Cognitive therapy and the elderly assignment

Philosophy

Problem Statement: Magnitude of Problem: Aging is an occurrence we are all familiar with, a trait characteristic of all mankind. According to the U. S. Census Bureau’s, the elderly population will more than double between now and the year 2050. By 2050, as many as 1 in 5 Americans will be elderly; and as the United States elderly population increases, so does the need for diverse health care (National Institute of Health, 2003). Moreover, it is estimated that 18 to 25 percent of elder adult are in need of mental health care for depression. Research Proposal 2

As professional social workers know, depression is an illness than can have debilitating effects on individuals and families. The disorder can feature symptoms such as sadness, irritability, hopelessness, helplessness, loss of energy, feelings of worthlessness and thoughts of dying. The impact that depression can have on the quality of life can be all encompassing, and can lead the individual to withdraw from activities of daily living. Fit With Previous Literature: With this in mind, cognitive behavioral therapy has been clinically shown to improve depression in late life adults.

Unfortunately, the majority of studies conducted have been with individuals who are demographically and clinically homogenous. They are largely white educated and physically healthy. There has been little or no research conducted with patients who are ethnically diverse, less educated, physically and/or functionally impaired. Research Proposal 3 Future research for cognitive behavior therapy will need to address the efficacy and effectiveness for cognitive behavioral therapy for a broader range of patients (Arean, Perri, Nezu, Schein, Christopher, Joseph, 1993, p. 003). To pay for the study, a research career grant will be applied for. The grant will provide “

support to develop new knowledge about ways to improve the prevention and/or treatment of substance abuse and/or mental illness, and to work with State and local governments as well as providers, families, and consumers to apply that knowledge effectively in everyday practice” (U. S. Department of Health & Human Services, 2009, p. 1). With these findings in mind, there is an urgency to improve treatment to reduce depression among ethnically diverse older adults.

The role that cognitive behavioral therapy plays in geriatric treatment for depression will be investigated. Hypothesis and Theory: Furthermore, the research suggested that cognitive behavioral therapy intervention can also be a useful approach which supports the ecological perspective. Research Proposal 4 They purposed that cognitive strategies can be utilized to help clients improve their connections with the ecosystem surrounding their social environment. Cognitive behavioral therapy can be successful in treating depressed older adults.

Unfortunately, research for depression in older adults is not extensive and further examination is needed to provide solid evidenced based treatment. The following four literature reviews will attempt to demonstrate and support the hypothesis that cognitive behavioral therapy is effective for depression in geriatric patients Review 1: Satre, Knight and David (2006) proposed that looking at the social context along with cognitive behavioral therapy is an important factor in treating the older individual. The suggested that the goal is to solve problems in “ social functioning” by changing how the individual interacted.

They explained that environmental factors could often influence the individuals and the therapist should be familiar with all aspects of their client’s lives in order to treat them successfully. They also examined cohort differences, and cognitive changes that come with aging (p. 490). Cohort differences were defined by birth year differences and educational level. The researchers claimed that each generation had differences that could be explained by birth year. They defined cohort differences in aging to be earlier born cohorts, and later born cohorts (Satre et al. 006, p 490). They claimed that earlier born cohorts tended to be better in math and verbal skills, whereas, later born cohorts tended to be stronger in “ reasoning and spatial orientation” (Satre et al, 2006, p 490). The researchers stated that many later born cohorts were more receptive to therapy than younger born cohorts and younger born cohorts tend to view therapy as the stereotypical in that it is never ending. Research Proposal 5 The researchers also explored cognitive changes that are associated with aging.

