

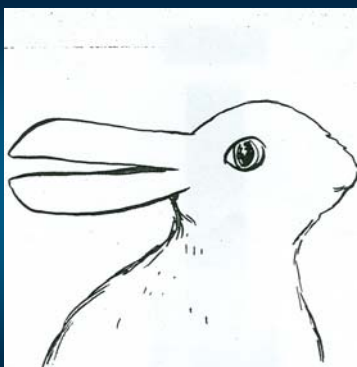
Evidence Based Treatments for Late-life Depression & Distress for Family Caregivers of Older Adults

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Overview

- ◆ What is meant by Evidence Based Treatment?
- ◆ Results of recently published reviews for treatment of
 - Late life depression
 - Distress in family caregivers of older adults
- ◆ Some examples of components/strategies
- ◆ “Practice”



Definition of EBT

- ◆ **Evidenced Based Treatment: intervention programs that meet specific criteria established by the American Psychological Association (i.e. coding manual developed and updated by the Society for Clinical Psychology (Weisz & Hawley, 2001).**
 - Relevant published papers were identified
 - Reviewers independently coded each article
 - Both between-group (prospective designs and random assignment) and within-group (single-case) designs were acceptable, but a minimum of 30 participants, across at least two studies, must have received the treatment in question.
 - Same age group, target problem, treatment.

- ◆ **Treatment (e.g., CBT, reminiscence therapy) must be the same across studies. If there was a question about this, reviewers were expected to study Rx manuals and/or contact the authors to determine the protocol followed.**
- ◆ **Results must show X treatment is either better than a control condition, or comparable to an already established EBT; that is, at least 50% of the outcome measures found a significant difference between groups in favor of the treatment.**
- ◆ **A treatment must also have a between group effect size, as measured by Cohen's d or delta, of at least 0.2 to be considered better than a control condition.**

Importance of Identifying EBTs

- ◆ **Late life depression and family caregiver distress are relatively prevalent problems with public health significance (REACH II, 2007; Scogin et al., 2005; 2007).**
- ◆ **Need to identify evidenced-based treatments.**
 - equips the public with knowledge to be an informed consumer of psychological services (growing evidence older adults prefer psychological treatment to pharmacotherapy)
 - guides professionals in their choice of treatment dependent upon the client's presenting problem
 - influences future research designed to fill the gaps

Methods Overview

Additional Comments: Depression

- Team led by F. Scogin (University of Alabama); Scogin, Welsh, Hanson, Stump & Coates, 2005, reviewed in 2007; currently updating.
- Did not include studies with combination treatments of antidepressant medication and psychotherapy (e.g., Beutler et al., 1987; Reynolds et al., 1999; Thompson, Coon, Gallagher-Thompson & Koin, 2001), as it would be impossible to isolate the specific effects of psychotherapy.
- However, studies using combination treatments deserve recognition, and it would be beneficial to have additional categories for coding these studies.

Methods Overview

- ◆ 116 geriatric depression studies were identified and abstracts reviewed
- ◆ 35 studies were coded to determine whether they met criteria as an evidence-based treatment; 20 of these studies provided information relevant to EBT status
- ◆ 6 treatments are thus far considered evidence-based
- ◆ 4 treatments partially met criteria for an evidence-based treatment, but were without corroborating studies

Summary of Findings¹

- ◆ Behavioral Therapy (n = 5)
 - Process promoting the recognition of the relationship of events that improve or negatively affect mood.
- ◆ Cognitive Behavioral Therapy (n = 7)
 - Adds to behavioral therapy (including behavioral activation, relaxation training and assertiveness); cognitive component teaches older adults to identify challenge and alter unhelpful/maladaptive information processing.
- ◆ Cognitive Bibliotherapy (n = 4)
 - Self administered treatment format involving reading and written exercises; used Feeling Good (Burns). Therapist initiated treatment check in calls.

¹Scogin, F. (2007). Introduction to the Special Section on evidence-based psychological treatments for older adults. *Psychology and Aging, 22*, 1-3; Scogin, F. et al. (2005). Evidence-based psychotherapies for depression in older adults. *Clinical Psychology: Science and Practice, 12*, 222-237.

