The Assessment and Treatment of Older Adults

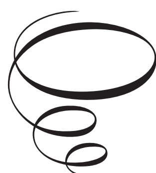
The Assessment and Treatment of Older Adults:

The Watch and Wait Holistic Model

Edited by

Lee Hyer

Cambridge Scholars Publishing



The Assessment and Treatment of Older Adults:
The Watch and Wait Holistic Model

Edited by Lee Hyer

This book first published 2020

Cambridge Scholars Publishing

Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Copyright © 2020 by Lee Hyer and contributors

All rights for this book reserved. No part of this book may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior permission of the copyright owner.

ISBN (10): 1-5275-3859-1
ISBN (13): 978-1-5275-3859-7

TABLE OF CONTENTS

Preface vii

Contributors xi

Chapter 1 1
Watch and Wait Model
Lee Hyer

Chapter 2 35
Meta-Trends of Aging
Lee Hyer and Lauren Lee

Chapter 3 99
Assessment
Lee Hyer and Kristin Wagner

Chapter 4 153
Watch and Wait: Perspective and Practical Issues
Lee Hyer

Chapter 5 202
Screen Measures of Five Domains
Lee Hyer

Chapter 6 265
Application of Watch and Wait to Chronic Medical Conditions
and Comorbid Behavioral Health Problems
Catherine A. Yeager, Ian A. Yeager and Lee Hyer

Chapter 7 344
Cognition
Christine Mullen and Lee Hyer

Chapter 8 417
Depression
Lee Hyer, Catherine A. Yeager and Ian A. Yeager

Chapter 9 486
Anxiety
Lee Hyer and Krystal Jackson

Chapter 10 527
Life Adjustment
Lee Hyer

Chapter 11 574
Personality
Lee Hyer

Chapter 12 628
Perspectives on Health Care
Lee Hyer

Appendices 653

PREFACE

We expand on our first book in 2014 (Hyer, “Treatment of Older Adults: A Holistic Model”). In that book we laid out plans for a holistic perspective on assessment and care of older adults. Here we update that book, unfold the complexity of the core domains, specify assessment plans, argue for necessary treatment, and place holistic care in perspective. Treatments work at best only 50% of the time and most often not permanently. Older adults persist as both system and self-change failures. We need better models. For older adults with the usual problems of depression, anxiety, cognitive decline, an admixture of somatic ills (health), or the plethora of life adjustment issues of later life, a focus on integrated care seems not only reasonable but now required. Treating “depressive symptoms” in isolation of the whole person, especially one with cognitive and physical limitations, risk a less-effective reduction in overall symptoms. Evidence for such multi-faceted approaches to treatment is growing, but we must borrow from the depths of literature for each problem and look at the efficacy for older adults, as well as what works for younger adults.

What is the best way to address the modal psychosocial problems of late life taking into account what science has to offer, what seems the clinical case has featured, and what can be done, for ONE person. What are the reasonable concepts and learnings required for care of older adults? In the long run to benefit elderly patients in the community, personalization of care must employ comprehensive common sense care algorithms targeting both modifiable predictors of poor outcomes and organizational barriers to care.

This book argues for a case-based model with differences in the approach and in the interventions. We need an all-encompassing model for change. . The care algorithms based on this model should of course target clinical/biological predictors of adverse outcomes of depression (or the core problem), but also address unmet needs through linkage to appropriate social services, enhance the competencies of elderly persons so that they make use of their resources, and attend to patient psychotherapy issues of psychoeducation, behaviors, thoughts, and emotions. We provide a model of care then that advocates for something more than a diagnosis.

Over the last 30 years, there has been a dramatic change in the treatment of older adults where mental health is concerned. Aging then is not a meaningful explanation by itself as to why one might experience a problem like cognitive decline or impairment. We need to look at the whole person who is older and has accumulated stuff. What are the variables of most concern? The focus should be on identifying markers that place the person on a continuum, not whether or not that person is in a specific group. This involves the idea that there is a mystery unfolding, where risk factors in genes and the environment interact and accumulate.

Given these concerns, what is a healthcare provider to do? This book addresses an effort to simplify the mental health problems at later life around five core areas with some flexibility regarding assessment and treatment. The five areas include depression, anxiety, cognition, medical concerns, especially pain and sleep, and finally life adjustment. Life adjustment, the last variable, involves all of the day-to-day reality-based concerns that unfold for older adults. Based on this model, it is believed that better psychological and psychiatric care can be attained in the context of primary care.

Several rubrics will drive the thinking where treatment is concerned. We believe in a "Watch and Wait" model; that is, people are assessed and a careful monitoring time is instituted where the patient is given hope, psychoeducation, support, and a belief that change will occur with careful preparation. This is most of all based on validation and connection. From this, there evolves a clear case-based, person-centered care process that leads to the application of care with an admixture of best evidence (empirically supported tenets) as well as practical clinical common sense. This is another way of looking at a stepped care model. In this effort, teams are used and of course monitoring and special efforts are made toward addressing all of the five areas, not just the one that is most of concern.

This is a book for the psychosocial and medical disciplines who wish to address the new care of older adults. Health care professionals, especially in psychology, social work, and nursing, are targeted. It is intended to address a "just sufficient" level of data and extant research, to be integrative, to be practical, and to challenge professionals to assess and treat this population inside and outside the box. Importantly, it stresses the need for an interdisciplinary activity and primary care involvement. It stresses the need for seat-of-the pants interventions. It is also case-loaded and applies an assessment program that sets the stage for care.

