
- Monitor
- Make choice: Combination therapy or Psychosocial therapies
- Psychosocial effective first-line treatments include
  - Behavioral activation
  - PST
  - CBT
- Use case manager/family/PCP
- Exercise
- Monitor (Compliance and Health Literacy)
- If Problems: Change direction…….

- Problem: Comorbid depression/anxiety: treat depression first

Psychotherapist as Rehab Provider



The good news is that most psychotherapies developed for younger patients appear useful for older adults when applied in an age-informed and age sensitive manner."
Henrichsen, 2008; Knight, 2004

Cognition, Depression, Anxiety, Somatic/Sleep, Life Adjustment