A Community Outpatient Model for the Treatment of Depression

The Baycrest Psychiatric Day Hospital Intervention Training Manual

Edited by Dr. Ken Schwartz, MD, FRCPC and Dr. Robert Madan, MD, FRCPC
Department of Psychiatry

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Dr. Ken Schwartz
Department of Psychiatry
Baycrest
3560 Bathurst St.
Toronto, ON   M6A 2E1
Email: kschwartz@baycrest.org

Dr. Robert Madan
Department of Psychiatry
Baycrest
3560 Bathurst St.
Toronto, ON   M6A 2E1
Email: rmadan@baycrest.org

<u>Contributors</u>

Andreah Barker, M.A. Dance, B.A Dance
Dance Movement Therapist, Baycrest Psychiatric Day Hospital for Depressed Seniors

Marni Bleeman, B.A., BSc. O.T., O.T. Reg. (ONT)
Occupational Therapist, Baycrest Psychiatric Day Hospital for Depressed Seniors

Judi Cohen, M.S.W., R.S.W.
Social Worker, Baycrest Psychiatric Day Hospital for Depressed Seniors

David K. Conn, M.B., B.Ch., B.A.O., FRCPC
Vice President of Education & Director
Centre for Education and Knowledge Exchange in Aging, Baycrest
Professor, Department of Psychiatry, University of Toronto

Sofia Klim, R.N., C.N.O.
Nurse, Baycrest Psychiatric Day Hospital for Depressed Seniors

Robert Madan, MD, FRCPC
Psychiatrist-in-Chief & Executive Medical Director, Department of Psychiatry, Baycrest
Medical Program Director, Baycrest Psychiatric Day Hospital for Depressed Seniors
Assistant Professor, Department of Psychiatry, University of Toronto

Tamara Oomen, S.S.W.
SW student, York University in collaboration with Baycrest Psychiatric Day Hospital for Depressed Seniors

Maxine Parvovnick, R.N., BScN.
Nurse, Baycrest Psychiatric Day Hospital for Depressed Seniors

Bibi F. Rahman, R.N., BScN., M.N.
Nurse, Baycrest Psychiatric Day Hospital for Depressed Seniors

Marsha Rosenberg, MD, FRCPC
Psychiatrist, Baycrest Psychiatric Day Hospital for Depressed Seniors
Lecturer, Department of Psychiatry, University of Toronto

Ken Schwartz, MD, FRCPC
Psychiatrist, Baycrest Psychiatric Day Hospital for Depressed Seniors
Assistant Professor, Department of Psychiatry, University of Toronto

Katie Sheehan, PGY-III, Department of Psychiatry, University of Toronto

Christina Van Sickle, M.S.W., R.S.W.
Professional Practice Chief of Social Work, Baycrest

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Chapter 1

Introduction

Given the extraordinary current and projected growth of our elderly population and the relationship between wellness, perceived isolation, and social engagement (Cornwell & Waite, 2009; Croezen et al., 2009), the use of groups and group therapy is indicated with this population. The depressed elderly, the focus of this manual, are often socially isolated and without adequate social supports. Higher levels of social support predict a significantly improved course in the treatment of depression in the elderly (Sherbourne et al., 1995).

The goals of optimal treatment models include symptom reduction, minimizing the risk of relapse and recurrence, improving the quality of life for clients, maintaining independent functioning, improving physical health, reducing mortality from medical causes and suicide, and decreasing health care costs (NIH Concensus Development Panel, 1992). Day Hospitals are an example of an approach that can meet these goals. They offer intensive and structured clinical services within a stable therapeutic milieu that usually employs group therapy, biological psychiatry, milieu principles and a systems orientation (Ogrodniczuk & Steinberg, 2005).

The six principles of effective milieu therapy are as follows: (a) encouraging responsibility in clients, (b) fostering mutual respect between staff members and clients, (c) requiring client participation in the treatment of clients, (d) collaborating with higher-order systems, (e) judiciously using authority, and (f) operating multiple groups at multiple levels throughout the system (Piper et al., 1996). Groups have been a central feature in the history of therapeutic communities and of psychiatric day hospitals.

The Baycrest Psychiatric Day Hospital for Depressed Seniors (PDH) combines the use of non-psychotherapy groups and group therapies providing opportunities to acquire and develop interpersonal and communication skills leading to the necessary self-awareness to generate and sustain social integration (Leszcz, 1997). The PDH recognizes the potential limitations of brief interventions for chronic depressive conditions because depression in older adults is commonly associated with chronicity and undue suffering for clients and their families (Leszcz, 2002). It is thereby designed to provide acute, continuation, and maintenance treatment to address symptom relief and interpersonal, intrapsychic, and developmental issues to best ensure the durability of gains. It offers an alternative in the provision of both a short-term and long-term outpatient model of care to help meet the growing demand for service from the depressed elderly residing in the community (Schwartz, 2004).

The goals of our manual include:

1) To increase the awareness that depression in older adults is a major public health concern because it is associated with high prevalence, morbidity and health care cost.

2) To help in the development of effective treatment goals for depressed older adults which assumes an even greater importance with an ever-increasing but often underserviced aging population struggling to cope with multiple losses and psychological stressors.

3) To disseminate the clinical knowledge and expertise that the Baycrest Psychiatric Day Hospital has accumulated in over 25 years of operation.

4) To assist other health care professionals in developing, organizing and implementing a similar and effective multi-component and multidisciplinary psychiatric day hospital or more intensive outpatient community treatment program.

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Chapter 2

Depressive Disorders in Late-Life

A variety of systems can be used to classify psychiatric disorders. In Canada, the DSM-IV-TR (American Psychiatric Association, 2000) is used for this purpose. The differential diagnosis of depressive symptoms in the elderly includes the following: Major Depressive Disorder, Dysthymic Disorder, Bipolar Depression, Depressive Disorder Not Otherwise Specified, and Mood Disorder due to a general medical condition (American Psychiatric Association, 2000). The following is a brief review of the epidemiology, etiology, phenomenology, and treatment of depressive disorders in the elderly.

Prevalence rates for depressive disorders among older adults vary considerably depending on the method used to assess depression, severity of illness included and the setting. Community based studies of individuals 65 years of age or older suggest that 1% suffer from Major Depression and another 3% from Dysthymic Disorder (NIH Consensus Conference, 1992). If all older people with depressive symptoms are included, the rates climb to between 10 and 15%. There is some evidence that under-reporting of depressed mood by older adults may be responsible for somewhat lower than expected rates (Gallo & Lebowitz, 1999). It is also worth noting that a recent meta-analysis of community-dwelling adults over age 75 found higher prevalence rates for major depression ranging from 4.6 to 9.3% (Luppa et al., 2010). Rates of major depression are much higher in medical settings, including primary care clinics and among hospitalized clients. In a recent review of studies in long-term care homes, the median prevalence of major depression was 10% and the median prevalence of depressive symptoms was 29% (Seitz, Purandare & Conn, 2010). An increased risk of depression is associated with female gender, living alone, poor social support, caregiver burden, prior history of depression, recent bereavement, cognitive problems, alcohol abuse or dependence, medical illness and physical disability. There is evidence that depression among the elderly is often under-recognized and under-treated (Katon & Schulberg, 1992). It is also important to note that rates of completed suicide are especially high in older populations, particularly among white males.

A Major Depressive Episode (MDE) is marked by the presence of depressed mood or a lack of interest accompanied by at least 4 other symptoms of depression (see Table 1). The diagnosis of Major Depressive Disorder (MDD) cannot be made when the episode is due to the direct effects of a substance or medical condition, or it occurs in a client with Bipolar Disorder. This illness can originate in early or late life. Like many mental illnesses, MDD can present for the first time at a young age and is often accompanied by a family history of the illness. However, MDD can develop for the first time at an older age. For these clients it is especially critical to rule out reversible conditions that can present with depressive symptoms. There are medications that are often

prescribed to seniors that can have a depressogenic effect. Some examples include benzodiapzepines, beta-blockers, and narcotic analgesics. In addition, a variety of medical conditions are strongly linked to MDD such as stroke, myocardial infarction, and Parkinson 's disease. Other conditions present with symptoms suggestive of MDD such as hypothyroidism, vitamin B12 deficiency, and anemia as a few examples. Health care professionals assessing an elderly client with a first episode of depression in late life must carefully assess for these types of conditions.

Dysthymic disorder is a "low grade" depression that does not cause the same distress or impair functioning as a MDE. Criteria are mostly similar, although fewer symptoms are required to make the diagnosis. Also, the time course is a minimum of 2 years and there is early and late onset. Another phenomenon is sub-threshold or minor depression. This is not described in the DSM-IV-TR, yet it is quite prevalent and written about in the medical literature. This diagnosis is made when there are depressive symptoms that do not meet the threshold for a MDE or the time criteria for Dysthymic Disorder and when an Adjustment Disorder with Depressed Mood is ruled out. In the DSM-IV-TR classification system, the diagnosis for "minor depression" is Depressive Disorder Not Otherwise Specified. The presence of "minor depression" is associated with a 10-25% conversion rate to MDE in 1-3 years (Cuijpers & Smit, 2004). One study examining older adults specifically concluded that approximately 8-10% of older persons with minor depression developed major depression per year and its presence appears to negatively affect quality of life and health (Meeks et al., 2011).

Bipolar Disorder is an illness marked by the presence of at least 1 manic or hypomanic episode which is not induced by antidepressants or substances. These episodes involve expansive, elated, or irritable mood accompanied by other symptoms (see Table 2). Clients suffering from Bipolar Disorder also develop depressive episodes which are commonly found in late life. Like MDD, clients with this disorder may have developed it at a young age or in late life for the first time. Late onset Bipolar Disorder may be associated with cerebrovascular disease (Pompili, 2010).

The assessment of a client presenting with depressive symptoms involves a complete psychiatric history from the client and an informant, often a family member. Laboratory investigations and neuroimaging can be pursued in cases where medical conditions are thought to be contributing factors. Similarly, a focused physical examination can be done, particularly a neurological examination.

The primary treatment modalities for depressive disorders include pharmacotherapy and psychotherapy. There are a variety of medications that physicians can choose from in treating depression. They act on various neurotransmitters in the brain including serotonin, norepinephrine, and dopamine. Physicians will often select an antidepressant that has few drug-drug interactions. Side effects differ amongst clients, but some can be predicted with certain medications. Commonly used first line

antidepressants include serotonin reuptake inhibitors (SSRIs) such as citalopram, escitalopram, and sertraline. Other commonly used medications are listed in Table 3. If there is an insufficient response, physicians may consider switching to another antidepressant or to combine the current antidepressant with another medication including another antidepressant, lithium, or an atypical antipsychotic. Medications have potential risks and benefits which need to be discussed when obtaining informed consent to treatment.

There are a variety of psychotherapies that can be used for the treatment of late life depression. There is substantial evidence for the use of brief therapies, particularly cognitive behavioural therapy. Other useful therapies include problem-solving psychotherapy, mindfulness based psychotherapy and both long term and brief dynamic psychotherapy. Psychotherapy in various modalities can be delivered in a group format. This will be described in later chapters.

Table 1: DSM-IV-TR Diagnostic Criteria for a Major Depressive Episode

	Diagnostic criteria and symptoms
A	Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure
	i) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
	ii) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
	iii) significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
	iv) insomnia or hypersomnia nearly every day
	v) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
	vi) fatigue or loss of energy nearly every day
	vii) feelings of worthlessness or excessive or inappropriate guilt which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
	viii) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
	iv) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
B	The symptoms do not meet criteria for a Mixed Episode.
C	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D	The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
E	*The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.*

Reference: American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed., text rev. Washington, DC: American Psychiatric Association; 2000: 356.

Table 2: DSM-IV-TR Diagnostic Criteria for a Manic Episode

	Diagnostic criteria and symptoms
A	A distinct period of abnormally and persistently elevated, expansive or irritable mood lasting at least 1 week (or any duration if hospitalization is necessary).
B	During the period mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree: i) inflated self-esteem or grandiosity ii) decreased need for sleep (e.g., feels rested after only 3 hours of sleep) iii) more talkative than usual or pressure to keep talking iv) flight of ideas or subjective experience that thoughts are racing v) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) vi) increase in goal-directed activity (at work, at school, or sexually) or psychomotor agitation vii) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
C	The symptoms do not meet criteria for a Mixed Episode.
D	The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
E	The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment) or a general medical condition (e.g., hyperthyroidism).

Reference: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed., text rev. Washington, DC: American Psychiatric Association; 2000:365.

Table 3: Commonly Prescribed Antidepressants in Older Adults

Antidepressants
Citalopram
Escitalopram
Sertraline
Mirtazapine
Venlafaxine
Duloxetine
Bupropion

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Chapter 3

Structure of the Baycrest Psychiatric Day Hospital for Depression

The concept of the therapeutic milieu is central to the function of the Psychiatric Day Hospital. The therapeutic milieu is a group treatment environment which is supervised and designed by health care professionals of various backgrounds. It provides a model of the everyday world of reality and maximizes opportunities for clients to benefit from their social and physical surroundings (Di Bella et al., 1982).

Psychiatric inpatient settings necessitate clients be entirely removed from their homes and communities. This may be necessary for those depressed individuals who are too psychotic, suicidal, non-compliant, or lack adequate family or social resources to have them remain safe or able to come to a Day Hospital or outpatient setting. However, consequences associated with inpatient hospitalization include undue regression and loss of independence.

Outpatient psychiatric treatment, be it psychotherapy and/or medication management for depression usually occurs once weekly or less. As well, there is usually just one physician involved and the many therapeutic benefits offered by different disciplines is not present. Community Psychogeriatric teams can involve various team members treating depressed individuals in the community but it cannot match, when required, the more intensive 4-day group program of a Day Hospital.

Day Programs provide structured, supervised, social and recreational services to a population, usually the frail and cognitively impaired elderly. They do not aim to treat depressed individuals.

Initially conceptualized in the 1930's and implemented in the Soviet Union in response to bed shortages, psychiatric day hospitals have gone in and out of vogue ever since. They became a popular alternative to inpatient treatment in the 1960's in the USA, when partial hospitalization programs first became mandated. Over the next several decades, however, their popularity declined as their effectiveness began to be called into question, particularly as cost-effectiveness became more doubtful; more and more programs seemed to have become expensive "day centres", offering a variety of programs and respite care that could otherwise be provided by far less skilled workers.

Day hospitals are time-limited programs often used as "step down" from inpatient psychiatric care. The format usually involves a group of clients who meet for a few hours on some days of the week for psycho-education, support, and activity based treatments. The clinicians are typically a combination of non-physicians (e.g., mental health nurse, social worker, occupational therapist) along with a consultant psychiatrist.

This form of treatment has been shown to improve client outcome and prevent acute hospitalization (Cochrane, 2003).

The Baycrest Psychiatric Day Hospital for Depression has been in existence since 1986 and has treated many elderly clients with depressive disorders. It is an integrated and comprehensive outpatient treatment program occurring within a therapeutic milieu for older adults with depressive disorders. It is one element in a continuum of care, both accepting referrals from and sending referrals to outpatient settings and inpatient units, both at Baycrest and in the surrounding community. It provides a more intensive form of treatment than usual outpatient care.

The clinical treatment team is composed of one social worker, one occupational therapist, two nurses, two full-time psychiatrists, a part-time dietitian, and a part-time dance movement therapist. Students play a key role on the team. Psychiatry residents, occupational therapy, nursing, and social work students train for various periods of time and are valued team members. Consultations, when necessary, may be arranged with other specialists within or outside Baycrest hospital with psychologists, medical specialities such as ophthalmology, audiology, dental, physiotherapy or podiatry. Referrals to community care agencies are occasionally arranged upon discharge.

Admission Criteria

The treatment program accepts clients that are 65 years and over with a diagnosis of a mood disorder including Bipolar Disorder, depressed phase. There is no geographical catchment area. As a result, clients are referred from various parts of the city, and sometimes even other provinces in Canada. Clients are excluded if there is a diagnosis of dementia. The program requires a certain degree of cognitive ability. Otherwise, clients with dementia have difficulty finding their way, following what happens in the groups, and often end up feeling worse and stop attending. Clients with mild cognitive impairment are accepted. Clients with active suicidal ideation or much psychotic ideation may need inpatient psychiatric hospitalization. Language barriers, hearing difficulties and medical illness preventing clients from adequately participating are also barriers to entry into the program.

Length of Treatment

Each client has a four month course of treatment in the program. The clients do not all start at the same time. There is continuous process of admission and discharge. As a result, at any given time in the program, there will be a mix of clients at various points in the treatment program. The clients who are being discharged often provide encouragement and positivity to newcomers who are sometimes ambivalent or feel hopeless.

<u>Initial Screening</u>

Clients are referred from a variety of sources including family doctors, inpatient psychiatry programs, and community psychiatrists. The social worker receives the faxed referral form and then speaks to the client and often the referral source, particularly if the client is an inpatient or if clarification is required. The client and an informant, often a family member, are then invited for a brief, thirty minute screening interview with a psychiatrist and the social worker. The goal of this interview is to get to know the client, perform a history of present illness, assess safety, and inform the client and family about the program. The client and family are given written materials about geriatric depression, (www.ccsmh.ca/en/booklet/index.cfm), a pamphlet about the Baycrest program, and a date is set for a full interdisciplinary team assessment. If the client is not found to be a suitable candidate for the program, the social worker and/or psychiatrist speak directly to the referral source to discuss the client and communicate thoughts about alternatives.

<u>Assessment</u>

The client is assessed by the team within 1-2 weeks of the screening interview. This assessment involves multiple interviews which each take one hour and are all done on one day. The client meets with a nurse, social worker, occupational therapist, and psychiatrist consecutively, with a 1 hour lunch break. Students are an integral part of the assessment process as well.

The psychiatrist or psychiatry resident completes a psychiatric assessment, including The Montreal Cognitive Assessment. This is a measure of cognition that is sensitive to mild cognitive impairment. The social work assessment involves an assessment of social support, past history, and life events. The occupational therapy assessment involves an assessment of current and past occupational functioning and satisfaction with life. The nursing assessment involves completion of the Hamilton Rating Scale for Depression, the Geriatric Depression Scale and a thorough review of the client's prescription and non-prescription medications and remedies that the client is asked to bring to the assessment. All assessments and notes are documented in the electronic medical record. A list of the rating scales used in the program can be found in Table 1.

Once the team completes the assessment, the case is discussed at team rounds and a final decision is made about suitability. Each team member presents their portion of the assessment and the formulation and problem list are created.

Course of Treatment

The clients participate in the program for 4 months. There is a maximum of twenty clients in the program at any given time. The first goal is for the newly admitted client to become a cohesive member of the program and groups. The client will then do a significant amount of psychological work in the program. The final portion of the time is devoted to termination and discharge planning. Each client is assigned a contact person (social worker, occupational therapist or nurse) and psychiatrist.

Each client is assessed for the potential use of psychotropic medications. Some clients have recovered from depression without the use of medication. Many clients are referred because they have been reluctant to take medication and the day hospital environment provides them with the education and security to try a medication. The role of medication is often discussed in group therapy and amongst clients. Psychoeducation is provided by the staff and in the weekly Treatment of Depression Group.

Psychotherapy is one of the key elements in the treatment of clients in the Psychiatric Day Hospital. Individual psychotherapy is often integrated and tailored to the needs of the client. Elements of psychodynamic, cognitive behavioural, developmental and interpersonal models are used in both individual and group therapies. There is a significant emphasis on group psychotherapy and this is described, in detail, in later chapters. Other key elements to recovery include socialization and the development of feelings of improved self-esteem and competence gained through attending the non-psychotherapy groups and being a member of a welcoming and supportive therapeutic milieu.