Summary of Findings¹

- ◆ **Problem-Solving Therapy (n = 3)**
 - Teaches skills to approach problems in an active, adaptive fashion and to view problem solving as a coping strategy.
- ◆ **Brief Psychodynamic Therapy (n = 2)**
 - Focus on identifying conflicts and unresolved issues around dependence and independence, exploration of unconscious processes especially as these are enacted through the therapeutic relationship, and facilitation of client insight.
- ◆ **Reminiscence Therapy (n = 4)**
 - Clients review their life histories and focus on the significant aspects of important positive and negative life events; designed to help resolve conflicts and help clients accept both the successes and failures. Designed specifically for older adults.

Treatments Requiring Additional Evidence

- ◆ **Behavioral Bibliotherapy**
- ◆ **Interpersonal Therapy**
- ◆ **Personal Construct Therapy**
- ◆ **Goal focused Therapy**
- ◆ **Longer versions of CBT and psychodynamic**

Implications

- ◆ **The identification of EBTs has significant implications for clinical practice.**
 - In a health care environment where payers may be reluctant to cover psychological treatments, identifying treatments with solid empirical support may facilitate coverage of these services.
 - Identifying EBTs may encourage continuing education for those interested in using these modalities.
- ◆ **Identifying EBTs will also:**
 - Enhance the credibility of psychology, counseling and behavioral health as disciplines integrating science & practice.
 - Encourage further research for these treatments.

Conclusions

- ◆ Several evidence-based treatments have been identified as beneficial for treating geriatric depression.
- ◆ Health care providers now have more options to consider when determining treatment plans for geriatric depression.

Evidence Based Treatments for Family Caregiver Distress

Caregiver - The Hidden Patient

AT RISK FOR:

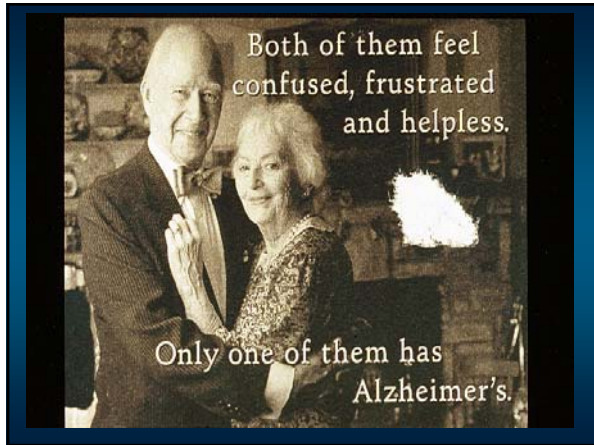
- Depression (>50% caregivers are depressed)
- Extreme fatigue, stress, anger/frustration
- Anxiety, upset, feeling overwhelmed
- Financial loss
- Social isolation
- Physical health problems/Morbidity
- **Mortality**

Coon, Gallagher-Thompson & Thompson, 2003 (Eds.), *Innovative Interventions to Reduce Caregiver Distress*, Springer; Ory et al., 1999, *The Gerontologist*, 37, 804-815; Schulz, et al., 1995, *The Gerontologist*, 35, 711-791; Schulz & Beach, 1999, *JAMA*, 282, 2215-2219

Impacts of Dementia Caregiving

(Ory et al., 1999; NAC/AARP, 1997)

- ◆ ADLs/IADLs
- ◆ Employment Changes
- ◆ Financial hardship
- ◆ Give up leisure
- ◆ Reduced time for family
- ◆ Family conflict
- ◆ Emotional strain
- ◆ Physical strain
- ◆ Physical health problems
- ◆ Greater amounts of service utilization
- ◆ **NOT ALL NEGATIVE!**



General Summary of Reviews

- Numerous reviews unable to identify the one best treatment to alleviate caregiver stress.¹
- No single, easily implemented, consistently effective method, particularly for dementia caregivers.
- Especially true considering different caregiver needs and responses, related to racial & ethnic diversity.
- Results suggest comprehensive, intensive, and individually tailored interventions are more effective.

¹ (Bourgeois, Schulz & Burgio, 1996; Dunkin & Anderson-Hanley, 1998; Kennet, Burgio & Schulz, 2000; Knight, Lutsky & Macofsky-Urban, 1993; Pusey & Richards, 2001; Schulz et al., 2002; Sorensen et al., 2002).

