

Cognitive Behavioral Therapy and Reminiscence Therapy in the Treatment of Depression: A Convergent Palliative Care Methodology in Geriatric Psychotherapy

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Abstract

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 American Medical Association sponsored studies. In the following essay, we will consider briefly two evidence-based treatment options available to the counseling and psychotherapeutic community dealing particularly with palliative psychotherapeutic depression, namely, Cognitive Behavioral Therapy (CBT) and Reminiscence Therapy (RT). Following this brief discussion, we will explore the integration of CBT and RT into a single treatment modality used in palliative care of the elderly suffering from debilitating depression. Five brief case studies will be presented as illustrations of its use and effectiveness as reported in recent clinical studies. As we know, biogenic depression calls for pharmacological intervention and, therefore, medical oversight. However, our interest here is rather to call attention to two proven modalities of treatment available for the non-medically trained psychotherapist dealing with palliative psychogenic depression. 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.

Keywords: Cognitive behavioral therapy, depression, geriatric psychotherapy

Geriatric psychotherapy within the health care professions (Areal, 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 Unutzer, 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).

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.

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 consider briefly two evidence-based treatment options available to the counseling and psychotherapeutic community dealing particularly with palliative psychotherapeutic depression, namely, Cognitive Behavioral Therapy (CBT) and Reminiscence Therapy (RT) (Scogin and McElreath, 1994). Following this brief discussion, we will explore the integration of CBT and RT into a single treatment modality used in palliative care of the elderly suffering from debilitating depression. Five brief case studies will be presented as illustrations of its use and effectiveness as reported in recent clinical studies. As we know, biogenic depression calls for pharmacological intervention and, therefore, medical oversight. However, our interest here is rather to call attention to two

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 along with well as 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 including such components as visual arts 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, 2012a). 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). Our interest here, however, is in CBT and RT and the convergence of these two methods of treating depression among elderly palliative care patients.

Behavioral therapies, particularly Cognitive Behavioral Therapy (CBT) and Rational Emotive Behavior Therapy (REBT), being the most used modalities of treating non-medical or psychogenic depression among older clients 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 (King, Heisel, and Lyness, 2005). 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 versus wait-list controls and no treatment at all (Floyd and Scogin, 1998; Siskin, 2002). 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 (Stanley, Wilson, Novy, Rhoades, Wagener, Greisinger, and et al., 2009).

Cognitive Behavioral Therapy (CBT) is based essentially upon the cognitive model proposing that thoughts, feelings, and behaviors are interconnected and that any improvement in the emotional life of a troubled individual can only occur when the client is able to overcome his difficulties by acknowledging, identifying, and addressing dysfunctional ideas and thoughts as well as counter-productive behaviors and distressing emotional responses to life's situations (Cappeliez, 2001). CBT suggests that thoughts, feelings, and behavior constitute a tripartite inter-dependence, each affecting the other in both positive and negative ways (Landreville, Laudry, Baillargeon, Guerette, and Matteau, 2001). Re-directing cognition, or how an individual thinks about himself, the world, and the future, constitutes the primary mechanism by means of which long-term emotional and behavioral desirable and self-affirming changes can take place. The relationship between the therapist and the client is one of aggressive interaction involving a collaborative reliance upon the development of a re-configuration and re-conceptualization of the client's worldview and strategized behavioral response to it (Barrowclough, King, Colville, Russell, Burns, and Tarrier, 2001).

Cognitive Behavioral Therapy (CBT) is a long established approach to the treatment of dysfunctional emotions, maladaptive behaviors and cognitive processes and contents through the use of a variety of goal-oriented, explicit systematic procedures. The focus is upon therapies dealing with cognitive and behavioral issues in which the patient is led to understand that the dysfunctional emotions and resulting behavior, such as debilitating depression among the elderly, has to do with the cognitive aspects of perception and recollection of the interpersonal encounters from which distorted reactions derive (Landreville, Laudry, Baillargeon, Guerette, and Matteau, 2001; Macklin and Areal, 2005). By “blending” or “collapsing” the patient’s remembered experience with a redefined or reconstructed understanding of these distorted experiences, the patient is led to a more positive and self-affirming explication of those experiences. Problem-solving approaches employed by CBT focus upon thought-processes or strategies for the patient in reconfiguring otherwise negative and disempowering remembrances and recollections towards more nurturing and promising understanding. CBT has consistently demonstrated its effectiveness in treating such emotionally charged conditions as mood swings, anxiety, personality dysfunctions, eating disorders, substance abuse, and most effective of all in the treatment of debilitating depression. Evidence-based verification of effectiveness is common, and CBT has become the most favored approach to symptom-based diagnoses in psychodynamic treatment plans (Chambless and Hollon, 1998; Gatz, Fiske, Fox, Kaskie, Kasl-Godley, and McCallum, 1999; Bartels, Dums, Oxman, et al., 2002).