The weekly schedule can be found in Table 2.

The Role of the Contact Person

The relationship of the client to their contact person is an essential factor in their treatment. The contact person (who may be a nurse, social worker or occupational therapist) meets with the client for 1 hour every week and often more frequently. The contact person also works closely with the psychiatrist and they both see the client together once per week. The contact person helps to coordinate the various treatments and appointments. If a client is late or does not show up, the contact person will phone the client to assess their mental state and solve any problems leading to the client not attending the program. Clients often form strong relationships with the contact person.

Medication Reconciliation

The client is asked to bring in all of their prescription and non-prescription medications (including herbal remedies) for the assessment day. The medications are reviewed by the nurse and a list of current medications is generated. This list is compared against the referring physician's medication list and the pharmacy list of medication. The medication list is faxed to the family doctor with the written consent of the client. The client is provided with this updated list and is asked to keep it with them at all times. If the psychiatrist in the Psychiatric Day Hospital Program makes a change to any medication or adds a medication, the list is updated, faxed to the family physician and given to the client to replace the old list. The client is asked to report any medication changes made by other physicians. If a change is made, the medication list is updated and the copies are given to the client and faxed to the family physician.

Discharge Planning

This phase of treatment occurs in approximately the last 4 weeks of the program. Clients who previously were depressed are asked to begin to think about discharge well before the date arrives. Many clients find discharge from the program to be extremely difficult. This is particularly the case with clients who were previously very socially isolated, those with personality disorders (e.g., Borderline, Dependent), and with clients who have previously sustained significant earlier losses (e.g. survivors of the Holocaust). Reaction to the idea of pending discharge from the program evokes a variety of reactions such as sadness, anxiety, and even anger. Some clients protest discharge and need time to work through their feelings. More about this phase of treatment will be described later.

Table 1: Rating Scales

Scale	Admission	Mid-point	Discharge
Hamilton Depression Rating Scale	X	X	X
Geriatric Depression Scale (15 item)	X		X
Montreal Cognitive Assessment	X		X
Satisfaction with Life Scale	X		X
CAGE questionnaire	X		
General Assessment of Functioning (GAF)	X		X

Table 2: Weekly Schedule

Time of Day	Monday	Tuesday	Wednesday	Thursday
9:00-9:30	Coffee time	Coffee time	Coffee time	Coffee time
9:30-10:00	Exercise Group	Exercise Group	Exercise Group	Exercise Group
10:00-11:00	Dance/Movement Therapy Group	Treatment of Depression Group (Psychoeducation)	Project/Activity Based Group	Family Tree Group *and* Integrated Group Psychotherapy alternating weekly
11:00-1:00	Appointments with contact person/psychiatrist, lunch, social and leisure time	Appointments with contact person/psychiatrist, lunch, social and leisure time	Appointments with contact person/psychiatrist, lunch, social and leisure time	11:00-11:30 Weekend Planning Group 11:30-12:00 Appointments with contact person and/or psychiatrist
1:00 – 2:15	Integrated Group Psychotherapy	1:00-2:00 Life Skills Group	1:00-2:00 Cognitive Behavioural Group Therapy	
2:15-2:30	Relaxation Group	2:00-2:30 Community Meeting	2:00-2:30 Relaxation Group	

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Chapter 4

The Psychiatric Day Hospital Staff and Roles

<u>Psychiatry in Mental Health:</u>

Psychiatry emphasizes a biopsychosocial model for understanding and treating mental health problems for all age groups. However, for many years, the concept of ageism, a term first coined by Butler (1975), which can affect both young and old and mental health professionals, contributed to the idea that old adults are naturally prone to depression, or "what can you expect, your too old to change". As well, much before Butler, Freud (1905), at the age of 49, believed older people (the over 50's in his day) were ineducable and contributed to a therapeutic nihilism towards the development of psychological models and psychotherapy for older adults. Psychotherapy theory instead focused on childhood development, with later life neglected as a developmental stage. An exception to this was the work of Erikson (1963) who identified 'eight ages of man' in terms of dichotomies, with 'generativity vs. stagnation' and 'ego-integrity vs. despair' describing the development challenges of later life. Still, today the dominance of the biological or organic models in geriatric psychiatry and neuropsychology has tended towards 'brain-based' rather than 'psyche-based' explanations for illnesses in later life (Hepple, 2004). With the advent of more evidence-based individual and group therapy interventions for the elderly, there is now the more modern idea that psychotherapy with older adults is 'not too late', but instead that for many, it can be just in time (Hepple, 2004).

<u>Psychiatric Role in the Program:</u>

There are two full-time psychiatrists on the Psychiatric Day Hospital staff. While one functions as the co-director of the program, both are involved in screening and assessing clients for admission, conducting individual and group psychotherapy, prescribing and monitoring medications, leading a clinical team meeting focusing on the treatment of clients and supervising psychiatric residents. A third part-time psychiatrist co-leads one of the weekly aftercare psychotherapy groups.

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Nursing in Mental Health:

Nursing plays an important role in health promotion and illness prevention in the psychiatric day hospital for depression and in after-care groups. Guided by legal and ethical standards, nursing provides evidence-based, client-centered care that is authentic and unique to nursing, and support leadership, autonomy, shared governance, accountability, and mentorship in a multidisciplinary team environment. Upon initial contact with the clients and throughout each phase of their therapy, nursing establishes a nurse-client therapeutic alliance that is based on trust, hope, support, caring and collaboration. This framework is grounded in theory and enables nurses to work closely with clients through each treatment phase leading to positive outcomes (Dziopa & Ahern, 2009; RNAO 2006; Peplau, 1987).

Nursing Role in the Program:

The role of the nurse in the program is often multi-faceted and complex and requires both nursing and non-nursing duties. Expectations of the role include but are not limited to providing case management duties, facilitating and co-facilitating groups, performing individual therapy and co-therapy, participating in team and family conferences, and mentoring nursing students. The role becomes particularly unique to clinical nursing and requires expertise in the Psychogeriatric field of nursing especially when a client becomes acutely ill or has sustained a fall during program hours. In such cases, the nurse becomes the first line of contact with the client and the health care team through performing a health assessment and monitoring the client's physical and mental status. Critical thinking and decision making skills are paramount in maintaining the integrity and health of the client.

Given that clients who attend the program are elderly, they are often frail with both emotional and physical issues. Clients sustain falls and other types of injury, or may complain of feeling dizzy or physically unwell. When these incidents occur, clients are assessed by the nurse, their vital signs monitored, and a clinical decision around care is determined. For example, if the client is medically unstable, the nurse initiates a code for medical emergency, may send the client to the nearest hospital emergency department via EMS, assists the client in informing the family doctor or makes a referral to a nearby walk-in clinic. Some clients may present with a skin tear or open wound. A skin assessment is carried out by the nurse, and a dressing is applied after the wound is cleansed. Any acute changes in the client's physical condition would be reported to the family doctor for further investigation and treatment.

Nursing performs a thorough medication assessment that incorporates the values of medication reconciliation. On assessment day, the client is asked to bring in all the medications they are currently taking, prescribed or otherwise. The aim is to ensure accuracy, efficacy and safety in medication use. Medication dosage, times, indications

for use, or special precautions are assessed and recorded. Any side effects or allergic reactions that the client may be experiencing are noted and discussed in the team meeting. The client is asked to sign a consent form to send a list of the medications to the family doctor. This process has been helpful in uncovering and correcting any medication errors. If a client is started on a new psychotropic medication, when necessary, blood work and electrocardiogram are performed. The nurses are trained to perform these functions and monitor the client status. If a client is on Lithium, a protocol which involves drawing blood regularly at scheduled times, and monitoring vital signs are implemented and performed by the nurse.

On the day of assessment, a questionnaire about the general use of medications is used by the nurse who records the responses in the medication assessment database. The questions are as follows:

1. Do you use any measure to help to organize your medicines?
2. Does anyone help you with your medicines?
3. Do you feel you need more information about your medicines?
4. Do you feel you need more support/help with taking your medicines?
5. Do you ever take anyone else's medications?
6. Are you allergic to any medication?
7. Have you had a reaction to any medications?
8. Are you able to read the container label(s)?
9. Are you able to open-up the containers?
10. Who is your pharmacist? If more than one pharmacist, the client is counselled to limit to use one.

Clients are asked if they have brought in all the medications they are currently taking. Sometimes, clients have forgotten to bring in their medications, and instead may produce a list of their medications, or try to recall the medications they are taking. The nurse uses her judgment and inputs the Best Possible Medication History (BPMH) as well as the source of the medication history, in its draft stage into the medication reconciliation database. The complete medication assessment is deferred until a future time when the client is able to bring the medications utilized. The nurse arranges to meet with the client privately at which time the medication assessment is finalized in the medication reconciliation database.

If a blister pack is used, the information that is printed on the blister pack by the providing pharmacy is recorded and the medication in each blister pack is assessed for accuracy by visually scanning the medications through the cellophane wrap. Sometimes, clients bring in a dosette where they or a support person have put their medications for the week. These are also visually scanned for accuracy. The client is questioned if there is a discrepancy and it is discussed in the team meeting.

Where the client is taking the medications by blister pack, dosette, or from the individual containers, the nurse uses the five rights of medication administration, namely, the right route, the right client, the right time, the right drug, and the right dosage in her assessment. Additionally, start and stop dates, or the prescribing physician are noted. Expired medications are removed with the client's consent and sent to the Baycrest pharmacy for disposal. Clients who bring in homeopathic medications or over-the-counter medications are also assessed for their knowledge and how these non-prescription medications are utilized. The medications are entered into the database as part of the client's medication regime.

At the completion of the medication assessment, two lists are printed out, a copy for the client and a copy that will be faxed to the family doctor.

The client is asked to sign a privacy and confidentiality consent for the family doctor during the interview. On a few occasions, clients have declined to sign the consent for personal reasons. Clients who are visually impaired or unable to sign the consent may give a verbal consent for a copy of their medication list to be sent to the family doctor.

The nurse also measures the client's depression by using the Hamilton Depression Scale, the Geriatric Depression Scale, and the CAGE questionnaire on assessment, after two months and at discharge, please reference the scales.

Nursing, in collaboration with other members of the team, initiate referrals and linkages to ongoing community supports and reconnect clients to previously enjoyed or to new activities as part of the discharge planning. When appropriate, nursing serves as liaison with the Baycrest inpatient unit, Geriatric Psychiatric Community team, the Wagman Center and other community centers. Nursing supports people to function at optimal levels of health and to become self-sufficient; coordinating, negotiating and managing the complex care of clients; facilitating collaborative practice; providing therapeutic intervention to the client and their families; providing supportive counseling; problem solving; medication monitoring and relapse prevention; teaching psychosocial rehabilitation; linking clients to others services in the community; and participating on assertive community treatment teams. They maintain continuing education and demonstrate interest in life-long learning, sharing their knowledge with students. It is important that nurses work closely with clients, learning the personal meaning of their health situations and collaborating with the team (Touhy & Jett, 2010; Eliopoulos, 2010). Through understanding, support, and clinical expertise, nurses play an important role in empowering clients, and teaching them that self-care is an important step in the recovery from depression. Nurses also co-lead groups or lead groups on their own, such as the relaxation or stress management group. Nursing also co-leads the integrated group therapy in the 4-month program, two of the aftercare groups, the community meeting, weekend planning and exercise groups. (All of these groups will be discussed later in the manual.)

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<u>Social Work in Mental Health:</u>

The goal of social work is to advocate for and empower individuals, families and communities. As we know, individuals who have a lived experience of mental health are often heavily stigmatized and misunderstood in society, and that "discrimination persists in the organization and provision of hospital care and community health care for people with mental illness" (Canadian Mental Health Association, 2012). Social workers are in a very suitable position to assist with individuals who are mental health service recipients as "a social worker shall respect the intrinsic worth of all persons he or she serves" and "shall advocate change in the best interest of the client" (Ontario College of Social Workers and Social Service Workers, 2008).

Social workers look at a person holistically and applies a critical lens to the "social and environmental factors related to mental health" (Larson, 2008, p. 42). Factors such as socioeconomic status, education level, family dynamics, housing, employment, disability, preferred language, gender, sexual orientation, cultural background, and many others create an individuals' lived reality. These factors give an incomplete list of the many social determinants of health (Ontario Association of Social Workers, 2012), or the different environmental systems which impact the overall health of an individual. It is within these systems that social workers serve as change agents with clients to create hope and transformation.

Highlighted by the Ontario Association of Social Work position paper on Social Work in Mental Health and Addiction Services, social workers co-create a therapeutic relationship with their clients which is the vehicle to:

> restore, maintain and enhance the functional quality of life of individuals, families and groups by mobilizing strengths; supporting coping capacities; assessing and helping people to modify patterns of relating and acting; linking people to necessary resources; addressing environmental stressors individually/collectively; and providing psychosocial education related to wellness and overall well-being (OASW, 2012).

Mental health cannot be reduced to a medical diagnosis. There are many intertwining social and environmental dynamics that influence mental well-being and health. Social workers endeavour to utilize with these dynamics to provide a variety of interventions that support the growth and empowerment of individuals, families and groups. Within the myriad of human complexities "social workers' empowerment approach" is "a unique and significant contribution to the mental health system" (O'Brien & Calderwood, 2010, p. 331).

<u>Social Work Role in the Program:</u>

The social worker in the Psychiatric Day Hospital for Depression collaborates with other members of a multi-disciplinary team to provide comprehensive assessment and treatment to clients suffering from depressive disorders. The social worker provides individual counseling and is the case manager or "contact person" for a certain number of clients in the program.

One of the important responsibilities for social work is to provide intake services for the program. This involves the processing, screening and arranging of assessments for all applicants. This often involves liaison with the referral source, the client and families, particularly when the client is apprehensive about the program.

Each client is interviewed by the social worker and undergoes a formal assessment. The goal is to get familiar with and understand the client's personal history, life stressors and social supports. With the client's permission, one or more family members are interviewed. This helps us better understand the client's situation and the impact of the illness on the family system. It also helps to involve family in the treatment of their loved ones.

Once in the program, the social worker acts as a contact person for several clients. The social worker also acts as a primary liaison to the families of all the clients. In this role, the social worker provides education and support to family members that may be often overwhelmed by their relatives' depression. On occasion, the social worker also acts as a co-therapist for marital or family therapy that may be as required for any of the clients.

Upon discharge, the social worker facilitates referrals to other social and recreational programs in order to provide a cohesive experience for clients who move to different services.

The social worker is involved in co-leading several groups that are a part of the PDH including the Family Tree Group, Integrated Group Psychotherapy, Weekend Planning Group, Community Meetings and one of the aftercare psychotherapy groups. As well, the social worker helps the social work student in leading the 8-week Reminiscence Group.

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Occupational Therapy in Mental Health:

Occupational Therapy is deeply rooted in mental health. A comprehensive review (Sedgwick et al., 2007) highlights the origins of the profession dating back to the earlier part of the 20th century. Occupational therapists are concerned with the areas of self-care, leisure and productivity all of which can become disrupted when an individual is faced with mental health issues. From its earliest days, OT intervention focused on "leisure as a means to mental health" and today, occupational therapists "continue to share a concern for the importance of meaningful occupation in both work and leisure as an important component of mental health" (Sedgwick et al., 2007, p.415). Occupational therapists view individuals as occupational beings and work collaboratively with clients who have mental health issues to enhance occupational performance and enable engagement in meaningful occupations. As stated in the Canadian Association of Occupational Therapists 2008 position statement on Occupational Therapy and Mental Health, "OTs understanding of the relationship among person, occupation and environment uniquely positions the profession to provide quality mental health service in environments where people live and work." As well, "OTs address barriers to mental health by creating home, work and community environments that facilitate meaningful occupation."

Older adults with psychiatric disorders often experience a variety of functional deficits that affect their independence, safety, and activity level (Trace & Howell, 1991). OTs work to address these deficits and to promote optimal functioning. OTs also provide older adults with mental health issues the opportunity to express emotions in a safe, supportive environment and promote the development of coping skills (Bondar & Dal Bello-Haas, 2009).

OT Role in the Program:

The Occupational Therapist (OT) in the Psychiatric Day Hospital help clients lead more productive, active, and independent lives through a variety of methods. The OT can help clients when they may have lost confidence in doing previously meaningful activities. Many elderly depressed clients find day-to-day activities difficult and would like to improve their ability to look after themselves or take part in community activities. The OT provides assessment and treatment of individual's physical, psychological and social abilities through the use of specific purposeful activities that help people learn to engage in and cope with daily life. The OT's role includes initial OT assessment (formal/informal), case management, interventions in the form of supportive individual counseling, group therapies (i.e. psychoeducational and activity-based groups) consultation and discharge planning. The OT also facilitates one of four weekly exercise groups, co-facilitates an aftercare support group and the program's weekly community meeting, weekend planning groups. The OT may also conduct assessments of functional cognition (i.e. Cognitive Performance Test) and home safety assessments

(i.e. Safety Assessment of Function and the Environment for Rehabilitation) in order to evaluate the functioning and independent living skills of clients to prepare them for discharge. Providing relevant information and insights during weekly interprofessional team rounds is another important part of the OT role. The OT also provides yearly supervision to OT students in the Masters program at the University of Toronto.

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Dance/Movement Therapy in Mental Health:

The history and practice of dance/movement therapy are grounded in both dance (or movement) and psychology. Fundamentally, dance/movement therapy is a person-centered approach incorporating the physical, emotional, cognitive, and social needs of each participant (ADTA, 2007). Its holistic nature allows for the exploration of the connection between mind and body as a creative outlet for self-expression. As a component of a mental health program, dance/movement therapy has the ability to create a greater quality of life by decreasing social isolation and inactivity while facilitating reminiscence and creativity (Johnson & Sandel, 1987).

In working with a variety of populations, dance/movement therapists have employed theories developed by psychologists throughout the profession's development. Marian Chace, an American dance/movement therapy pioneer, was influenced by Harry Stack Sullivan's theories of understanding schizophrenic clients through the observation of their interpersonal relationships. Her work at St. Elizabeth's Hospital in Washington D.C. and the Chestnut Lodge in Rockville, Maryland, explored innovative concepts in movement as a form of nonverbal communication, the group dynamics of shared movement experiences, and the influence of rhythmic sound in a session (Sandel, Chaiklin & Lohn, 1993).

Dance/Movement Therapy Role in the Program:

The role of the dance/movement therapist in the Psychiatric Day Hospital for Depression is to provide one group session per week on Monday morning. This session provides group members with an opportunity reconnect with each other after the weekend and to express themselves non-verbally through movement.

The dance/movement therapist can assist with unlocking stored emotions by expanding each member's range of motion and establishing a safe environment for the expression of thoughts, memories, and feelings. Throughout each session, the dance/movement therapist will also work to promote a more open relationship between body and mind through expressive rhythmic and functional movement, tension release, as well as social interaction.

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Chapter 5

Treatment of Depression Group

<u>Theoretical Rationale:</u>

This group was initially referred to as the Medication Group and provided an opportunity for clients to discuss with other group members and the group leader, a psychiatrist, concerns regarding medications. Information was exchanged both about side effects and benefits experienced with their various medications. Misinformation was able to be clarified, for example, when a client attributed certain side effects to a particular medication, when in fact, it was more likely due to another type of medication. This was especially important as this member may have been thinking of discontinuing the medication. In this way, the message of first consulting with their physician about changing meds, rather than doing it on their own, was reinforced. As well, the importance of the medication card, a list of all medications, prescription and over-the-counter, (see Figure1) was emphasized, including the instructions to "keep the card with you at all times, keep the card up-to-date and ask your doctor and/or contact person to write down all changes so the card remains accurate and up-to-date".