They cited that people slow down with age and are relatively slower at processing; thus have reduced cognitive performance (Satre et al, 2006, p. 490). Satre et al, (2006) also claimed that cognitive changes come with aging. They claimed that the elder individual’s cognitive performance decreases with age. Because the elder is slower at processing they have a decline in coping with changes in life. They claimed that learning and memory are also affected with decline in functioning. The older adults often had problems with word recall, had a slower process time and needed simpler phrasing (Satre et al, 2006, p. 90-491). The researchers were in agreement that cognitive behavioral therapy had a lot to offer the older

individual. They explained that CBT was adaptable to a variety of issues faced by the geriatric patient. However, they all agreed that further investigation is needed to increase the effectiveness with older adults (Satre et al, 2006, p. 491). Review 2: In addition, Teasdale, Moore, Hayhurst, Scott, and Pope (2003) proposed a randomized controlled study in a community mental health setting. They wanted to know if " cognitive therapy prevented relapse in residual depression" (Teasdale et al. , 2006 p. 47). They used two treatment sites and 158 patients who had been diagnosed with recent major depression. Becks Depression Inventory, Hamilton Rating Scale for depression, and Global Assessment of Functioning GAF were used to measure the outcome of CT on the patients. Both groups received " 20 weeks of treatment and one group received additional 16 CT sessions" (Teasdale et al. , 2006 p. 348). Research Proposal 6 The researchers claim that the rate of relapse was significantly reduced with use of cognitive therapy. Their study formulated that the participants were dysfunctional in their attitudes and beliefs.

They claimed that the use of CT helped reduce the patient's dysfunctional attitudes (Teasdale et al. , 2006 p. 348). Overall, the researchers suggested " findings that cognitive therapy may prevent relapse by allowing patients to disengage from a habitual, dysfunctional cognitive mode at times of relapse. They suggested that interventions that focus on changing patients relationship to their dysfunction thoughts and feelings, rather than attempting to modify thought content or belief was more useful" (Teasdale et al, 2003, p. 55). This study was somewhat lacking in that out of 158 participants, 68% of the participants terminated prematurely for various

reasons. Also, the researchers were not able to carefully select patients because of the outpatient setting (Teasdale et al, 2003). Review 3: People experience positive and negative life events every day. How they cope with these events is the purpose of the research done by Kraaij, Pruymboom and Garnefki (2002). They proposed that older people experience less negative life events than younger people.

They suggested that elderly people experience more loss events and tend to suffer from more depressive symptoms (Kraaij et al, 2002, p. 275). They purported that the “ accumulation of life events have been found to be strongly related to depression in the elderly” (Kraaij et al, 2002, p. 275). Furthermore, the researchers claimed that a history of depression would influence treatment and the patient’s ability to cope with stressors. They also suggested that early depression is a pre-indicator of later depression in the elderly. Research Proposal 7

The researchers collected two measurements, one at the initial interview and then again during the follow-up. They “ measured depressive symptoms, cognitive coping strategies during both measures. The researchers also measured negative life events at both times covering different time periods” (Kraaij et al, 2002, p 276). The subject’s depressive symptoms were measured using the geriatric depression scale. The scores ranged from 0 to 30 with the higher scores showing more depressive symptoms. The researchers measured coping strategies by using the Cognitive Emotion Regulation Questionnaire.

They also used a Negative Life Events questionnaire which was used before the initial interview to measure life events from “ all developmental periods, ranging from childhood to the year prior to the interview” (Kraaij et al, 2002, p 277). Research Proposal 8 Review 4: Research Proposal 9 The researchers used chose five master level social workers and trained them in cognitive therapy. The treatment included 16 sessions and there was an opportunity to expand the sessions to 20 if needed. The treatment consisted of twice weekly sessions for the first month and then weekly thereafter.

The tools used were homework assignments, memory aids, and activity scheduling (Scogins et al, 2007, p 659). Measuring tools included the “ QOLI which assessed such items as philosophy of life, health, self regard. The SCL-90R was also used to measure overall psychological symptomlogy” (Scogins et al, 2007, p 659). Research Proposal 10 Method Sample: The research will be an availability sample of 70 older adults from two local mental health agencies. The ages will range from 55plus years of age. The sample will consist of approximately 58% female and will be at ethnically diverse as possible.