Book Perspective

While this is my work, I have had the luxury of colleagues and many students. Many have helped here and are featured in the chapters. They have been magnificent with input, case correction, citations, and ownership. At the end of my career this book like the previous one has been what I called a “labor of love.” In the transition of the first book to this one, the words of Maya Angleou are apt: “Do the best you can until you know better. Then when you know better, do better.”

Chapters

Chapter 1 provides a backdrop to the field of gerontology and geriatrics. It addresses the changes in the last decade, the current clinical field, and the need for a change. It provides needed background information for the care of older adults. Importantly, it argues for the Watch and Wait Model and the five core, “just-sufficient,” domains of aging care.

In Chapter 2 (with Lauren Lee, intern) we discuss the 10 meta-trends of our society and professional organizations that set the backdrop of aging assessment and care. These are the meta-factors that set the stage for the care of older adults for the last decade. We include in this the importance of psychological care and general life adjustment and quality of life.

In Chapter 3 (with Krissy Wagner, intern) we consider assessment. This is a critical and under-represented aspect of aging. We discuss the unique needs and dilemmas/background for older adults. We argue for screens in each of the five domains as well as a recommended expanded assessment package.

Chapter 4 expands on the model. We discuss the importance of Watch and Wait and how this adds to the evaluation/treatment of older adults. The Watch and Wait model is then outlined in an in-depth manner. This is then a core chapter for the working of the Watch and Wait model.

Chapter 5 unpacks the five domains and reasons for their importance. We address the need for each and interrelationship among them. Since the modal problems at late life, anxiety, depression, somatization (health) and cognitive decline, as well as adjustment, are inter-connected, they are best dealt as a group (a profile of the person on the five domains) with modular interventions. There is, therefore, a unified approach to treating problems at late life.

Chapter 6 considers health (Dr Catherine Yeager and Ian Yeager); Chapter 7 addresses cognition (Christine Mullen, intern); Chapter 8 tackles

depression (myself along with Dr Yeager and Ian Yeager); Chapter 9 unfolds anxiety (Dr Jackson, former intern); and Chapter 10 explicates life adjustment. Assessment makers are outlined for each domain and cases provided. Most patients fail treatment because their problems exceed the ability of the effectiveness of our science, or they or we expect too much from our therapies. We address the problems of diagnosis, problems with extent treatment, and problems with aging in each domain. We highlight treatment and seek integration with the other factors. Cases are liberally presented.

In Chapter 11 we present personality as the bedrock of the core domains just discussed. The person responds to life problems based on their temperament/personality and this information is seen as important for the understanding and treatment of the older person. Personality at later life is not only intriguing but informative and highly relevant.

The last chapter (Chapter 12) makes an effort at perspective. The effort is made to see the problem of aging from a societal and policy perspective. We summarize the book and its importance in psychosocial care of older adults.

Any one of the problems in this book can by itself be tumultuous. The desire to find a clear and identifiable cause including factors that could have prevented this is seductive. But simple cause-and-effect decisions imply that it is possible to trace a straight line from some specific event/act in the past leading to the emergent problem(s). Then we can rewind the film to the beginning and see the problems. This is quixotic. Nonetheless, this process is relevant and important as we approach an aging person with a plan and a model that can assist in the care. Then outcomes become the marker. We hope we do this in this book.

CONTRIBUTORS

Catherine Yeager, PhD, Health Psychologist, Dwight David Eisenhower Medical Center, Ft Gordon, Augusta Georgia

Ian Yeager, B.S., Medical Student, Philadelphia Osteopathic School of Medicine

Christine M. Mullen, Psy. D., Neuropsychology Postdoctoral Fellow, Physical Medicine and Rehabilitation, University of Utah School of Medicine

Kristin Anne Wagner, BS, Intern, Mercer University College of Health Professions Clinical Psychology Doctoral Program

Lauren Pierson, MS, Intern, Georgia Neurosurgical Institute

Krystal Jackson, Psy.D. Middle Georgia Counseling & Testing, Centerville, GA, 31028

CHAPTER 1

WATCH AND WAIT MODEL

In 2014 we published the book *Treatment of Older Adults: A Holistic Model*. This book articulated a Watch and Wait model of care and posited that there are five core domains necessary for the understanding of older adults. We have had a few years to muse over this effort, have watched the field of geriatrics and geropsychology mature, and have made several additions to that tome. We have noted that over the last 30 years there has been a dramatic change in the understanding and treatment of older adults, especially where mental health is concerned. This continues. We believe that it has been reasonably confirmed that the efficacy of psychopharmacological and psychological approaches is small. If anything, multiple interventions are attempted for the many problems and some cohesion is certainly helpful. Usually there results a "response" to a problem, not a remission. If truth be told, older adults improve because they and their caregivers commit to them and optimize life style and avoid negative behaviors. The utility of a psychiatric classification as determining the course of treatment is poor. In fact, psychiatric/psychological care is less than efficient relative to other medical disciplines. Perhaps it is more complicated or has more causal density. It can be argued further that there are few in the way of unique geriatric syndromes. Fortunately, we can build on the work at earlier ages.

