

Special Article - Psychopathology in Older Adults

Cognitive-Behavioral Therapy for Depression and Anxiety in the Elderly

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Received: June 15, 2015; **Accepted:** September 08, 2015; **Published:** September 10, 2015

Abstract

Depression and anxiety are two of the most common psychiatric problems among older adults and frequently co-occur. Geriatric patients with depression and anxiety also present special challenges for physicians. For example, increased medical comorbidity and changes in cognitive status may confound diagnosis. Other cohort characteristics (e.g., fears of stigma regarding mental illness; tendency to attribute psychiatric symptoms to medical causes) may lead to underreporting of psychiatric symptoms. In addition, older adults seek psychiatric care from primary care physicians rather than from mental health specialists. System challenges in the primary care setting (e.g., short appointment times) present additional barriers to assessment of late-life depression and anxiety.

Depression and anxiety are significant problems among the elderly. Due to complexities in the medical management of elderly patients, researchers and clinicians have sought psychosocial alternatives to pharmacotherapy in order to treat depression and anxiety in the elderly. Cognitive-behavioral therapy in particular has been investigated as a promising treatment. Research conducted to date has established that cognitive-behavioral therapy produces significant improvement in depression and anxiety symptoms among the elderly.

Keywords: Cognitive-behavioral therapy; Elderly; Depression; Anxiety

Depression and Anxiety in the Elderly

Depression is not a normal part of aging [1]. It is a medical problem that affects many older adults and can often be successfully treated. Symptoms of depression include: depressed mood, loss of interest or pleasure in activities, disturbed sleep, weight loss or gain, lack of energy, feelings of worthlessness or extreme guilt, difficulties with concentration or decision making, noticeable restlessness or slow movement, and frequent thoughts of death or suicide or an attempt of suicide.

Up to 5% of older adults in the community meet diagnostic criteria for major depression, and up to 15% have clinically significant depressive symptoms that impact their functioning (otherwise known as sub-syndromal depression or minor depression). However, the prevalence of depression is substantially higher in older adults with medical illnesses, and in those who receive services from aging service providers. For instance, a recent study found that more than one-quarter (27%) of older adults assessed by aging service providers met criteria for having current major depression and nearly one-third (31%) had clinically significant depressive symptoms. Depression is often under-recognized and under-treated in older adults [2].

Depression can impair an older adult's ability to function and enjoy life and can contribute to poor health outcomes and high health care costs. Compared to older adults without depression, those with depression often need greater assistance with self care and daily living activities and often recover more slowly from physical disorders. Without appropriate treatment, symptoms of depression can limit an older adult's ability to achieve successful aging.

Depression in older adults may be linked to several important risk factors. These include, among others:

- Medical illness (particularly chronic health conditions associated with disability/decline) [3,4],
- Perceived (self-reported) poor health, disability, or chronic pain,
- Progressive/disabling sensory loss (e.g., macular degeneration),
- History of recurrent falls,
- Sleep disturbances [5,6],
- Cognitive impairment or dementia,
- Medication side effects (e.g., benzodiazepines, narcotics, beta blockers, corticosteroids, and hormones) [7,8],
- Alcohol or prescription medication misuse or abuse [9],
- Prior depressive episode, or family history of depression,
- Extended or long-standing bereavement,
- Stressful life events (e.g., financial difficulties, new illness/disability, change in living situation, retirement or job loss, and interpersonal conflict) [10],
- Dissatisfaction with one's social network.

Like depression, excessive anxiety that causes distress or that interferes with daily activities is not a normal part of aging. Anxiety disorders cause nervousness, fear, apprehension, and worrying. They can worsen an older adult's physical health, decrease their ability to perform daily activities, and decrease feelings of well-being.

3 to 14% of older adults meet the diagnostic criteria for an anxiety disorder; however a greater percent of older adults have clinically significant symptoms of anxiety that impact their functioning. For instance, a recent study found that more than one-quarter (27%) of aging service network care management clients have clinically significant anxiety. The most common anxiety disorders include specific phobias and generalized anxiety disorder. Social phobia, obsessive-compulsive disorder, panic disorder, and Post-Traumatic Stress Disorder (PTSD) are less common. Like depression, anxiety disorders are often unrecognized and undertreated in older adults. The detection and diagnosis of anxiety disorders in late life is complicated by medical comorbidity, cognitive decline, changes in life circumstances, and changes in the way that older adults report anxiety symptoms.

