Aging Changes Things: Adapting ACT to Meet the Needs of an Aging Population

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Disclosure

I have not received and will not receive any commercial support related to this presentation or the work presented in this presentation

Set an Intention

Objectives

- Introduction
- Rationale & Research
  - ACT for Depression
  - ACT for Anxiety
  - ACT for Chronic Pain
- Assessment Considerations
- Specific Adaptations for OA
- Case Studies
- Experiential Exercises

Rationale

- Older Adults (OA) are a rapidly growing segment of populations around the world
- OA are typically underserved and in need of MH treatment
- MH professionals are and will be seeing more older clients
- Need to strengthen workforce training to meet the unique needs of OA
- ACT is an EBT that is effective in addressing uncontrollable aspects of aging that contribute to late life suffering (loss, illness, chronic pain, etc.)

Petkus & Wetherell (2013); Karlin et., al (2013)

Benefits of ACT with OA

- Lower attrition rates in ACT vs. CBT
- Just as effective with OA as it is with younger adults
- Gerontological theories of adult development and successful aging suggest ACT is beneficial for challenges faced in late life (e.g., *illness, pain, disability, grief, loss and relocation)*
- Emotional Resiliency
  - Emotion regulation improves with age
  - OA often have lower levels of cognitive fusion
- Can be a way for OA to re-evaluate and "take stock" even when they believe that most of their lives have already passed them by
- Can help OA to reconnect with long-held values and find satisfaction in spite of emotional, physical, and existential pain

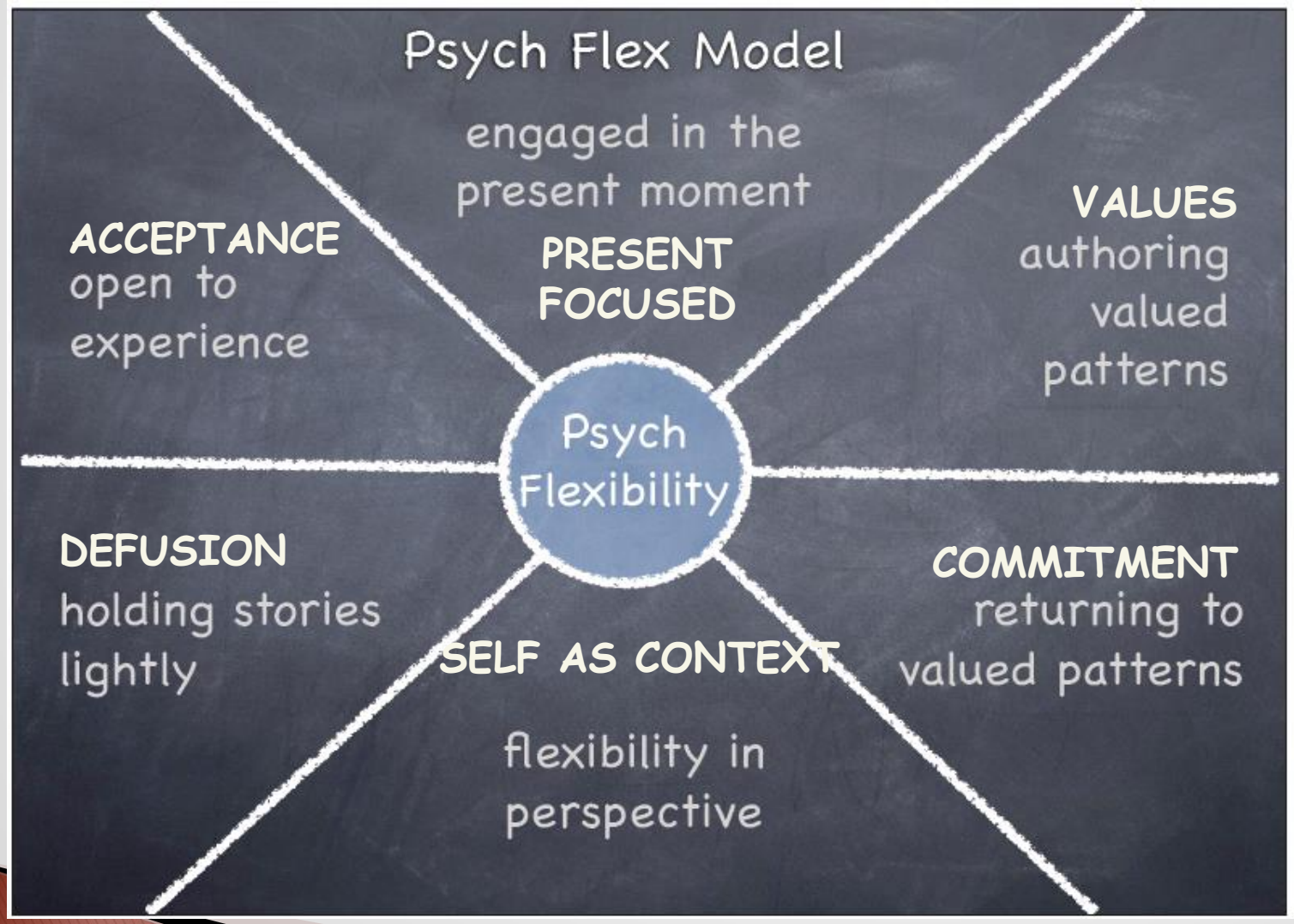
Petkus & Wetherell (2013); Karlin et., al (2013)