This book attempts to expand on that Watch and Wait model that, again, pays some attention to the nuanced differences in treatment (one antidepressant vs another, one psychotherapy vs another, medication vs psychotherapy, etc.), but that more importantly devotes time to the whole person and their world. In effect, we expand on our model and argue that traditional actuarial foundations are necessary but not sufficient for treating older adults.

Background: The Bad News

We now know more about aging itself. Biological aging is largely determined by the internal biological clock and an accumulation of insults through living. Where the lifespan of the organism is closely related to biological aging, individual longevity is always a function of specific environmental circumstances, the accumulated insults. The two operate at every level of the bio-hierarchy – genes, proteins, cells, organs, and organisms. As we shall see, epigenetics reigns as it accounts for changes in gene expression that are not mediated by mechanisms of the DNA. In fact, we are best considered products of the biopsychosocial model where there are varying levels of physical, cognitive, emotional, behavioral, and environmental factors that contribute in the formulation of the older person (Andrasik, Goodie, & Peterson, 2015).

The complexities of addressing the psychosocial variables responsible for later life issues are readily apparent. The realistic constraints of living into later life make outcomes worse for older adults. Health now rests on our daily behavioral routines. The average health care costs per year are directly related to income: Those living in poverty cost almost twice that compared with those with more means. We believe that the biomedical model is reductionistic and dualistic. Added to this big cost picture, mental health by itself accounts for only 6% of all US health care costs: It influences 50% of all medical illnesses. Over 90% of people over 65 take some form of medication. Psychiatric drugs exceed all other mental health costs. Most older adults have a chronic disease, which is the cause of seven out of 10 deaths. In 1965, the average life expectancy was 70.2 years. By 2012, it had risen to 78.8 years. In 1965, the Medical Board of Trustees projected the Medicare costs for 1990 would be around 9 billion dollars. The actual cost was just short of 70 billion. In 1970, the ratio of tax payers to Medicare beneficiaries was 4:1 and Medicare represented 3.5% of the Federal budget. By 2030, the ratio is expected to be 2.3:1 and Medicare likely to represent over 20% of the budget. Americans today collect Medicare benefits for two and one-half times longer than they did in 1965. In 2012, lifetime Medicare contributions from the average American worker came to about $114,000. Between retirement and death, the same worker used $355,000 in Medicare benefits. The first baby boomers began receiving Medicare in 2011. When the last boomer starts receiving Medicare in 2029, there will not be enough tax payers in the work force to cover the shortfall. Compared to other age groups, older adults have the highest numbers of doctor visits and hospital stays, and the highest prescription medication usage. Left unchecked, healthcare

expenditures will likely rise from the current level of ~15% to 29% of gross domestic product (GDP) in 2040.

As intimated, medication use is high among the elderly. Adverse drug reactions account for a substantial amount of emergency room use, hospital admissions, and other healthcare expenditures. Only 50% of medication is taken properly, and there are 1.9 million drug-related injuries per year (Cogbill, Dinson, & Duthie, 2010). Taking just blood pressure medication as an example, only 25% of older patients remain in treatment and consistently take their medications in sufficient amounts for blood pressure control. Poor medication use has been attributed to several barriers. These include physical illness, medication side effects, cognitive dysfunction, psychiatric conditions such as mood disorders, functional loss, social loss, and inability to afford the medication at full dosing (Cogbill et al., 2010). As people age, their activities of daily living (ADLs) decline dramatically between 65 and 74 years – a fourfold change in ADLs generally and a threefold change in independent activities of daily living (IADLs). Looking more closely at functional decline, adults older than 75 years account for 59% of fall-related deaths, but make up only 5% of the population.

Perhaps dealing with aging issues is both a biological problem, where knowledge of geriatrics is concerned, and an ethics problem, as most problems involve values. Medicine becomes a help or a hindrance, but is not curative. Therefore, the need to expand the moral imagination regarding the older adult becomes critical. Healing will involve reweaving the most primal of connections to this sacred web. This is not "psycho"therapy. But it is close. Older adult problems are essentially fragmented and a meaningful intervention can be the glue for personal and group coherence. The therapist often becomes an ethician, translating values and goals into medical care (life prolongation, maximization of function, or maximization of comfort). The ethical parameters of autonomy, beneficence, justice, and non-malfeasance become the new paradigm of care. After all, psychiatric care does best with mild-moderate problems of any sort. Why? Because it is something human contact and intervention can change, if done reasonably well – validation, hope, and a script as well as follow-up. Good care in later life is a creative admixture of common sense, perhaps as deliberated by ethics, and science. In some ways it is as much a philosophical or psychological enterprise as a disease process.

This book attempts to walk the line for healthy aging and validated psychological care rubrics. This crucible is built on a model that hopes to unfold the many real dilemmas of our living longer and making it work with what we know about health and human struggle. It is a holistic, even a person-centered program. The Watch and Wait model is alive and well.