Anxiety in older adults may be linked to several important risk factors [11]. These include, among others:

- Chronic medical conditions (especially Chronic Obstructive Pulmonary Disease (COPD), cardiovascular disease including arrhythmias and angina, thyroid disease, and diabetes),
- Perceived (self-reported) poor health,
- Sleep disturbance,
- Side effects of medications (e.g., steroids, antidepressants, stimulants, bronchodilators/inhalers),
- Alcohol or prescription medication misuse or abuse,
- Physical limitations in daily activities,
- Stressful life events,
- Adverse events in childhood,
- Neuroticism or preoccupation with somatic (physical) symptoms.

Older adults with mixed anxiety and depression often have more severe symptoms of depression and anxiety, poorer social functioning, greater use of health care services, more physical health symptoms (e.g., chest pain, headaches, sweating, gastrointestinal problems), more thoughts of completing suicide, and a slower response to treatment. Older adults with depression and anxiety are more likely to stay in treatment if they are seen frequently and are told that they should call with any concerns related to treatment [12].

Cognitive-Behavioral Therapy in the Elderly

Cognitive-behavioral therapy is an efficacious, enduring treatment for late-life depression. CBT also is considered effective for older patients with anxiety disorders. Modifying CBT to focus on the meaning of losses and transition and accommodating cognitive decline is likely to improve efficacy.

CBT is a brief, structured psychotherapy that focuses on the key roles that cognitions and behaviors have in the onset and maintenance of mental illness. CBT has been shown to be effective in treating a wide range of mental disorders, including depression, anxiety, bipolar disorder, substance use disorders, eating disorders, insomnia, and personality disorders. In addition, recent research has also shown CBT to be efficacious in treating symptoms of schizophrenia, with

additional research currently underway. CBT has also been shown to be at least as efficacious as medication for moderate to severe major depression. For many patients, a combination of CBT and medication has shown to be more effective than either treatment alone. CBT has also been shown to have enduring effects that often far outlast the completion of treatment.

Over the last several decades, there has been significant research examining the efficacy of CBT with older adults, specifically. These researches have consistently shown that CBT is efficacious with older individuals. Much of these researches have focused on the use of CBT for treating depression in older adults, although there has been increasing researches in recent years documenting the efficacy of CBT for the treatment of late-life anxiety, insomnia, and pain. In general, older adults can benefit from CBT to approximately the same degree as younger adults. Specific adaptations to the therapy strategies and process can maximize treatment gains with older clients, although the core ingredients of CBT remain the same when working with older adults.

Adapting CBT for Older Patients

When using CBT with older patients, it is important to keep in mind characteristics that define the geriatric population. Laidlaw et al. [13] developed a model to help clinicians develop a more appropriate conceptualization of older patients that focuses on significant events and related cognitions associated with physical health, changes in role investments, and interactions with younger generations. It emphasizes the need to explore beliefs about aging viewed through each patient's socio-cultural lens and examine cognitions in the context of the time period in which the individual has lived.

Losses and transitions. For many older patients, the latter years of life are characterized by losses and transitions. According to Thompson [14], these losses and transitions can trigger thoughts of missed opportunities or unresolved relationships and reflection on unachieved goals. CBT for older adults should focus on the meaning the patient gives to these losses and transitions. For example, depressed patients could view their retirement as a loss of self worth as they become less productive. CBT can help patients identify ways of thinking about the situation that will enable them to adapt to these losses and transitions.

Changes in Cognition

Changes in cognitive functioning with aging are not universal and there's considerable variability, but it's important to make appropriate adaptations when needed. Patients may experience a decline in cognitive speed, working memory, selective attention, and fluid intelligence. This would require that information be presented slowly, with frequent repetitions and summaries. Also, it might be helpful to present information in alternate ways and to encourage patients to take notes during sessions. To accommodate for a decline in fluid intelligence, presenting new information in the context of previous experiences will help promote learning. Recordings of important information and conclusions from cognitive restructuring that patients can listen to between sessions could serve as helpful reminders that will help patients progress. Phone prompts or alarms can remind patients to carry out certain therapeutic measures, such as breathing exercises. Caretakers can attend sessions to become

familiar with strategies performed during CBT and act as a co-therapist at home; however, their inclusion must be done with the consent of both parties and only if it's viewed as necessary for the patient's progress.

Additional Strategies

For patients with substantial cognitive decline, cognitive restructuring might not be as effective as behavioral strategies-activity scheduling, graded task assignment, graded exposure, and rehearsals [15,16]. Because older adults often have strengthened dysfunctional beliefs over a long time, modifying those takes longer, which is why the tapering process usually takes longer for older patients than for younger patients? The lengthier tapering ensures learning is well established and the process of modifying dysfunctional beliefs to functional beliefs continues. Collaborating with other professionals – physicians, social workers... – will help ensure a shared care process in which common goals are met.