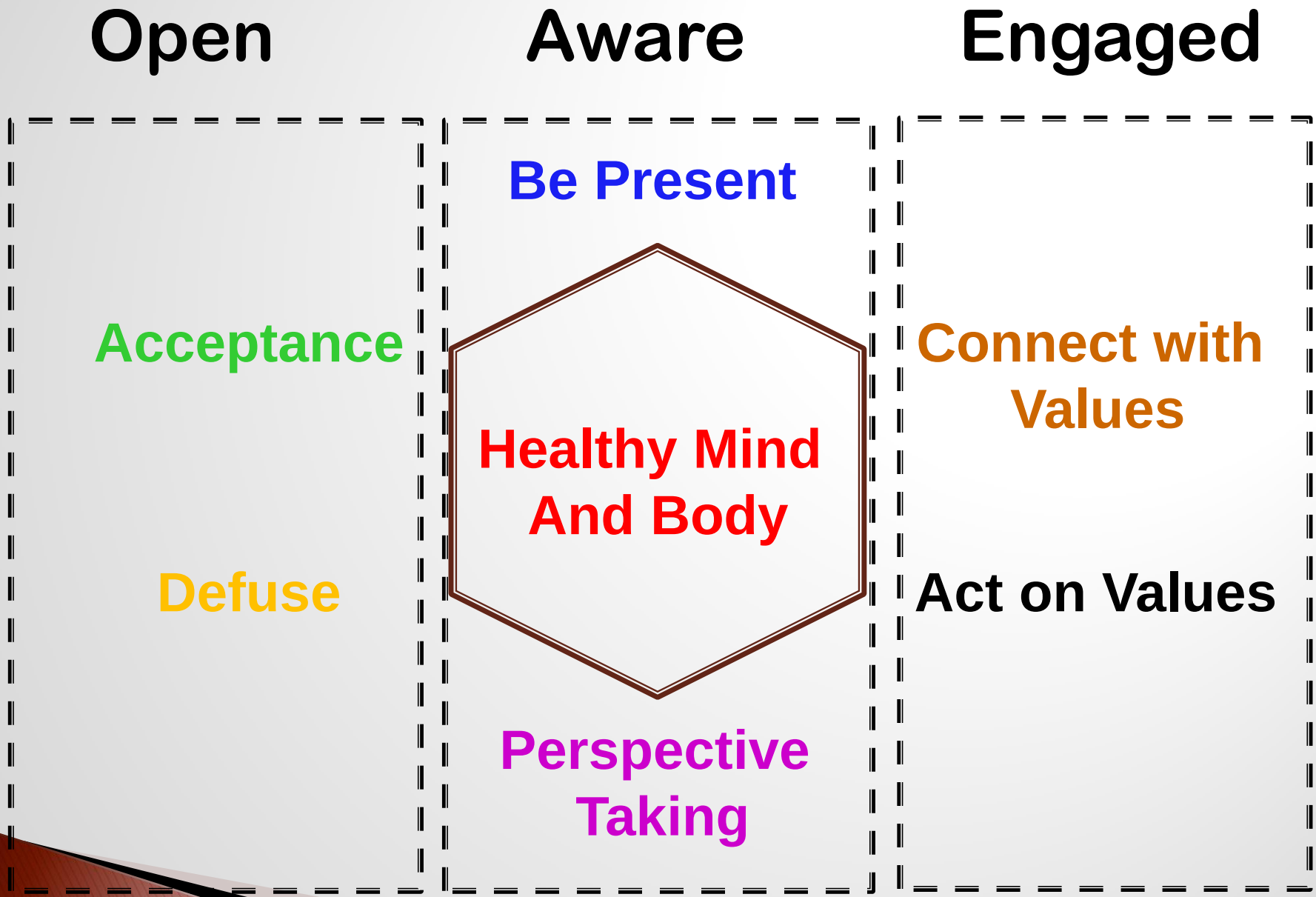
Six Reasons ACT Works with OA

1. Understanding that time is limited *(values-focused work becomes even more important)*
2. Heterogeneity (*ACT = transdiagnostic approach*)
3. Shortcomings of CBT
4. Developmental loss-gain ratio shifts may be more amenable to acceptance vs. thought changing
5. Cognitive declines with uncertain prognosis or etiology
6. Collaborative therapy process in ACT respects life-long knowledge and experience

Roberts and Sedley, 2016

ACT: Do What Matters





Stroshal (2015): FACT Workshop

Literature Review

- **Psychological Acceptance and QOL in LTC and community dwelling OA** (Butler & Ciarrochi, 2007).
- **Health –Related Anxiety** (Jourdain & Dulin, 2009)
- **GAD** (Petkus & Wetherell, 2013; Wetherell et al., 2011)
- **ACT with OA Rationale & Considerations** (Petkus & Wetherell, 2013)
- **Anxiety & Depression** (Roberts & Sedley, 2016)
- **Anxiety & Depression LTC** (Davison, et al., 2017)
- **Depression 1:1** (Karlin et al., 2013)
- **Depression Group** (Karlin et al., 2016)
- **Chronic Pain** (McCracken & Jones, 2012)
- **Chronic Pain Review Analysis** (Barban, 2016)
- **Pain ACT and SOC LTC** (Alonso-Fernandez, et al., 2016)

Special Considerations

Assessment Considerations

- Cohort-specific issues
- Collateral data from other providers, family and caregivers
- Obtain collateral on daily and cognitive fx
- Suicidality
- Substance use
- Changes in sleep architecture
- Cognitive Fusion (attitudes toward aging, chronic illness, functional impairments and disability)
- Self-As-Context (perspective of limitations and damaged self)

Assessment Measures

- **Cognitive Screening** (MoCA, MMSE, 3MS)
- **Valued Living Questionnaire** (VLQ)
- **Acceptance and Action Questionnaire** (AAQ-2)
- **Five Factor Mindfulness** (FFMQ)
- **Anxiety**: BAI, GAI, GAD-7; HAI, HADS
- **Depression**: BDI-II, GDS, PHQ-9, CSDD, HADS
- **Pain Anxiety Symptom Scale Short** (PASS-20)

**Enlarge print when possible*

Assessment Measures

- **Chronic Pain Acceptance Questionnaire** (CPAQ)
- **Pain Catastrophizing Scale** (PCS)
- **Selective Optimization & Compensation** (SOC) short form
- **World Health Organization Quality of Life** (WHOQOL-Bref)
- **Working Alliance Inventory** (WAI-SR)