With time, the medication group was re-named the Treatment of Depression Group to better reflect the treatment approach employed by the PDH. There are 3 main components to treatment: 1) antidepressant medication, 2) psychotherapy (individual, group, family and marital), and 3) various non-psychotherapy groups along with the opportunities for socialization that the therapeutic milieu affords. Individual psychotherapy coordinates the various biopsychosocial treatment approaches. The potential benefits of combined pharmacotherapy and psychotherapy include a greater breadth and response to treatment, improved quality of life, decreased relapse and recurrence rates and facilitation of the use of reduced amounts of medication (Hollon & Fawcett, 1995). For example, the development of a therapeutic alliance along with the use of psychoeducation, support and the endorsement of other group members who have benefited from medications may all be necessary to increase client compliance with medication (Leszcz, 1997).

Therapeutic factors present in the Treatment of Depression Group include psychoeducation, interpersonal learning, instillation of hope, universality, and identification. With respect to group content, clients are instructed on the importance of the medication sheet and to ask medication-related questions, primarily related to anxiety, depression, sleep and cognitive concerns. However, discussion in the redesigned group can also address what depression is, and how physicians assess and choose which treatment to use for each individual. Members are also instructed as to how physicians after taking a previous history of any depression and antidepressant medications, and medical history, for example, will choose one medication over another. Questions are answered regarding how long they will have to remain on medication if they improve, and how they might switch to another medication if treatment isn't initially effective. They will also learn when and why certain combinations of antidepressants and/or mood stabilizers may be used. The idea is that if they can better understand

how physicians think and how to talk with them, they will be better suited to be an active participant in their care through better communication with their physicians.

Members are encouraged to ask questions about what psychotherapy is and how it works. Discussion may also ensue about the program itself. The group may sometimes adapt a more experiential approach as members share relational difficulties exacerbated by their depression. The topic at times may turn to the stigma of having depression or of seeking mental health help especially in a cohort their age. What members read or hear in the media is encouraged to be brought into the group so that misconceptions or resistances to complying with medication or treatment or to even accepting the diagnosis of depression itself can be addressed.

Goals:

The goals of the group include the following: to increase depressed members' knowledge of what depression is and the various treatments for depression, to learn more about both the potential benefit and/or side effects of medication, to improve medication adherence, to increase members' comfort about discussing their concerns and treatment with physicians, both in individual and group formats, and to better deal with stigmas and misconceptions of their relatives, friends and community with regards to mental health.

Group Format:

The group meets once a week for one hour and is led by a psychiatrist. On occasion, nursing staff and/or students attend the group.

Case Example:

The group begins with the leader reviewing both what the group is about (content) and how the group works by emphasizing both leader and member participation and interaction (process).

Psychiatrist: What is the group now called?

Mrs. V: The Depression Group.

Mr. W: Actually, it's the Treatment of Depression Group.

Psychiatrist: Why was the group name changed from the medication to the treatment of depression group?

Mr. B: To point out there's 3 components to the treatment.

Psychiatrist: Yes and they are?

Mr. B: Medication.

Mrs. T: Psychotherapy.

Mrs. S: Group and individual…

Mr. W: Cognitive behavioural and understanding ourselves and our relationships and where we are in life.

Psychiatrist: Yes, Cognitive Behavioural and an Integrated therapy that also emphasizes understanding, relational styles, and the life stage you're at. And what's the third component that hasn't been mentioned yet?

Mrs. Y: Miscellaneous.

Psychiatrist: Meaning?

Mrs. T: Coming here gives us a place to go and be with other people.

Psychiatrist: Yes, coming here gives you structure, purpose and meaning and a chance to be active and socialize while at the same learning more life skills, to better relax and to participate in a community…

Then once the introduction is completed with the psychiatrist emphasizing the importance of the medication card and the need to keep it up to date, accurate and with them for all medical appointments, questions and concerns are invited from the group members.

…Mrs. X has been struggling with low energy, increased fatigue and low mood. Concurrently, over the last several months, she has lost weight and has developed low blood pressure. In her individual sessions with her psychiatrist and contact person, she has questioned whether her symptoms are psychological or physical. After hearing other clients discuss their symptoms in the Treatment of Depression Group, Mrs. X is now better able to reflect on her own symptoms and acknowledge that she may likely be experiencing depression. She then begins expressing her apprehension about taking antidepressants to which various group members both relate their own similar struggles and provide encouragement to try taking medication…

Mrs. K: When I first started the program a couple of months ago, I was like you but I gave medication a chance after my physician assured me he would "start low and go slow". I got better and I still don't know whether it was just the medication or the psychotherapy, or just being here, but I don't care.

Mr. D: Try the medication and see how it goes.

Mrs. X: OK, I get the message. I'll speak to my psychiatrist and see what happens.

Psychiatrist: Let us know what happens so we can discuss any concerns that may come up. People find it better to discuss concerns about medications, treatment and the program itself with others as well as their own psychiatrist and contact person.

Zaslav & Kalb (1989) suggest that the approach to the taking of medication may serve as a metaphor for interpersonal relationships; thus clients who limit the discussion of drugs to the more technical aspects of the medication and its effects are indicating their discomfort with sharing their feelings about needing medications. This is the case with Mrs. X who had difficulty accessing her emotions because of depression and personality factors. Fain et al. (2008) demonstrated how a "living with medications" group in a psychiatric day treatment program, by identifying object relations themes in the group discussion, contributed to the demystification of the pharmacotherapy and permitted clients a more open and beneficial disclosure with their physicians. For example, for many clients the need for medication was first and foremost experienced as a narcissistic injury, a shaming stigma that separates them from "normal" society (Fain et al., 2008). The participation in a Treatment of Depression Group allows Mrs. X and others to address their inner perception of being damaged. The universality of the group, that is, the realization that other group members taking medications may suffer from similar fears or shame pertaining to the use of antidepressant medications coupled with the increased awareness that others benefit from these medications often leads to hope and acceptance of the use of medication.

Figure 1

Medication Card						
PRESCRIPTION FOR: XXXXX					DATE: XXXXX	
Medication	Instructions	Number of doses				Reasons for medicine
		Morning	Lunch	Dinner	Bedtime	
Sertraline	100 mg with dinner			1		Depression
Metformin	500 mg with breakfast and dinner	1		1		Diabetes
Warfarin	3.5 mg at dinner			1		Blood thinner
Acetaminophen	325 mg Take 1 to 2 tablets when necessary					Back pain
Psyllium Hydrophilic	1 tbsp at bedtime				1	Constipation

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Chapter 6

Cognitive Behavioural Therapy

Theoretical Rationale:

Cognitive Behavioural Therapy (CBT) is an evidence based psychotherapy that is effective for the treatment of depression and anxiety and has been shown to be effective in the geriatric population (Laidlaw et al., 2008; Peng et al., 2009; Stanley et al., 2005; Thompson et al., 2001). It can be delivered in individual therapy or group therapy formats. This form of psychotherapy is a brief treatment (16 weeks) and is useful in the Psychiatric Day Hospital (PDH) setting for treatment of depression and concurrent anxiety.

CBT involves addressing the dysfunctional thinking and maladaptive behaviours that perpetuate depression and anxiety. Similar to other specific forms of psychotherapy, it is most effective when the client is motivated and feels positive about the therapy. Specific suitability criteria for CBT exist. In addition to motivation, some examples include the ability to access thoughts, acuity of the depression, alliance potential with the therapist, and ability to differentiate emotions. The ability to read and write is essential in order to be able to complete the reading and homework assignments, such as thought records (see Figure 1). This type of therapy would not be effective for a client with dementia or significant cognitive impairment. It involves learning and applying new knowledge and skills. Adaptations for the geriatric population include presenting the material at a slower pace, using handouts and notebooks, and having the clients summarize the material (Stanley et al., 2003; Thompson et al., 1996)

As previously described, clients admitted to the PDH are accepted if they have a depressive disorder without dementia. They are not screened for suitability for CBT. As a result, at any given time, the client group will consist of a mix of those who are suitable and not suitable for CBT. Clients do not receive a "one size fits all" treatment in the program. Treatment is tailored to their individual needs and capabilities. All clients participate in weekly group CBT with the understanding that individuals will take away different things from the group. For clients who appear to be suitable, the clinicians may utilize CBT techniques quite heavily in their treatment.

Figure 1: Thought Record

Moods (feelings)	**<u>A</u>utomatic thought**	**<u>B</u>e a skeptic**	**<u>C</u>reate a new thought**
Hint: Circle the mood(s)	**Hint:** Write down the main thought that is bothering you	**Hint:** Challenge your thought	**Hint:** Come up with a new thought
Mad Sad (circled) **Worried** **Other:**	I can't do anything right	I was given good feedback about what I did in the Project Group yesterday I helped someone in group psychotherapy My psychiatrist and contact person explained to me that I have depression and that making a meal can be difficult now I have had many successes in my life such as raising my children, my occupation, caring for my parents, etc.	Although I did not think that the meal was as good as usual, I was able to do it despite being unwell, and I have been able to accomplish many things in my life

<u>Individual CBT</u>

A person with depression or anxiety will be subject to distortions in thought that relate directly to mood. The cognitive errors are part and parcel of depression and anxiety. One of the goals in this therapy is to teach clients how to challenge their thoughts in order to improve mood symptoms. This is done by having the client learn how to complete a dysfunctional thought record in which an identified erroneous and negative thought is weighed for validity with evidence and then replaced with a more balanced thought.

<u>Case Example:</u>

Mrs. T Is a 76-year-old woman with Major Depressive Disorder. She felt particularly down after having made a meal which she perceived as not up to her usual standard. This was discussed at a session with her contact person and psychiatrist. They introduced the thought record (Figure 1) and explored her thoughts in this situation. Her thoughts included "I can't do anything right", "I'll never recover", and "people must think that I am stupid." The thought identified to be most related to her depressed mood was "I can't do anything right." The clinicians helped her elicit evidence to challenge this thought by asking a number of questions. These questions called into question the validity and accuracy of the dysfunctional thought. The client was then asked to replace her dysfunctional thought with a new and more balanced thought, after having considered and reviewed the evidence. She rated her mood as having improved after the exercise. Over the next few weeks, Mrs. T learned how to complete the thought record on her own and used it effectively when her mood was low or anxious with good results.

The PDH is an ideal setting for testing intermediate beliefs (e.g., assumptions and rules) by experimentation. For example, during the course of treatment, it became apparent that Mrs. T had certain rules. For example, she did not like to try new activities in the Occupational Therapy Project Group. She told her contact person and psychiatrist that she is afraid of showing others that she can make mistakes. This affected her behaviour in that she did want to try new things and potentially make an error in front of others. Her assumption was: 'if I make a mistake others will see me as incompetent.' Her rule was: 'avoid situations where you may not be fully competent.' In collaboration with the client, the therapists designed an experiment to test her assumption and rule. The client decided to try a new activity (a game) in the Project Group the following week and then elicited feedback from others including the occupational therapist and the other clients. After the Project Group, Mrs. T was asked to complete her experiment record and describe the results. She was pleased to discover that others did not criticize her or think that she was incompetent even though she was not perfect in the activity. This had a positive effect on her mood and continued to improve her depression.

Similarly, core beliefs can be addressed throughout the program. For example, in the case of Mrs. T, who clearly has difficulty with self-esteem, her thoughts and intermediate beliefs are clearly related to her core belief, in this case "I am incompetent." The therapists can use thoughts record and a core belief worksheet in order to address this belief and develop a new belief. The client will be asked to generate evidence that does not support the original core belief and find evidence that supports a new, healthier and more accurate belief.

Mrs. T began working on the core belief worksheet. Initially, she had great difficulty finding any evidence that her belief "I am incompetent" was not entirely true all of the

time. The psychiatrist and contact person asked her about a recent event in the Psychiatric Day Hospital when she helped a new client in the Project Group with an activity. Mrs. T was asked to continue to find examples of small successes in her life. Over the next few weeks, the client had listed twelve pieces of evidence from her life dating back to when she was much younger to recent time during her treatment program. Over time, she began to accept that evidence of competence existed and that she had discounted this evidence during her episode of depression. The client was given a copy of her exercise to keep along with the other materials in order to keep working on it and refer back to it when the belief becomes active.

Group CBT

CBT can be effectively used in the group format and has shown to be effective in the elderly. Modified versions of CBT for the group format for seniors exists. As previously noted, not all clients in the PDH Program are ideal candidates for CBT. All clients participate in the weekly CBT Group and will benefit from the group one or more of three ways. First, some clients learn the basics of CBT and the knowledge and skills are further developed with their individual therapists. Second, some clients benefit from helping others and contributing to the group process. Finally, some clients benefit most from the behavioural components.

The CBT Group program has evolved over time. Initially, the CBT Group focused mainly on differentiating between moods, behaviours, and cognitions. It evolved to include and focus on teaching clients how to use thought records. Eventually, this was abandoned because it became evident that many clients were simply not able to complete thought records for various reasons. Barriers include not being able to access automatic thoughts, language barriers (English as a second language), severe depression, mild cognitive impairment, and dyslexia. Another format was to try to use whatever material the clients brought to the group and to use a CBT technique during the session, but not exclusively thought records. Although this format resulted in high attendance, it was difficult to prepare for sessions not knowing what would be discussed on that day. Within the last two years, the CBT therapists have employed a curriculum (see Table 1). Although it has changed slightly over time, it appears to have resulted in a good balance of didactic teaching, discussion, and clinical treatment. Clients enter the PDH Program at different points in time the curriculum, but each person ends up receiving the full course of CBT throughout their PDH admission.

Table 1: Curriculum

Week	Topic
1	Introduction to CBT: The model
2	Differentiating moods from thoughts
3	Introduction to the thought record
4	Thought records — finding evidence
5	Thought records
6	Cognitive distortions
7	Action plans
8	Action plans follow-up
9	Experiments—intermediate beliefs
10	Experiments—intermediate beliefs
11	Core beliefs
12	Core beliefs

Case Example:

Ms. M is an 83-year-old widow who has been in the program for one week. The CBT group on this particular week reviewed various cognitive distortions. Clients were asked to express any thoughts related to their mood. Ms. M stated that she was depressed and that "this program will not help me." The co-therapist of the group helped identify the type of cognitive distortion within a list of cognitive distortions (fortune telling). Some of the other clients related to that type of thinking. The group already had three sessions on thought records and how to achieve balanced thinking. The group was asked how Ms. M could feel better and a thought record was recommended. Group members aided Ms. M in finding evidence that did not support her thought. In particular, a number of clients who were remitting from their depressive episodes provided real evidence that depression is a treatable illness and can remit. Ms. M's mood improved as she achieved a balanced thought.

In session 7, clients divided into groups of four and they created personal action plans with the help of the co-therapists. Ms. M has withdrawn from her friends and acquaintances. She has not been returning phone calls and has been declining invitations to go out. Along with the help of other group members, she decided on the action plan of returning a phone call to a friend. Ms. M completed the action plan worksheet. In session 8, Ms. M was asked to report back on an action plan that she worked on from the week prior. She reported that she was able to complete the action and that her mood improved as a result. The friend that she spoke to was happy to hear from her. Having achieved this success and seeing the effect on her mood, Ms. M decided that she would call a friend for five minutes three times per week. She discussed her achievement with her contact person who continued the work in an individual session.

In summary, individual and group CBT can be a powerful and effective tool in the treatment of geriatric depression. A semi-flexible approach is used in the PDH Program at Baycrest with the understanding that different clients will be impacted in different ways.

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Chapter 7

Integrated Psychotherapy

<u>Theoretical Rationale:</u>

An integrated psychotherapy model, featuring developmental, psychodynamic, interpersonal, and cognitive behavioural approaches is helpful in treating a range of depressive disorders. It can be practiced in individual or group therapy formats. It can be applied in both brief (16 weeks) or in long-term psychotherapies.

Clients often enter the Psychiatric Day Hospital (PDH), bitter and demoralized, unsuccessfully struggling with Erikson's developmental stage of 'integrity versus despair' (1950) and in need of help to rework the unsatisfactory resolutions of earlier developmental conflicts to more effectively deal with current late-life issues (Liptzin, 1985). Past feelings and regrets, are met with understanding and acceptance, which with time, contribute to lessened feelings of shame and guilt. Past accomplishments and areas of competence and pride are highlighted to help restore feelings of worth, status and competence through the articulation of past successes as the declaration of one's credentials (Leszcz, 1997). Clients are helped to understand that the cause of difficulties are not derived exclusively from the first few years of life and that personality development and emotional growth are possible at any age (Schwartz, 2004). Clients are helped to explore and understand the interpersonal difficulties they experience with others, both in and outside the program. The cognitive behavioural component emphasizes that there are both good and not so good things that can be improved in oneself and others, in contrast to viewing things as all good or all bad.

The integrated group and individual sessions focus on the client's current life stage, interpersonal difficulties, and ability to mourn and cope with depressive symptoms and age-related losses. Both the here-and-now and/or the then-and-there are explored and worked with. As each personal relationship involves the client as well as another person, the client is occasionally encouraged to become more aware of a problem in a relationship by considering the following 7 questions developed by Zeisel (2009) (1) What am I feeling?, (2) Why am I feeling this way?, (3) What would I like to say or do to this other person now?, (4) How would it affect him/her if I said or did this?, (5) What is he/she feeling now?, (6) Why is he/she feeling this way now?, (7) What does my ego or more mature self want to say to this person now?

In concurrent individual and group psychotherapy, individual therapy is usually considered the main treatment. Some suggest, however, that group therapy be considered primary, with individual therapy serving as an adjunct (Rutan & Alonso, 1982). In the PDH model, both the CBT and Integrated individual psychotherapies serve an adjunct and organizing role with respect to group psychotherapy, help with increasing adherence with medication and the program, and with discharge planning.

Lipsius (1991) proposed guidelines to optimally handle the interface between combined individual and group sessions in an attempt to address concerns that individual

sessions can drain away group interaction and that group process can interfere with the confidentiality and transference of individual sessions. The guidelines stress client initiative with the therapist making clear that it is the responsibility of the client to bridge the material from setting to setting. In individual therapy, the therapist might also encourage the client to raise group-related feelings in the group. If the client resists, the therapist in the group is encouraged to use the least intrusive interventions operating at the lowest levels of inference required to bridge the division. Options include encouraging the client to explore the difficulty or asking the client's permission to raise the material in the group.

Concurrent Integrated Group and Individual Psychotherapy

Theoretical Rationale:

Group therapy with seniors is an effective treatment, both in the actual provision of social support directly and in the provision of opportunities to acquire and develop interpersonal communication skills and the necessary self-awareness to generate and sustain social integration (Leszcz, 1997). Group therapy appears as effective as individual therapy in meta-analytic reviews (McRoberts et al., 1998). It benefits both young-old and oldest-old (Payne & Marcus, 2008). Concurrent group and individual therapy, as practiced in the Baycrest PDH, is an effective and unique treatment with its own indications, contraindications, mechanisms of therapeutic action, developmental stages, and technical requirements (Porter, 1993).

Group Format:

Groups are led by co-therapists of different mental health disciplines and gender. The groups contain up to 20 members, making them considerably larger than the usual outpatient group of 6-8 members. Another distinguishing characteristic of the day hospital group is that it encourages members to freely interact outside of groups with the aim of counteracting the social isolation that increases the vulnerability of seniors to depression (Schwartz, 2004).