The clients will be clinically assessed and referred by four Cognitive Behavioral Therapy (CBT) trained clinical staff at the two mental healthagencies. The clinical staff will receive a three-day training course on Cognitive Behavioral Therapy. Participants who meet the above criteria and who satisfy the diagnostic criteria for major depression as defined by the Diagnostic and Statistical Manual of Mental Disorders within a 12 month period will be chosen. The participants will not have met any criteria for

bipolar disorder, anti-social personality disorder, psychosis or have any active substance abuse issues.

The sample will be chosen from a city whose population is 72, 000. The population consistsof approximately, 58% Caucasian, 30% African Americans, 10% Hispanic and 2% are other. Design: The design will be an experimental design with an experimental group and a control group. Subjects for the experimental group will come from clinic A and subjects for the control group from clinic B. The experimental group will receive (CBT) and the control group will receive services as usual. The subjects will be randomly chosen within each agency. Research Proposal 11

The subjects will be given the Becks Inventory at the time of the interview and again at the conclusion of treatment. The subjects will be administered the outcome rating scale before each session. This type of design will potentially allow the researcher to gather information which will increase understanding on how cognitive behavioral therapy can reduce depression. This design will also allow for flexibility with research procedures. The disadvantage of this research is that finding cannot always be generalized to the population and conclusions can be subjective. Measures:

A structured qualitative in-depth interview will be administered by four (CBT) trained clinicians. The clinicians will conduct the assessment and Axis I and II will be determined. They will also gather age, gender, ethnicity, marital status, income, and educational background information. Severity of depression will be measured by direct observation and utilizing Becks Depression Inventory (BDI). The BDI is a widely used self-reports utilized to

measure the severity of depression. This 21-question tool will be used during initial interview and again at the conclusion of treatment. This tool is reliable for “. 92 of clinical patients and . 3 for non-clinical individuals. When compared with Becks Hopelessness Scale and Hamilton Psychiatric rating scale for depression, it was found to be valid for . 93” (Beck, Steer, Brown, 1996, n. p.). The BDI addresses many topics such as sadness, self dislike, suicidal thoughts, and worthlessness. Murphy-Brief Counseling Handout will also be used prior to each therapy appointment. This low/high rating scale has four questions and will be used to measure levels of depression. Research Proposal 12 The self report handout measures client functioning in certain areas of their lives within a predetermined time frame.

The subjects will be referred by the two local mental health agencies. They will be approached individually and will be provided with information about the nature of the treatment and the requirements of the study. If agreeable, they will sign a form of consent and it will be collected by the four therapist assigned to the research project. The participants will be scheduled at the two locations and will attend individual therapy twice monthly for five consecutive months Clinic A will be given treatment with a therapeutic tool commonly referred to as Cognitive Behavioral Therapy (CBT).

CBT was developed specifically to help patient’s change cognitions and behaviors related to their ailment. “ CBT aims to provide the patient with skills to modify distorted beliefs through techniques of identifying and testing the validity of such biased thoughts. Therapy is strength focused and relies on an active collaboration between patient and therapist” (Wilkinson, 1997, para. 3). Clinic B will be given services a usual. This research proposal will

allow researchers to examine the role that cognitive behavioral therapy plays in geriatric treatment for depression. Abstract: Research Proposal 13

Research Proposal 14 References Arean, P. A. , Perri, M. G. , Nezu, A. M. , Schein, R. L. , Christopher, F. , Joseph, T. X. 1993. Comparative Effectiveness of Social Problem-Solving Therapy and Reminiscence Therapy as _ Treatments for Depression in Older Adults. _(61)6, 1003, doi: 10. 1037/0022-006X. 61. 6. 1003 Beck, A. T. , Steer, A. , Brown, G. K. , (1996). Beck Depression Inventory-Second Edition (BDI-II,) _ 1996. _ Retrieved July 28, 2009, from: http://www. acf. hhs. gov/programs/opre/ehs/perf_ measures/reports/resources_measuring/res_meas_phic. html Becks Depression Inventory, (2009).

