Cognitive Behaviour Therapy with Older People

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What is Cognitive Behaviour Therapy?

What does the therapy aim to do?
What sort of interventions does it use?
How long does it last?
What does a CBT session look and sound like?- What are its characteristics?
Cognitive Behaviour Therapy

- A short term, structured form of therapy which
- provides patients with a rationale for understanding their problems
- A vocabulary for expressing themselves and
- Training in techniques for surmounting distressing affective states and solving problems
How does it work?

- Different types of CBT- but all work focus on problematic patterns of thinking and behaviour.
- Misinterpreting situations undermines how people cope and behavioural responses serve to maintain and exacerbate problems.
- CBT aims to break this cycle by encouraging people to re-examine their thinking. Beliefs are a hypothesis to be tested. The therapist helps the client to explore alternative interpretations using cognitive and behavioural techniques.
Cognitive Model of Emotional Disorders
Padesky and Greenberger, 1996

Environment

Thoughts

Behaviour

Emotion

Biology

Thoughts

Behaviour

Emotion

Biology

Environment
Characteristics

- Agenda
- Problem oriented
- Ahistorical
- Scientific
- Homeworks
- Collaborative
- Active and directive
- Socratic questioning
- Openness
How long does it take?

- Usually consists of weekly sessions
- Typical course consists of eight to twelve sessions—though this changes depending on the condition.
  - 1 single 3 hour session for phobias
  - Years for BPD.
Cognitive theory

- Based on an information processing perspective.
- Beck states that information processing bias are present in all psychopathological states. (Beck 1967, 1976, 1987)
- The faulty information processing is part of the complex symptom profile that serve to maintain the disorder.
Schema

- A cognitive structure
- Content of schema is considered important for emotional disorders
- 2 types of informational content in Beck’s theory
  - Beliefs: core constructs, absolute in nature taken as truths e.g. “I’m vulnerable”
  - Assumptions: conditional, they are contingencies between events and self appraisals e.g. “having a bad thought means I’m a bad person”
Learning experience

Danger schema formed (beliefs/assumptions)

Critical incident

Schema activated

Negative Automatic Thoughts

Anxiety symptoms

Behavioural responses

Cognitive biases

Generic model of anxiety disorder
Empirical support for the model 1

- The classification system DSM IV has to identify those symptoms that are specific to the disorder. Cognitive symptoms of worrying and apprehension expectation are detailed as symptoms of GAD and PD respectively.

- A cognition check list (CCL) can differentiate between people with problems of depression, and panic- generalised anxiety is less easy to discriminate from depression (Clark, Beck & Beck 1994).

- Wells (1997) cites a number of studies where patients with anxiety report thoughts and visual fantasies concerning danger (death disease and social humiliation).
Think of an occasion when you were anxious- balloon experiment.
Beck’s Cognitive Theory of Depression

- Negative Automatic Thoughts
- Systematic Logical thinking errors
- Depressogenic schemata
Beck’s Theory of Depression

Early experiences

Core beliefs

Dysfunctional Rules

Critical incident (and activation of assumptions)

Problems

Depressed mood  Behaviour  physiological problems  Negative Automatic Thoughts
A number of scales have been developed to measure negative thinking. These show greater negative thinking in depressed people compared with controls; and greater than depressed people in remission. (Blackburn et al 1986; Eaves and Rush 1984)
Empirical support

- Teasdale & Dent (1987)
- Induced temporary depressed mood with previously depressed and never depressed groups.
- Results- recovered depressed persons more likely to recall negative adjectives endorsed as self descriptive than never depressed group.
People have specific vulnerabilities to depression. Schema content can predict the stressor likely to result in depression. 2 categories- Sociotropic (interpersonal) and autonomous/ self criticism.

Nietzel & Harris 1990 (cited in Leahy 2004) found a match between cognitive style and congruent life event in depressed patients. Also found that there were greater levels of depression in the sociotropy group.
Efficacy of CBT for Anxiety and Depression
Randomised Controlled Trials

- Clark et al used an RCT to compare cognitive therapy, applied relaxation and imipramine in the treatment of Panic disorder (n= 64).
- Comparisons with waiting list showed all three treatments were effective. Comparisons between treatments showed: cognitive therapy was superior to both applied relaxation and imipramine on most measures.
- After 3 months CT superior to AT and imipramine. After 6 months CT= Imipramine but superior to RT. After 15 months CT superior to RT and imipramine
RCT Two psychological Treatments for Hyperchondriasis

- Clark et al. 1998. N=48 randomly assigned to CT or behavioural stress management (BSM).
- Both superior to waiting list control group.
- CT < BSM on measures of hyperchondriasis at mid treatment and post treatment.
RCT for PTSD

- N=97 (RTA survivors)
- CT < self help in reducing symptoms of PTSD, depression, anxiety and disability.
- At follow up CT had fewer PTSD symptoms than Self help.
6 year outcome of CBT of recurrent depression.