In addition to Cognitive Behavioral Therapy, we are suggesting that it be blended with Reminiscence Therapy (RT) for a creative composition of both cognitive behavior and memory. RT is recognized by the American Psychological Association as “the use of life histories – written, oral, or both – to improve psychological well-being. The therapy is often used with older people.” Consistently effective by evidence-based studies in palliative care of the elderly, RT has been most beneficial in the treatment of debilitating depression among the elderly particularly in palliative care settings. What is called the Webster Reminiscence Functions Scale (RFS) looks particularly at eight specific reasons why older people have a tendency to reminisce, and the purpose of RT is to address these reasons with therapeutic intent. They include boredom reduction, bitterness revival, preparation for death, conversation, identity, intimacy maintenance, problem solving, and teaching/informing others (Morgan, 2011; Morgan, 2012d; Morgan, 2012e). RT has been consistently beneficial in psychotherapeutic usage, and what we are suggesting here is combined with CBT’s emphasis

upon reconfiguring cognitive behavioral dysfunctions such as distorted recollections. The emotional benefit for the palliative care elderly patient has proven significant (Morgan, 2013a).

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. 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. There is, however, a consistency of characteristics of the various definitional parameters of the term and its usage. There is a systemic 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 usage of RT in the treatment of dementia showing effective results in enhancement of self-esteem, improved communication skills, self-worthy 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 facilities, 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 (Knight and McCallum, 1998; Knight, 1999).

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 onset 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 relationship 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 (Morgan, 2015). Reminiscence Therapy (RT) is proving to be one of those which is providing evidence-based validation of its effectiveness.

As clinicians are discovering, when this modality of treatment is supplemented with the use of “technologies” as explored by Lazar and team (Lazar, Thompson, and Demiris, 2014), such things as photographic artifacts as well as period-based music used in the facilitation of social interaction within groups as well as individual treatment plans is gaining support within the counseling and psychotherapeutic communities, the positive results are most impressive. 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 (Pasacreata and Pickett, 1998). 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 behavioral 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 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, i.e., 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 treatment modality 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 increased effectiveness for group therapy beyond its already validated effectiveness with individuals.

The blending of treatment modalities in the care of the elderly suffering from depression is most common and what is being suggested and illustrated here is simply one instance of a combining of two treatment modalities, CBT and RT, with a heavy emphasis upon the palliative care of the elderly patient suffering from debilitating depression (Satre, Knight, and David, 2006). As neither CBT nor RT are pharmacologically based treatments, we will address ourselves strictly to the psychogenic depressive symptoms of the elderly in palliative care with an emphasis upon the existential nature of care, namely, the goal is not cure but nurture of the terminally ill older patient. Both cognitive behavior and the act of reminiscing constitute a paralleling of reflective self-consciousness, the former addressing an

understanding of the behavioral what and why and the latter addressing the recollection and memory of life events. To combine both the behavioral matrix of self-awareness with reflections upon past events seems a natural coupling of two conscious processes operative within the human mind and susceptible to therapeutic intervention. Since CBT strives to assist the patient in understanding an event or occurrence in his/her life which has produced a depressive reaction, the aim is to revisit that event with the aim of reconfiguring it or reconstructing it with a more positive understanding and outcome. Reminiscence Therapy, likewise, encourages the patient to reflect upon past events and occurrences with the aim of identifying those which offer nurture and positive memory responses and to de-sensitize those events which conjure upon negative feelings and emotions. In both instances, CBT and RT, the aim is to so reconstruct the remembered past such that it serves as a repertoire or reservoir of nurturing memories.

Illustrative of the use and effectiveness of this combination of CBT and RT approaches the case of Mrs. Williams, a nursing home patient in her mid-80s suffering from acute and near debilitating depression. Other complicating health issues include high blood pressure, diabetes, and arthritis. A retired librarian for some twenty-plus years, Mrs. Williams came to the nursing home after falling in her home where she lived alone. The decision was made for institutional care in conjunction with family members (all distant cousins as she was widowed with no children). In meeting with her over several sessions, the therapist struggled with finding the “door of happy memories” through which to follow Mrs. Williams. Finally, during the third clinical session, some passing reference was made to her childhood farm life and swimming with her girlfriends in the cow pond behind the barn. As this passing reference seemed to cause her to pause and smile as she was formulaically reciting her life’s story to the therapist, it became clear to the observing therapist that she enjoyed the memory and might enjoy elaborating upon it. The result was a meandering recollection of her childhood experiences with her friends on the family farm which, she said, “I haven’t thought of in years.” Subsequent sessions always harped back to these happy memories and provided a substance to her solitary reflections beyond the therapy sessions.

Often, the geriatric patient needs assistance in conjuring these past episodes of happiness and the therapist then can employ what I have chosen to call “memory suggestions,” viz., asking the individual to backtrack consciously in search of illustrative events in his or her life to which they themselves attribute a blissful and happy experience. However, an important key here for the therapist to keep in mind is “stress avoidance,” that is,

redirecting the individual away from remembered events in their past which clearly, by facial expression or voice intonation, suggest stress or anxiety or unhappiness (Morgan, 2010). Family history is quite frequently the source of these happiness episodes, but the therapist is advised to watch carefully lest the family history stories drift downward into negative memories.