- **Simplified Case Conceptualization** (Harris, 2009)

Age-Specific Challenges

- Fatigue
- Physical Health
- Sensory Changes
  - Vision loss
  - Hearing loss
- Normative Cognitive & Physiological Changes
  - Reduced processing speed
  - Reduced working memory capacity
  - Reduced abstraction

Age-Specific Challenges

- **Functional Barriers to Treatment**
  - Weather, illness, inability to find a caregiver for an ailing family member, disability, lack of transportation, financial concerns

- **Tangential/Circumstantial Thinking/Rambling**
  - **Many OA experience difficulty staying on tra**ck
  - Find "nuggets" in the rambling and can use that to hone in on values, or examples of fusion, avoidance, etc.

Age-Specific Challenges

- **Cognitive Changes**
  - Difficulty processing, encoding information efficiently
  - Difficulty retaining new information
  - Stimulus over-selectivity (inability to adapt to new information and quickly adhering to "old rules of thumb" – i.e., psychological inflexibility)
  - Metaphors & experiential exercises can often be too abstract for individuals with cognitive impairment or those that are very concrete

Adaptations for OA

- **Cognitive/Sensory changes**
  - Minimize distractions
  - Use hearing aides and/or amplifiers
  - Wear eyeglasses
  - Provide all exercises in writing (*enlarged to 14pt font*) and on colored card stock for homework
  - Simplify protocol by introducing only one experiential exercise or metaphor per session
  - Offer audio recordings of exercises and/or sessions

Adaptations for OA

- **Physical Impairments/Medical Conditions**
  - Set realistic weekly committed actions (goals) commensurate with vet's physical abilities/medical status
  - Focus on strengths vs. losses (allow vets to use their own metaphors)

- **Use of Props**
  - Ex., Chinese finger trap, white board, markers, rope, specimen cup, raisins/nuts, chess board, post-it notes, etc.,

Adaptations

- Include family and other care providers, when appropriate, to help follow-through on committed actions and other homework assignments
- Modify manualized protocols, metaphors and experiential exercises
- Brief, more selective and flexible approaches can be beneficial (e.g., FACT)

Adaptations

Repeat, Repeat, Repeat!!!