Technical Considerations:

Modification of technique is necessary with older adult groups containing members who are experiencing a lack of energy due to aging, physical illness, depression and demoralization associated with existential issues. Therapists leading these groups which may be lacking in energy and initiative are encouraged to be more active (Leszcz, 1997) without undermining members' autonomy and causing a further loss (Schwartz, 2007). Some older adults entering the PDH Program for Depression and not particularly seeking group therapy may be lacking psychological sophistication and may require help in understanding a connection between symptoms and the relationship difficulties they are experiencing. It is also a challenge for therapists to determine when members' focus on medical issues and medication represent genuine concerns or is a resistance to self-reflection and exploration of feelings. The use of humour is of value to balance the "graveness" associated with dealing with themes of aging, illness and death

(Schwartz, 2007). Humour can also help therapists endure the depth of the difficulties some members experience. It must always be done judiciously and in good taste. It must not serve as a wish to disengage from the "onerous task" of therapy (Salvendy, 1989).

Initial Stage of Treatment

Beginning the day hospital necessitates the simultaneous entry of individuals into group and individual sessions. This presents a special challenge for a depressed older adult who may feel triply stigmatized by societal attitudes toward the aged, the depressed, and the need for help from mental health professionals (Schwartz, 2004). Consequently, there often exists much initial resistance to entry into the program and psychological treatment.

Case Example:

Mrs. B is an 86-year-old woman with Major Depressive Disorder. Although feeling very alone in her condominium, she initially resisted following through on the referral to the PDH because of the stigma associated with mental illness. She tried to hide her low mood from others but her friends noted the change in her and encouraged her to be more accepting of the suggestion to seek treatment. She finally agreed because she felt she must do something to help herself get better. Once in the program, the initial focus was to address her ambivalence and increase her comfort. She was warmly welcomed by the others and received strong encouragement to remain in the program. On occasion, collaboration with referring mental health professionals and family is necessary to manage a new member's anxiety and resistance to continuing in the program.

A therapeutic stance, in maintaining both a belief in the strength of members and hope that they will benefit with therapy is essential at the beginning of therapy, until the effects of the power and strength of the group can itself occur (Schwartz & Schwartzberg, 2011). For example, it is extremely powerful when members can hear from others that they felt similarly depressed upon entry to the group, but after several months they feel much improved (Schwartz, 2004). Hence individuals experience relief when they realize their suffering is not unique. This is consistent with the observation that homogeneous groups, such as is the case with the PDH groups, are likely to gel more rapidly than heterogeneous groups, are more cohesive, offer more immediate support, have less conflict, and provide more rapid relief of symptoms (Salvendy, 1993).

Middle Stage

Once the therapeutic alliance is established with the contact person, psychiatrist and program, members have the opportunity to talk about their depression and interpersonal relationships in both individual and group therapy. Possible biopsychosocial causes and core psychological issues, past and present, contributing to the individual's depression are identified. Ongoing communication in team meetings identifies issues clients may be avoiding discussing, in any one of the therapies. The therapists explore the source of the difficulty and encourage the client to address the issue in the other modality (Lipsius, 1991).

Gans (2005) has written about the courage necessary to join a group. Recognition of this and encouraging each individual to speak when they are more comfortable with the program helps address the client's difficulty in raising issues. Saiger (2001) working in a similar outpatient setting, describes many members experiencing shame of having lost who they were, and viewing the incompetent (physically and/or mentally) replacement to which they must adjust as a bad self. He explains that when these members are able to be assisted to learn that their presumed badness is simply human or related to negative feelings associated with depression and that other group members also engage in similar thoughts and feelings, then a reduction in shame can occur and the individual member can begin to share more personal feelings.

Case Example:

As Mrs. B became more engaged in treatment, the therapists in individual therapy first addressed her tendency to hide her feelings behind a smile and then helped her to understand this better. She recalled as a young child that she felt her mother always favoured her younger brother and regarded him as "beautiful" leaving her to feel like the "ugly duckling". She grew up shy and self-conscious and although later matured into an attractive woman, who married and raised a family, remained sensitive to how she was perceived. She found it hard to be comfortable in unfamiliar situations, especially as she experienced the effects of aging and also became a widow. She wanted the therapists to "fix me" so she would be able to relate better in the PDH and elsewhere. The individual and group therapists, while empathic with her fear and shame of appearing unattractive and suffering further loss and rejection, nonetheless encouraged her to take a risk and speak up in group therapy. She was assisted in discussing her behaviour of hiding behind her smile and then to check out how other group members perceived her.

Other common themes include coping with depression, including the frustration of not feeling understood by family and/or society who are either not depressed or of a younger generation. For example, some members point out that no one can understand them unless they've been depressed. The task of the co-therapists is to point out even in the group they don't always feel understood by others when another member might imply "if you just do what I do, you'll be all better." Similarly, the co-therapists point out that some individuals in their community seemingly always know what to say as they are able to empathize with those who are physically ill or

depressed. Loss of status, changing roles, dependency issues, regrets, guilt, death of a spouse, loneliness and styles of relating that lead to interpersonal conflicts in and or out of the group are other prominent themes.

Discharge/Termination Stage

Relationships with staff and other members develop and flourish so that others are occasionally regarded as "family". The older adult group member has been described as particularly vulnerable to the ending of yet another series of relationships: with the therapists, with each member, and with the group collectively (Salvendy, 1989). Day hospital clients additionally end relationships with other staff members, the entire program, and often with their individual psychiatrist (Schwartz, 2004).

For a population of older adults, ending the program can result in a resurfacing of previous life issues with separation, loss and abandonment. Loss of family in the Holocaust and/or recent losses of spouses may be reactivated by the stress of discharge. It is not unusual for certain members to experience a re-emergence of symptoms. As a result, a discharge date is agreed upon in an individual session approximately 4 weeks prior to discharge. The personal meaning of termination is explored in both group and individual sessions providing members another opportunity for further growth if they are successfully assisted in mourning the negative feelings upon leaving the program and groups.

Case Example:

Mrs. B with much encouragement from her individual therapist and contact person was able to discuss her fear of non-acceptance if she shared her feelings. She received much support from the others who shared similar fears and issues related to shame and rejection. Then came talk of discharge which led to a resurgence of feelings of dependency and sadness related to anticipated loss. A family meeting resulting in the showing of much support and understanding from her children further bolstered her mood and lessened feelings of being alone and abandoned. Coupled with the therapists' encouragement to actively participate in planning aftercare activities while also discussing her feelings related to discharge resulted in enough support so she did not experience a relapse of depression. She was agreeable to attending an aftercare group.

It needs to be noted that discharge is sometimes not handled well because of a therapist's own difficulties with loss or feelings of responsibility in adding to a particular member's sense of loss. This may be detected when, for example, a therapist's difficulty with setting a discharge date becomes apparent in a team meeting when his or her views are markedly different from other team members and from how the therapist usually handles termination (Schwartz, 2004).

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Chapter 8

Family Therapy

Theoretical Rationale:

Clients with mood disorders are often part of a family system. Both the client and family are affected by this illness, particularly when it is chronic. Unhealthy dynamics are set up amongst the family members and are maintained homeostatically, sometimes for years or decades. These relationship difficulties are important precipitating and perpetuating factors in the illness. Brief family interventions in psychiatric illness have been shown to reduce relapse rates, improve recovery, and increase family well-being (Herus, 2006). The research specifically studying the effects of family therapy in Major Depression and Bipolar Disorder is plagued with methodological problems (Henken et al., 2009; Justo, Soares & Calil, 2009). As a result, it becomes difficult to draw conclusions regarding efficacy specific to these mood disorders. Nevertheless, withholding this therapy from a family or a family and client in crisis is not best practice. Although treating the client alone is an option, it is optimal to have an understanding of the environment of the person's illness and the ability to address the contributing psychosocial factors. The Psychiatric Day Hospital (PDH), when deemed appropriate, provides family therapy as a part of the standard of treatment.

Case Example 1:

Mr. X is a 75-year-old man diagnosed with Major Depressive Disorder and Dysthymic Disorder. He was referred to the PDH by his psychiatrist for further treatment of the current episode. On assessment, it was revealed that Mr. X is the caregiver for his wife who has moderate dementia. They have three children: a son and daughter that live locally, and another son who lives at a distance in another country. Mr. X has had to take over a number of roles since his wife developed dementia. He feels overwhelmed and burned out.

Mr. X reports perceived little support from his children. He has no relationship with the son who lives out of town. There is a significant amount of hostility between him and his daughter. Mr. X reported that his daughter yells and makes no efforts to offer support. He disclosed that the other son is withdrawn and says very little. He is angry at his daughter-in-law stating that she has kept the grandchildren away.

Mr. X's adult children were contacted by the team social worker. They reported Ms. X as having a pre-morbid narcissistic personality style. He was experienced as being critical and angry through most of his children's lives. They reported that no amount of help or support that was offered was considered to be adequate, and this was amplified as his needs increased.

<u>Case Example 2:</u>

Mrs. Y, a 74-year-old married woman, presented to the PDH with a diagnoses of Major Depressive Disorder and Dysthymic Disorder. She identified martial problems as being a significant factor contributing to her depression. Mrs. Y reported that her husband does not seem to understand her illness and that his expectations are unreasonable. Further, she stated that he does not offer support and shows little empathy. Mr. Y is contacted by the team social worker. He is invited for a marital session which is attended by the couple, social worker, psychiatrist, and contact person. Mr. Y clearly required education about the illness. He reported feeling frustrated and helpless and did not have the knowledge or skills to cope with the impact of the illness. They both explained that they have had difficulties with communication and conflict resolution for years.

These case examples are typical of the cases that are managed in the program. The difficulties in the relationships are strong contributing factors in the illness. Treating this person's depression in isolation of the family problems would be less than ideal. Management of precipitating and perpetuating psychosocial factors would lead to a better outcome.

A relationship history is taken as part of the initial assessment of each client. With consent, the social worker contacts family members to acquire collateral history. Family members are sometimes relieved by the opportunity to express their feelings and point of view, whereas there are cases where the family refuse to be contacted, do not return the call and are estranged. Clients are offered family or marital therapy when indicated. Family members are approached by the social worker and invited to an initial session with the consent of the client. These family members often already have some relationship with the social worker who may have acquired the collateral history. There are times when the social worker provides individual support and education to family members with whom they already have a strong therapeutic rapport. Once it is clear that family or couples therapy intervention would be useful, it is discussed with the client. With consent, family members are invited for an initial family therapy session where the focus is on developing therapeutic rapport with the clinicians, and developing a problem list for each participant. If the participants are motivated for therapy, they are invited for a focused, brief course of family therapy which occurs separately from the individual sessions with the client who is attending the program. The psychiatrist, contact person, and social worker provide co-therapy. The individual client sessions presents an opportunity to de-brief with the client and work on specific skills and to address the emotional impact of the meeting with the spouse or other family members.

Specific Techniques

The Initial Session:

The initial session involves developing rapport with the client and family members. This is a critical issue. The therapeutic alliance will facilitate success. Efforts are made to make the family members comfortable. It is important that there is no perception of favouritism towards the client or that the therapists are taking sides because of the pre-existing relationship with the client. In the first session, all participants are asked to describe the problems in the relationship and their particular goals. A problem list or "wish list" is created for each family member by asking "if the therapy is successful, what would be different?" Participants are asked to report on their thoughts, feelings, and motivation regarding family therapy. Importantly, the family is screened for violence and substance use. Abuse or violence needs to be addressed immediately. Some families do not have the tools to deal with conflict, and respond well to the initial limit setting by the therapists when it comes to abuse or violence, be it verbal, emotion, and/or physical in nature.

Psychoeducation:

Many families have little in the way of knowledge about mental illness. Mood disorders may present for the first time in late life. Written materials for family members are available, such as the Canadian Coalition for Seniors Mental Health education online booklets (CCSMH, http://www.ccsmh.ca/en/booklet/index.cfm). Psychoeducation is particularly important in cases where family members misinterpret symptoms as "personality" or "behaviour". Symptoms such as loss of interest, irritability, anxiety, expression of negative cognitions, psychosis, and suicidality are particularly distressing for families and need to be addressed.

Behavioural Techniques:

Behavioural techniques can be useful in family therapy. Families and couples are encouraged to follow specific rules and guidelines to diminish disputes. For example, they are taught how to recognize when an interaction is turning into an argument and how to abort the conversation and return to it later. They are encouraged to spend positive time together and provide one another with positive feedback when the interactions are positive.

Improvement of Communication:

Most couples and families that are having problems have difficulty in the area of communication. Participants are assessed for their ability to express, listen, and understand one another. They are given tools that facilitate the expression of their needs and the ability to empathize with others. Much of this work begins in the office

and direct real time feedback can be given. Family members will eventually be given the task of practicing the new techniques on their own and can debrief in future sessions.

Negotiation:

The ability to negotiate is essential in resolving conflict. Once family members have understood one another, the next step involves a negotiation to meet people's needs and to prevent further problems. Negotiation is only possible if the involved parties have expressed their points of view and feel understood and listened to in a manner that a benefit can be experienced by both sides.

Sex Therapy:

It is a myth that older adults are no longer sexually interested or active (Schwartz, Myran & Sokolowski, 2007). In addition to negative feelings from a dispute, there are other factors that can be involved in disrupting the sexual relationship in this population. Some examples include physical factors such as pain or erectile dysfunction, and loss of libido from depression. Older adults are often able and willing to talk freely about this topic when it is addressed respectfully.

Case Example 1 Follow Up:

Mr. X, his son and daughter began family therapy. It became immediately apparent that they had significant difficulty in expressing their feelings and needs without getting into an argument. Mr. X was encouraged to explain to his children what his needs were. His children in turn had the opportunity to do the same. They were given a template to use when expressing themselves. Mr. X began to understand that he often made his children feel dismissed and put down and that this reduced their ability to help him and get closer. His children learned that by distancing themselves or being hostile, that it made Mr. X feel alone and devalued, which in turn fueled his behaviour towards them. The participants were given tasks to improve positive feelings, such as regular, brief interaction. Mr. X learned that his children wanted to be more involved, provided that it was noted and valued. Mr. X learned how to ask for help and provided positive feedback to his children. Although the relationships in the family were not perfect, there was a substantial improvement, with less hostility and more interaction.

Case Example 2 Follow Up:

Mr. and Mrs. Y attended marital therapy sessions with the psychiatrist, social worker, and contact person. Mr. Y had received education about depression in individual sessions with the social worker. He was able to understand his wife's illness and the effect on her behaviour. In the marital sessions, Mr. Y expressed empathy for his wife. The couple also had difficulty with conflict resolution. Examples from the week prior

were used to help them learn how to express their points of view and needs clearly and negotiate a resolution. They were eventually asked to do this exercise on their own with de-briefing and fine tuning in the marital sessions. The couples had fewer arguments and Mr. Y felt better in his role in the relationship.

In summary, marital and/or family discord are important precipitating and perpetuating factors in depressive disorders. Family and marital therapy can be an effective tool and is offered in the program when required.

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Chapter 9

Family Tree Group

<u>Theoretical Rationale:</u>

The family tree group provides clients with an opportunity to reminiscence and to discuss the role that family dynamics, both past and present, has played in their lives. Early family experiences influence personality development contributing to who people are and how they perceive and interpret events that have happened in the past. In other words, the past is an important part of who they are today and how they cope with their depression. Clients are reminded that although they cannot change what's happened in the past, they can change how they look at things that have happened, and how they allow the past to effect them. Erikson (1950) believed examining one's life and determining there was some purpose or meaning allows people to achieve a sense of integrity as opposed to despair. Erikson also believed that in order for an individual to attain ego integrity in the later years of life one had to integrate previous life experiences with those of the present (Stinson, 2010). Using the image of the Family Tree to introduce the concepts and therapeutic benefits of the genogram (see Figure 1), the group is supported in discussing family relationships, ties, challenges, losses and strengths.

The family tree group provides clients with an opportunity to examine, reminiscence, and discuss their past in the context of the families that they grew up in. Early family experiences influence personality development contributing to who people are and how they look and interpret events that have happened in the past. This group is similar in many ways to a reminiscence group which can be effective form of therapy in the elderly. Based on Butler's (1961) theory, reminiscence is viewed as a normal part of aging brought about by the realization of approaching death and recounting the past and assists elders to attain a positive understanding of their life and accomplishments and their value to others. The family tree group is also designed to allow the client to reflect on the past and consider the effect of their past family life on them currently. It gives the client an opportunity and a forum to express emotion and to provide validation of feelings and experiences. Qualitative studies have reported that after participating in a reminiscence group, elders experienced greater life satisfaction, increased well-being, and increased social interaction through sharing of common experiences and of providing a support system for each other (Guitinan, 1990; Harrand & Bollsletter, 2000; Jonsdottir, Jonsdottir, Steingrimsdottir & Tryggvadittir, 2001; Singer, Tracz & Dworkin, 1991; Zausniewski et al., 2004)

<u>Goal:</u>

The goal of the group is to enable individuals to identify the family system, examine it, and gain an understanding of complex family dynamics as they have developed and as they affect their current situation (Hartman, 1978).

<u>Group Format:</u>

The group begins with a request for a volunteer from the group to complete their family tree. When completing the family tree, members are advised that the emphasis is on the relationships and not the dates. A genogram is used on a flip chart so that people can visualize what is being discussed. During this process, other clients are given the opportunity to speak as the content often triggers memories to their own emotionally – laden past family experiences.

The family tree generally starts with people's parents and then grandparents, afterwards moving to siblings, spouse, and children. While doing this, common themes emerge that can then be used as a springboard for the entire group. Some of these themes include influence of grandparents, siblings relationships, influence of birth order, child rearing attitudes, opportunities or lack there of due to the influence of world events.

<u>Case Example:</u>

SW: This the Family Tree Group. This is the group where we talk about our families, particularly the families that we grew up in. We do that because our families are an important part of who we are and how we look at things. Although we cannot change what has happened in the past, we can change how we look at things and/or how we allow things to effect us. One way we do this in this group is by someone in the group volunteering to do their family tree and using that person's tree as a spring board for discussion. Is there anyone who would like to volunteer to do their family tree?

Mrs. V: I'll do mine to get it over with.

SW: Well Mrs. V, nobody has to do their family tree, but I'm glad you volunteered. I think others who've done it will tell you, it's not that painful.

Mr. M: I did it a few weeks ago, and found it quite interesting.

SW: Let me go over some of the ground rules. Firstly, you can talk about as much as you want to or as little as you want to. Secondly, it should not just be me asking the questions and guiding Mrs. V, everyone should feel free to ask questions. Thirdly, we'll take breaks periodically to hear from other people, because inevitably, there will be things that are brought to mind from what Mrs. V says that will relate to your own experiences.

Let's get started.

SW: Mrs. V, you're one of how many children?

Mrs. V: I'm the oldest of 6.

The SW draws on the flip chart (see Figure 1 for Mrs. V's completed family tree).

SW: The circles are for women, and the squares are for men. Let's start with your parents. Would you like to start with your mother or your father?

Mrs. V: Let's start with my mother. Her name was Goldie.

SW: Tell me about her. What was she like?

Mrs. V: My mother was always sick. She spent much of her time in bed. As the oldest, I was expected to take care of things that she couldn't – including the youngest children.

Mrs. F: Was that hard for you?

Mrs. V: Yes. Sometimes it felt like I didn't have a mother or that I couldn't be a child. I was always taking care of other people. Sometimes I was resentful of my younger siblings, that they didn't have the same responsibilities as I did.

Mrs. F: I know what you're talking about. I'm also the oldest and a lot more was expected of me. Both my parents were always working in the store. The difference is that I liked the extra responsibility.

SW: What about other people in the group? Are there other people in the group who are the oldest?