> "…the physician's primary duty is to provide the best possible care. It should be whatever is best and reasonable for the patient. I do not believe that patients want their physicians to shrink from making recommendations. Like me, most patients want their physicians to explain to them the options and recommend the best the best course of action. This is done by discussing risks and benefits within the context of mutual decision-making. This provides the means for putting caring ethics into practice."
>
> William Branch, MD JAMA Apr 14, 2015

Outline

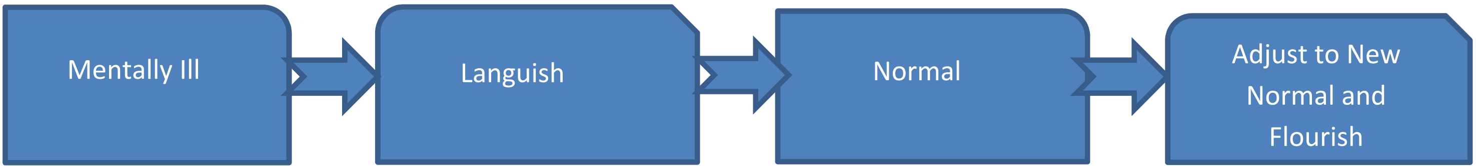
This book is intended to be practical, based on the modal clinical problems of older adults. It is the problem list of the older adult (perhaps) that is most relevant for targeted care and change. We explicate this especially with an guided assessment of older adults and unfold this with therapy suggestions. We have previously discussed our model, Watch and Wait (Hyer, 2014), but address this again in chapter 1 and further in chapter 4. In chapter 2 we discuss the meta-trends in aging and health care over the past decade leading to this book. Then we address the value of assessment and why assessment screens are important in chapter 3. Chapter 4 unfolds the model more completely and expresses psychotherapy perspectives. We then devote chapter 5 to the five key areas posited by the model. For each domain we recommend unique measures. For each area we cover some background, recommend a specific battery, and discuss its role in care. We also set the stage for each domain to be covered separately, providing a distinct chapter for each one (chapters 6-10). Always we interweave medical and health issues. We conclude this consideration of the domains with a discussion regarding personality (chapter 11) as this highlights the expression of the five core domains. It is the scaffold for the profile of problems. We end with some perspective on aging and a summary in chapter 12.

We seek to be clinical and practical. The issue with older adults has now morphed into multiple mid-level problems played out in a complex environment and beset with a unique set of strengths and weaknesses. Our intent, then, is to cover core areas that represent the Watch and Wait model. We over-focus on assessment and treatment for older adults. This is a book about practical clinical problems and their assessment in regard of older adults.

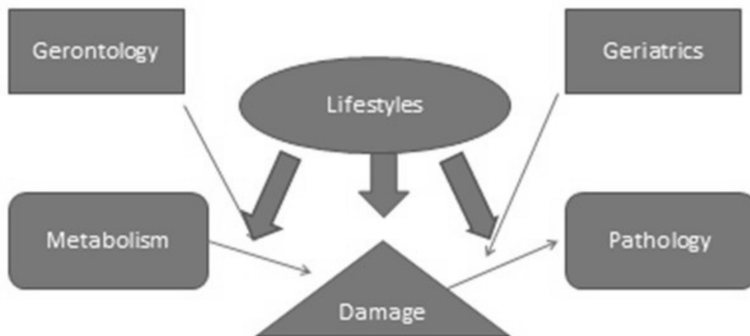
Model: Watch and Wait

Overview: The Watch and Wait model requires some introduction. The schema below best accounts for change within a more progressive medical model. It is not a disease model. Mental disorders continue to be identified as variegated syndromes and may never be amenable to specific diagnostic tests. Remission is partial and short-lived, and as many as one third do not respond. Cures are a misnomer. In the Flourish Model of mental health (Keyes, 2007), positive psychological functioning (self-acceptance, personal growth, purpose in living, environmental mastery, autonomy) and positive social functioning (self acceptance, social actualization, social contribution, social coherence, social integration) are key. This model does not operate in a world where not being mentally ill is healthy. The absence of depression is not happiness. The ideal is not going from -1 to 0 but -1 to +1. It thrives on baby steps with a new habit taking form over time. Languishing, the non-remitted state concerning clinical problems, is not a status of chronic human imperfection but one of many negative and few positive emotions. The ideal is to extend beyond normal and to flourish, to be optimally responsive to living, in essence to be happy. This can involve a meaningful attachment to accepting life as the new normal and, by acceptance, flourishing.

The model for the care of older adults requires more explanation. One way to view this is through the lens of gerontology and geriatrics (below). The slow alteration in the accommodation and assimilation of life is first attached to the elements of gerontology, an element of care that is based on awareness of the components of good living, meaning that the phenomenology and epigenesis of culture and psychosocial factors impact the phenomenology of living. This is most influenced by lifestyle. Health care providers need to give respect to both gerontology and geriatrics: Homage to the latter masks the subtle power of the former. Gerontology leads the way. Aging is the result of an ongoing metabolism that collects insults and degrades because it becomes less efficient at house cleaning. Inflammation, oxidation, impaired immune reactions and the like become enemies of cells. Intra-cell and extra-cell damage occur. Amyloid and tau, the building blocks of plaques and tangles, are often the result. Gerontology impacts the pre-processes for damage and geriatrics provides tertiary cures when possible. But the factor that activates change is lifestyle and a consequential committed attitude to living well. It is best done in mid-age and continuing, but is helpful at any age.