Retrieved July 29, 2009, from the STS Wiki: http://en. wikipedia. org/wiki/Beck_Depression_Inventory Kraaij, V. , Pruymboom, E. , Garnefski, N. (2002). Cognitive Coping and Depressive Symptoms in doi: 10. 1080/13607860220142387 Mental Health and Aging, (2005). Retrieved July 29, 2009 from: http://www. mhaging. org/pubs/01- 05. html National Institute of Health, (2003). Older Adults: Depression and Suicide Facts. Retrieved July 7, 2009, from http://www. nimh. nih. gov/health/publications/older- Rubin, A. , Babbie, E. , (2007). Essential Research Methods for Social Work. (p. 258). California: Brooks/Cole.

Scogin, F. , Morthland, M. , Kaufman, A. , Burgio L. , Chaplin, W. , Kong, G. , 2007). Improving _ Quality of Life in Diverse Rural Older Adults: A Randomized Trial of a Psychological_ _ Treatment. _Psychology and Aging, (22)4, p657-665, doi: 10. 1037/0882-7974. 22. 4. 657 Research Proposal 15

References Satre, D. , Knight, B. G. , David, S (2006). Cognitive-Behavioral Interventions With Older _ Adults: Integrating Clinical and Gerontological Research_, American Psychological Association (37)5, 489-498, doi: 10. 1037/0735-7028. 37. 5. 489 Teasdale, J. D. , Scott, J. , Moore R. G. , Hayhurst, H. Pope, M. , (2001). How Does Cognitive American Psychological Association (69)3, 347-357, doi: 1. 1037//0020-006X. 69. 3. 347 U. S. Department of Health & Human Services. Retrieved July 29, 2009, from http://grants. nih. gov/grants/funding/ac_search_results. htm Wilkinson, P. , (1997). Cognitive Therapy With Elderly People. Retrieved July 28, 2009, from http://findarticles. com/p/articles/mi_m2459/is_n1_v26/ai_19369831/ Research Proposal 16 Appendix I (Measurements Tools Used) Research Proposal 17 Overview Clinical Assessment Planning the assessment (why is person being assessed?)

Data collection (interviews, tests, observations etc) Data processing (clinical assessment) Communicating findings (written reports) Research Proposal 18 Outcome Rating Scale (ORS) ATTENTION CLINICIAN: TO INSURE SCORING ACCURACY PRINT OUT THE MEASURE TO INSURE THE ITEM LINES ARE 10 CM IN LENGTH. ALTER THE FORM UNTIL THE LINES PRINT THE CORRECT LENGTH. THEN ERASE THIS MESSAGE. Individually (Personal well-being) I ————————————————————————-I Interpersonally (Family, close relationships) I————————————————————————-I Socially Work, school, friendships) I————————————————————————-I Overall (General sense of well-being) I————————————————————————-I Institute for the Study of Therapeutic Change www. talkingcure. com Research Proposal 19 © 2000, Scott D. Miller and Barry L. Duncan Research

Proposal 20 (Example of the questions) (0) I do not feel sad. (1) I feel sad. (2) I am sad all the time and I can’t snap out of it. (3) I am so sad or unhappy that I can’t stand it. Research Proposal 21 Appendix II Potential Risk to Subjects Research Proposal 22

Researchers can never wholly guarantee no harm and therefore the subjects should be aware of the risks and accept them before taking part in the research. There could be a risk of psychological harm to the subject such as the treatment many result in undesired change in thought process and emotions. The participant may also encounter stress or guilt associated with sensitive topics. To ensure the safety of the subjects, they will be provided a 24 hour hotline for emergency services. The subjects will be provided care on a needed basis until the problem is resolved (Rubin, Babbie, 2007, p. 258).