- N=42 successfully treated with antidepressants randomly assigned to CBT of residual symptoms or clinical management. In both groups antidepressants tapered then discontinued.
- CT resulted in 40% relapse
- Clinical management 90% relapse
Efficacy of CBT

- The effectiveness of cognitive therapy for the treatment of depression, anxiety, and an extensive list of other disorders, is now well supported by a large body of research.

- Results of have been shown to translate to clinical practice. (Gillesphie et al 2002)
Efficacy of psychotherapy with Older Adults

- Meta–analytic review
- Robinson, Berman & Neimeyer 1990
- Analysis of 58 studies
- Overall effect size for treatment vs no treatment is 0.73 (0.8= large, 0.5= moderate, 0.2= small)
- All forms of psychotherapy more effective than no treatment.
Outcome studies CBT

- Tend to be completed for late life depression.
- See table- highlight that CBT is an effective treatment for late life depression.
Obstacles

- A Freudian view that older people lack the mental plasticity to change or benefit from psychotherapy.
- Knight (1996) argues that those who work in the field tend to be more optimistic.
Myths and psychotherapy (Laidlaw et al 2003)

- You can’t teach an old dog new tricks.
- It must terrible getting old.
- Old people don’t want psychotherapy
Stages of CBT

1. Assessment and Formulation
2. Socialisation
3. Treatment- symptom specific (Cognitive techniques- eliciting and modifying Negative Automatic Thoughts, Behavioural Techniques- activity, behavioural experiments)
4. Treatment schema based (Behavioural experiments, positive data logs)
5. Relapse Prevention (Blue prints)
The main purpose of assessment is to develop a formulation.

Formulation is a way to understand the idiosyncratic nature of the person's difficulties (Padesky and Greenberger 1995).

CBT formulation is suited to working with older adults because it is individualised.
Additional considerations for older adults

- Cohort beliefs- shared beliefs and experiences of a generation. (Niederehe 1992 stigma of mental illness)
- Role Investment- the importance and functions of roles carried or lost. (Champion and Power 1995 noticed gender differences).
Considerations for older adults

- Socio cultural beliefs- the internalising or rejection of beliefs about aging in the society or culture in which older people live.

- Intergenerational links- the stresses and supports of important close relationships. Thompson 1996 highlights relationship strains can trigger depression. E.g. differences in views on relationship.
Early experiences

Core beliefs

Activating event

Cohort beliefs

Intergenerational Linkages

Role investment

Sociocultural context

Dysfunctional Rules

Problems

Depressed mood

Behaviour

physiological

Negative

Health status
Treatment strategies cognitive

- Identification and modification of negative automatic thoughts
- Thinking biases.
- Common age related NAT’s
  - It’s just my age
  - I’m a failure
  - “If only” thinking
Strategies for modifying NAT’s

- Examining the evidence
- The consequence of holding x belief
- Putting someone else in my shoes
- Reviewing past successful coping methods.
Treatment Strategies Behavioural

- Activity scheduling – the importance of increasing activity levels.
- Increase in pleasurable activities (this needs to be realistic and possible).
- Practical problem solving.
- Relaxation training.
Anxiety

- King and Barrowclough (1991) showed 7/10 benefited from standard interventions of anxiety.
- Evidence in this area is impoverished.
Depression in Dementia.

- Teri et al reported two behavioural treatments (one focusing on problem solving and one focusing on increasing pleasant events.) Both were shown to have beneficial effects for the person with dementia and their caregiver.
Memory Problems

- Information presented slowly
- Mnemonic devices, (say it show it do it)
- Folders/ files/ note books
- Flip chart in sessions
- Rehearse homework's in session
- Tape sessions
Multi morbidity

- Communication with multi disciplinary team e.g. medications, inadequate resources.
Internalised ageism

- Dispel some myths with recent research.
- Books such as Aging: exploding the myths
  WHO 1999
Story Telling

- Inclination to provide extensive details.
- Set up ground rules once alliance is established - permission to interrupt.
- Provide frequent summaries.
References

References

References - effectiveness


References- evidence for the model