- Start each session with Mindfulness
- Invite the OA to lead, if comfortable
- Review home practice and previously covered concepts
- Repeat demonstrate newly learned concepts and homework instructions

Case Example #1

VA ACT-D Protocol Depression and Suicidal Ideation

Background

73 year old, married, Caucasian, male veteran on HBPC service referred by psychiatrist for psychotherapy to target severe, debilitating depression (refused ECT)

PMH:

- Bipolar Disorder I, MRE depressed, severe w/psychotic features
- CVA
- TIA
- Cognitive Disorder NOS
- Abnormality of Gait
- Sensorineural hearing loss, asymmetrical
- Sleep Apnea
- Low Back Pain
- Cataract surgeries
- Hypertrophy (Benign) of Prostate
- SPONDYLOS NOS W/O MYELOP
- URINARY INCONTINENCE,
- LUMBAGO HYPERLIPIDEMIA
- HYPERTENSION
- DIABETES MELLI W/ COMP TYP II
- OBESITY

Relevant Psychosocial Hx

- Forced to retire from prestigious academic career 2/2 severe back pain approximately 10 years ago
- Difficulty ambulating due to chronic pain and obesity
- Nearly completely dependent on his wife for care
- Limited social interactions
- Strained relationships with children
- Low self-esteem
- Loss of identity
- + trauma history (father's death, mother's mental illness)
- Devout practicing catholic— financially supported a friend who terminated a pregnancy

Psychiatric Treatment Hx

- Onset of severe depression in 1990's s/p MVA with residual debilitating back injury
- Suicide attempt via OD
- Failed numerous medication trials in 1990's-2000—
- *SSRI-induced manic episode—diagnosed with Bipolar I with psychotic features*
- ECT in 2000, with some benefit but continued to have disturbing intrusive thoughts/memories exacerbating depression and triggering suicidality
- Several inpatient admissions for depression w/suicidality
- Recently dc'd from inpt admission refusing another course of ECT--spending 18+hrs/day in bed---referred to me for psychotherapy
- 4 biweekly visits of combined family and individual sessions targeting behavioral activation and increased independence---transitioned to a 16 week ACT protocol

VA ACT-D Protocol:

- Values Clarification
- Creative Hopelessness
- Control as the Problem
- Willingness and Acceptance
- Defusion
- Self as Context
- Committed Action
- Values Re-clarification

Outcome

- Vet used mindfulness skills to enhance awareness of private internal experiences and acquired the ability to make contact and stay in the present moment when triggered
- Tug of War metaphor as reminder of when he was getting "in the struggle" with pain, depressive thoughts/feelings/sensations
- Flat Tire metaphor when he noticed his mind luring him into reason-giving
- Story Write/Re-write exercise to help him defuse from the story of his depression and create a life worth living in spite of his depression

Outcome Con't

- At the end of 12 weeks, the veteran made considerable progress in terms of compliance with outpatient visits, home exercise program, dietary change, weight loss, pain management and willingness to engage in pleasurable activities (e.g., travel, attending family events, scheduling daily outings w/wife, etc.). He was only in bed 8-9 hours per night to sleep and had discontinued use of Valium. He continued to use etoh, in moderation, on special occasions.

- Self-report depression screenings (BDI-II) improved considerably over the course of treatment:

  BDI-II(pre tx) = 50/63, consistent with severe sx's of depression

  BDI-II(post tx) = 8/63, consistent with minimal sx's of depression

- After 4 monthly follow-up maintenance sessions, the veteran had maintained therapeutic strides with continued use of ACT strategies to improve quality of life and remain re-engaged in a life consistent with what he values.