Variety of Interventions for Distressed Family Caregivers

- ◆ Education (e.g. lectures, presenting facts about AD)
- ◆ Skill Training / Psychoeducational Programs to enhance coping strategies
- ◆ Psychotherapy for more complex problems
- ◆ Support Groups are peer led and community based
- ◆ Environmental Modifications to improve safety/ function
- ◆ Technological Methods (e.g. telephone support groups)
- ◆ Care Management for coordination of multiple providers
- ◆ Respite Care for a temporary break from caregiving
- ◆ Multi-component Programs draw from several of these

Methods Overview

Additional Comments: Caregiver Distress

- ◆ Caregiver research team focused on intervention studies to alleviate distress among caregivers assisting older adults with cognitive impairment and/or frailty.
- ◆ Using Medline, PSYCHINFO, and ERIC, we conducted a review of published articles between 1980 and 2005. We found more than 350 articles, of which 155 were rated.
- ◆ Using two coders per study, 59 studies were able to be coded; only 19 studies met full EBT criteria.

Methods Overview

Additional Comments: Caregiver Distress

- ◆ Focused on psychological treatments for reducing distress, and improving well-being, of family members caring for an elder relative with significant cognitive &/or physical problems.
- ◆ However, did code for all categories prior to publication. Results presented here were the same.

Summary of Results¹

Three categories of treatments met EBT criteria in this review:

- ◆ Psychoeducational Programs (n=14)
- ◆ Psychotherapy (n=3) (CBT)
- ◆ Multi-component Interventions (n=2)

¹ Gallagher-Thompson, D. & Coon, D.W. (2007). Evidence-Based Psychological Treatments for Distress in Family Caregivers of Older Adults, *Psychology and Aging*, 22, 37-51.

Results Continued

- ◆ Psychoeducational included skill training programs focused on behavior management, depression management, or anger management, and the progressively lowered threshold model.
- ◆ Psychotherapy: cognitive-behavioral therapy enjoyed the strongest support.
- ◆ Multi-component refers to programs using a combination of at least two distinct theoretical approaches.

EBT Supported Interventions

- ◆ **Psychoeducational Programs**
 - Focus on education & skill training of the caregiver (Burgio et al., 2003; Burns et al., 2003; Coon et al., 2003; Teri et al., 1997; Gallagher-Thompson et al., 2003; McCurry et al., 1998; Oswald et al., 1999).
 - Derived from cognitive and behavioral theories and practices, typically offered in a small group format, and focus on improving adaptive coping skills and reducing the use of avoidant coping strategies.

The 14 studies in this category were sub-grouped into the following:

- ◆ **Behavior Management** (n=3) taught caregivers behavior management skills: how to change antecedents of problem behaviors, and/or change the caregiver's responses to these behaviors.
- ◆ **Depression Management** (n=3) focused on mood management skills including cognitive reappraisal, relaxation training, and problem solving.

Sub-Groups Continued

- ◆ **Anger Management** (n=2) focused on recognition of sources of frustration and the use of a variety of cognitive and behavioral strategies for self-management.
- ◆ **Progressively Lowered Threshold Model** (n=2) focused on developing "low-stimulus" care plans to address dysfunctional behavior.
- ◆ **Mixed** (n=4) is defined as including several components done in a structured format; but, more emphasis on education and support than skills.

Psychoeducational Skill Building Groups

- ◆ always time-limited (e.g. 6-12 sessions)
- ◆ usually 6-10 caregivers who commit to attending weekly
- ◆ detailed agendas with specific goals; a structured treatment manual is followed
- ◆ active in-class participation to learn skills (e.g. role plays)
- ◆ extensive use of homework assignments

(Beck et al., 1979; Lewinsohn et al., 1986; Gallagher & Lovett & Gallagher, 1988; Coon et al., 2003; Gallagher-Thompson et al., 2001; 2003; Thompson et al., 2000).

Psychoeducational Approach

- ◆ Why use this approach?
 - ❖ Theory-driven: CBT (e.g. Beck's & Lewinsohn's focus on increasing pleasant activities) in which feelings, thoughts, and behaviors are seen as interrelated.
 - ❖ Appeal: "problems in living"
 - ❖ Outreach: less shame
 - ❖ Less time-consuming
 - ❖ More economical

Case Example

- ◆ Valeria is a 57-year-old Latina who has been caring for her 64-year-old husband Ernesto. The couple has an 18-year-old grandson living with them who provides minimal assistance with Ernesto's care. She came to the group stating that after 25 years of marriage, she was having a difficult time understanding her husband's behavior: he was diagnosed with Alzheimer's disease a little over a year ago, and in this short period of time, had his driver's license revoked and lost contact with many of his friends.

