Psychiatr. Pol. 2015; 49(6): 1373–1377
PL ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
www.psychiatriapolska.pl
DOI: http://dx.doi.org/10.12740/PP/59543

Letter to Editor

Is it possible to support cognitive behavioral therapy, led remotely, by determining so-called therapeutic tasks?

Andrzej Brodziak[1], Alicja Różyk – Myrta[2], Agnieszka Wolińska[2]

[1] Institute of Occupational Medicine and Environmental Health, Sosnowiec
[2] Institute of Nursing of University of Applied Sciences, Nysa

Summary

In this letter to the Editor, the authors comment recent publications about the attempts to remote realisations of Cognitive Behavioural Therapy (CBT) in the treatment of anxiety disorders in elderly. The distinguished clinical situation is a part of a wider problem that can be named as "global crisis of aging populations". The use of CBT in many geriatric clinical situations is very effective; however, such therapy is very time-consuming, what hamper its widespread utilisations in practice. The authors therefore propose to support this form of treatment by determining so-called 'therapeutic tasks'. They derive the rationale for the proposed method from the analysis of the acting elements of various, new forms of CBT in combination with the analysis of sources of psychological resistance (resilience) of those older people who are doing well. The essence of the method proposed by the authors is assigning tasks which facilitate to patients' remembering of their 'trajectory of life'. The patients are then much more aware of unresolved psychological conflicts. The next tasks aid the patients to search for solutions to such mental problems and create a balanced imagery of their lives.

Key words: anxiety disorder, geriatric mental health crisis, cognitive behavioural therapy, theory of mind, therapeutic tasks

Brenes et al. proved that it is possible to deliver the Cognitive Behavioural Therapy (CBT) to older adults, with generalised anxiety disorder, by telephone and that this kind of therapy is more effective than so called Nondirective Supportive Therapy [1]. The detailed description of this randomised clinical trial enables to realise the effort necessary for the experimental delivery of CBT sessions.

Eric J. Lenze, in the accompanying editorial discussion, clearly justifies the need and usefulness of psychotherapy delivered to older people, discussing the possible

solutions for actual "geriatric mental health crisis" [2]. He writes "we need geriatric mental health treatment packages in modern technology to extend their reach while retaining effectiveness". He remarks, however, that CBT-T "is just as time-intensive as in-person therapy" and continues, stating "doing the demographic math, it seems that we must move toward more nonconsumable (i.e., computerised) interventions to fill the gap between consumer need and provider availability" [2].

The needs and usefulness of CBT, provided to older people with anxiety was reviewed by Chojnacka [3]. She emphasised that the treatment of generalised anxiety disorder by anxiolitic medicaments is not sufficient and that the health care in the case of just this syndrome should be assisted by some forms of psychotherapy [3]. Chojnacka anticipated the development of different modifications of CBT adjusted for elderly people [3].

Wilkos et al., few years later, discussed some of such new modifications of CBT [4].

Other authors discuss other, newer kinds of psychotherapy [5, 6, 7]. Some authors recently noticed the significance of recalling of past attitudes of parents, what is important to work out a balanced view of own life [8, 9].

The applications of most of these therapeutic procedures indeed require considerable expenditure of time and personal involvement of therapists. We recently gathered our experiences in the realm of the evaluation of risk factors of cognitive impairments and trials of its modification among the participants of so-called University of Third Age [10]. This allows us to suggest a partial solution for the problem of excessive time needed for application of CBT. The presentation of our proposals we should, however, precede by emphasising the essence of CBT. It is important to realise, that CBT is focused on problem solving [5].

In their study Brenes et al. [1] compared two kind of psychotherapy "delivered by telephone" and stated that their procedures of CBT consisted on: "recognition of anxiety symptoms, relaxation, cognitive restructuring, the use of coping statements, problem solving, worry control, behavioural activation, and exposure therapy. The Nondirective Supporting Therapy (NST) provided by telephone consisted only on the creation of "a warm, genuine, accepting atmosphere and supportive relation".

