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PALLIATIVE PSYCHOTHERAPY IN THE TREATMENT OF GERIATRIC DEPRESSION: A REVIEW OF EVIDENCE-BASED PSYCHOGENIC OPTIONS

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Abstract

There are a large number of counselors and psychotherapists as well as psychiatrists, however, who find themselves with an increase in post-retirement clients and patients but without the benefit of specific training in treating this particular constituency. There is a large population of older individuals in need of assistance in dealing with depression and its cognates of anxiety and self-esteem issues which are of particular concern to the health care profession working in palliative care medicine. That there is a relative void in the training of palliative care health professionals in geriatric psychotherapy, particularly as relates to the treatment of depression, is very evident according to recent AMA-sponsored studies. In the following essay, we will delineate and discuss briefly evidence-based treatment options available to the counseling and psychotherapeutic community dealing particularly with palliative psychotherapeutic depression

Key words: Palliative psychotherapy, geriatric depression, non-pharmacological treatments, cognitive behavioral therapy, reminiscence therapy, interpersonal psychotherapy

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Neither psychotherapeutic nor biological psychiatry has made a name for itself in developing new approaches to the treatment of depression among the palliative care patient community. However, what is now being called palliative care psychiatry is on the rise as an emerging subspecialty where palliative medicine and psychiatry converge (Fairman and Irwin, 2013). The interfacing of palliative care medicine with psychiatry is being heralded throughout the medical community as a positive step forward in the development of modalities of treatment, both pharmacologically-linked and psychotherapeutic, which may be further researched and evidence-based tested for efficacy.

The development of geriatric, late life, and post-retirement psychotherapies within the health care professions (Arean, Hegel, Vannoy, Fan, and Unutzer, 2008; Ayeers, Sorrell, Thorp, and Wetherell, 2007; Landreville, Laudry, Baillargeon, Guerette, and Mattewa, 2001) including, and of particular interest to us here, palliative psychotherapeutic care has in recent years become an increasingly important component of comprehensive health care treatment options. There are a large number of counselors and psychotherapists as well as psychiatrists, however, who find themselves with an increase in post-retirement clients and patients but without the benefit of specific training in treating this particular constituency (Karel, Ogland-Hand, Gatz, and Unuetzer, 2002; Gatz, Fiske, Fox, Kaskie, Kasl-Godley, and McCallum, 1999; Hinrichsen, 2008). There is a large population of older individuals in need of assistance in dealing with depression and its cognates of anxiety and self-esteem issues which are of particular concern to the health care profession working in palliative care medicine (Stanley, Wilson, Novy, Rhoades, Wagener, Greisinger, 2009; Knight and McCallum, 1998).

That there is a relative void in the training of palliative care health professionals in geriatric psychotherapy, particularly as relates to the treatment of depression, is very evident according to recent AMA-sponsored studies (Gallagher-Thompson and Steffen, 1994). In the following essay, we will delineate and discuss briefly evidence-based treatment options available to the counseling and psychotherapeutic community dealing particularly with palliative psychotherapeutic depression (Scogin and McElreath, 1994). As we know, biogenic depression calls for pharmacological intervention and, therefore, medical oversight. However, our interest here is rather to call attention to several proven modalities of treatment available for the non-medically trained psychotherapist dealing with palliative psychogenic depression (Knight and Qualls, 2006). There are several modalities of treatment for late-life depression for both institutionalized patients and those living at home

(Francis and Kumar, 2013) including cognitive and behavioral therapy, problem-solving therapy, reminiscence and life review therapy, brief psychodynamic therapy, and interpersonal therapy. These studies are consistently showing evidence-based findings validating the use of each of these modalities of treatment of depression and depressive symptoms in older adults.

There are consistent evidence-based studies showing that non-pharmacological interventions offer the prospects of reducing cognitive decline in late life depression patients as well as the improvement of psychosocial aspects of older individuals suffering from mild cognitive impairment or Alzheimer's dementia (Herholz, Herholz, and Herholz, 2013). The absence of side effects owing to the non-pharmacological therapies employed make those therapies attractive options for the therapist, the patient, and the family involved. Recent studies will be reviewed here including those involving cognitive training and reminiscence and also such components as visual art and music, physical activities, and electromagnetic stimulation.