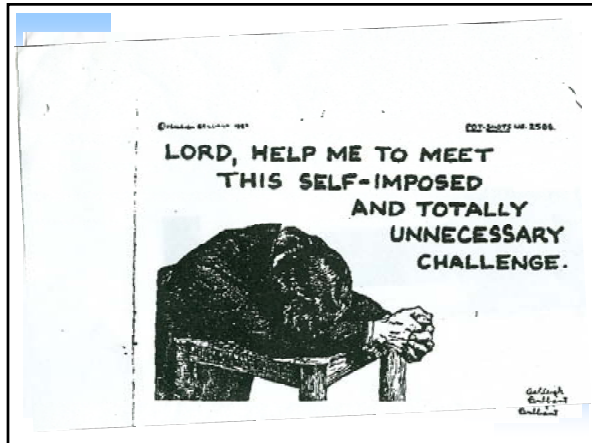
Behavior Log

Please use this log to write down the things your relative does (or that you do) that upset you.

Date/ Day of week	Time	Person Present	Trigger	Behavior	Reaction
Every- day	In the AM	Myself and Husband	He wakes up in the morning and knows that it is time to get dressed.	When he dresses himself, he insists on wearing the same outfit he has worn for the past five days	I am feel angry because he does not want to look and smell clean

Strategies Caregiver Can Use to Prevent the Problem Behavior

1. Set out fresh clothes for him and reward him when he wears them; give him a compliment on how nice he looks or make him his favorite breakfast.
2. Hide the outfit he really likes where he cannot find it.
3. Buy him several pairs of the same pants and shirt so that he thinks he is wearing his favorite outfit
4. When he goes to bed, take his clothes and put them in the laundry machine. Set the machine on the soak cycle so that if he looks for them and notices they are wet, he will need to find something else to wear.





Mood Module

- Learn new forms of “self-talk” so that you can be encouraging yourself mentally as you go through the day.
- Three steps to managing your feelings:
 1. Stop and identify current thoughts.
 2. Challenge & replace unhelpful thoughts.
 3. Pay attention to how you feel.

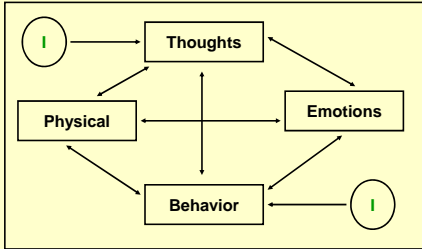
Thought Record

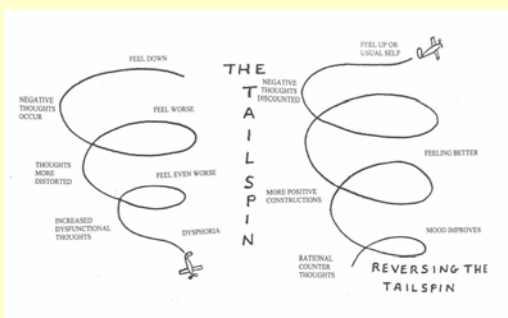
Situations	Current Thoughts	Feelings	Challenge & Replace	New Feelings
My neighbors and children will see my husband in the same clothes.	Everyone will think I don't care about my husband. Everyone will still think he is dirty and his clothes are dirty. My children will think I have given up.	Stressed. Guilty. Sad. Embarrassed.	I told my neighbors. They asked for information about Alzheimer's. I took my daughter with me; they all told me how much they believe I do for Ernesto. My children say "You are smarter than ever"; "You do a great job"; "We hope our spouses love us as much as you love Papa". He is clean; he is happier; We are not arguing.	Less trapped and less guilty. Happier. More relaxed. Less embarrassed with those who know me.

Psychotherapy Interventions

- ◆ **Psychotherapy** (e.g. Gallagher-Thompson & Steffen, 1994; Marriott et al., 2000; Akkerman & Ostwald, 2004).
 - Successful programs derived primarily from CBT theories and techniques.
 - Typically involves 10-20 individual sessions
 - Indicated for caregivers with significant emotional problems, such as diagnosed depression, severe anxiety, or extreme emotional stress.
 - Requires skilled clinicians with specialized training/experience.