Mentally Ill
Languish
Normal
Adjust to New Normal and Flourish

We get more bang for our life buck in gerontology than in geriatrics: knowledge, prevention and discipline before medical treatment. The former is the biopsychosocial dynamic of life; the latter is the secondary prevention or fixing of its maladies. The dynamic for both is to optimize the culture of positive living and growth. This includes having a healthy lifestyle and a positive attitude. But age and disease eventually win out and how this interaction is slowed and softened becomes another key to better living. Damage will occur and have to be attended to. The unfolding of problems leads to aspects of the disability model and negative consequences mandating secondary and tertiary care.



Lifestyle is the most salient gerontological and geriatric influence. Dhalwani et al. (2017) studied the association between lifestyle factors and the incidence of multi-morbidity in an older English population. There was clear evidence of a temporal association between the combination of different unhealthy lifestyle factors with multi-morbidity. Population level interventions, therefore, were encouraged to include the reinforcing of positive lifestyle changes in a population to reduce the risk of members of the population developing multiple comorbidities. The multiple comorbidities included such things as diabetes, hypertension, stroke, myocardial infarction, congestive heart failure, angina, lung disease, chronic obstructive pulmonary disease, asthma, arthritis, osteoporosis, cancer, hearing problems, Parkinson's and Alzheimer's disease, other dementias, macular degeneration, and glaucoma. This group found a dose-response association between unhealthy lifestyle factors and multi-morbidity. Physical inactivity increased the risk of multi-morbidity by

32% on its own and inadequate fruit and vegetable intake increased the risk by 65% in women. When physical inactivity was combined with obesity or smoking, the risk increased by 2 or 3 times and by more than 4 times when combined with both smoking and obesity. Data sets showing these results are almost commonplace now.

Watch and Wait: This model targets five areas of adjustment for older adults. By addressing core psychosocial problems, including depression, anxiety, cognitive impairment, general health and life adjustment, we believe that we provide for the necessary focus to help the patient adapt and cope with their problems, promoting successful outcomes. So, if the older adult has depression, then we seek to treat depression in the context of the person. This means creating a profile, regarding the five domains, which provides the best understanding of the person, but a depression focus is primary for the moment.

Of course, evidence for such multi-faceted approaches to treatment is nascent, so we borrow from each problem and look at the efficacy for older adults, as well as what works for younger adults. Due to the complexity of patients, the normal application of empirically supported therapies (ESTs), the nuances of the research, and the use of predictor variables in care, while helpful, are not robust enough to warrant allegiance beyond just some respect. We maintain that the differences between one antidepressant and another, one psychotherapy and another, or one medication versus another or a psychotherapy provide us very little help. As we noted in the first book (Hyer, 2014), published reports suggesting that attending to novel "significantly better," or "evidenced-based," will result in better patient outcomes is helpful, but doing so with older adults often diverts attention from the real world issues, and has only marginal evidence of benefit. We believe that a comprehensive algorithm for treating more than one problem in older adults is more important (Thielke, Vannoy, & Unützer, 2007). This is also the thinking and position of the transdiagnostic model (reviewed later).

We explicate the Watch and Wait model around case-based care. We emphasize a case-based plan, applying information, validation, assessment, and a plan of treatment modules. A careful and slow process of care is an improvement over fast-paced primary care and psychiatric clinics. The therapist does not pick one best treatment at the outset. Mistakes are often made at the gate (e.g., deciding too quickly to initiate care, under-dosing, inadequate trial duration, poor frequency of follow up, and lack of monitoring). Problems actually better confess themselves over time. According to the model, patients are carefully assessed and monitored. The patient is given hope, a humane context through psychoeducation and

support, and a belief that change will occur with careful preparation. This is a case-based, person-centered model that leads to the application of best evidence in the real world. In 3-5 sessions, the health care provider recognizes how the patient presents with and experiences the five problems, validates and builds alliances, provides necessary psychoeducation, carefully selects treatment options, applies objective measures for a treatment response, and monitors. Changes are made with equal deliberation. One does not get better if the person does not have preparation for and then "experience" in the intervention. We also know that in the complex treatment of older adults, success depends on patient beliefs and organized extra-therapy variables, as much as the actual treatment plan and monitoring.

FAILURE POINTS:

1. Deciding too quickly to initiate care
2. Under-dosing
3. Inadequate trial duration (6 weeks necessary)
4. Poor frequency of follow up
5. Lack of monitoring
6. No team or family involvement
7. Wrong Rx: Only SSRIs, for example
8. Insufficient time: Noncompliance with meds, dropout of psychotherapy
9. Wrong dosage: Too little or not in the "window"
10. Interference from other Rxs: Med side effects
11. Adherence issues: Pt does not do tasks
12. Complex families
13. Use of substances: Opioids, other meds
14. Wrong diagnosis

Case Formulation: A Watch and Wait strategy is a deliberative process of care. It involves assessment, psychoeducation, trust building, concerns about treatment options, team interaction needs, and then availability of modules. As noted, the therapist does not pick one best treatment at the outset. Rather the therapist recognizes how patients present with and experience depression or other problems, carefully selects treatment options, and applies objective measures for a treatment response. Changes are made with suitable deliberation where monitoring and an exposé of the issues dictate change. We also know that in the complex treatment of older adults, the choice of treatment plan matters and needs to be tweaked and

re-tweaked over time. In fact, the case formulation marches through standard tasks. The model provided by Barlow (2008) is most helpful: The patient is assessed, monitored, and followed over time. Nomothetic treatment is identified and applied. Problems are noted and, when prophecy fails, the person-based characteristics are entered. Should change not be seen, then the therapy can be altered, perhaps in the service of a functional analysis.