Four people raise their hand in the group.

SW: What about you Mr. M, did you have extra responsibilities?

Mr. M: No. I was the boy, but my sister, who is 2 years younger, had to help my mother with the housework and all the other chores.

Mrs. V: My brothers never had to help out as much as the girls.

Other clients join in the conversation, and the group continues to discuss the different expectations of male and female children when they were growing up.

SW: Mrs. V, let's get back to your family tree. Tell us about your father.

What was he like?

Mrs. V continues to talk about her family. She is able to identify her role as caretaker for 3 generations, as she examines her family. Meanwhile, the SW diagrams all the information about Mrs. V's family.

Mrs. V: I guess it's been easier to take care of others than to take care of myself. That makes me sad.

Mrs. F: (to Mrs. V) I can relate to that. I'm just like that. Only now, as a result of coming here, I'm finally able to do things that will help me move along. I realize that I can't take care of others, if I don't take care of myself.

SW: Mrs. V, what do you think about what Mrs. F is saying?

Mrs. V: I think that it sounds like good advice. For me, coming here is the first step towards feeling better about myself.

The discussion continues and Mrs. V finishes her family tree.

Facilitating questions commonly included in each family tree group are the following:

1. Relationship with parents – describe your parents, which parent were you closest with/farthest from, what were they like, early parental loss, who was the disciplinarian, strict vs. not strict, etc.
2. Grandparents – did you know any of your grandparents? Which ones? What was your relationship like with them? Did they live close or far away? If there was a grandparent that lived with you then the discussion is about what it was like to have multiple generations in the house, etc.
3. Sibling order – were you the oldest? Youngest? In the middle? How many children were in the family? What was it like to be in that role in your family? How did others treat you because of your birth order? Were you close or how has that changed over the years. If you were an only child, what was that like? How did that influence you?
4. Marriage – How did you meet? When did you get married? Elaborate on separations, divorces, deaths, etc.
5. Children – Who are they? Are they married? What can you say about them?
6. Grandchildren - How did you relate your parent's childrearing, to yours and to your children's style? Would you do things differently if you could? Are there things that you modeled from your own parents? Or are there things that they said that you vowed you would never do?

Upon completion of the family tree, the client is asked for their thoughts as they view the entire family tree. Themes and patterns are identified. All the clients are encouraged to consider how the themes and patterns that are identified in their family tree still may be affecting them currently.

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Figure 1
Family Tree of Mrs. V

-Came to live with Mrs. V before she died

CHANA
d. 1945

DAVID
- Died just after
d. 1915

- Always sick
- Spent time in bed

GOLDIE

JACOB
- 'rags' salesman
- Kind, loving but unable to cope with sick
- Wife & 6 children
- Came to live with Mrs. V after his wife died

- Expected to look after younger siblings
- Always took care of others
- Mrs. V took care of her granddaughter after her daughter-in-law died

DAVID
-Died 1975

SAUL

SAM
- Died 1922 as a young boy in an accident

SARA

MORRIS

MRS. V

MR. V
- Plumber
- Successful business
- Made lots of money
d. 1994

-Stroke 19835
- Mrs. V took care of him until, 2 years ago

SHIRLEY

LOUIS

HERBERT

MARSHA
d. of cancer 1963

ANNA
Named after Chana (grandmother)

1st husband
RILI

2nd husband
HOWARD

GOLDIE
- Never married
- Mrs. V very upset about that
- Conflict between Goldie and rest of family
- Isolated herself

LORRAINE
Very supportive of Mrs. V more like daughter than daughter-in-law

DONALD
Skills Group

JANICE

DAVID
d. 1976

Chapter 10

Life Skills Group

Theoretical Rationale:

Depression can become chronic and disabling affecting an individual's daily functioning. Practical life skills are required to cope effectively with everyday life situations. Life skills programs address the needs associated with independent functioning, often part of the treatment/rehabilitation process for chronic psychiatric clients. The role of the Occupational Therapist (OT) compliments the nature and purpose of this group. The OT focus is on enabling engagement in everyday living through occupations. Addressing life skills also compliments the OT philosophy of health promotion and the development of the necessary skills for optimal daily functioning. Blazer (2002) noted the importance of older adults developing skills to promote positive mental health. Developing skills such as improving social ability, while enhancing personal integrity can help the older adult to adapt to the "challenges of aging, challenges that lead to brief episodes of sadness and loneliness, and place the elder at risk for developing a mental illness" (p.318).

Goals:

The goals of the group are to explore, develop and strengthen specific skills required for clients to successfully manage/cope in the community. In addition, the group aims to build on the strengths of the individual, including such things as their ability to learn, understand, problem-solve and contribute interactively within a group.

Group Format:

This group occurs once a week for one hour. A large program room is used for each group. Participants sit on arm chairs in a circle. Equipment may include a flipchart, clipboards, pens, DVD player and TV, laptop and overhead projector. The life skills group is a semi-structured interactive psychoeducational discussion group that enables clients to develop specific practical skills required for everyday living. Groups are planned and organized to meet the diverse learning needs of each individual. Older adults have various learning preferences depending on their age (i.e. some learn best by thinking and watching, while others learn optimally by doing) (Truluck & Courtneay, 1999). Various teaching modalities are used in the life skills group to address a range of learning needs. These include instruction, handouts, modeling, role play, rehearsal, feedback and handouts. Topics address practical skill areas identified as important by group members in planning and needs assessment sessions. Common themes include: coping with aging, assertiveness training, anger management, goal setting, home safety, coping with grief and loss (i.e. roles), leisure, relaxation strategies, support

networks, managing anxiety, and developing self-esteem. All topics are divided into series lasting approximately 2-4 sessions. For example, a series on assertiveness would begin with an introductory group addressing the difference between passive, aggressive and assertive communication styles. The next sessions would focus on learning and implementing assertive techniques (i.e. Broken Record technique, WIN formula) in a supportive, non-threatening environment. Research has shown that training in assertiveness can significantly increase an individual's level of assertive behaviour (Lin et. al., 2008) and increase self-esteem (Brown & Carmichael, 1992).

Evaluation of the group begins with informal, non-threatening discussion within the group regarding how members have implemented various skills into their everyday lives. The facilitator also observes change/development of behaviours. The group leader also consults with and considers team members observations' of clients in one-to-one encounters and in other groups. Components of the Canadian Occupational Performance Measure (COPM) have been used in the past on a trial basis.

Case Example:

OT: Welcome to the Life Skills Group. This group occurs once a week on Tuesday afternoons from 1:00-2:00 pm. Can someone begin to explain the purpose of this group for the new members and help to refresh those of you who have been here before.

Mrs. A: I think it's about learning coping skills to deal with life.

Mrs. L: How to better ourselves. Things like communication and how to speak up.

Mr. C: You mean asserting ourselves.

Mrs. L: Yes, that's right! We also talked about managing our anger.

OT: Yes. Exactly. The life skills group is essentially a time when we come together to discuss various practical strategies and skills we use to cope with everyday life situations. Some of you have already given some examples of life skills topics we've discussed in the past. Are there any other topics we've covered that you can think of?

Mrs. S: Doing things that help us feel good about ourselves.

OT: Yes, those were the sessions on developing self-esteem, another popular life skills topic. Other examples of topics include how to expand support networks, goal setting, developing leisure interests and last week we began to look at attitudes towards aging. That topic was voted on by all of you when I handed out a survey 2 weeks ago. Today we will continue to explore your experiences of getting older, how you cope, in particular with loneliness. This theme came out of our discussion last week.

The OT moves toward flipchart and reads out the goals for the session:

- To define alone vs. lonely
- To discuss experiences of loneliness
- To brainstorm strategies to help cope with loneliness
- To identify at least one new strategy to implement into your everyday life.

OT: What comes to mind when you think of the word alone?

Mrs. N: Not having anyone else around.

Mr. C: Being by yourself.

The OT begins to record group members' responses on the flipchart where there are 2 columns already listed: alone vs. lonely.

OT: Yes, those are all good definitions. Another definition from Webster's dictionary defines alone as "being apart from others; solitary". So, being alone emphasizes being apart from others but does not necessarily imply unhappiness. What are your thoughts about the following quote: "I'm never less alone, than when I am alone."

Mrs. A: That's like me, I have no problem being alone. I like to read, watch tv and relax.

Mr. C: I'd rather have someone to do things with. Like a companion. My wife was my companion, but now she has Alzheimer's and its lonely without her.

OT: So, Mr. C is referring to his experiences of loneliness and the challenges of dealing with his loss. What is loneliness?

Mr. C: Sadness because you are alone. It hurts when someone you love is not there anymore. You get used to doing things together, having that closeness. It's not the same now.

OT: What do others think about what Mr. C is saying?

Mrs. N: I feel bad for him. His wife was his best friend. He's lonely without her even though he has some friends.

Mrs. H: You can be surrounded by people, but still feel lonely. I had that experience last month. I went to a luncheon and although there were people I knew around, there was no one I really felt close to. I didn't feel like I belonged so I ended up leaving.

| OT: | That's an example of how loneliness involves more of an emotional component. Alone relates more to a state of being whereas loneliness connotes a deeper emotional involvement. |

The OT proceeds to read the following Webster's definition of lonely: "being without company; not frequented by human beings; sad from being alone; producing a feeling of bleakness or isolation."

| Mrs. B: | That makes sense. All I know is that lately as I've been thinking about being discharged from the program I've been feeling lonelier and worrying about how I will cope. |

| Mrs. N: | Are there any things you can do to keep busy? |

| Mrs. B: | Yes, I guess. My contact person and I are working on creating a schedule. I also plan to come to one of the aftercare groups so I have people to talk to who might understand me. |

| OT: | That takes us into an important part of the session today which is to identify practical ways to cope with loneliness. One important strategy you have all been engaged in here already is talking about your feelings and experiences of loneliness. Together, let's identify more ways to cope effectively with loneliness. |

| Mrs. B: | Ok, good, I need this badly. |

The OT passes around a handout with various tips for dealing with loneliness. She asks for a volunteer to begin reading some of the points and then others read from the list. Discussion ensues after each tip is read and group members give their own personal examples…

| Mr. C: | I like the one about nurturing other close relationships. There is one other person in my life aside from my wife that I've confided in. I trust him, but since I've felt depressed I haven't been in touch. |

| Mrs. S: | Maybe you can call him and make some plans to get together this weekend or even just talk on the phone? |

| Mr. C: | That's actually not a bad idea. I'll try that. |

| OT: | And how about the rest of you… are there other tips from the list or ones you can think of that you can implement into your everyday lives? |

| Mrs. A: | I might consider joining the diner's club at the senior's centre near my building. It's one less night a week I'd be eating alone. |

Mrs. T: I'm going to try to start going back to church. After the service, there is a social get-together. I haven't been in ages, but I used to go and it was nice to chit chat. I even got involved once in the rummage sale. Maybe I can volunteer there.

The OT goes around the circle and encourages each member to identify one tip they can try out in the next week and then come back to the session to report on how things worked out.

The OT processes the session by reviewing the benefits of discussing this topic and asks for feedback from participants about both the process and content of the session. Members are thanked for their involvement and reminded to refer to their handout for additional strategies as well as to discuss further thoughts and feelings, in individual or group therapy, if relevant.

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Chapter 11

Activity Group

<u>Theoretical Rationale:</u>

Leisure, along with self-care and productivity, is considered one of the major occupations of human beings. It is therefore an area of focus for the occupational therapist (OT) in the Psychiatric Day Hospital. The positive influence of activity as a treatment for depression of older adults has been well documented in the literature. Moll, Valiant, and Cook (1997) highlight the use of activity-based groups that engage participants in purposeful tasks. The authors note that through the process of engagement, clients can be encouraged to: develop cognitive skills/ strategies (e.g. concentration, decision-making, organization, problem-solving), develop positive self-concept, increase their interaction and connection with others, develop healthy, balanced activity routines and increase their enjoyment and connection to meaningful occupational roles.

In activity groups, individuals are facilitated in their recovery from depression using activity and engagement in leisurely pursuits (Lloyd et al., 2007). "Leisure is important as it plays a part in contributing towards a balance in a person's life and in promoting health, well-being and overall life satisfaction" (Melamed & Meir, 1995, p.36; Lloyd et al., 2007). By targeting depression from a "doing" perspective, the OT is promoting engagement in meaningful leisure occupations thereby positively impacting one's quality of life. Participation in leisure activities later in life has been shown to positively impact life satisfaction and psychological well-being (Genoe & Singleton, 2006). Herzog et al. (1998) have demonstrated the positive link between engagement in stimulating leisure activities and lower levels of depression. Studies have also shown that increased levels of social interaction and support decrease depressive symptomology (Fulbright, 2010).

<u>Goals:</u>

The goals of the group include the following: to increase the participant's independence in his/her chosen occupations within the areas of self-maintenance, productivity, and leisure through the provision of graded tasks; to increase the client's sense of achievement and success through graded/reachable opportunities for task mastery; to increase participants' feelings of self-confidence and self-esteem; to improve concentration, attention-span, decision-making, problem solving and organization through education/training in relevant cognitive skills and strategies, and hands on engagement in activities/tasks; and to increase clients' self-awareness of strengths and abilities and to improve participants' abilities to cope effectively with success and failure with the group process.

The group is used as a medium for assessment and intervention by providing opportunities to assess clients' current level of skill within cognitive, physical, interpersonal, and intra-personal performance components. The group also allows the facilitator to work with participants to establish client-centered goals related to the occupational performance issues prioritized by them.

Group Format:

The group occurs once a week for approximately one hour and is facilitated by the occupational therapist and one occupational therapist assistant. It takes place in the occupational therapy room which is specifically set up in activity stations. Arranged at the beginning of each group, the stations provide a number of choices for engagement in activity. Materials for various projects and tasks are located on each table. Other equipment required is accessible from organized storage areas (e.g. labelled cupboards and shelves). The kitchen connected to the activity room is used for extra activity space and occasionally for cooking and baking. With the prior consent of members, soft music (e.g. classical) is played throughout the hour, including set-up and clean-up time. The environment is systematically organized to enable independence.

There are usually 1-4 participants at each station depending on the activity (i.e. there may only be one group member engaged in a craft activity, 3-4 individuals may be playing a game). If a participant tires of a particular activity (e.g. not the right fit, interested in another activity), he/she has the freedom to choose another station or activity.

The group is an activity-based program. Examples of projects or tasks include the following: crafts, reading the newspaper and sharing opinions re-current events, creating a group newsletter, games (e.g. scrabble, rummikub, cards, checkers, chess), games on the computer (e.g. solitaire, scrabble), surfing the internet, journal writing, sketching, and occasional opportunities for cooking and baking (i.e. at holiday time). The group is designed to provide viable leisure options that clients could realistically engage in post discharge.

Group members are encouraged to bring materials and projects from home. This assists them to begin to reconnect with previous interests and share their creations. Especially for those who are just starting the program, new projects or activities are overwhelming. Using the familiar enhances one's comfort level and facilitates the transition to a new setting. Once members are more at ease, other opportunities appear less threatening. The likelihood of taking on new roles and behaviours develops and successful experiences are created. Clients are encouraged to be involved in all stages of the project group including getting started, setting up, choosing an activity, participating in an activity, cleaning up, and evaluation. Facilitators and group members commend participants for their successful involvement in an activity and their

contribution to the group. Feedback to staff is encouraged and all activities/projects suggested are explored and discussed with members.

Case Example:

The OT meets the participants in the regular group room following their morning exercise session and escorts them across the hall to the OT room where the Occupational Therapy Assistant (OTA) is waiting. Some activity stations are already set up and classical music is playing in the background. Members who are familiar with the structure of these sessions and have activities in progress immediately gravitate to various activity stations (i.e. games room-Rummikub table, card-making). The OT and OTA work with newer members and/or reluctant participants to connect them with an activity of his/her interest.

Mr. S is a new member. He described himself as a loner during the initial OT assessment. He is uncertain about where to begin…

OT: Mr. S, welcome to the project/activity-based group. This is a group that meets every Wednesday from 10:00-11:00 am where we encourage involvement in activities of your interest. In this group, we use activity as the form of therapy whereas in the group psychotherapy session you attended on Monday afternoon, talk therapy is the focus. The idea here is to help treat depression through the use of engagement in meaningful activity. Are there any particular interests/hobbies that you have or anything you used to do that was enjoyable?

Mr. S: I've never really had many hobbies other than fishing, watching sports and reading the newspaper. I used to like to keep up with current events, but I can't concentrate right now on anything with how I've been feeling lately.

OT: Well, difficulty with concentration is a common symptom of depression. There are some activities you can participate in that can help to address this issue and improve your ability to focus on tasks.

Mr. S: If you think so, but as long as it's not arts and crafts. That's not for me.

OT: I understand. Let's see what we can find that might interest you today. Why don't you have a seat at this table next to Mrs. R? (Mrs. R is working on a word search she started last week).

Recognizing Mr. S's previously enjoyed interests and a cognitive skill that he's identified as problematic, the OT suggests the following activity…

OT: Mr. S, one activity that can help build your concentration is a word search puzzle. Have you ever done one of these before? (OT holds up an example of a word search).

Mr. S: No, but my wife loves them and does them all the time at home. She has a huge book just full of them. You'll have to teach me.

The OT finds a word search with a sports-related theme. Necessary materials are gathered and placed in front of Mr. S.

OT: This one I have here has a sports theme. It's also in larger font as I know you have some difficulty with your vision. Let me show you how to start.

The OT explains the instructions and guides Mr. S as he searches for the first word. The OT provides some strategies to help simplify the activity (i.e. using a ruler to focus on one line at a time, focusing on the first letter of the word and then looking around at the surrounding letters, taking frequent breaks).

Mr. S: Wait a second here, I think I found the next word. There it is, "Goaltender."

OT: Yes you got it. Great job!

Mr. S: So, I just circle it like this?

OT: Exactly. Perfect! Now you can cross it off the list and move to the next word. It looks like you are getting the hang of it. I'm going to let you continue through the list and you just call me over if you need any help.

Mrs. R: You can also ask me if you need any help.

Mr. S: Ok. Thanks.

Mr. S is able to tolerate his activity for approximately 30 minutes. Mrs. R occasionally checks in with him and they exchange some friendly conversation. The OT and OTA are circulating around the room and observing group members already engaged in their activities, assisting where necessary. Two participants are painting with water colours at the craft table and a gentleman is sitting on the couch reading the newspaper. Five women are seated at a table, four are engaged in a game of Rummikub, one is observing and learning how to play. Two group members seated at the craft table are engaged in lively conversation as they knit their scarves.

OT: (checks Mr. S's progress) You have completed half the puzzle already. How are you finding this activity?

Mr. S: At first, it wasn't easy, but I'm catching on.

Mrs. R: He's a fast learner.

Mr. S smiles and thanks Mrs. R for her help and keeping him company.

OT: (announces to the group) We only have a few minutes remaining so please finish up for today and you can continue next week. Mr. S would you like to take the word search home with you to complete?

Mr. S: No, I think I'll just leave it here and maybe continue working on it next time. I can always try one of the one's my wife has at home too.

The OTA asks Mr. S to initial his page and files it in the activity cupboard for next week's group. Group members help to clean up the space and they are thanked by the facilitators for participating in the session today. They are also reminded to let the OT know if there are any supplies that they would like to have for the group.

The following week, Mr. S arrives asking for his word search to complete. He says that over the weekend he worked on a puzzle with his wife. He is displaying increased motivation and interest compared to the previous session. His activity tolerance and ability to focus on the task has also increased to a full hour.