It is crucial that the therapist keep in mind the logotherapeutic agenda lest one imagine that the purpose and goal of the therapeutic session is to search out the “meaning and purpose of life” yet to be lived. With the older and elderly patient, the acutely practical nature of the existential utility and viability of therapy must always be kept in the forefront of the therapeutic encounter. Though sometimes a challenge in dealing with the elderly (geriatric dementia often manifests itself in the individual’s disinclination to converse), the therapist must employ what I have chosen to call “points of conversation” as an impetus and incentive for the geriatric patient to engage the therapist in the quest for existential episodes of happiness (Morgan, 1987). Places, times, and people constitute for me the three fundamental arenas within which the patient may find these points of conversation leading to the “discovery” and “revisiting” of happiness episodes in their earlier life.

Another example of this geriatric psychotherapeutic approach is the case of Dr. Watson, a retired philosophy professor living alone in his home as a widower having two adult children living far away. Dr. Watson is in his late 80s, was once a nationally recognized scholar, author of several books, but these days finds reading increasingly difficult owing to glaucoma while writing is virtually impossible due to arthritis in both hands. Reduced to sitting on his expansive front porch when weather permits and before the fireplace otherwise, Dr. Watson has sunk into a debilitating depression resulting in a consistent failure to eat regularly or to converse over the phone with friends and family. A concerned son precipitated the contact with a therapist who made an initial home visit, finding the above situation. Dr. Watson had essentially “given up,” as he put it, because of an inability to read or write which was his life’s work and passion. When the therapist encouraged the professor to “tell me about your life’s work,” Dr. Watson commenced slowly and deliberately rattling off his educational background, teaching appointments, books written, conferences attended, all with little passion and near expressionless. However, when the therapist asked about specific colleagues mentioned in the monotone narrative, he noticed that the patient became somewhat animated, enthusiastic, even excited to relate story after story involving colleagues, happy stories, fun stories, all leading to an extremely productive journey through time and people of

importance. Subsequent sessions centered upon the same topics with the result that Dr. Watson began calling old friends, inviting other retired colleagues in town to come for morning coffee and chat. The door of happy memories had been opened and entered and Dr. Watson's life took on renewed vitality.

One of the greatest challenges for the therapist is to acknowledge and own the inevitable reality of the brevity of life left to the elderly patient. The palliative therapeutic goal here is clearly not some form of contrived cure for what might be the presenting symptoms of depression which is most commonly the driving force in seeking help for the patient either by the patient or the family or residential institutional staff responsible for caring for the patient. A cure certainly is not what is sought here, but rather, beyond and after the notion of a cure for the aged patient, there is an urgent need for the identification of the rightful place for palliative care in such situations. A quest for existential happiness, episodic joys in happy memories, constitutes the driving force in the therapeutic encounter with the geriatric patient who most commonly is suffering from depression.

A concluding illustration of the value of geriatric psychotherapy and its use in existential counseling of the depressed patient is the case of Miss Horton, an elderly spinster school teacher from a small town, whose life had been synonymous with teaching elementary school children, living in the background, watching them grow up, move away, establish families, and launch careers. Now nearly 90 years old residing in an assisted living facility in her little town, she had drifted into depression owing to a lack of social stimulus (most other residents were suffering from acute and severely debilitating geriatric dementia). Her health had declined gradually owing to heart problems and towards the end of her life, she had taken to the bed and was less and less willing to converse with even the nurses. The nursing director called in the therapist (based on the therapist's reputation in dealing with geriatric dementia), and from the beginning the initial encounter was fruitless, boarding on hopeless. As the therapist explored Miss Horton's social life through interviews with nursing staff who knew the patient's personal history and in the therapist's search for the "magic door" that would introduce happy memories and reflective thoughts of joys gone by, it occurred to him that since her life had been lived for the children she taught, why not get some of those children, now adults, to come say goodbye to her in her closing days of life. It worked wonders. Through the local school, the therapist was able to contact several of her past students, now parents and successful people, to come for a visit. Since most people are uncomfortable visiting someone on their death bed, the therapist always arranged to be

present, coaching the visitor to help Miss Horton remember episodes in the classroom and on the playground in which she was a major player and to share with her, as she lay mute but alert, the stories of their own lives as they left school and entered the world, always with reference to her contribution to their own personal lives. The results were remarkable, not that she lived much longer, for she did not, but during the closing weeks of her life, she became conversant, sitting up in bed, asking about this student and that student, remembering to the therapist more and more “happy moments” in her teaching life that brought a twinkle to her eyes and a smile on her face.

A convergent palliative care approach to geriatric psychotherapy has been explored for some time now within the medical community, particularly among primary care institutions (Akechi, 2010; Arean and Ayalon, 2005). The blending of Cognitive Behavioral Therapy and Reminiscence Therapy in the treatment of geriatric depression is increasingly becoming a reality and the evidence-based validation of its effective use is consistently showing results.

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