Specific treatment modalities which have an evidence-based effectiveness record to date include Cognitive Behavior Therapy (Barrowclough, King, Colville, Russell, Burns, and Tarrier, 2001; Cappeliez, 2001; Siskin, 2002), Brief Dynamic Therapy (Messer, 2001), Interpersonal Psychotherapy (Hinrichsen and Clougherty, 2006), Reminiscence Therapy (Bohlmeijer, Smit, and Cuijpers, 2003), and Geriatric Logotherapy (Morgan, 2012). These are commonly used by non-medically oriented psychotherapists and professional counselors in palliative health care facilities and, as will be indicated, have proven consistently to be effective tools for therapy in dealing with older clients as illustrated by evidence-based empirical studies (Arean and Ayalon, 2005).

Behavioral therapies, particularly Cognitive Behavioral Therapy (CBT) and Rational Emotive Behavior Therapy (REBT), have been the most used modalities of treating non-medical or psychogenic depression among older clients and have the largest data-base evidence for effectiveness (Floyd and Scogin, 1998). Depression is considered within the cognitive behavioral school of psychotherapy to essentially constitute the inability of the individual to cope with stress brought on by the aging process itself including such things as problem solving skills, isolation within the social matrix of daily living, and the decline in physical skills capabilities. The emphasis in these CBT treatment options focuses upon the practicalities of skill enhancement and the intentionality in the reorientation towards life stressors by reconfiguring

the client's daily schedule, priorities, and inclinations (Gatz, 2007). CBT and its variants have proven very effective in facilitating the older client, post-retirement particularly, in redefining one's life situation, the *Sitz im Leben*, to accommodate a new understanding of one's relationship to the social environment of interpersonal relationships, life skills, and self-satisfaction. Evidence is strong for the overwhelming success of CBT compared to other modalities of depression treatment as well as wait-list controls and no treatment at all. And, this evidential data demonstrates that CBT has a longevity value beyond that of pharmacological treatments as well (Hyer, Hilton, Sacks, Freidman, and Yeager, 2009). The CBT agenda is two-fold, viz., to reduce the psychogenic depression and to elevate the social interaction and the physical skills-based functioning of the client. Reduction of depressive behavior while increasing social and physical activity constitutes the treatment agenda of CBT, and the evidence for its effectiveness is substantial.

It is generally agreed among health care workers that psychosocial factors constitute a significant component in the care and treatment of the elderly and recipients of palliative care. Up until just recently, however, data-based evidence of the effectiveness of the various treatment modalities has been absent or grossly under represented (Rodin, 2013). The consideration of significant developments in psychosocial research relative to this population as recipients of palliative care treatment modalities is crucial if continued development of effective care treatments are to be produced and refined. The various factors of methodological limitations, protective attitudes of health-care providers, and the progressive deterioration of patients with terminal disease have heretofore proven effective deterrents to evidence-based studies. Recently refined and improved valid and reliable measurements of various psychological features of distress and well-being has greatly improved the potential for producing evidence-based results in palliative care treatment of the elderly and terminally ill.

One area in which palliative care medical practice has only just begun to address itself is the realization that since half of cancer patients today continue to die of the disease, there is inevitably a persistence of psychological distress associated with it. Though not inevitably a death sentence, diagnosed cancer can and does produce emotional stress and often debilitating depression on the part of the patient though little research yet exists addressing this reality. An assessment of the work of the Japan Psycho-Oncology Society (Akechi, 2010) is relevant to this agenda particularly as relates to the psychiatric conditions produced within the diagnosed patient. Such patients frequently develop adjustment disorders and debilitating depression including anticipatory

nausea and vomiting for patients receiving emetogenic chemotherapeutic agents. Common throughout the medical community is the awareness that terminally ill cancer patients inevitably prefer psychotherapeutic intervention rather than pharmacological therapy for the management of their depression. The amelioration of depression within the palliative care treatment patient using evidence-based effective psychotherapies constitutes the agenda for the health care giver and the institutional support team of medical personnel.