Limitations to Consider

- Time: A 12-16 week, weekly session, protocol is not always possible with this population
- Metaphors & experiential exercises can often be too abstract for individuals with cognitive impairment or who are very concrete
- Brief, more selective and flexible approaches can be beneficial in these cases……

Case Example #2
Brief, Flexible ACT Intervention

Health-Related Anxiety and PTSD

Background

- 64 year old, separated, Latino, male, veteran referred by primary care provider for medication management s/p relocating to RI for AVR and need for close monitoring by family

- PMH :
  - Major Depressive Disorder w/psychotic features, Anxiety Disorder NOS w/ PTSD, GAD and PD features; h/o suicidal ideation and complex trauma history
  - Alcohol Use Disorder, in fsr
  - Open and other Replacement of Aortic Valve
  - Aortic Valve Stenosis
  - Dyspnea
  - Osteoarthritis
  - Upper GI bleeding
  - Hypertension
  - Iron Deficiency Anemia
  - Hemorrhoids
  - Diabetes Mellitus, Type II, with complications

Relevant Psychosocial Hx:

- Forced to relocate from FL to RI in for open heart surgery w/ difficulty adjusting to new environs and lifestyle changes
- Separated from wife for >20 years, but not divorced—estranged
- Strong familial support—feels very guilty re: dependency
- Limited social interactions
- Low self-esteem
- + trauma history (mother's death age 2, witnessed a homicide, home robbery, job loss & homelessness, several life threatening medical crises & surgeries w/complicated recovery)

Psychiatric Treatment Hx

- 1994-30 day psychiatric admission for SI w/severe depression w/ psychotic features and agitation in the context of etoh intoxication after witnessing a homicide—sober 1994-1996; resumed drinking until cardiac surgery 2012.
- 2011-2012 outpatient psychiatry debilitating sx's of Panic and Generalized Anxiety and depressive symptoms
- 2012- Brief CBT for Panic Disorder (2 sessions)
- Transferred to PVAMC without MH follow-up—meds expired and symptoms of depression, anxiety and panic exacerbated and impacted his functioning (bordering on agoraphobia)
- Evaluated by Interim Care for med refills and psychiatry services were re-established
- Engaged in brief 6-session ACT intervention targeting exposure and re-engagement in valued living

Intervention Treatment Plan

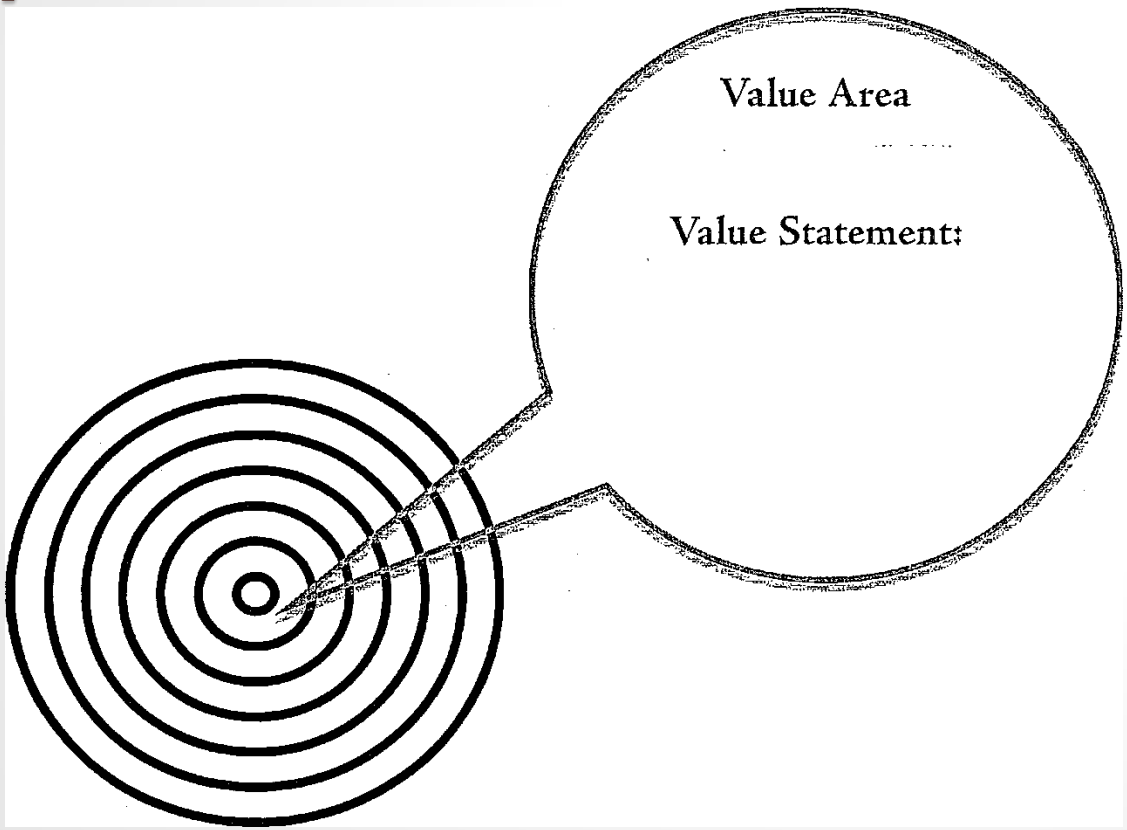
- ID struggle via ACT Case Conceptualization
- ID Core Processes to Target
- Values Clarification
- Bull's Eye Exercise
- Mindfulness & Experiential Exercises *(exposure-based interventions)*