Cognitive Behavioral Model:





UNHELPFUL THOUGHT RECORD

A ANTECEDENT OR SITUATION	B BELIEFS OR THOUGHTS	C CONSEQUENCE S OR EMOTION(S)	D DEVELOPING ADAPTIVE RESPONSES	E EFFECTS OR OUTCOME	F FUNCTIONS
Describe the event or experience leading up to your unpleasant emotion	Write down your negative thoughts and/or negative self-talk that occurred in connection with the event or experience just described. Rate your degree of belief in the thoughts or self-talk, from 0 to 100%.	Write down what you are feeling (sad, anxious, angry, etc.) Rate degree of emotion from 1 to 100%	Try to challenge your negative thoughts or self-talk. Think about: What is the evidence for the idea? What are its pros and cons? Can I think of an alternative? Rate your degree of belief in these new thoughts, from 0 to 100%	Re-rate your belief in your original negative thoughts, from 0 to 100%. Specify and rate your emotion num. from 1 to 100%. What behaviors would you do differently, now?	How will change your thought would affect your behavior?

Pleasant Events: Identifying PE's

- What counts as a Pleasant Event?
- Start Small *and* Keep it Simple.
- Daily engagement is key.

Pleasant Events

- Identify & Schedule.
 - Material.
 - Time/Location.
 - Steps needed for success.
- Home Practice & Potential Barriers.

**Pleasant Events:
Events for CR & CG**

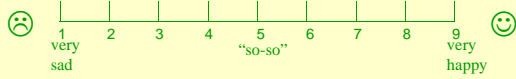
- Develop list.

Our list of Pleasant Events

☺ ☺ ☺ ☺ ☺ ☺ ☺ ☺ ☺ ☺
1. Look at family photo album.
2. Take a walk in the park.
3. Listen to music.
4. Garden.

Daily Mood Rating Form

1. Using the nine-point scale, please rate your mood for each day. If you felt good, put a high number on the chart below. If you felt "so-so," mark a 5. And if you felt low or depressed, mark a lower number.



2. In the column next to your mood rating for each day, please briefly give two major reasons explaining your feelings for that particular mood. Try to be as specific and concise as possible.

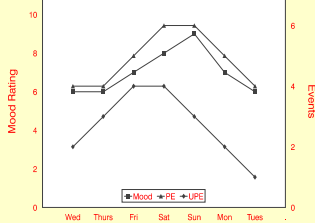
Day/Date	Mood Score	Why I think I felt this way:
		1. _____ 2. _____
		1. _____ 2. _____
		1. _____

Tracking Pleasant Events: Learning To Put Pleasure into One's Life

Pleasant Events	Days						
	1	2	3	4	5	6	7
1. Working on Computer	✓		✓		✓	✓	
2. Reading Religious Books	✓	✓					✓
3. Attending a Good Movie				✓			
4. Going for Walks	✓	✓	✓	✓	✓	✓	✓
5. Browsing in Library			✓				✓
6. Listening to Car-Talk						✓	
7. Listening to Music	✓	✓		✓	✓	✓	✓
8. Doing Physical Exercises		✓		✓		✓	
9. Meeting with Friends	✓		✓			✓	✓
10. Getting out for a Drive						✓	✓
Total	5	4	4	4	3	6	5

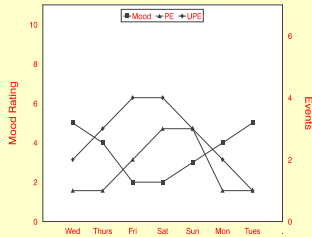
The Power of Pleasant Activity in One's Life Situation

Impact of Pleasant and Unpleasant Events on Mood when Pleasant Events are High



Letting Unpleasant Events Be in The Driver's Seat

Impact of Pleasant and Unpleasant Events on Mood when Pleasant Events are Low



Four Pleasant Events a Day Keep the Blues Away

- They don't have to be huge pleasant events.
 - But they must be **Consciously Chosen**, and **Deliberately Done** to experience control.
1. Events Control Mood.
 2. To some extent you can control events.
 3. Therefore, you can control mood.