The above-mentioned considerations of Wilkos et al. emphasise that so-called Cognitive Remediation Therapy (CRT) improves the methodology of reasoning, in other words, improves planning and control of mental operations, in particular, increases awareness of own cognitive processes and improves the ability to change own beliefs [4]. CRT is used as an introduction to the essential CBT sessions. In turn, so-called Mindfulness-Based Cognitive Therapy (MBCT) has roots in Far Eastern techniques of contemplation. This kind of training increases ability to remain in the present time and ability to experience own emotions and signals from inside of the body. MBCT can be an introduction to one of the "third wave" of new kinds of CBT, it means to so-called "Acceptance and commitment therapy" (ACT) [4]. ACT therapists encourage patients to accept and focus on the pursuit of their personal values. They help patients to make choices consistent with their beliefs. So-called Social Cognitive and Interaction Training (SCIT) is also a new therapeutic procedure [4]. At the beginning this technique facilitates the recognition of emotions and understanding of getting rid

of blaming others and assigning them malevolent intentions as well as prevention of drawing conclusions without thorough analysis of situation. It leads to the improvement of so-called theory of mind. This relatively new concept of neural structures, called the theory of mind (ToM), is the ability to consider own and other's mental states, like beliefs, intents, desires, knowledge and to understand that they are usually different in minds of other human beings.

It is also important to know sources of resilience in elderly people. Recently some studies on resilience have been published [11, 12]. Janssen et al. conclude that the main sources of strength relay on: "beliefs about one's competence, efforts to exert control, the capacity to analyse and understand ones situation and also on pride about ones personality, acceptance and openness about ones vulnerability, the anticipation of future losses, mastery of practicing skills, the acceptance of help and support, having a balanced vision on life, not adapting the role of a victim and 'carpe-diem attitude'" [11]. The quality of social interactions is also important here, especially so-called "power of giving". Rutten et al. in turn, write that resilience depends on: "secure attachment, experiencing positive emotions and having a purpose in life". They claim that reward experiences are of key importance [12].

So, there is a certain consistency between the objectives of particular forms of CBT and determinants of resilience of older people.

The key to reduce time-consuming use of CBT is the possibility to increase the activity of neural structures, called the theory of mind, through setting and self executing specific tasks.

The real, practical application of the proposed method is possible on the assumption that:

- A therapist who is going to help a certain patient should get to know him personally and: (a) settle somatic determinants of his health; (b) issue him or point to the source of the questionnaires, facilitating to determine the details of his "trajectory of life (health)" [10]; (c) establish for the patient a "data file", which notes outsourced supporting tasks and memorises the patient's reactions;
- The process of the initial diagnosis and subsequent therapy is already "structuralised". The causes of anxiety, depression and other syndromes can be systematised according to the most frequent adverse life events. Such negative elements of life trajectories should be linked to the possible "counteracting advices", and next – should be transferred to patients by the recommendation of tasks augmenting the understanding of the existing problems, increasing resilience, facilitating problem solving [3–7].

The essence of the proposed method consists on designation of several series of tasks that should be performed by the patient. The first, "diagnostic" series concerns the activities helping the realisation of own "trajectory of life", creating in patient's mind a chain of live events, causing the negative mental changes. Examples of such tasks would be a recommendation to: (1) begin to write patient's own biography; (2) perform particular trips, which will enhance recalling of facts from own past (so called

"personal pilgrimage"). These tasks are excellently illustrated by novels of Nobel Prize winner Partick Modiano ("Un cirque passe", "Quartier perdu", "La petite bijou").

The second series of tasks concerns the psychological neutralisation of still remembered adverse life events and generation of so-called "balanced view of own life" [11]. Other task should facilitate the problem solving [5, 6], problem adaptation [7], and establishment of ways for possible life rewards [12].

These "therapeutic" tasks could consist especially on the recommendation of reading of very particular novels. It is already proved that reading adjusted literary fiction improves not only the understanding of personal situations but usually enhances the overall empathic attitude [13]. E.g. the short story, tuned to the feelings evoked by a daughter, who was abandoned by a mother, was written by Alice Munro ("Silence" – short story printed in the volume "Runaway", Vintage Books, 2013). Often, a desirable mental effort important to obtain a balanced assessment of one's life requires restructuring of recalling memories and judgments about his family. An example of a book facilitating this task is e.g. John Irving's novel "The Hotel New Hampshire" (Ballantine Books, 1997).