One of the great advances in the care and treatment of the end-of-life patient has been the rapid and substantial recognition on the part of medical personnel of the central importance of the psychological and social aspects of palliative care treatment (Pasacreta and Pickett, 1998). The acceleration of anxiety, distress, and depression occurs along the illness trajectory, and the psychological and social *milieu* within which the patient lives, institutionalized or at home, creates the potential for effective care based on an understanding of the attending physician, the care giver, and the family of these factors.

Studies (Connell, 1988) are now regularly providing evidence-based data to validate the effectiveness of Reminiscence Therapy (RT) used in the treatment of geriatric depression within the nursing home institutional setting. RT is a non-pharmacological intervention involving the prompting of past memories on the part of the palliative care patient. Clearly the most prevalent mental health disorder among institutionalized elderly is that of depression and Reminiscence Therapy. What is important in the Connell study is the use of RT “intermittently” rather than as the one primary modality of treatment employed once. Data is now showing that periodic, spaced, intermittent uses of RT have a greater evidence-based benefit.

Systematic assessment of the use of Reminiscence Therapy (RT) in the treatment of patients suffering from minor as well as major dementia (Dempsey, Murphy, Cooney, Casey, O’Shea, Devane, Jordan, and Hunter, 2014) reveals that there is currently no consistent definition of RT within the healthcare literature or professional practice though there is a consistency of characteristics of the various definitional parameters of the term and its usage. There is a characteristic divergence in the goals, theory base, and content of the competing definitional matrices of RT practice including the use of such terms as life review, early life events, remembered childhood relationships, etc. However, universally agreed upon components of RT include stages of life, age, life transitional events, attention span issues, recall ability over time, vocalizations including tunes, and remembered stress situations. These

studies demonstrate the common useage of RT in the treatment of dementia care showing effective results in enhancement of self-esteem, improved communication skills, self-worth, personal identity and a sense of individuality.

To date, studies of meta-analysis focusing on psychosocial interventions have failed to address specific treatment of individual Behavioral and Psychological Symptoms of Dementia (BPSD) involving personalized interventions. Based on 641 care home and nursing home studies involving cluster randomized controlled trials as well as pre- and post-test studies (Testad, Corbett, Aarsland, Lexow, Fossey, Woods, and Ballard, 2014), good evidence supporting the use of Reminiscence Therapy in improving mood swings and a diminishment of agitation is being regularly and systematically found.

The benefits of Reminiscence Therapy (RT) for the improvement of the quality of life of individuals, both in and out of institutionalized care facilitites, suffering from dementia has consistently produced evidence-based validation. However, the value of RT for care givers has yet to be researched and documented (Melunsky, Crellin, Dudzinski, Orrell, Wenborn, Poland, Woods, and Charlesworth, 2014). Based on a recent study of 18 family care givers involved in group sessions, the evidence for effectiveness in enhancing their skills in interacting with dementia patients proved inconclusive with the suggestion that further study is needed. Without further study and evidence-based findings, the suggestion is that there is little justification in the continuation of joint reminiscence groups in dementia care.

Owing to the acute adaptation difficulties of older individuals being institutionalized for palliative care, the emergence of depression and cognates including agitation, apathy, and the on-set of minor dementia symptoms as well as a diminishment of a feeling of general well-being is proving consistently evident in nursing home reports (Melendez-Moral, Charco-Ruiz, Mayordomo-Rodriguez, and Sales-Galan, 2013). Reminiscence Therapy (RT) has consistently proven to be among the most effective non-pharmacological intervention modalities of palliative care treatment with a minimum of debilitating side-effects while maximizing the reduction of these depressive symptoms.

In spite of the frequency of reports of effectiveness in the use of Reminiscence Therapy (RT) in the treatment of depression and dementia among the institutionalized elderly population (Klever, 2013), there is a conspicuous absence of actual research evidence addressing the specifics of the connection between reminiscence functions and the

reduction of depressive symptoms (Hallford, Mellor, and Cummins, 2013). The Hallford and colleagues' study tests the hypothesis regarding the "indirect associations of adaptive integrative and instrumental reminiscence functions with depressive symptoms," addressing the question regarding whether or not these relationships might differ from younger to older patients. This study of 730 younger and 725 older individuals provided evidence-based validation of the effectiveness of RT in the treatment of both age groups in the reduction of depression and depressive symptoms including having substantive impacts upon meaning of life issues, self-esteem, and personal optimism about the future.