Multi-component Interventions

- ◆ **Multi-component** (Mittelman et al., 1995, 2004; Toseland et al., 2001)
 - Combines more than 2 components without clear prioritization (e.g., telephone counseling, family meetings, behavioral management and attendance at a support group).

Promising Interventions

- ♦ **Environmental Approaches** (e.g., Gitlin et al., 2001; 2003).
 - Environmental manipulation, often designed to reduce care recipient behavioral problems.
- ♦ **Technological Approaches** (e.g. Mahoney et al., 2003; and some encompassed by other areas, such as Eisdorfer et al., 2003; Steffen, 2000)
 - Introduction of video, interactive voice response systems, computer integrated telephone systems in combination with education, referral, skill development.

Physical Environment

Case Scenario

- Distractible, Poor eating, fear of malnutrition

Intervention

- Red placemat
- White plate
- One food item
- Cereal
- Spoon

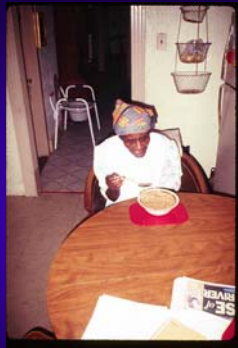


Gitlin et al., 2003

Physical Environment

NOTE: Use of turban

- Culturally appropriate
- Preservation of role



Gitlin et al., 2003

REACH Caregiver Network Computer Telephone Integrated System (CTIS)

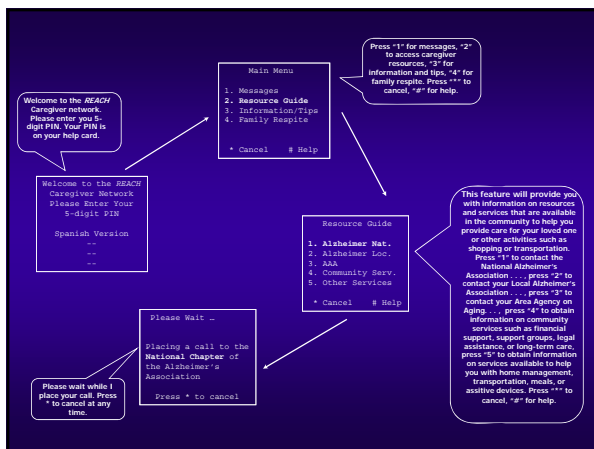
The CTIS system is a computer-integrated telephone system designed to:

- ◆ Facilitate caregiver access to information and resources
- ◆ Enhance communication
- ◆ Reinforce the content and strategies of the intervention
- ◆ Enhance social support.

Computer Telephone Integrated System Description of the CTIS



- Simple to use and “works” like a regular telephone.
- Menu driven.
- User is guided through the menus by visual and voice prompts.
- Menus customized for the language preference of the caregiver (English vs. Spanish).
- System collects real-time usage data on a per call basis.



Interventions Needing Additional Support

- ◆ **Support Groups**
 - Self-efficacy as Moderator (Rabinowitz et al., 2006)
- ◆ **Care Management & Memory Clinics**
 - The “Box”
- ◆ **Respite**
 - Effective use of “down time”

Resources Enhancing Alzheimer’s Caregiver Health



Supported by the National Institute on Aging and the National Institute of Nursing Research
(REACH II Investigators, 2006)

Concluding Thoughts

- ◆ **Design and implementation of caregiver interventions continues to improve:**
 - grounding in theoretical frameworks
 - clearer relationship between intervention and outcomes (proximal vs. distal outcomes)
 - better treatment fidelity/implementation
- ◆ **Three key categories of interventions met EBT criteria: psychoeducational skill-building programs; psychotherapy (CBT based); and multicomponent interventions.**

Concluding Thoughts

- ◆ **Challenges:**
 - plethora of intervention approaches, outcomes and measures
 - lack of support for replication
 - samples often lack ethnic and racial diversity and do not reflect the changes in our aging society.
 - the need for effective translation.

Next Steps

- ◆ Transferability into everyday practice settings including the refinement to enhance interventions' modular quality to meet the needs of diverse settings.
- ◆ Tailor for other ethnic/racial groups other types of caregivers.
- ◆ Integration of multicomponent approaches; and, the investigation of technology's role.
- ◆ Examine maintenance of gains; longer term outcomes.
- ◆ Evaluate cost effectiveness more closely.