In order that our proposal to support psychotherapy, by setting "therapeutic tasks" could be applied on a larger scale, it would be necessary to convince many psychiatrists, clinical psychologists, general practitioners and nurses for participation in co-creation of a record of data set of pertinent literature pieces, useful for therapy found in cultural resources. Editors of medical journals should express their concern and acquiescence for presenting proposals about the found and verified effective tools of "indirect psychotherapy" [14].

References

1. Brenes GA, Danhauer SC, Lyles MF, Hogan PE, Miller ME. *Telephone-delivered cognitive behavioral therapy and telephone-delivered nondirective supportive therapy for rural older adults with generalized anxiety disorder: a randomized clinical trial*. JAMA Psychiatry 2015; 72(10): 1012–1020.
2. Lenze EJ. *Solving the geriatric mental health crisis in the 21st century*. JAMA Psychiatry 2015; 72(10): 967–968.
3. Chojnacka M. *Przegląd badań efektywności terapii poznawczo-behawioralnej w zaburzeniach lękowych uogólnionych u osób w podeszłym wieku*. Psychiatr. Pol. 2009; 43(5): 557–569.
4. Wilkos E, Tylec A, Kułakowska D, Kucharska K. *Najnowsze kierunki terapeutyczne w rehabilitacji pacjentów z zaburzeniami psychicznymi*. Psychiatr. Pol. 2013; 47(4): 621–634.
5. Simon SS, Cordás TA, Bottino CM. *Cognitive Behavioral therapies in older adults with depression and cognitive deficits: a systematic review*. Int. J. Geriatr. Psychiatry 2015; 30(3): 223–233.
6. Alexopoulos GS, Raue PJ, Kiosses DN, Mackin RS, Kanellopoulos D, McCulloch C. et al. *Problem solving therapy and supportive therapy in older adults with major depression and executive dysfunction: effect on disability*. Arch. Gen. Psychiatry 2011; 68(1): 33–41.

7. Kiosses DN, Ravdin LD, Gross JJ, Raue P, Kotbi N, Alexopoulos GS. *Problem adaptation therapy for older adults with major depression and cognitive impairment: a randomized clinical trial*. JAMA Psychiatry 2015; 72(1): 22–30.
8. Sobański JA, Klasa K, Rutkowski K, Dembińska E, Müldner-Nieckowski Ł, Cyranka K. *Parental attitudes recollected by patients and neurotic disorders picture – sexuality-related and sexuality-unrelated symptoms*. Psychiatr. Pol. 2013; 47(5): 827–851.
9. Wajda Z. *The perception of the relationship between parents, patterns of attachment and psychopathological symptoms in girls in late adolescence*. Psychiatr. Pol. 2013; 47(5): 853–864.
10. Brodziak A, Różyk-Myrta A, Wolińska, Ewa Ziółko. *The structuralized interview for evaluation of medical and mental risk factors, which predispose to the early cognitive impairment and dementia*. Med. Sci. Monit. 2015 (w recenzji).
11. Janssen BM, Van Regenmortel T, Abma TA. *Identifying sources of strength: resilience from the perspective of older people receiving long-term community care*. Eur. J. Ageing 2011; 8(3): 145–156.
12. Rutten BP, Hammels C, Geschwind N. *Resilience in mental health: linking psychological and neurobiological perspectives*. Acta Psychiatr. Scand. 2013; 128(1): 3–20.
13. Kidd DC, Castano E. *Reading literary fiction improves theory of mind*. Science 2013; 342(6156): 377–380.
14. Jeste DV, Palmer BW, Rettew DC, Boardman S. *Positive psychiatry: its time has come*. J. Clin. Psychiatry 2015; 76(6): 675–683.

Address: Andrzej Brodziak
Institute of Occupational Medicine and Environmental Health
41-200 Sosnowiec, Kościelna Street 13