

CBT in Neuropsychiatry

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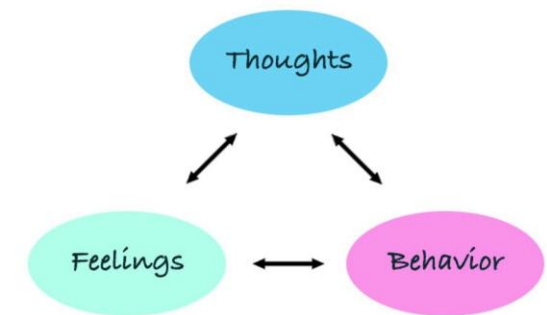
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Disclosures

**“Neither I nor my
spouse/partner has a relevant
financial relationship with a
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Cognitive-Behavioral Therapy

- Evidence-based, goal focused, short-term treatment
- Considers the interrelationships between thoughts, feelings and behaviors.
 - How cognitions or interpretations influence emotions and behaviors (Beck, 1979) and how behaviors affect thought patterns and emotions (Skinner, 1974).
 - Changing or altering one or more of these patterns creates ripple effects that can alleviate distress and decrease the severity of psychiatric concerns.



CBT Treatment

- Cognitive interventions
 - *Aim:* to modify unhelpful cognitions, self-statements or beliefs
- Behavioral interventions
 - *Aim:* to decrease maladaptive behaviors and increase adaptive ones
- Physiologic interventions
 - *Aim:* to decrease physical symptoms that feed negative cognitions, behaviors

CBT within Neuropsychiatry

- Effective for symptoms possibly exacerbated by neuropsychiatric conditions
 - Mood alterations (depression, anxiety, euphoria, and disinhibition)
 - Psychotic manifestations (delusions and hallucinations)
 - Various symptoms with motor manifestations (agitation, wandering, and aggressiveness)
 - Sleep or appetite changes

How CBT is different within Neuropsychiatry

- Thoughts
 - Related to cognitive changes and fears
 - Potentially more concrete
- Cognitive limitations
 - Simplify protocols, use of prompting/cueing
 - Might focus more on shifting behavior vs cognitions
 - In session a-has vs promise of long-term a-has
 - Multimodal/multisensory techniques to help with learning/encoding
 - Binder of in session material, visual aids and diagrams, recordings of sessions and reframes
- Carer involvement
 - Carer/Collateral as “coach”

Why CBT with MCI or Dementia

- Anxiety and depressive disorders/symptoms frequently coexisting with MCI or dementia
- Untreated mood can worsen cognitive concerns (Galimberti et al., 2020; Hort et al., 2010; Mah, 2015; Mokhtari et al., 2023; Potter & Steffens, 2007; Setiawan et al., 2018; Voros et al., 2020, Wu et al., 2021)
- Psychosocial and nonpharmacological intervention due to vulnerability to drug interactions/ complications (Beers Criteria, 2015; Buchanan et al., 2015, Dubrall et al., 2020; Kwon et al., 2021; Salzman, 2008; Scales et al., 2018)
- Because behavioral and some cognitive strategies are still effective, with improvements seen in anxiety, depression and carer/collateral distress (Charlesworth et al., 2015; James, 2010; Jeff et al., 2021; Kraus et al., 2008; Mohlman et al., 2003; Ortega et al., 2021; Paukert et al., 2010; Spector et al., 2015; Stanely et al., 2013; Tay et al., 2019; Teri et al., 1997; Tonga et al., 2021)
 - thought-feeling discrimination also possible in people living with dementia (Stott et al., 2020)

Research

- Modifications made in the content, structure, and delivery of CBT
- CBT-AD (Kraus et al., 2008)– participants with dementia (in SNFs) and anxiety, adaptations (simplified psychoeducation, cued coping statements, self monitoring and BA, physiological approaches, carer/collaterals in session) -> improvements in anxiety
- Peaceful Mind Protocol (Paukert et al., 2013; Stanely et al., 2013)– participants with dementia (mostly mod, some mild) and anxiety
 - Adaptations:
 - Weekly in-home sessions and phone check-ins; Workbooks and agenda
 - Include carer in sessions
 - Modules cueing calming statements, diaphragmatic breathing, self-awareness/self-monitoring, increasing activity (BA), developing sleep skills, relapse prevention/booster sessions
 - Results: Improvement in anxiety and quality of life (aim to test longer protocol d/t lack of sustained improvement), less noted distress by caregiver re: loved one's anxiety
- Formulation based CBT- (Spector et al., 2015) – participants with anxiety and/or depression and dementia
 - CBT manual (developed for study) or TAU
 - Adaptations:
 - Phase 1- building collaborative relationship, psychoeducation, self-monitoring, developing individualized formulation and goals
 - Phase 2- identifying and restructuring unhelpful cognitions, cued calming thoughts, behavioral experiments, addressing interpersonal difficulties between carer and person with dementia.
 - Phase 3- relapse prevention/consolidating learned skills, consideration of continued carer role
 - Results: Anxiety improvements and these remained at 6 months (approached significance), Significant improvements in depression and remained significant at 6 months.
- Cordial Program- (Tonga et al, 2021)- participants with depressive symptoms and mild cognitive impairment or dementia
 - Intervention consisting of CBT, cognitive rehabilitation, and reminiscence
 - Adaptations:
 - 11 sessions in total and caregiver participated in every other session (with supplemental material provided to help coach/cue)
 - Flexibility for trained clinicians to distribute the time between treatment modules and in tailoring the therapy to each patient's needs
 - Use of electronic memory aids

Case Presentation

- Age- 62, married man, recently retired earlier than planned from work as a small business owner.
- MCI, 1–2-year hx of progressive short-term memory problems.
- Depression and Anxiety- low motivation, ruminative, negative self-worth influenced by cognitive changes
- Wife in helping role
- Workup by neurology, neuropsychiatry and neuropsychology – referred for CBT.

Case Interventions

- Sessions split- half of the time with Pt alone and half with Pt and wife (“coach”)
- Psychoeducation about the depressive cycle
 - (low mood/stress -> negative thoughts and doing less -> worsened mood)
- Behavioral Intervention: Behavioral Activation
 - Activities with low enjoyment/importance?, engaged in activities past their benefit
 - Exploring life areas, values and activities
 - Scheduling in valued activities
- Physiologic Intervention: Posture Awareness
 - Awareness to shift turning inward stance

Case Interventions

- Cognitive Intervention
 - Working with Pt to create positive self-statements/reframes
 - “I forget everything” → “There are many things I can remember” (neutral: some things I forget and some things I remember)
 - “I have lost control” → “I do have control”
- Multimodal/multisensory
 - Binder of in session material, recordings, visual aids, calendar
 - Alarms for activities/reminders for positive self statement
 - Cueing also with Spaced Retrieval (Benigas, 2015; Camp, 1990) methods

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