Case Conceptualization

1. What valued directions does the vet want to move in (what is important to him)?
   - Spend time with family; Enjoy walks in the park; Watch scary movies; Be able to drive and go shopping alone
2. What stands in the vet's way?
   - Fear of having a panic attack; fear of having a heart attack; fear of being hospitalized; feeling deprived, isolated, helpless, hopeless and worthless and guilty
3. What is the vet fused with?
   - Rules—if I exercise too much I will have a heart attack; If I drive in traffic I will have an accident; If I get startled I will have a heart attack; If I eat the wrong things my blood sugar will get too high and I will have to be hospitalized…..
4. What private experiences is the vet avoiding?
   - Trauma memories and related emotions and physical sensations
5. What unworkable action is the vet taking?
   - Misinterpreting symptoms of anxiety/panic for cardiac distress; worries about not eating the right things, excessive blood glucose monitoring and misinterpreting feedback; avoiding driving alone, declining invitations to visit with family, discontinuing home exercising program, skipping meals

Harris (2009): ACT Made Simple

Bull's Eye



1	2	3	4	5	6	7
Not Consistent	Slightly Consistent	Somewhat Consistent	Consistent	Remarkably Consistent	Very Consistent	Bull's-Eye!

Adapted from
Robinson, Gould & Stroshal (2010): Real Behavior Change in Primary Care

Outcome

- Mindfulness skills to enhance awareness of private internal experiences and ability to make contact and stay in the present moment when triggered

- *Tug of War* metaphor as reminder of when he was getting "in the struggle" with depressive/anxious thoughts/feelings/sensations

- Remembered the *Taking Your Mind For a Walk* exercise when he noticed his mind getting entangled with unhelpful thoughts-- was able to get enough distance from them to choose a response that was consistent with what was important to him-- in that moment

Outcome Con't

- At the end of 6 sessions, symptoms of anxiety and depression were still present, but vet was able to relate to them much differently and re-engage in values-based activities (e.g., driving to his son's, spending time in the park watching baseball games, watching scary movies, going shopping alone, exercise program and following DM recommendations).

- Bull's Eye Ratings:

  Pre-tx = ranged from 1-2/7 (not or slightly consistent w/stated value)

  Post-tx = ranged from 6-7/7 (very or fully consistent w/stated value)

- After 2 monthly follow-up maintenance sessions, the veteran had maintained therapeutic strides with continued use of ACT strategies to improve quality of life and remain re-engaged in a life consistent with what he values.

Case Example #3
Brief, Flexible ACT Intervention
End-of-Life

Background

- 78 year old, widowed, Caucasian, male referred to HBPC for advanced cardiopulmonary illness, O2 dependent and largely homebound
- Initially admitted for *routine care*
- Referred to me by his psychiatrist for psychotherapy for "refractory depression" (i.e., severe MDD w/chronic suicidal ideation) in the context of prolonged grief

Relevant Medical & Psychiatric History

PMH:

- Coronary Artery Disease
- Hypertension
- Hyperlipidemia
- Congestive Heart Failure
- COPD (*oxygen dependent*)
- Cataract, Nuclear Sclerosis
- Colonic Polyps
- DM Type II, w/o comp
- Age Macular Degeneration, Dry
- Atrial Fibrillation
- Bronchiectasis
- Iron deficiency anemia
- Raynaud's Syndrome
- Osteoarthritis
- Idiopathic Periph Neuropathy

PPH:

- Major Depressive Disorder
- Mild Neurocognitive Disorder

Relevant Psychosocial Hx

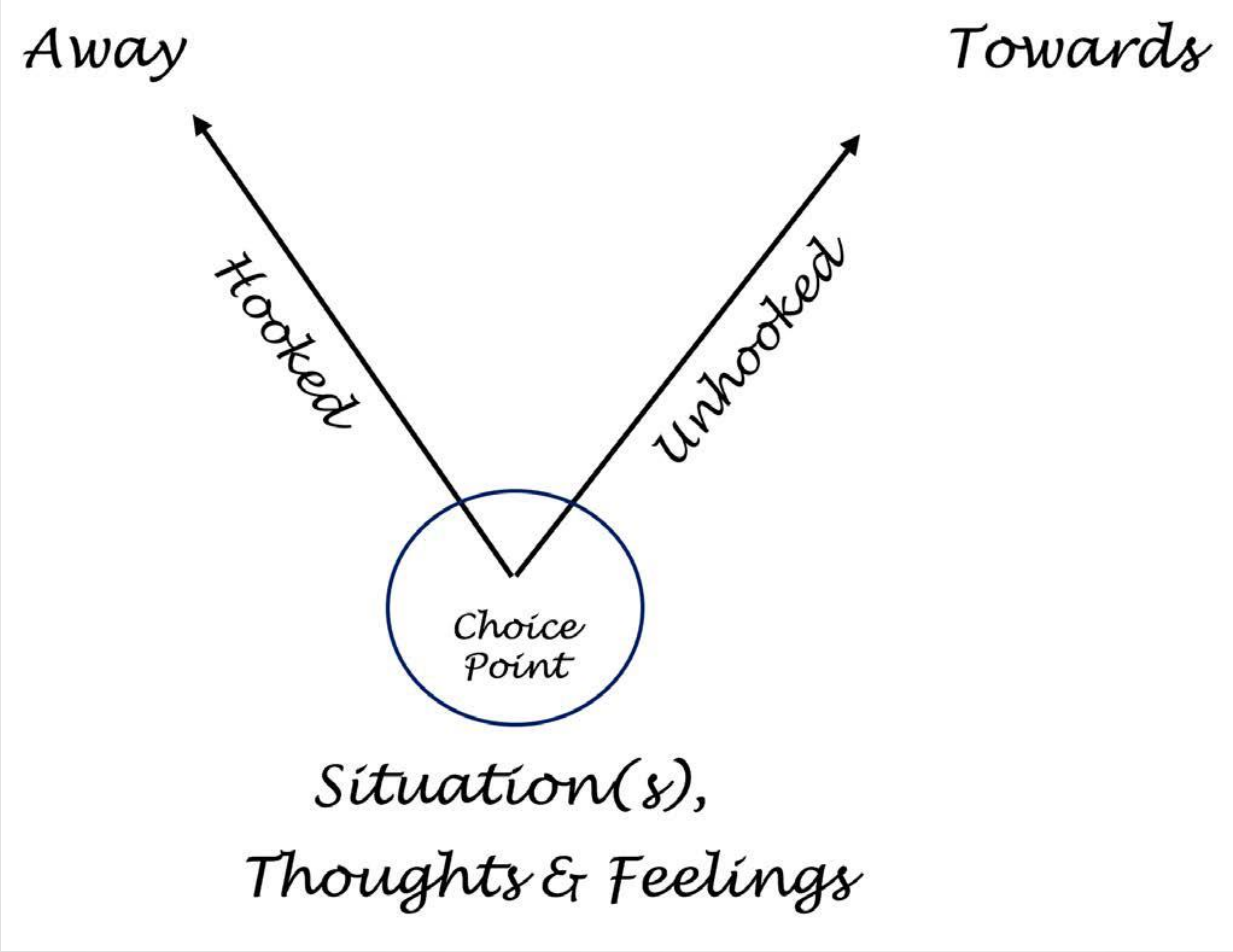
- Unremarkable childhood—youngest of 12, urban upbringing, impoverished, but "good"
- Army 1954-1956 (non-combat)
- Worked for a cable company—retired in 1970's due to back injury
- Married for 47 years-- two children--2 grandchildren
- Resides in two-family home; dtr and her family live downstairs
- Good support system
- Wife committed suicide 2003 while Vet was hospitalized in ICU for a cardiac event w/ poor prognosis
- Difficulty ambulating due to poor endurance r/t advanced COPD, CHF
- Requires assistance with ADLs
- Limited social interactions—due to poor endurance
- + Trauma history (wife's suicide; several life threatening medical crises & surgeries w/complicated recovery)

ACT at the End-of-life

Embodies the essence of ACT i.e., *Living life fully in the present moment,* requires no changes to the therapy

- Values: What is important in the time left
- Acceptance vs. Suffering (physical and emotional)
- Self-as-Context: leaving a legacy, life review
- Willingness to be present with uncomfortable experiences and…
- Take Committed Actions: preparing self and others for death

Choice Points



Choice Points 2.0 Harris (2017) actmindfully.com.au

Experiential Work

"Tell me and I forget..
Teach me and I may remember …
Involve me and I learn."