With both the rise of dementia and psychogenic depression among the over-65 year old population in the U.S. which continues to rise exponentially owing to the baby-boomers, there is evidence of an increasing need for more responsive evidence-based validated psychotherapeutic modalities of treatment. Reminiscence Therapy (RT) is proving to be one of those which is providing evidence-based validation of its effectiveness and is supplemented with the use of "technologies" as explored by Lazar and team (Lazar and Demiris, 2014). Such things as photographic artifacts as well as period-based music used in the facilitation of social interaction within group as well as individual treatment plans is gaining support within the counseling and psychotherapeutic communities. A diminishment of depression and a documented rise in self-esteem are two prevalent benefits of the use of these material supplements called Information and Communication Technologies (ICT). Another benefit documented in these evidence-based studies is that of patients actually taking ownership of conversations in both group settings and with one-on-one relationships with a family member, therapist, or care giver. The use of what are referred to as multimedia reminiscence materials also results, according to these studies, in the reduction of barriers to motor deficits in the interaction.

A specific study of male veterans (Chue and Chang, 2014) utilizing Group Reminiscence Therapy (GRT) was conducted in a nursing facility's intervention program evaluating 3-month and 6-month effects on depressive symptoms for institutionalized male veterans. Following a 4-week intervention, the evidence-based findings validated the effectiveness of this treatment plan based on reduced depressive symptoms. This increasingly popular variation on Reminiscence Therapy labeled Group Reminiscence Therapy (GRT) is commonly used within a group of age peers suffering from psychogenic depression in an institutional setting such as a residential nursing home. GRT functions

as a brief and structured intervention and according to Gaggioli and colleagues (Gaggioli, Scaratti, Morganti, Stramba-Badiale, Agostoni, Spatola, Molinari, Cipresso, and Riva, 2014), it is proving with evidence-based demonstrations the increased effectiveness for group therapy beyond its already validated effectiveness with individuals.

Problem-Solving Therapy (PST) (Kiosses and Alexopoulos, 2014) is a component of the treatment of geriatric psychogenic depression and is consistently reporting an evidence-based effectiveness rate justifying both its continued use and further data-collection and assessment. PST has demonstrated empirically its effectiveness comparable to those studies using paroxetine and placebo treatment plans with patients suffering from minor depression as well as dysthymia. Its effectiveness has been further demonstrated in reducing symptoms of depression in undiagnosed patients. A particularly attractive feature of PST is that among stroke patients, for example, they were less likely to develop depressive episodes, both major and minor, than those who receive placebo treatment. One final and important finding was that PST patients had significantly lower 2-month incidence rates of major depression than those receiving usual institutional care and were less likely to develop apathy than placebo treated patients.

Meaning Centered Group Psychotherapy (MCGP) is also becoming increasingly recognized as a legitimate treatment modality addressing the spiritual and values-based worldview of the terminally ill and end-of-life elderly palliative care patient (Breithart, Rosenfeld, Gibson, Pessin, Poppito, Nelson, Tomarken, Timm, Berg, Jacobson, Sorger, Abbey, and Olden, 2010). Though begun gradually, the increased acceleration of the acceptance of MCGP by the medical and palliative care community has provided a new arena for the religiously oriented individual and family to seek out and respond to medical care and treatment which demonstrates a sensitivity to the worldview and ethos embodied in a faith-based patient's life. In a study reported by Breithhart and colleagues, there were 90 terminally ill patients who participated in an 8-week treatment intervention followed by another 8-week intervention two months later. Assessments included measuring spiritual well-being, meaning, hopelessness, desire for death, optimism/pessimism, anxiety, depression and overall quality of life. The evidence-based study showed a considerable improvement in the patient's sense of spiritual well-being and a sense of meaning to life with an even greater advancement in these feelings following the second intervention. However, there was no measurable improvement among individuals participating in the Supportive Group Psychotherapy (SGP) which led the researchers to suggest that more study of the efficacy of the MCGP approach to end-of-

life palliative care should be aggressively pursued owing to the initial very positive findings.