In the unfolding of the Watch and Wait model, the deliberation by the clinician involves two things: case formulation (step care) and assessment. In mental health case formulation this has been formally recommended for over four decades. In later life any symptom can be generated by multiple permutations of multiple causal factors amid multiple causal paths. The health care provider formulates cases based on confirming and disconfirming data to determine whether selected empirically supported causal variables (e.g., cognitive distortions, medically related problems, poor self control, ineffective problem solving, low rate of positive reinforcement) are relevant, operative, and meaningful to this particular patient. Case formulation is always individualized and multivaried. It is also malleable. Life adjustment interventions can be easily assessed as the outcomes become apparent quickly. Cognitive restructuring too can be tested by decreasing self-defeating thinking, using behavioral experiments to test the validity of a belief, bibliotherapy, modeling, mild refutation, didactic explanations, homework assignments, visualization, and the use of caregivers, to name a few.

Process of Evidence-Based Practice

1. Monitor problems over time
2. Diagnose and formulate a case
3. Match patient problems to nomothetic, empirically supported treatments
4. Based on psychopathology and patient characteristics, use behavioral targets and apply idiographic interventions
5. Apply a functional analysis on non-responsive, deteriorating cases

Evidence-based practice then needs to be personal. It involves using the best available scientific evidence, individualizing the evidence for unique needs and preferences for each person, and a commitment to an ongoing expansion of the evidence in clinical expertise. In this context, clearly informing patients and families about the evidence, engaging them in the process of informed shared decision making, and protecting their rights to self-determination has generally lagged behind this goal. The

2003 President's New Freedom Commission on Mental Health report indicated that nearly every consumer of mental health services expressed the need to fully participate in his or her plan of recovery. Person-centered care and accountability are clearly high on the list for effectiveness in care. In the Institute of Medicine (IOM) landmark report, *Crossing the Quality Chasm: A New Healthcare System for the 21st Century*, person-centeredness was cited as one of the six primary aims of a transformed quality of healthcare delivery system. Not only does the report identify core goals or domains, it also identifies rules and principles that should guide and shape the provider in this behavior (New Freedom Commission on Mental Health. Achieving the Promise: Transforming Mental Healthcare in America, 2003).

Understanding Watch and Wait

From a Watch and Wait perspective several features are worth highlighting. First, a slow process of validation is implied. This includes not only joining but motivational interviewing with a clear objective to challenge subtly and often indirectly. It can involve many "therapies." Acceptance/commitment and mindfulness (Acceptance and Commitment Therapy) are in play early. Mindfulness and acceptance do not change reality; they encourage the heart to accept it. Additionally, psychoeducation emphasizes that the older person be encouraged to accept the reality of the issue. This encourages problem solving. Later there are many components for "real psychotherapy interventions" involving CBT, PST, self-instruction, exposure, distraction, and many other curative features in standard psychological therapies. There is a constant interplay also with the environment (with caregivers if necessary) and health care issues. The provider can pick and choose among the empirically supported techniques. As we have implied, reality often asserts a strong influence over psychological methods. Also, consistently there is an ear to on-going monitoring and assessment. Assessment is treatment.

Second, a case formulation (again) is always core to a model for change with Watch and Wait. Tritely but importantly, these always involve being empathic and non-judgmental in reviewing assessment data, working collaboratively with the individual in the family to create and sustain a helping partnership, using respectful first-person language, and avoiding the use of jargon and labels, engaging the individual and the family through motivational interviewing, encouraging the individual to determine who is present during the assessment and planning of meetings, being culturally competent and sensitive to the influence of cultural factors, implementing a team approach, being actively supportive with the

individual and the family's choices, and seeking feedback on his or her performance. The model that has often been used in identifying the components includes creating a narrative summary of the history of the patient, presenting symptoms, the precipitating events, predisposing factors, the perpetuating factors, and previous treatment and response. This goes to the core of the case formulation and implies everything that has to do with care.

Third, person-centered care focuses on targets that are distinct from traditional care. It is then person centered and not practitioner-based (Mast, 2012). It involves a strength-based and not problem-based focus. It clearly endorses a skill acquisition and not a deficit focus. Collaboration, community integration, and quality of care are core. Community-based and not facility-based care is also empowered. The least restrictive path to outcomes and preventative actions is clearly implied.

Fourth, Watch and Wait is a form of step care approach. Older patients pose additional difficulties in disease management due to multiple comorbidities, cognitive issues, and lack of social support. A step care approach to treatment delivery systems represents a reasonable attempt to maximize the efficiency of the resource allocation of ESTs. This is a kind of pyramid. In mental health and with older adults less is more and slow is good. Less intensive treatments are used to treat greater numbers of patients at the bottom of the pyramid, while fewer patients are treated with progressively more intense treatments at the top of the pyramid. The entry level is simple, cost efficient, and the least intrusive. Succeeding levels become more intrusive and expensive. The "stepped up" care is progressive and programmatic. This stepped up care can mean a change to more treatment or adding an additional mode of care. There is no cure for most maladies of later life adults, and the progressive nature of diseases requires effective disease management. Disease management is challenging due to exacerbations, complicated treatment regimens, and hospitalizations.