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Chapter 12

Dance/Movement Therapy Group

Theoretical Rationale:

Many depressed clients have a concave, protective, and burdened posture with a downward focus, rigidity, excessive tension in the body, and shallow breathing. They often have somatic complaints and tend to be immobilized by their thoughts or feelings. As a result they do not move a great deal. Dance/movement therapy serves to activate and motivate these clients by tapping into the healthy parts of each individual. By encouraging spontaneity through movement, a creative atmosphere develops which enhances the client's sense of vitality and self-esteem. The group modality offers a safe environment for clients to explore and express both negative feelings, either alone or with others who share similar difficulties.

Goals:

The goals of the group are to increase self-awareness of existing capabilities, improve self-esteem, and improve socialization skills through peer interaction. In addition, the group aims to provide a non-verbal means of communication within a supportive, caring environment.

Group Format:

The dance/movement therapy group occurs for one hour every Monday morning. A typical dance/movement therapy session consists of a warm-up, sitting and standing components, as well as a warm-down. All participants, including the therapist, begin their experience by choosing a chair in the pre-arranged circle. The inclusiveness of this formation promotes social interaction through conversation and the sharing of movement ideas while supporting the individual experience within the group.

The goal of the warm-up is to assess the mood and needs of the group by observing energy level, facial expression, body rhythm, posture, spatial awareness and ability to interact socially. The warm-up movement, which takes place seated, focuses on activating the muscles and joints of the upper and lower body in order to prepare the participants for the remainder of the session. Exercises tend to be more repetitive but can vary in the dynamics. For example, the warm-up can range from light, indirect and free arm movements in the far-reach space to direct, strong, rhythmic foot movement.

The core of the session, based on the observations of the warm-up, can consist of either improvised or choreographed movement. If the participants are experiencing very little initiative in creating their own movement, the therapist can either choose to teach them a choreographed dance or provide props to inspire new ideas. Teaching set choreography can provide a sense of mastery while the use of props has the ability to draw participants out of their prescribed movement patterns.

The use of music and rhythm is an integral aspect of a dance/movement therapy session. The choice of music can inspire creativity, lift energy, facilitate reminiscence, draw participants out of habitual rhythms and achieve group cohesion through moving simultaneously (Sandel, Chaiklin & Lohn, 1993).

Returning to or remaining seated, the warm-down brings the session to a close through breath, relaxation or stretching. This moment allows participants to prepare themselves physically and mentally for the transition from the dance/movement therapy session to the next activity of their day.

Case Example:

This is a brief example where the thematic approach taken by the dance/movement therapist (D/MT) incorporates a balance between light, indirect, and free movements contrasted by direct, task-oriented movement. Themes of taking control and letting go emerge throughout the work.

For this exercise, each participant in the circle is given a hand-full of soft feathers. There is light instrumental music playing in the background.

D/MT: Take one feather at a time and lift it as high as you can. When you are ready, let it go and simply watch it make its journey to the floor. Leave the feather where it lands. Repeat this movement until you have let go of all your feathers.

The room becomes silent as each member begins their own dance with the feathers, each engaged in their own process of letting go and observing the journey.

D/MT: Would anyone like to share their observations with the group?

Mr. D: My feathers seemed heavy and fell to the ground quickly.

Mrs. M: My first two fell to the ground quickly and then I tried to get the rest to float.

D/MT: What were some of your strategies?

Mrs. M: Well, for one of them I tried to throw it farther from my body. For another I tried to blew on it to keep it in the air longer.

D/MT: Did anyone else want to share any observations from their own experience?

Mrs. V: I wish my body could move like the feather.

D/MT: What would that feel like?

Mrs. V: Like floating. It would feel free and not stiff. There would be no pain in moving.

D/MT: What would floating look like with your body? Could we try to move like the feather together?

Mrs. V: Not today.

D/MT: What if the group tried it together? What if we all tried to be only as light and free as we can be today? Not all of the feathers moved in the same way. Some of us had to find new strategies to get the feather to float. What strategies can we use to overcome the challenges that our bodies present us with every day?

For a brief moment, the participants moved together. Mrs. V looked at the ceiling while lifted up her chest and opened her arms out beside her. There was a soft, subtle movement in her fingertips that didn't reach farther than her palms. While her movement was minimal, her body language suggested a freedom that hadn't been there a moment earlier.

D/MT: Let's look down at the feathers for a moment.

Mrs. B: It looks like art.

Mr. H: It does look nice. We created something without trying.

Mrs. A: I think it looks like a mess. Who's going to pick them all up? Should we get a broom?

D/MT: I will pick up the feathers in just a moment. Like art, life moments can be seen and interpreted in so many different ways. In movement, each body can find its own way to explore freedom and lightness.

Reference

Sandel SL, Chaiklin S, Lohn A, eds. *Foundations of Dance/Movement Therapy: The Life and Work of Marian Chace.* Columbia, MD: The Marian Chace Memorial Fund of the American Dance Therapy Association; 1993.

Chapter 13

Exercise Group

<u>Theoretical Rationale:</u>

Research from the National Institute of Health indicates that the lack of exercise in seniors is more harmful to their health than exercising. For example lack of exercise can diminish their health in the areas of strength, balance, flexibility, and endurance. Clients are assured that it is never too late to begin to exercise (Yan et al., 2009). There are significant psychological and physical benefits to exercise (Mather et al., 2002) and meta-analytic evidence of benefit for Major Depression (Krogh et al., 2011). Exercise fosters social contact and favourably affects quality of life (Antunes et al., 2005). In addition, exercise is helpful to improving clients' mood and sleep, and regular exercise is effective in reducing functional decline associated with aging (Antunes et al., 2005).

<u>Goals:</u>

The exercise group is meant to enhance physical health and energy. At the same time, a client can contribute to better mental health by improving concentration, attention-span and enjoyment in the company of others. It is now believed that exercise also contributes to improved memory. Having an exercise component in the program first thing in the morning allows an opportunity for the clients to start the day with a lighter activity. The ultimate goal is to further reduce depressive symptoms as part of the multi-component program.

<u>Group Format:</u>

The exercise group is a half-hour of supervised, gentle, group exercise that occurs each morning that is led by either one of the nurses or occupational therapists. The clients are encouraged to participate in as much as their medical conditions will allow. For example, they are encouraged to participate in non-stress movement whether standing up or sitting down. To the accompaniment of music, various muscle groups are gradually engaged in movement. Clients are also encouraged to exercise in their homes on days they are not attending the program.

<u>Case Example:</u>

Contact person: Hello everyone. I've just put the C.D. in. Let's begin by standing up. Try to keep in mind everyone's body works at a different pace. There's no need to compare or compete. And keep in mind the reasons we're exercising here. Can anybody think of some reasons? While we talk, let's start by swinging our arms from front to back.

Mrs. Z: So that we feel better.

Contact person: Yes, as most of you know, when you are depressed you don't feel like doing things. However, it's important to engage in being active, even when you don't feel like it. Gradually, the motivation will come back. Doing this exercise is a good start.

Mrs. A: I find doing this gives me more energy.

Mr. I: I use the breathing exercises when I'm nervous.

Contact person: Exercise is also good for our circulation and blood pressure. Now let's also do our deep breathing. Take a deep breath in – hold – and breath out. Now let's exercise our shoulders…our arms…our legs…

Mrs. D: This feels better than when I first started the program two weeks ago.

Mr. B: Yes, I notice the difference.

Contact person: Anybody else want us to know how you're feeling.

Mrs. Z: I feel better now than I did before the group. I might even start trying this at home on the weekend.

Contact person: Yes, it can help you cope better with daily stress and anxiety. But remember it's a learning process, but gradually with practice, you'll be able to relax better.

References

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Krogh J, Nordentoft M, Sterne JAC, Lawlor DA. The effect of exercise in clinically depressed adults: A systematic review and meta-analysis of randomized controlled trials. *Journal of Clinical Psychiatry.* 2011; 72(4):529-538.

Mather AS, Rodriguez C, Guthrie MF, McHarg AM, Reid IC, McMurdo M. Effects of exercise on depressive symptoms in older adults with poorly responsive depressive disorder. *British Journal of Psychiatry.* 2002; 180:411-415.

Yan T, Wilber K, Wieckowski J, Simmons WJ. Results from the healthy moves for aging well program: Changes of the health outcomes. *Home Health Care Services Quarterly.* 2009; 28(2):100-111.

Chapter 14

Relaxation Group

Theoretical Rationale:

The Relaxation Group incorporates a behavioural approach. Relaxation, a simple and effective strategy for reducing anxiety, a common symptom of late-life depression, includes techniques such as deep abdominal breathing, muscle relaxation, and the utilization of imagery. Relaxation therapy provides excellent results in becoming more alert, more energetic and stronger. It helps to build confidence, self-worth and can improve quality of life.

Goals:

The goals of the group are to teach participants a practical technique to help them to relax and cope with daily stressors. Participants are trained in ways to cope with stress, control anxiety, chronic pain and improve sleep.

Group Format:

The group is held twice per week at the end of the day and is led by one of the registered nurses. Clients sit in a circle for the half-hour group. Clients are led through a series of deep diaphragmatic breathing exercises, progressive muscle relaxation and use of guided visual imagery to induce a complete relaxation of the mind. Clients are encouraged to use these techniques at home. Relaxation tapes are provided upon request.

Case Example:

RN:	Let's begin muscle relaxation. I will lead you through relaxation of all your muscles in your body and then of your mind through the use of imagery. When we're finished, you will feel more relaxed and have more energy. Now let's begin by resting your arms either on your lap or on the arms of the chair. Place your feet flat on the floor and make yourselves comfortable in your chairs with your back straight. Now close your eyes. Inhale slowly and take a deep breath in through your nose so your abdomen expands and then exhale slowly through your mouth allowing your whole body to let go of the tension every time you breathe out.

Now I'd like you to focus on your feet, move the toes and allow the feet and toes to relax. Direct your attention to your lower legs muscle and allow the lower legs muscles to be soft and relaxed. Concentrate on your upper legs and allow these muscles to be smooth, soft and relaxed. Let go of the tension in your muscles …

RN: Now that your body is relaxed. I'd like you to visualize a safe, calm place. You are going to the garden. The sky is blue. You could hear the birds singing. Perceive all the beauty: the flowers, little bushes and big trees. You are alone but you are not lonely …

As the relaxation process concludes, the nurse asks the clients to slowly open their eyes. She instructs them to stretch their arm and leg muscles, and to take some deep breaths to stimulate the circulation and ensure that clients are awake and alert before leaving the group.

The nurse encourages the clients to use this technique at home, in order to cope with daily stress and anxiety.

Now, the nurse asks each client whether they were able to relax. For those who were having difficulty, she reminds them that it is a learning process, and that gradually, with practice, they will be able to relax. She reminds the clients they may borrow a recorded version of the relaxation technique.

References

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Chapter 15

Reminiscence Group

Theoretical Rationale:

Therapeutic reminiscence has been found to have a positive influence on depression, self-esteem, and socialization among older adults (Adamek & Slater, 2008; Cappeliez & Robitaille, 2010; Stinson et al., 2010). Gibson (2004) defines reminiscence as the process of remembering, recalling, reviewing, and reconstructing memories. White and Epston (1990) posit that "the stories [people tell] about their lives determine both the ascription of meaning to experience and the selection of those aspects of experience that are to be given expression, these stories are constitutive or shaping of persons' lives" (p. 40). Memories are often modified when entertained or shared with others, and a reframing of the past may allow group members to gain a greater sense of understanding about themselves and the present context of their lives.

Goals:

The goals of the group are to decrease isolation by fostering a sense of belonging, to provide an opportunity for self-reflection and restoring as well as to explore and reinforce past methods of coping. In addition, the group aims to learn more about other's experiences through celebrating commonalities and differences and to integrate past experiences within the present context.

Group Format:

The group is led by a Social Work Student (SWS) and runs for 8-10 weeks once a year. During this time, it occurs once a week for one hour. The social worker and/or psychiatrist attend the group, primarily as observers. The format of the reminiscence group is semi-structured and organized around themes or topics. Burnside recommends the inclusion of group members in the selection of topics (McInnis-Dittrich, 2009). Examples of such potentially suitable topics include: childhood, school days, travel, friendship, and the seasons. It may be important to take into account the gender of group members, cohort experiences of older adults, different cultures represented, and the location when determining suitable topics. Props or triggers may be used to evoke memories (Haight & Gibson, 2005). Group members should be encouraged to bring in personal memorabilia when appropriate.

Case Example:

SWS: Let's begin by going over what we will be doing here. What does reminiscence mean?

Mrs. G: It's about remembering the different things that have happened to us. Where we were, who we were with…

Mrs. D: It's about the past.

SWS: You're both right, reminiscence is about remembering some of the different things we've experienced in the past. And in this group there's another piece to reminiscence.

Mrs. S: Telling our experiences to others.

SWS: Exactly, so reminiscence in this group refers to the act or process of recalling and sharing memories. Why do we do this? What might some of the benefits be?

Mr. B: It is nice to remember good things that happened.

SWS: You're right. It can be enjoyable to remember the past. But this is a space where we can talk about good and bad memories. What are some of the other reasons we might reminisce?

Mrs. G: To look at how we dealt with different things in the past.

Mrs. D: To think about what we've done that was good.

SWS: Two very good points have been made. Reminiscence allows us to look at past methods of coping, and also enables us to take stock of our accomplishments. Both of these situations offer an opportunity to self-reflect and also to bring the past into the present. This week's topic is School Days. Today we have some props intended to stimulate memories.

The SWS distributes a vintage wooden ruler and piece of chalk to each group member.

SWS: I'm going to play a short audio clip of school sounds. You've just arrived at school. Likely you walked there. Maybe alone, maybe with a group of

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local kids from your neighbourhood. What does the school look like? You walk up the steps and enter the building. You walk through the hall and take a seat in the classroom.

The SWS plays the audio clip. The sounds include: walking, the creaking of desks, books being placed down, bells and the ABC song.

SWS: What are people thinking about right now?

Mrs. S: I'm thinking about songs. We didn't sing that son, but we sang other ones. (She sings a few lines of a song).

Mrs. G: I remember songs we used to sing too. So many different songs.

SWS: Do you remember how you felt when you used to sing songs at school?

Mrs. D: It was nice to sing something altogether, where everyone knew all the words. It made you feel connected to others.

Mr. B: No, not for me. I was always going to different schools, and they taught in different languages.   One year it was Romanian, the next Serbian, Croatian…it was very hard.

SWS: That must have been difficult for you, to switch schools so often. But look at you now, you can speak all of those different languages! So in some ways it may have enriched your life. Does Mr. B's experience resonate with anyone?

Mrs. G: Well, I was living in Montreal, but my family spoke English at home. So school was a very different experience than what I was used to.

Mrs. D: Where were you living in Montreal? I'm from Montreal.

Mrs. G: We lived in the east end. I went to the school E…

Mrs. D: I went there too! Did you ever have Mr. W? He was great.

Mrs. G: I had him in my second year. He was a very kind man. You got the sense that he cared about what he was doing.

SWS: Does anyone else remember a certain teacher that really had an impact on them?

The discussion continues, and the SWS attempts to engage different group members and makes connections between experiences. To conclude, the SWS outlines some of the themes that have emerged. Group members may be reminded to speak to their contact person before they leave if the discussion has brought up some unsettling thoughts or anything they would like to address further.

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Chapter 16

Community Meeting Group

Theoretical Rationale:

Community meetings provide an opportunity for clients to meet to discuss issues that pertain to the group "community". Community meetings are essential when groups are part of a larger treatment program, as in a Day Hospital. It is a time for making announcements; a time to ask about people who are sick and a time to say good-bye to people who are leaving.

Goals:

The goals of the group are to create a better understanding of group process and the day hospital, to provide an opportunity for clients to share concerns about the program, to further develop a sense of community and community responsibility, as well as to provide an opportunity for staff to share administrative information.

Group Format:

The community meeting is held weekly for one-half hour. Both staff and clients are expected to attend. The group begins with a staff member explaining the purpose of the group at the beginning of each meeting. Clients are encouraged to ask questions. Examples of questions address why programs exist as they do, concerns about aspects of the program clients are uncomfortable with, and the sharing of information and ideas that might be helpful to others especially about events that may be of interest in the community in which they live. Also, the process of saying good-bye to members who are leaving that week begins.

Case Example:

SW: Welcome to the community meeting. This is the group where we come together as a day hospital community to discuss any issues or concerns that you may have about the day hospital. It's a time for making announcements, for letting you know about community events, for making suggestions for improvements and for asking about people who are missing. It is also an opportunity to say good-bye to anyone who is leaving the group. Does anyone have any issues or concerns that they want to raise today?

RN A: When Mrs. W was here, she used to water the plants in the group room. Now that she's gone, I want to know if someone is interested in watering the plants?

Mrs. G: Well, I don't get here as early as I used to, otherwise I'd do it.

RN B: Mrs. G, you can do it in your leisure time here.

Mrs. G: That's a good idea. O.K. then I can do it.

RN A: Thank you Mrs. G, that's very kind of you.

OT: Next week I'm going to be on vacation, so I won't be here the whole week.

Mrs. S: But you are my contact person. Does this mean that I won't have a contact person for next week?

OT: No. I have already made arrangements for you as well as my other clients to be assigned to the other team members who will be here next week.

Mrs. S: Thank you.

RN A: We have a group member leaving the day hospital this week, so I'd like to give Mrs. F an opportunity to say good-bye (to Mrs. F). Mrs. F, is there anything that you'd like to say to the group?

Mrs. F: It was nice to get to know all of you. Thank you all for your kindness. I'd like to say thank you to the staff for their warmth and understanding.

RN A: Mrs. F, I just want to say that you deserve a whole lot of credit for coming here.

Psychiatrist: Yes, you deserve a whole lot of credit. I've seen a lot of good changes in you since you started here.

Mrs. G: Be good to yourself and enjoy your retirement from the program. Be kind to yourself.

Mrs. C: Mrs. F, your being here has taught me a lot. Your courage to face each day has been an inspiration to me.

Mr. F: It was really something to get to know you. I'm going to miss you.

RN A: I guess what I'm hearing is that you gave a lot to the group.

SW: We all wish you the very best Mrs. F.

Reference

Dibella GAW, Weitz GW, Poynter-Berg D, Yurmark JL, eds. *Handbook of partial hospitalization.* New York, NY: Brunner/Mazel; 1982.

Chapter 17

Weekend Planning Group

Theoretical Rationale:

Symptoms of depression can include difficulty with making plans. Attending the Psychiatric Day Hospital provides members with structure and plans. However, not attending Friday, Saturday and Sunday sometimes proves to be problematic for many members in keeping active which may lead to feeling more depressed by the time they return to the program following the weekend.

Goals:

The goals of the Weekend Planning Group are to motivate and encourage clients on the weekend to begin new tasks or resume activities they stopped due to depression, to help clients become more active in planning their weekends, as a prelude to planning their future upon discharge, and to encourage clients to appreciate that small gains in completing everyday tasks or activities is part of the way improvement from depression occurs.

Group Format:

Various members of the team (psychiatrist, contact people) meet weekly for one-half hour. The group is the last meeting of the week. One by one, each member is encouraged to share their plans and any difficulties they may have in planning. The group is started by simply asking a member "What are your plans?" As members often have difficulty with weekend planning, staff emphasize that a plan does not have to be elaborate or necessarily involve any other person. For example, it is pointed out to clients that if they plan to go home and make dinner and then watch television, it is as valuable as planning to go out to a movie. Members who are more improved are often involved in assisting to motivate those who are more depressed and are finding it difficult to make plans.

Case Example:

RN A: I wonder if somebody would like to explain the purpose of the planning group?