Benjamin Franklin

Vignette

82 y.o. male w/ PMH significant for diabetes, heart and lung disease (CAD, COPD) severe osteoarthritis and bilateral hearing impairment referred to you by his primary health care provider (PCP)

Presents with vague complaints of “not feeling like myself”

On brief assessment, denies changes in mood, appetite, interest in pleasurable activities, but admits to not being able to do what he used to do.

States he sleeps a bit more than usual during the day due to chronic pain and lack of energy, and endorses shortened duration of sleep at night, which he finds somewhat bothersome.

Overall, his goal is to “feel better.”

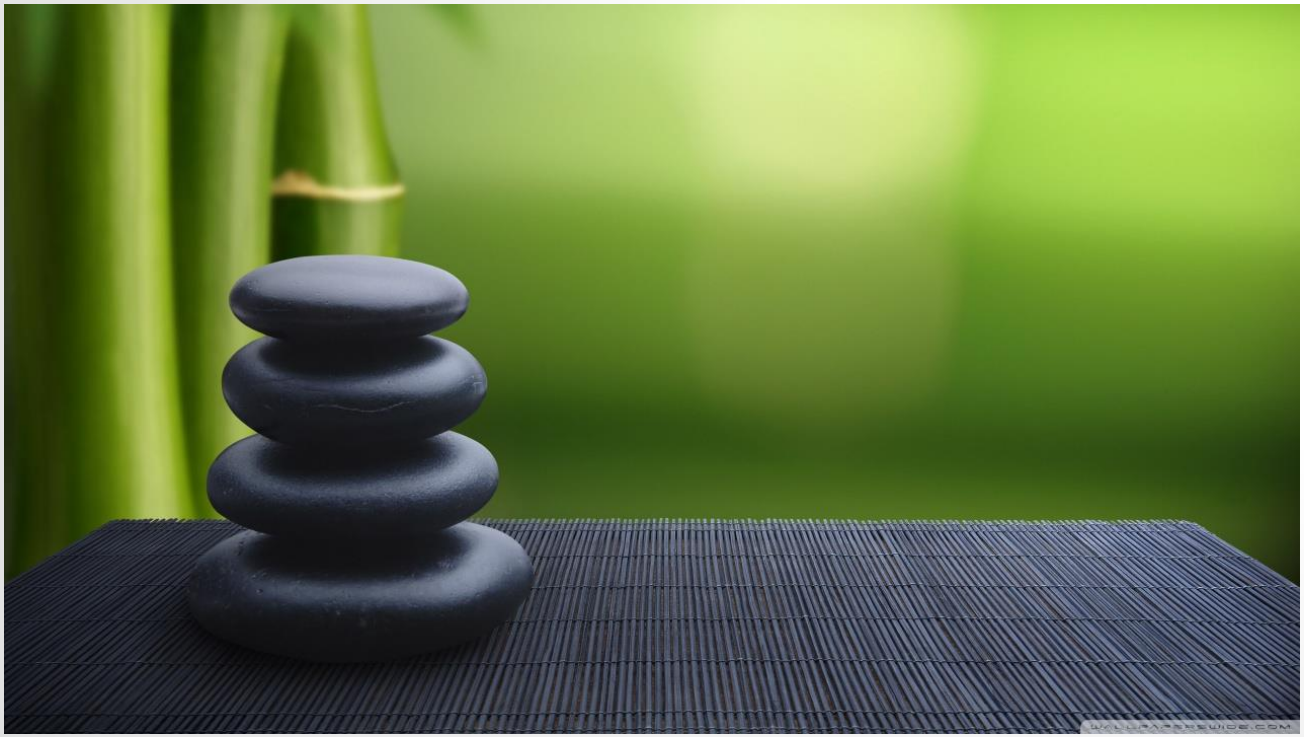
Questions

- What other assessments might you consider?
- What type of intervention(s) might you consider?
- What special considerations should you be aware of?
- What accommodations need to be made?

Stuck Points

In your work with ACT and OA where do/might you find yourself stuck?

Reflection



Thank you

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