Step Care Models

There are several (watch and wait) models that assist in the biopsychosocial model. These are stepped care models. These models have been shown to be especially valuable in primary and secondary healthcare systems, such as outpatient mental health systems where demand for service outweighs supply. Originally developed for primary care in the United Kingdom, stepped-care has recently been reimagined (O'Donohue and Draper, 2011) for rapid access to mental health services in a wide range of settings. The model offers the lowest level of intervention intensity warranted by single or ongoing assessments;

treatment intensity can either be stepped up or down, depending on the level of patient distress or need.

Many promising online mental health tools have been developed and are available for purchase or licensing and can be developed at various levels within the stepped-care model. Traditionally, evidence-based mental health treatment interventions have been designed to be intensive and to be offered one-on-one by a highly paid specialist. Lower intensity and less expensive care that could address mental health concerns before they become acute or chronic are virtually non-existent in North America. Such lower intensity care may be seen as more palatable to a larger portion of those in need, who are not quite ready to accept all of the challenges of ongoing psychotherapy or of making needed life changes. Less intensive online programs can also allow users to test whether the actions include assessment, monitoring, psychoeducation, interactional health modules, therapist-assisted mental health actions, or intensive therapy for specific mental health problems, as well as several interventions in the family and in the community. Healthcare is also involved at all of these levels since it is central to older adult problems. Case management is also an essential referral issue.

Cornish et al. (2017) noted that the stepped-care model integrates a range of established and emerging online mental health programs systematically along dimensions of treatment intensity and associated needs for patient autonomy. Program intensity then can be stepped up or down, depending on the level of need. In the context of monitoring, which is configured to both the healthcare provider and the patient, feedback unfolds and the stepped-care model empowers patients to participate actively in the traditional process.

The TIP intervention (Treatment Initiation and Participation) is one example of a step approach. It is based on the premise that when a patient can articulate their goals, barriers, or concerns, and has an understanding that good care is dependent on working with their physician, they are more likely to participate in care (Sirey et al., 2017) TIP includes five steps and is delivered in three 30-minute sessions during the six weeks just after an antidepressant is prescribed: (1) review symptoms and antidepressant regimen, and conduct a barriers assessment; (2) define a personal goal that can be achieved with adherence; (3) provide education about depression and antidepressant therapy; (4) collaborate to address barriers to treatment participation; and (5) create an adherence strategy, and empower the older adult to talk directly with the health care provider about treatment. This type of patient participation may mitigate concerns about stigma and reluctance to report side effects, and will hopefully reduce early drop out.

Trans-Power

Person-centered care focuses on targets that are distinct from traditional care. It’s of course person centered and not practitioner-based. As noted, it involves a strength-based and not a problem-based focus. It clearly endorses a skill acquisition and not a deficit focus. Collaboration, community integration, and quality of care are core. Community-based and not facility-based care also is empowered. The least restrictive path to outcomes and preventative actions is clearly implied.

First, we address the transtheoretical model. This is a friendly model that provides help for the overall intervention to be applied. This is applied as a conceptual formulation for motivation with patients who are struggling to make changes. Prochaska, Norcross, and Diclemente (1995) noted the importance of having some understanding of the stages of change that people go through. They posited that therapy works through a process: first is pre-contemplation where the individual has no formulation set to attack the problem in any meaningful way; then contemplation when this alters, and the person is somewhat ambivalent, but willing to look at the issues of the pros and cons of the problem; next comes preparation, which is the deciding to change and the building up of the confidence to do so; then comes action, which is actually changing; and last is maintenance, which usually occurs after about 6 months of the action phase. Lapses (temporary failures) can occur and the model repeats. This model serves as a nice understanding of the way in which people struggle to make their life go in a more meaningful way. It is implied too in our Watch and Wait formulation.

Enter the transdiagnostic model. The treatment of psychiatric disorders is entering a new phase characterized by a greater concern with the integration of treatment principles and methods across therapies. This supports our therapy-ideals of empathic, nonspecific validation procedures that build across therapies. The use of eclectic and pragmatic treatment strategies and the emergence of more modular and trans-diagnostic approaches, focusing on specific domains of pathology rather than global diagnoses, is one example. Livesley, DiMaggio, and Clarkin (2016) labeled this approach the Integrated Modular Treatment. They suggested individual patients present with a unique array of problems spanning multiple domains of functioning and that treatment should utilize an integrated array of strategies and techniques to address these diverse impairments. Domains of impairment such as symptoms, problems with emotion and impulse control, interpersonal patterns and self-identity problems, and overall severity of dysfunction, stand out as the focus of the

intervention rather than a more globally conceptualized categorical disorder.

A positive outcome is more a function of a structured approach and change mechanisms common to all effective treatments than to treatment-specific interventions. In this sense, the results of the outcome of treatments for a personality disorder, for example, converged with the results of psychotherapy outcomes generally: For more than 40 years outcomes have been similar across therapies, which suggest that different therapies share common elements associated with successful outcomes. The evidence is clear that outcome studies do not evaluate the mechanisms of action. The guiding principle then is that treatment should start not from a narrowly focused disorder-specific manual, but from a detailed analysis or deconstruction of the patient's psychopathology into domains of dysfunction and that treatment methods should be selected on the basis of what works for a specific problem and domain that are the focus of the therapeutic intervention.