Mr. O: I don't know the exact purpose, but I know that we talk about our weekend.

SW: But why do we do this?

Mrs. D: When I'm depressed, I just want to stay in bed if I have nowhere to go.

Mrs. E:	I start worrying about the weekend on Wednesday. I dread it.
SW:	The purpose of the planning group is to assist and encourage people to make plans. These plans may involve gradually getting back to things you've dropped because of your depression. They don't have to be elaborate plans, like going to a concert. They can be as simple as phoning a friend, washing your hair, going for a walk, beginning to cook, going shopping, or reading.
RN A:	Some people find that the first step in planning is to picture yourself doing it, and chances are that you will follow through.
Mrs. T:	I try writing a note at night and leave it on the counter. In the morning I read my note and I follow through with the plan.
RN B:	Mrs. H, would you like to tell us your plans?
Mrs. H:	I have no special plans. I'll just do the usual, like see my friends. Actually, I have to go to the cemetery. I have an unveiling for a friend.
SW:	How are you feeling about that?
Mrs. H:	It's not easy.
RN A:	Would you mind coming back and telling us how it went?
Mrs. H:	Well, O.K. I guess I will.
Psychiatrist:	We hope that you have a good weekend, all things considered.
SW:	Mrs. C, would you like to tell us your plans?
Mrs. C:	I'm going to my children and if I feel like it, I'll go shopping, and that's it.
RN A:	Mrs. C, it's important to try and then as you begin, the feeling will come. Mrs. C, may we wish you a good weekend.
RN B:	Mrs. N, would you like to tell us your plans?
Mrs. N:	On Friday, I'm going to do my volunteer work at the gift shop at the creative living centre.
RN B:	By the smile on your face it looks like this is something you really enjoy.
Mrs. N:	Oh yes! They asked me, "When are you coming back for good?" They're keeping a spot for me.
OT:	Good and what are you going to do for the rest of the weekend?

Mrs. N: I'm going to do some shopping and I will be going to the hairdresser.

SW: Mrs. G, may we wish you a good weekend.

RN A: (to Mrs. P) Would you like to discuss your plans for the weekend?

Mrs. P: I will be going to the hairdresser tomorrow. I have been debating this in my head for quite a while. I might even have a haircut.

RN B: Is there anything else that you're planning to do?

Mrs. P: I will be going with my husband to the bakery, to pick up some pastries for my children and grandchildren. They're coming on Friday. On Saturday, I'll be doing some shopping with my husband. And on Sunday, we must attend a friend's unveiling.

SW: Mrs. S, would you like to tell us your plans?

Mrs. S: It's very difficult for me to make plans. I kind of take things as they come.

OT: I understand that it is difficult, but I'm going to ask you to think of one thing that you might do this weekend.

Mrs. S: I'm supposed to go to lunch with a friend. I also want to get in touch with my sister-in-law to find out about the picnic.

RN A: Mrs. S, may we wish you a good weekend.

RN B: We want to wish you all a good weekend and we'll see everybody on Monday.

Reference

Dibella GAW, Weitz GW, Poynter-Berg D, Yurmark JL, eds. *Handbook of partial hospitalization.* New York, NY: Brunner/Mazel; 1982.

Chapter 18

Team Dynamics

Just as cohesion is crucial to the functioning of a group, cohesion is fundamental to the functioning of a special type of a group at the Psychiatric Day Hospital (PDH) - the interdisciplinary team of staff members. A cohesive team paves the way to more effective client care.

As with any group, both content and process contribute to or interfere with effective communication and cohesion. In the case of the PDH team, content refers to both the composition of the team members in terms of their training and profession, as well as what is said by each member. Process refers to how team members communicate with each other, in terms of listening, understanding and respectfully responding.

Many of the PDH staff have been together for a number of years. Nonetheless, any new team member, including students, regardless of background face a challenge similar to how any new group member feels upon entering an ongoing group. Questions such as "How will I be welcomed?", "Will I fit in?", "What will the others think of me?", "Is this where I want to be?", "What do I have to offer and will it be valued?" are often present (Dibella et al., 1982). At this early stage for the new member, a cohesive team that has close bonds between remaining members, will hopefully be able to both recognize and understand their own feelings of loss associated with the departure of the former member, and the difficult challenge a new member has in replacing a former popular staff or student. Hopefully, the new team member will be able to on his/her own and/or with assistance of the team be aware of his/her feelings and what is behind the attitudes and behaviours shown towards him/her by others.

A cohesive team is associated with the creation of a safe working environment for each member. However, interactions within cohesive interdisciplinary teams may at times be strained owing to status, hierarchy, and professional identity of the team members (Apker et al., 2005). One example of this is the formation of a sub-group or alliance between certain members who have similar ways of thinking or are of a similar background. A team that struggles is evident when there is more emphasis on the content and who is right or wrong, rather than focusing on how team members are actually interacting and why. Conversely, understanding the process will lead to more cohesive team relationships and client care.

Once team conflicts are understood, rather than acted-out, team members begin to feel safe enough to start sharing personal feelings about themselves and clients that they would have previously kept secret. Countertransferential content is more openly shared without defensiveness as differences in opinions are welcomed, not resisted. Team members are appreciated for the special contributions that they make based on their discipline and experience. When client difficulties arise, individual struggles are not the prime focus of inquiry. Instead the focus is on the functioning of the group and program as a whole, symbolizing the increased development of a mature group identity. The cohesiveness of such a team is also demonstrated in practical matters, such as various

team members volunteering to cover for each other during absences or for new committees that are being formed.

The PDH team meets on two separate occasions. One is the weekly clinical meeting where client care and management are discussed. The psychiatrist and/or psychiatry resident along with the client's contact person lead the discussion while also encouraging the input of other members who are familiar with the client through various groups they may lead or co-lead. A well-functioning mature team is also aware of exploring both individual and group process as a means of facilitating both client care and the cohesiveness of the team. Just as an effective leader models this process for a treatment group, so can the team leader enhance the important process of how team members relate.

These weekly clinical meetings do not bring together the entire team, as each psychiatrist and/or psychiatric resident attends only one of the two meetings. Instead, the entire team meets only once monthly in a business meeting which is led by the two leaders of the PDH team, the psychiatrist leader and the non-physician administrative leader. In these meetings, both clinical issues and administrative matters, pertaining to both the PDH and the larger hospital are discussed. Issues such as research, staffing, continuing educational opportunities and if present, significant clinical matters are raised.

Case Example:

Mr. O, an 83-year-old widower, living alone experiences a temporary onset of left-sided weakness and visual changes. He arrives safely at his destination but has vague complaints regarding residual difficulties with peripheral vision. The psychiatry resident, a new member of the team, encourages him not to drive until his vision can be better examined by an ophthalmologist and neurologist. Unfortunately, Mr. O now fearful of the loss of his license and independence, does not want to follow-up with any specialist. Furthermore, tearfully and angrily he refuses to see the psychiatric resident and wishes to see the psychiatrist.

At the best of times, reporting a client's medical difficulties to the government is a difficult emotional and legal decision, for the doctor, client and other staff. For instance, in this case, more experienced staff members initially unhappily focused on the loss of independence for the client and wondered aloud about the necessity of the decision. These feelings were communicated both in and out of the team meeting, both to the psychiatric resident and to the psychiatrist supervisor. In a supervisory meeting, both the practical and legal aspects of the decision were discussed. Then the emotional consequences of the decision was discussed both for the psychiatric resident and for the client. Finally, the decision was examined with an eye to the upcoming team meeting where the various interdisciplinary team members would speak directly about the decision and to the decision-maker.

At the meeting, the psychiatrist, the team meeting leader, spoke about the potential adverse impact the decision might have on the cohesiveness and effectiveness of the

team and that the ensuing discussion would proceed best with this in mind. Hence, special attention was paid to both the content and process. Once the responsibilities of the medical doctor were more fully explained to the group, and how the government would actually proceed with any reporting letter, the team became more understanding and supportive of the decision and of the psychiatry resident. The contact person volunteered to speak to Mr. O to help him understand what the decision actually meant, as well to encourage him to continue to discuss his feelings with the psychiatry resident.

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Chapter 19

Discharge Planning and Aftercare Groups

Theoretical Rationale: Discharge Planning

In keeping with the goal of continued mental wellbeing and further improvements in functioning and relief from depressive symptoms following discharge, the Psychiatric Day Hospital (PDH) team gives detailed attention to discharge planning. The contact person and psychiatrist start to develop a discharge plan with the client at approximately week 12 of the 16 week program. Each discharge plan is individualized, taking into consideration the client's interests and areas of competency, activities in which they have already been engaged, the need for structure in their daily lives, the impact of socialization on mood, and the need for ongoing psychiatric medication and therapy. In discussion with the client, ideas are generated regarding various programs in the community that the client may want to consider attending. For example, someone who is artistic or interested in arts and crafts would be encouraged to attend an ongoing arts and crafts program. The client is encouraged to attend the new activity prior to discharge and then discuss their experience and impression of the activity with the contact person and psychiatrist. Often clients are able to identify something new that he/she would like to try, such as learning more about computers. The need to have a routine that gives all clients a planned structure to their day following discharge is stressed. A weekly schedule is developed with the contact person so that on any given day, a client knows what the plan for that day is.

To minimize the risk of relapse, each individual upon discharge from the PDH is referred to a psychiatrist for ongoing care. Each person either returns to see their previous psychiatrist, or is assigned a new psychiatrist, either from the Day Hospital or from other psychiatric programs offered at Baycrest, such as the Geriatric Psychiatry Community Service (GPCS). Referral to the latter team involves being assigned a new contact person who would meet the individual prior to discharge and set up appointments. Such a referral is often made if these individuals are felt to need more ongoing support than would be received if only seeing a psychiatrist for therapy.

Theoretical Rationale: Aftercare Groups

The 4-month Day Hospital results in varying degrees of symptom relief, improved functioning and personal growth. In addition to having psychiatric follow up and social and recreational activities arranged, as already described, a weekly open-ended aftercare group is offered to members who show they are able to benefit from an Integrated group psychotherapy. The PDH is unique in that a combination of individual and group therapy is used in follow up, with an emphasis on the latter. Hence, the program has provided a weekly aftercare coping group since its opening. Three more groups have been started in the past 10 years because of the large number of clients attending the aftercare groups. Attesting to the success of the program, all four follow-up groups contain between 12-20 members representing a mix of newly-discharged

clients and those who have been attending for many years. Each group is co-led by a psychiatrist and a multi-disciplinary member of the PDH team.

Individuals who attend aftercare groups are comprised of some who are struggling with ongoing residual symptoms of depression but many are no longer significantly depressed symptomatically or functionally and come for an opportunity for further growth. They now realize that although they cannot change their past, they can take individual responsibility for the present. They also benefit from the social aspect of getting closer with others. In an aftercare group, they again feel like a "somebody", a situation in stark contrast to when they began the PDH when they felt like a "nobody" as often they begin treatment feeling disregarded and demoralized. Others attend because they know they are at risk of getting depressed again and the group functions as an "insurance policy." Others who may need re-admission to the PDH at some point, may continue to attend the aftercare group throughout their repeat admission, to maintain continuity and as a reminder that the group is where they are headed again, when in remission.

The psychological growth of individuals is manifested in the ability to both identify and express feelings. For example, individuals can now say "I am sad or angry" whereas previously they would either change the topic, keep their thoughts to themselves, or just mumble, in keeping with not being raised in an era that spoke "psychologese" (Saiger, 2001). Aftercare groups are more able to focus on the "here-and-now" interaction between group members. Such groups, mirroring reality, can result in conflict but also provide more opportunity for members to improve their understanding of themselves and others. Indeed, groups described both as an "amphitheatre and agent of change" (Ormont, 1981) can also help group members improve their relationships with others including family members, as they face and work through their fears.

Case Example:

A newly-discharged individual attended the aftercare group on two non-consecutive weeks and said little each time, although was she actively listening. She was welcomed to the group and seemed to want to come. Towards the end of her second group, another woman tried to engage her and asked how she was doing. This prompted a flow of tears from the new attendee, who answered, "not very good", but, despite gentle encouragement from others in the group, maintained that she did not want to talk. The group respected her decision and praised her for making the effort to come despite how badly she was feeling. To ensure her safety, the co-therapist who knew her well spoke with her at the end of the group and ascertained that, although depressed, she was not suicidal. Shortly into the next group, she spoke for the first time. She noted that she was feeling better and apprised the group of her losses and loneliness, her lack of familial and extra-familial support, and her tendency to feel depressed since losing a sibling with whom she was very close. The group members genuinely expressed an interest in her life and her well-being and she was able to acknowledge the support and caring coming from the group members. At the end of the group, two female group members came up to her and exchanged phone numbers with her, expressing a desire to get to know her and to befriend her.

Unlike most community outpatient interpersonal therapy groups, the groups offered in the PDH and the aftercare programs encourage the development of relationships both within and outside the therapy. Since many individuals have suffered from multiple losses and are socially isolated, the groups are seen as another opportunity to create new social networks and to feel supported and understood by others who, having experienced depression themselves, are sensitive to the feelings and moods of others as well as the impairment in daily functioning that may accompany depression. Group members sometimes are upset at the insensitivity of others, unfamiliar with depression, who tell them to "pick themselves up by their bootstraps" and "that their life is good so they have no reason to be depressed". In the group, they understand how hurtful such statements are, so that there is a sense of cohesion that develops from their common experience. This helps build trust within the group, so that when conflict in the group arises, there is sufficient goodwill to be able to work through it. However, they are also encouraged to understand the comments from non-depressed friends or relatives are often well-meaning albeit hurtful due to their lack of understanding, frustration or helplessness.

Case Example:

A disagreement ensued between a couple of group members and voices grew louder. Another member, Ms. U appeared visibly shaken and the co-therapists asked her to describe her feelings. She had difficulty doing so in the 4-month Day Hospital which she had finished several months before. She spoke of always being uncomfortable in such situations and expressed a wish to be elsewhere. As she spoke of a past where when she was young she was severely disciplined for disagreeing, she also expressed a wish to handle such situations better because of ongoing family conflict. With time, Ms. U. became pleased with her personal growth as she became tolerant of anger, her own and others. Instead of fearfully staying quiet in a group and trying to avoid her own feelings as well as others, in a parallel way, instead of passively dealing with her son's anger, for the first time she asserted herself and the relationship improved as the two of them became better able to separate and individuate from each other.

Open-ended aftercare older adult groups that provide a safe and caring setting can lead to the development of a closeness among its members permitting an awareness of the finiteness of life, while at the same time enabling members to become more able to live a fulfilling life through an acceptance of their situation as possible and improved relationships with significant others.

<u>Case Example:</u>

Mr. M, an 82-year-old man opened the group by sharing his feelings of loss at the death of a 78-year-old woman he had met four years previously at a community social group. He was attracted to her caring and gentleness. For the first time in his life, he experienced a "truly loving relationship", in contrast to the hurt and rejection he experienced both as a child and in an unhappy marriage. Sensitive to loss and abandonment, he had become depressed following the death of his wife and was referred to the PDH. His early days in the Day Hospital were marked by angry outbursts, following disappointments and perceived rejection by his new woman friend (and/or therapists). He would curse and march angrily into group meetings, seemingly oblivious to the effect he had on others. As he improved, he later described how with the help of the PDH he was able to let himself trust and get closer to others by talking about his feelings. He was confident with the continued help of the group he would be able to now appropriately grieve. The aftercare group members who had known him for years complemented him on his personal growth and strength and newfound ability to grieve his loss.

The group then inquired about Mrs. F, a 90-year-old woman who they remembered had mentioned the previous week she was going for an important medical appointment regarding possible treatment for cancer.

Sadly she spoke of her medical circumstances. The group responded by talking about what an inspiration she has always been while struggling with previous health and family problems with humour and a positive attitude. She responded by saying she did not view herself as special. To this, another woman commented "But look at how well you're handling so many things." Mrs. F then commented "life is wonderful, never give up, I don't want to die, I want to live. When you die, you're finished." A male group member noting Mrs. F was without a supportive family and has turned down the help of caregivers, expressed hope she would become better at receiving help. The therapist commented her coming to the group and sharing her feelings as genuinely as she could is an example of her increasing ability to receive help and expressed hope that Mrs. F will continue to allow others to help her as she has helped so many in the group.

Mrs. D, an 83-year-old woman, then spoke up and said she was initially not going to share her feelings in group, but instead planned to reserve them for individual therapy. However, inspired by the vulnerability that was being shared and how authentic other group members were, she felt "I should do my part here and thanked the group for giving me the courage to speak up." She spoke of "how at shivas or memorials people often joke or are blocked from their emotions, but the group here is very good for us because we can share our vulnerability. I used to think vulnerability was bad or a sign of weakness. For one, I was afraid of aging but I'm happily married for the second time and I'm still growing. I no longer get so angry and I can approach my children to talk." When a particularly positive woman, shouted out age is only a number, Mrs. D finished her comments by saying "Yes, I'm 83 and I'm having the best time of my life, but I'm still sad, why? I don't want it to end, I've never had this in my life before. It's so sweet so why have it end now?"

The group did end, but as always ended with cookies and coffee in the lounge, a chance to get nourished for the hard work of group, and a chance to socialize and to continue living life to the fullest, for however long as possible.

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Chapter 20

Putting It All Together: Case Illustration

<u>Case of Mr. X:</u>

Mr. X is a 75-year-old man diagnosed with Major Depressive Disorder and Dysthymic Disorder (low grade prolonged depressive disorder). He was referred to the Psychiatric Day Hospital (PDH) by his psychiatrist for further treatment of the current episode. On assessment, it was revealed that Mr. X is the caregiver for his wife who has moderate dementia. They have 3 children: a son and daughter that live locally, and another son who lives at a distance in another country. Mr. X has had to take over a number of roles since his wife developed dementia. His social network is diminished. His wife had the role of coordinating their social life and she can no longer do this. Mr. X has been so engrossed in his caregiver role that he has not made efforts to maintain friendships. He feels overwhelmed and burned out.   He has numerous symptoms of depression including depressed mood, lack of interest, impaired sleep and appetite, poor energy, and feelings of worthlessness. There were no thoughts of suicide. He is reluctant to try an antidepressant for fear of side effects and stating that it is "mind altering."

The past psychiatric history is remarkable for low grade depressive symptoms for decades, meeting criteria for dysthymic disorder. He had brief supportive therapy at one point in his life in the context of work related stress. His medical history includes hypertension, high cholesterol, and a remote colon cancer. His medications include an antihypertensive medication, a lipid lowering agent, and a multivitamin.   There is a family history of depression in a sister and parent.

Mr. X was referred to the PDH at Baycrest by his family physician. He attended a screening interview with the social worker and psychiatrist. He was at this meeting alone, stating that his children "have no time for me." He was found to be suitable for the program and returned the next week for a full day interdisciplinary assessment. The case was presented at team rounds and each discipline reported on their findings. The diagnosis was Major Depressive Disorder, single episode, and dysthymic disorder. His cognition was normal as assessed using the Montreal Cognitive Assessment (MOCA). Nursing reconciled the medications and completed rating scales. He scored 21 on the Hamilton Rating Scale for Depression and 10/15 on the Geriatric Depression scale. The occupational therapy assessment revealed that Mr. X was independent in basic and instrumental activities of daily living, and fairly socially isolated. He scored 15 (low) on the Satisfaction with Life Scale.