Criticisms of EBT

- ◆ Classification of some treatments as empirically-based may hinder practitioners' ability to provide other forms of psychotherapy/treatment that appear clinically useful but have not yet been sufficiently researched to meet EBT criteria.
- ◆ The implementation of EBTs in real-world practice may also differ from the conditions of many treatment outcome studies, which often include exclusionary criteria and stringent measurements of therapist adherence to treatment protocols.
- ◆ Instead of looking at brand-name treatments, it may be more beneficial to examine the change processes underlying the treatments.

Implications

- ◆ The identification of EBTs has significant implications for practice, policy and research.
 - In both public health and psychosocial service models, may facilitate both private and public funding streams to support them.
 - Help health care and social service organizations identify appropriate staff, as well as provide relevant training and supervision activities.
 - Encourage additional research in these areas (e.g., understand individual difference variables to increase client-treatment match).
 - Encourage the identification and/or development of practical interventions and outcome measures for translation into the field.

Sustaining Behavior Change

- ◆ Homework
- ◆ Maintenance Guides & Boosters
- ◆ Multiple Levels of Intervention & Multiple Strategies
- ◆ Target both High-Risk & Large Segments of the Population
- ◆ Take the "Long View" of Outcomes
- ◆ Multiple Disciplines Working in Partnership
- ◆ Bridging the Research & Community Gap
 - (Coon, Lipman, & Ory, 2003; Coon, Gallagher-Thompson & Thompson, 2003; Coon et al., 2005)

Strategies for Compliance with Homework Assignments

- Label the assignment something other than "homework", e.g. home practice, ways to learn more.
- Collaborate in developing home practice. Adapt as needed for late life challenges.
- Goal relevant, Realistic, & Specific:
 - Tie to caregiver's goals; can be accomplished without undue stress. Start small and gradually increase complexity and time required. Give positive comments and praise for attempting and/or completing tasks.

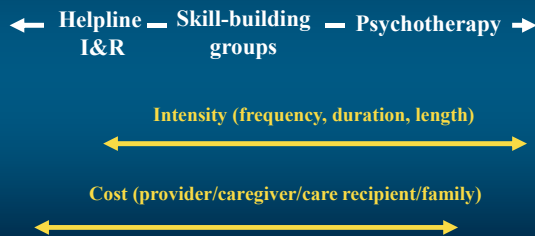
Survival / Maintenance Guides & Boosters

- Boosters: facilitate maintenance of gains.
- Rehearse how the client can handle critical incidents in the future that were usually depressogenic in the past.
- Help the client generalize beyond specific material covered in sessions.
- Summarize/Review specific skills and techniques most helpful for the client.
 - Prepare, with the client, a written "Survival Guide" containing this material. House useful assignments.

Multiple Levels of Interventions

- ◆ Individual
I&R/Hotline, skill-building groups, psychotherapy.
- ◆ Interpersonal
Early stage groups for spouses.
- ◆ Organizational/System
MCO/CBO care pathway partnerships.
- ◆ Community
Media campaigns or CCRC.
- ◆ Policy
NFCSP, AMA Caregiver Self Assessment Tool

Variability within Level by Intensity and Cost: An Individual Level Example



Variability within Level by Support and Significance: An Individual Level Example

← Helpline — Skill-building — Psychotherapy →
I&R groups

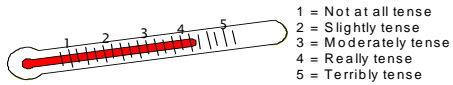
Support: Self-care/Informal Support/Formal Support

Significance (statistical & clinical: symptomatology, QOL, social significance, social validity)

Signal Breath

- Choose a word that represents relaxation for you (peace, relax, calm)
- Four deep breaths; mouth your word during exhale
- Rate tension (before & after)
- Practice!
- Alternative: Tense muscles on inhale and release while mouthing your word.

Use This Scale to Rate Your Level of Tension



Aging & Behavioral Health Projects

For information, please call:

(602) 543-6364 (English)

(602) 327-6010 (Español)

Key References

Coon, D. W., Rabinowitz, Y. G., Thompson, L. W. & Gallagher-Thompson, D. (2005). Older adults. In N. Kazantzis, F. P. Deane, K. R. Ronan, & L. L'Abate (Eds.), *Using homework assignments in cognitive behavior therapy* (pp. 117-152). New York: Routledge.

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