All of this implies that a global diagnosis based on current diagnostic categories is really insufficient. The ICD-10 now has over 70,000 diagnoses and as many procedures. In order to select appropriate interventions, a psychiatric entity needs to be decomposed into different functional domains. This reveals an additional benefit of integration and accommodates the considerable heterogeneity among patients with a given disorder and permits treatment to be tailored to the individual. The importance of tailoring treatment to the individual is illustrated by an outcome study of personality disorders by Gullestad et al. (2012) that assessed pre-treatment mentalizing abilities. Patients with lower pre-treatment "mentalizing" skills fared worse in day hospital treatment than in individual therapy. Mentalizing involves cognitive/affective strategies for change. This can be taught. It is both transdiagnostic and reflective of care based on other processes than diagnoses.

The model incorporates varying degrees of three routes of integration that have traditionally been described in general psychopathology literature. These include common factors, technical eclecticism, and theoretical integration. The common factors approach seeks to identify principles of change common to all therapies and uses these principles to establish the basic structure of treatment. Technical eclecticism uses treatment methods from diverse treatment models without the adoption of their associated theories. Most experienced clinicians show a degree of technical eclecticism as they use methods they have found to work, even though they may not subscribe to the theoretical position on which they are based. Theoretical integration is more complex; it seeks to combine

major components of two or more therapies to create a more effective model.

Watch and Wait Specifics

> Truth is confirmed by inspection and delay; falsehood by haste and uncertainty.
>
> Tacitus

Assessment: The belief here is that the basics of care for older adults require special consideration. There is a need to deliberate over the case, proceeding from the real world, targeting practical issues, and entering mental health treatment. This requires assessment and monitoring, as well as flexibility. There is no desire here to usurp the scientist-practitioner model as we need to do formal assessments and to attend to the input of science. There are empirically supported methods. But, as noted before, we need more. Mast (2012) argues for a "Whole Person" approach where the value of "the person" of the diagnostic category becomes as important as the process of the diagnosis and treatment plan. We agree, but add that we need to apply the better known cannons of our sciences to the person and formulate real plans that are titrated to tangible outcomes. Empathy and science together rule.

At some point something has to happen too. The patient needs to feel some relief or at the least a firm belief in the process. Context is a friend here. Often this can be done early in the process. In general, the type of problem for most older adults is not at the severe level. Problems are mostly mild or moderate. This includes extended problems with dementia issues. As such, the interventions generally need to be tailored to one who has multiple problems and who is mildly suspicious about the process. We need models of care then that encompass more than one diagnosis.

Clinical and psychosocial predictors of response to single antidepressants or comprehensive interventions have been identified. Less helpful factors include resistant anxiety, hopelessness, executive dysfunction, limitations in physical and emotional functions, chronicity of the current episode, and low income. There are of course more. But, such predictors can help in personalizing the first step of treatment for a given patient. Accordingly, a patient with one or more predictors of poor outcome may receive interventions targeting each modifiable predictor, as well as a more vigilant follow-up. For example, a low-income depressed elderly patient whose symptoms did not respond to an adequate trial of an antidepressant and who is experiencing hopelessness may benefit from a trial of

psychotherapy focusing on hopelessness, as well as case management connecting him or her with social services. This intervention will play out in the other 4 domains.

The critical issue in the Watch and Wait model is what to do before the total plan is activated. The application of this model hinges on the challenge of when to shift from the wait point to the activate point: When does the therapist pull the trigger for more active care? In the interim the health care provider can make a difference. The Watch and Wait model below advocates for the necessary and often sufficient conditions of the "psycho"social and "psycho"therapy process. There is always validation, empathy, and problem formulation. This can be stepped up or down through monitoring and mild experiments. We will dialogue about this throughout the book.

The process itself involves three or four sessions of assessment. Assessment of course continues beyond that but the case-based plan is enacted. Diagnosis is involved but it is only one factor. We espouse a problem-based approach. Problems include the five domains (below). The stage is set with care and monitoring, assessing, and even borrowing from other models. We use the traditional predictors but also personalize treatment for a given patient. Accordingly, a patient with one or more predictors of poor outcome may receive interventions targeting each modifiable predictor, as well as a more vigilant follow-up.

We address assessment formally in chapter 3. We start with screenings. Screenings are a necessary evil and have some limits. They do not form a diagnosis. They do not tell us definitively about the quantity of the problem. They also do not reflect the strengths either. Assessment needs reasonable anchoring beyond usual scales. All testing for Mr. X applies to Mr. X and his specific issues: his age, his education, his marriage, his occupation or lack thereof, his place in the country, his comorbidities, his nuanced ethnicity… you get the picture. There are no valid norms then for anyone of us. We get a person-picture, a helpful view of complexity, and a series of targets that, with other data, apply to Mr. X in such a way that we know more about him than otherwise. This involves heuristics. It is part of treatment, part of the unfolding story somewhere between a marker of the specifics of a blood pressure and the general trend of an A1C. The goal then is to take a variety of test-derived pieces of information obtained from multiple sources and place them in the context of historical information, referral information, and behavioral observations to obtain a cohesive and comprehensive understanding of the person being evaluated. Tests are imperfect tools representing the construct variability of the variable of interest (cognition for example), the interaction of age (with its moderating

variables), and real world or practice effects. They are, however, a good enough approximation of the real world of the older adult.