Mindfulness-Based Supportive Therapy (MBST) is addressed particularly to palliative psychotherapy employed in the treatment of psycho-existential suffering of the end-of-life patient. MBST consists of five key components, viz., presence, listening, empathy, compassion, and boundary awareness. There is yet to be produced evidence-based efficacy of this newly emerging palliative care treatment therapy, but confidence is high among the developers of this new therapy sufficient to merit further data-base study (Beng, Chin, Guan, Yee, Wu, Jane, and Meng, 2013).

From its early inception, the goal of palliative care has been portrayed as "helping patients to die with dignity." The overall characterization of palliative care has to do with dignity of the patient as a framework for the attending physician, the patient, the care giver, and the family in determining the objectives and therapeutic considerations essential to end-of-life care (Chochinov, 2002). A term increasingly used in this arena is "dignity-conserving care" for it places the responsibility on the health care environment to foster specifically this goal. It constitutes both a treatment objective as well as a governing principle for the entire health care environment.

Dignity Therapy (DT) is a short-term palliative psychotherapy developed for patients living with a life-limiting illness. However, there continues to be a need for the demonstration of the effectiveness of DT in the treatment of depression and anxiety among the elderly and those in palliative care treatment. In this study (Juliao, Barbosa, Oliveira, Nunes, and VazCarneiro, 2013), 60 terminally ill individuals participated in the assessment of the value and efficacy of DT. The findings verified the short-term beneficial effects on depression and anxiety, and the data were sufficiently strong as to merit further study.

The use of Dignity Therapy is definitely on the rise in both institutional care facilities for the elderly and for the treatment of end-of-life palliative patients (Juliao, Olivera, Nunes, VazCarneiro, and Barbosa, 2014). It is a brief psychotherapeutic modality treatment for depression and anxiety for the institutionalized elderly with terminal illness where a high level of distress is evidenced by palliative caregivers. Based on a study of 80 patients, it was found that dignity therapy resulted in a measurable evidence-based beneficial effect on both depression and anxiety. Over a 30-day period, the therapeutic benefits were maintained and, based on the efficacy of dignity therapy, future trials of DT should be commenced

and compared to other psychotherapeutic non-pharmacological approaches.

Existential Behavioral Therapy (EBT) was developed to support informal caregivers of palliative patients in the last stage of life and during bereavement as a manualized group psychotherapy (Febb, Brandstatter, Kogler, Hauke, Rechenberg-Winter, Fensterer, Kuchenhoff, Hentrich, Belka, and Borasio, 2013). Consisting of six sessions only, EBT was tested using 160 individuals for effectiveness in the treatment of mental stress and quality of life issues. The evidence-based study demonstrated an effective benefit in dealing with distress and anxiety as well as quality of life issues among caregivers of palliative patients. However, it must be emphasized that, given the uniqueness of the study and smallness of the sample, more study is required for conclusive validation of the early findings.

Even though palliative care is now considered an indispensable component of end-of-life care, there is still only a small amount of evidence-based effectiveness studies of its use assessing the efficacy of intervention-oriented treatments. There is one (Hansen, Enright, Baskin, and Klatt, 2009), called Forgiveness Therapy (FT) which is now beginning to provide evidence-based validation of its efficacy in improving psychological well-being on the part of the patient and promises to be a valuable component of terminal care treatment plans. Measuring such things as forgiveness, hope, quality of life, and anger issues, FT therapy groups consistently showed a measurable improvement in all areas tested sufficient to justify consideration as a standard treatment procedure in dealing with the terminally ill elderly.

Palliative psychotherapy is a fairly recent arrival in the care and treatment of the terminally ill and particularly geriatric institutionalized patients suffering from debilitating depression. Its rapid success in evidence-based effectiveness has inevitably insinuated its utility and value into the overall treatment of geriatric depression. What we have done here is to review some of the more successful and recently developed treatment modalities in palliative psychotherapy of geriatric depression patients, calling attention to the proliferation of evidence-based effectiveness studies and identifying those methodologies which are still in need of further development and effectiveness verification. In the meantime, palliative psychotherapy in the treatment of geriatric depression is a growing field of specialization, and it continues to justify its place in the overall treatment plan of institutionalized elder care.

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