Empirical Support for CBT in Older Adults

Literature on the effectiveness of psychotherapy specifically in older adults is more limited because less research has been conducted with this population generally. However, a Cochrane review of psychotherapeutic treatments for older depressed adults shows that both cognitive therapy and behavior therapy, the two components of CBT, have a significantly better effect than placebo on clinical outcome measures of depression [17,18].

Moreover, there is a significant difference in favor of CBT when comparing drop-out rates for CBT and wait-list control groups. CBT is effective for relapse prevention of mood disorders and may also play a preventive role in the development of major mood disorders in older adults who initially present with sub threshold symptoms.

CBT and behavior therapy are recommended interventions for the treatment of unipolar major depressive disorder. The evidence, although limited, suggests that in older adults, the combination of CBT with antidepressants results in a greater response rate than treatment with medication alone.

CBT has also demonstrated efficacy in the treatment of GAD in older adults, and may have a role to play in the prevention of other clinically significant anxiety disorders in older adults followed in primary care for 1 year [19,20]. However, response rates in older adults treated with CBT may not be as robust as those seen in younger adults treated with CBT, or in older adults treated with medication.

Evaluation of Cognitive Therapy with Older Patients

Depressive disorders

There has been a small number of outcome trials evaluating cognitive therapy in elderly subjects. These trials are mainly restricted to the treatment of depression. Steuer et al. [21] compared group cognitive with group psychodynamic therapy in patients with a mean age of 66 years. There was no control group and treatment lasted on average 37 weeks. The patients under investigation were atypical as they were media-recruited patients with a high level of educational achievement. However, there was improvement with both treatments with evidence of superiority of cognitive therapy. Other studies have included control groups. Beutler et al. [22] compared group cognitive

therapy with placebo and alprazolam over a period of 20 weeks and showed superiority of cognitive therapy over no active treatment. Thompson et al. [23] compared group cognitive, behavioural and psychodynamic therapies over 20 weeks with a 6-week delayed treatment group and demonstrated effectiveness of all treatments. Finally, Scogin et al. [24] compared the use of written cognitive therapy material with written behavioural therapy material with a delayed treatment group and found equal improvement in both treatment groups when compared with control.

Two studies address the longer term effects of cognitive therapy with older patients [25,26]. A trial comparing group cognitive therapy of depression with behavioural therapy and insight-oriented therapy showed early improvement in all groups. Improvement was sustained only in the cognitive and behavioural groups, with evidence that patients were continuing to use skills they had acquired. In a study conducted in the UK, patients received their usual treatment for depression and in some cases also received adjuvant cognitive therapy over a mean number of 14 individual sessions. After recovery, patients were maintained on either placebo or lithium carbonate. Those who had received cognitive therapy had significantly reduced depression scores at 1 year follow-up. The study, however, was of limited size and had a 50% drop-out rate [27].

There has also been some interest in treating the depressed carers of dependent elderly people. Gallagher-Thompson et al. [28] treated depressed caregivers (mean age 62 years) of elderly relatives with cognitive-behavioural and psychodynamic therapies: 71% were no longer depressed after treatment, with generally equal benefit from both therapies.

Although encouraging, these studies have methodological limitations such as small sample sizes, relatively young subjects, absence of more suitable control groups and unspecified treatment techniques.

Anxiety disorders

The treatment of anxiety disorders in old age is relatively neglected in the research literature [29]. A pilot case series, however, demonstrates the successful application of conventional individual cognitive therapy for a series of National Health Service outpatients with panic disorder, generalized anxiety disorder or agoraphobia, with reductions in most self-report measures of anxiety which were maintained over the 6 months studied [30,31].

Conclusion

CBT is an effective psychotherapy for late-life depression. The theoretical and applied components of CBT are often very well suited to depressed older individuals. In light of mounting evidence demonstrating CBT to be effective for late-life mental health and behavioral health conditions beyond depression, and increases in the accessibility of psychotherapy in the years ahead because of forthcoming changes in Medicare and private insurance, CBT very well may soon be an increasingly prominent psychological treatment for older adults [32,33]. Although CBT with older adults works in much the same way as it does with younger individuals, specific considerations and adaptations to CBT strategies and the therapy process with older clients can significantly enhance engagement, adherence, and outcomes.

Finally, for CBT clinicians who practice with older adults, the experience is often extremely rewarding. Older adults have extensive experience, personal resources, and wisdom to draw on that can make CBT a very dynamic, creative, and meaningful experience for therapist and client alike.

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