The social work assessment revealed that Mr. X was born in Portugal. His upbringing was marked by physical and verbal abuse from his father. His mother was reported to be emotionally absent. He did not complete high school and decided to work. His father emigrated to Canada when he was 13 years old and the family followed a number of years later. Mr. X had a difficult immigration, particularly in learning a new language and developing friendships. He eventually developed a few good friendships and got married at age 21. He eventually finished high school and completed a bachelor

degree. His marriage was generally satisfying. The relationship with his children is quite poor. He was a controlling parent who was verbally and physically aggressive at times. Mr. X wanted a better future for his children so he reported that he "pushed them" to succeed.

Mr. X's wife developed dementia 4 years ago. Mr. X perceives receiving little support from his children. He has no relationship with the son who lives out of town. There is a significant amount of hostility between him and his daughter. Mr. X reported that his daughter yells and makes no effort to offer support. He disclosed that the other son is withdrawn and says very little. He is angry at this daughter-in-law stating that she has kept the grandchildren away.

Mr. X's adult children were contacted by the team social worker. They reported Mr. X as having a pre-morbid narcissistic personality style. He was experienced as being critical and angry through most of his children's lives. They reported that no amount of help or support that they offered was considered to be adequate, and this was amplified as his needs increased.

Mr. X began the program and created goals of treatment with his contact person. These included: improvement in mood, re-establish relationships with friends, and resolve disputes with his children. His first impression of integrated group therapy was that it was 'brutally honest'. He was concerned that he would be on the receiving end of attacks, similar to the experience with his children. Like many, he felt stuck, not knowing what he would say in group therapy. He eventually began speaking in group therapy and often spoke his mind without thinking it through and considering the impact on other people. As a result, his relationship with other group members suffered. In the group, the therapist introduced a 7 question model (Zeisel, 2009) that encouraged members to examine both their feelings and feelings of others.

The group members offered Mr. X feedback after he reported on a recent disappointment. His son offered to bring him and his wife to a medical appointment for Mr. X's wife. His response to the offer was "I'd rather you come with me and visit your mother." Group members attempted to have him see the consequence of his response. In another example, a conflict erupted when his daughter and grandchild was visiting at their home. The daughter explicitly requested that the grandchild not be "forced" to hug, kiss or interact with Mr. X's wife for fear that the young child would be negatively affected. However, during the visit, Mr. X took the child by the hand, placed her on the lap of Mrs. X. The daughter was furious and left with the grandchild. The group focused both on his hurt and tried to show him that he should appreciate the time with the grandchild and enjoy it as best as he could – otherwise he may altogether lose the relationships. The group therapist and members worked with Mr. X to show him that he was not a passive victim, and that the manner of his responses to others (his family in this case) actively influence future interactions. A new motto for him to consider was to "enjoy the good and tolerate the bad." Over time, more examples were brought to the group and group members continued to encourage him again to both consider others more and the impact of his responses. The therapists in group provided a sobering message: (better relationships) begin when blaming others (and feeling victimized) end

and individual responsibility begins, i.e. the ability to understand oneself and other improves.

Mr. X does good work in concurrent group and individual therapy. He realizes that his desire has always been to be validated and acknowledged. In his childhood, his father did not validate him and this continues presently with family and friends. With the help of the group members, individual and group therapists, and contact person, Mr. X learns that his feelings of anger and sadness are often a response to not receiving validation and in turn leads to difficulty validating others. In the more caring, safer group environment, Mr. X receives both validation of his view, but is strongly encouraged, in a non-judgmental and safer therapeutic environment, to look at the impact of his responses.

Mr. X received education about depressive disorders and the treatment of depression. He agreed to try an antidepressant after having received the information that he required to diminish his fears and dispel the myths about antidepressants. The son and daughter of Mr. X participated in family therapy with some improvement. Mr. X began to accept his role in the dysfunction in these relationships and that there were limitations to what could be achieved – he had to accept that his children were not likely to live up to his expectations which were viewed as not being realistic based on family sessions. Mr. X also benefited from the cognitive behavioural therapy group. He learned to be aware of dysfunctional thinking and to challenge distorted thoughts. The use of action plans was effective in helping him lead a more balanced life.

With time, there was a gradual improvement in Mr. X's mood as he began to form healthier relationships with group members, and then with others outside the PDH Program. His depression went into remission. Mr. X had an opportunity to grieve, develop a sense of competence, and work towards achieving more balance between being a caregiver and social/recreational activity. In preparation for discharge, Mr. X and his contact person worked together to create a schedule of activities. He began to attend an aftercare psychotherapy group to continue the work that was being done in the program. Over the next months, Mr. X developed relationships with other group members in the weekly aftercare group. He practiced what he learned in the PDH program and made an effort to empathically validate and understand others. Mr. X continued to receive feedback from group members and applied new interpersonal skills in this everyday life. The relationships with his children still were not close, as he wished, but became more peaceful and civil. He was able to ask for help when needed and become more aware of expectations when they were not realistic.

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Chapter 21

Day Hospital Programs, Research and the Baycrest Psychiatric Day Hospital

Due of the lack of standardized definitions in the terminology of day hospitals, partial hospitalization, day treatment, day-clinic, and day care centres, as well as the non-uniformity in their structure and treatment goals, the population being served, and outcome measures, comparing effectiveness and outcomes of "day hospital" treatment to inpatient treatment and standard outpatient care has been fraught with difficulty.

Marshall et al. (2001), in their systematic reviews, defined day hospitals as "multidisciplinary day care facilities offering comprehensive psychiatric care, where: 'multidisciplinary' means involving, as a minimum, psychiatrists and nurses; 'day care facility' means a building open during working hours on weekdays, although extended and weekend opening is permissible; and 'comprehensive psychiatric care' means the diagnostic, medical, psychiatric, psychosocial and occupational treatments that would normally be available to psychiatric inpatients." They classified programs according to their function and specifically looked at the effectiveness of i) acute day hospitals as an alternative to inpatient admission for those with acute psychiatric disorders and at ii) day hospital versus outpatient care for clients with psychiatric disorders for whom outpatient care seemed insufficient and the day hospital was used to enhance the treatment. People over 65 were excluded from both of their reviews. In the first review, although no difference was ultimately found in the number of days in hospital (day hospital days and inpatient days combined) or in social functioning, there was a significantly more rapid improvement in mental state for those treated in the day hospital setting, at a lower overall cost. They concluded that day hospitals have a place in the treatment of acute psychiatric disorders, particularly where there are insufficient inpatient facilities to meet the high demand. In their second review, of day hospitals versus outpatient care for enhanced treatment of acute psychiatric disorders, there was evidence that day treatment was superior to standard outpatient care regarding the improvement of psychiatric symptoms, yet there was no evidence that either treatment was superior on any other clinical or social outcome variable or on costs. They concluded that there is some evidence, albeit limited, to support the use of day hospitals for those who have not responded to standard outpatient care.

A European multi-centre randomized controlled trial of day hospitals versus inpatient treatment, again excluding those over 65 years of age, showed that day hospital care was as effective as inpatient care in terms of psychiatric symptoms, treatment satisfaction, and quality of life, and that it was more effective on measures of social functioning (Kallert et al., 2007). However, their study and a companion paper comparing psychiatric day hospitals in five European countries highlighted the lack of uniformity in conceptualization of purpose (alternative to hospitalization, socio-rehabilitative and/or psychotherapeutic approaches) and their resultant structure and population served, again underlining the difficulty in doing and generalizing research in this area (Kallert et al., 2004).

In the elderly, there is considerably less research on day hospitals and their effectiveness than in the younger adult population. The generally accepted rationales for the use of day hospitals in the elderly include: maintaining people in the community with their social supports and networks intact and possibly increasing their social network, providing a comprehensive treatment option that is more intensive than routine outpatient care but less costly than inpatient treatment, reducing the caregiver burden in high needs situations, and providing an alternative to placement in long-term care institutions.   Interestingly, little has been written that unequivocally supports this treatment modality in the elderly.   In a review by Hoe et al. (2005), they reported that a national survey of old age psychiatric day hospitals in the UK showed that twice as many day hospital places existed for those suffering from dementia than for any other psychiatric illness and that their purpose was generally to offer support to caregivers as well as to provide comprehensive services to those with mental health needs; however, many of the day hospitals did not have time-limited assessment and treatment, meaning many people attended for years as a form of continuing care, and the advisability and cost-effectiveness of this was called into question. Ashaye et al. (2003) compared how well a day hospital program could meet the needs of their attendees when using a measure of needs assessment (Camberwell Assessment of Need for the Elderly, CANE) versus when not using the measure; the day hospital staff were equally effective at identifying and meeting the unmet needs of their clientele whether or not they were administered the CANE, which made no difference in outcome.

Bramesfeld et al. (2001), in Germany, reported on outcomes from their day hospital for the treatment of late-life depression. Forty-four clients met the criteria for inclusion in the study, with a Hamilton Depression Scale (HAM-D) score greater than 6, Mini Mental State Examination (MMSE) score greater than 25, and no symptoms of psychosis or substance abuse. All clients were simultaneously being treated with antidepressants. Various outcome measures evaluated severity of depression (HAM-D), cognitive status (MMSE), burden of medical illness, activities of daily living (ADL) and instrumental activities of daily living (IADL), as well as social situation and subjective quality of life. Treatment duration in the day hospital was 11 weeks. Mean HAM-D score at admission was 17.6 and, at discharge, was 9.3, an improvement of 8.3 points. A significant improvement was shown in the HAM-D, the MMSE, and in social activities and contacts; no change was found in ADL, IADL, living conditions, economic situation or physical morbidity. When the group was divided into responders who achieved remission (n=20, HAM-D less than 6) versus those who did not (n=24), it was found that only responders showed improvements on any measure and, in addition to improvements in cognition and social activities and contacts, additional areas of significant improvement included both IADL and satisfaction with life. In this study, a shorter history of depression and male gender were predictors of treatment response in the day hospital.

Some more recent studies from Canuto et al. in Geneva, Switzerland looked at outcomes in a psychiatric day hospital treatment program combining individual and group psychotherapy in a series of 122 elderly depressed clients (Canuto, 2008a). Outcome measures included i) the 15-item Geriatric Depression Scale (GDS), a screening tool for depression, ii) the Short Form Survey (SF-12), a measure of functioning and quality of life, iii) a therapeutic community assessment scale with two

versions, a self-report form (Client Assessment Summary, CAS) and staff evaluation form (Staff Assessment Summary, SAS), as well as iv) a Group Evaluation Scale (GES), which measures group progress and satisfaction in the elderly. Most clients were being treated with psychotropic medications (antidepressants and anxiolytics), which were not significantly changed throughout the study, emphasizing that the main focus of treatment was psychotherapy. Significant improvements from admission to discharge were shown on the GDS score (decrease of 1.8 points), the CAS and SAS scores, and the GES scores for each group, as well as on the mental component summary score of quality of life (SF-12 MCS), but not on the physical dimension of quality of life (SF-12 PCS). The assessment of the therapeutic community is a novel approach in the elderly. Unfortunately, the use of the GDS as a measure of depression severity, in the absence of an additional psychometric measure such as the HAM-D, is difficult to interpret since the GDS is essentially a screening tool rather than a validated measure of severity of depression.

In addition to the above study, Canuto's group have also looked at how personality traits influence clinical outcomes in the day hospital treatment of elderly depressed clients (Canuto et al., 2009). Using the NEO Five-Factor Personality Inventory (NEO-PI) to assess the impact of five personality dimensions (Neuroticism, N; Extraversion, E; Openness, O; Agreeableness, A; and Conscientiousness, C) on clinical outcome and the same outcome measures mentioned above, Canuto et al. showed that these personality factors may be independent predictors of response to treatment in day hospitals. Their results imply that a higher level of Neuroticism is associated with a slower improvement in depressive symptoms in the day hospital setting and higher GDS scores. Better self-perception of clinical progress was apparent in those with lower levels of the Depressiveness (N) and Modesty factors (A) and higher Openness to action (O). High Positive Emotions (E) was associated with improvement in quality of life. Given these results, they raised the question of whether routine assessment of personality factors may help to identify those elderly with depression who are more likely to respond to a psychotherapeutic day hospital program and, based on the specific results, if the program itself could then be tailored to different personality styles for optimal clinical outcome. Already they have demonstrated, in another study (Canuto, 2008b) that Agreeableness (A) and Openness (O) are significant predictors of successful termination of group psychotherapy in this population.

The Baycrest PDH has been evaluated at different points in time. The program was initially described and statistically analyzed during its first 2 and a half year period from September 1986 to March 1989 (Steingart, 1992). It has always been a time-limited program, based on an eclectic approach that includes biological, psychological, and social interventions, consisting of several "carefully coordinated interconnected group therapies within a therapeutic milieu" (Steingart, 1992). Outcome measures were administered from the outset, both at admission and discharge, and often at several points during admission. In his initial results, based on all referrals over the first 2 and a half years of the PDH, of 104 individuals admitted, all of whom had failed less intensive outpatient treatment or would otherwise have required inpatient treatment, approximately half experienced statistically and clinically significant relief from depressive symptoms. At admission, over 80% had scores on the HAM-D and GDS

suggestive of moderate to severe depression and 1/3 of the total had an MMSE score below 24, suggesting some concomitant cognitive impairment and a group of relatively severely depressed individuals with poor prognostic characteristics.   Mean age of attendees was 75 years old and average duration of admission was 4 and a half months.   At discharge, approximately half were rated as "marked improvement or improved" on the Clinical Global Assessment of Efficacy (CGAE), while less than 6% had deteriorated.   The mean HAM-D score at admission was 22.3 and dropped to 12.3 at discharge, a mean decline of 10.0 points.   Similarly, the mean GDS score (30-item) dropped from 20.8 at admission to 11.5 at discharge, with a mean decline of 8.9 for those for whom both scores were available.   In addition, the Relatives Stress Scale (RSS), a measure of stress that families experience as a result of having to care for an ill elderly person, showed a significant decline in families' perceived level of stress from admission to discharge.

Twenty years later, a follow-up study was done, looking at admission and discharge data for 708 individuals that had been admitted over a 16-year period (Mackenzie et al., 2006).   The format of the PDH had not changed appreciably although it decreased from a 4-day per week program to 3 and a half days per week, to accommodate a growing need for additional aftercare groups.   Some of the original staff continued to work in the PDH throughout this time.   Mean age at admission, 75 years old, was unchanged. Females still accounted for 70% of admissions.   Approximately 94% had a primary Axis I disorder of mood.   The HAM-D showed an average improvement of 6.0 points (declining from a mean on admission of 18.6 to a mean discharge score of 12.6) and the GDS showed a mean improvement of 7.1 (dropping from 18.9 to 11.8).   This indicated that approximately 80% showed some degree of improvement from admission to discharge and between 30% and 40% experienced at least a 50% improvement. When the sample was limited to those with higher admission HAM-D scores (HAM-D >17), a primary diagnosis of major depressive disorder (MDD), no Axis II diagnosis, and MMSE >23, the GDS improved by a mean of 8.8 points (from 21.6 at admission to 12.8 at discharge) and the HAM-D improved by a mean of 9.7 points (from 23.5 at admission to 13.7 at discharge), both of which are similar to what Steingart had reported in 1992. A 50% improvement on the GDS and HAM-D was experienced by almost 40% of individuals and 17% met HAM-D criteria for remission at discharge.   In addition, the number and severity of depressive symptoms at admission were strongly related to treatment outcomes but demographic characteristics did not predict treatment response. This suggests that the Baycrest PDH has good results for a wide variety of individuals, regardless of level of education, living situation, marital status, or mother tongue. This echoed the results of a previous study looking at the same data base, in which it was shown that there were no significant differences in severity of depression at admission for Holocaust Survivors (HS) compared to non-Holocaust Survivors (NS) and that, at discharge, there were similar improvements in both groups.   Although post-traumatic stress disorder (PTSD) was more likely to be diagnosed in HS, there were no significant differences in profile of depressive symptoms or outcome of depression between the two groups (Conn et al., 2000).

While the treatment outcomes from our PDH only seem to show modest improvement, this is in keeping with the findings of Bramesfeld et al. (2001) and better than the results

of Canuto et al. (2008a), although the latter is not directly comparable. It is also in keeping with the reported 7.4 point improvement in HAM-D in a large, placebo-controlled efficacy trial of sertraline in older outpatients with depression (Schneider et al., 2003). Given the very few exclusion criteria in our PDH and that it is a clinical program most often for those who have failed outpatient treatment, not a research sample with restricted inclusion criteria, it is more reflective of a typical clinical setting and likely more applicable to the real world, where it may be expected that treatment outcomes may be more modest. In addition, not having a control group is a definite limitation in drawing conclusions regarding attributing improvement to the PDH itself. Missing data, especially discharge data, is also a limitation, especially since this could introduce the possibility of a selection bias in the results. In addition, it is quite possible that the HAM-D, and especially the GDS, do not capture the type and extent of improvement that our clients experience; to this end, we have recently started to administer a quality of life measure, the 5-question Satisfaction With Life Scale (SWLS) (Diener et al., 1985). Adding a measure of group process and satisfaction as well as a therapeutic community assessment scale, as have Canuto et al. (2008a), may help to delineate further the therapeutic factors at work in the PDH. In addition, the minimal number of individuals diagnosed with Axis II traits or disorders (28%) (Mackenzie et al., 2006), may reflect a bias of the PDH team towards not diagnosing these in acutely depressed individuals, but which, in turn, may affect the treatment response in those who do, in fact, have an Axis II diagnosis. Administering a more formal measure of personality traits, such as the NEO-PI, as have Canuto et al. (2009), may help to clarify the presence of certain personality factors and how these impact the treatment outcome in the PDH.

A possible solution to overcoming difficulties associated with quantitative research is to instead use qualitative approaches. Program evaluation using qualitative methods reveal what helps, for whom, and with what consequences (Schwartz, 2011). Such programs allow health professionals to implement appropriate care in real-world contexts (Goering et al., 2008). The use of focus groups is an example of such qualitative research.

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Chapter 22

Education in the Psychiatric Day Hospital

Education is a significant point of focus in the Psychiatric Day Hospital Program. Education involves client and family education, and education for students and trainees.

Education for clients and families is provided at the beginning and throughout the program. The client and family are given written material on geriatric depression when starting the program. The current handout is the Coalition for Seniors Mental Health client and family handbook. This provides an excellent and easy to read overview of geriatric depression. The clients participate in a weekly Treatment of Depression Group with one of the psychiatrists. The focus of this group is to provide psychoeducation for clients in a group format. The psychiatrist provides information about the biopsychosocial approaches to treatment. Clients are encouraged to ask questions. Topics range from specific questions about medications or psychotherapy, to questions about the pathogenesis and biology of geriatric depression. One of the challenges in treating depression is reluctance by some clients to consider taking medication or to adhere to a medication regimen. This group provides a forum for group discussion about medications and an exchange of experiences and perspectives that clients find helpful. Clients also receive individual education from the contact person and their psychiatrist which is tailored to their specific needs.

Education for families is provided through written materials and then informally by the psychiatrist, contact person, and social worker. Depending on the need, the social worker may spend a significant amount of time with family members providing psychoeducation. Psychoeducation is further provided at a family meeting with the client and the health care team towards the later part of the time in the program.

Trainees play an important role in the Psychiatric Day Hospital. The program is involved in the training of psychiatry residents, social work, occupational therapy and nursing students from a variety of universities and colleges. The training blocks range from 6 weeks to 9 months. The trainees are considered team members who take on graded clinical responsibilities to meet their training requirement and objectives. Each trainee receives individualized supervision from their supervisor to discuss and learn about knowledge, skills, and attitudes. Each trainee is assigned a number of clients with whom to work individually. In addition, they co-lead group therapy or other activities depending on their discipline. As team members, trainees attend business meetings and clinical team rounds where they participate actively.

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