

A Series of Brief Cognitive Therapy Interventions with People Experiencing Both Dementia and Depression: A Description of Techniques and Common Themes

Keith A Scholey¹ and Bob T. Woods^{2*}

¹ *Department of Clinical Psychology, Ashworth Hospital, Liverpool, UK*

² *School of Psychology, University of Wales Bangor, UK*

Depression in the context of dementia is common, but treatment approaches are under-developed. This paper presents one of the first case series of cognitive therapy interventions with individuals with concurrent dementia and depression. Seven patients diagnosed as having mild/moderate dementia (MMSE range 20–30) each received eight individual cognitive therapy sessions. On average, there was a statistically significant 3.7 point improvement on the Geriatric Depression Scale (30 items). Two of the patients showed a significant Reliable Change Index. It is argued that with some modification a cognitive therapy approach can facilitate a reduction in the level of depression experienced by this particular group. In this sample, impaired cognitive abilities did not prove to be an insurmountable obstacle to the application of cognitive therapy. A number of common themes arose, including attributions about the cause of the cognitive impairment, catastrophic thinking regarding the implications of the diagnosis and the emergence of previous trauma. Whilst a full understanding of the interrelationship between dementia and depression has yet to be developed, a body of literature is developing that describes some of the skills necessary for this type of work. Controlled studies of psychological treatments for depression in dementia are now required. Copyright © 2003 John Wiley & Sons, Ltd.

INTRODUCTION

Dementia and depression are two of the most commonly occurring psychiatric disorders, particularly amongst older adults. Concurrent depression and dementia is therefore, not unusual. Studies measuring incidence of this dual diagnosis have shown

considerable variation: 23% of geriatric outpatients had both cognitive impairment and depression (Reifler, Larson, & Hanley, 1982), 17% of patients meeting criteria for Alzheimer's disease were diagnosed as having major depression (Rovner, Broadhead, Spencer, Carson, & Folstein, 1989), 14–87% of patients diagnosed as having Alzheimer's disease were observed to have depressed mood (Wragg & Jeste, 1989). After reviewing the literature, Ballard, Bannister, and Oyeboode (1996) suggested that

* Correspondence to: Professor Bob T. Woods, DSDC Wales, Ardudwy, Holyhead Road, Bangor, LL57 2PX, UK. E-mail: b.woods@bangor.ac.uk

approximately 20% of people with dementia had concurrent depression in clinical samples, with lower rates in the community.

Much of the variation can be accounted for in terms of the sampling technique used by the studies. Population studies appear to show much lower rates of dual diagnosis than studies of referrals to psychiatric or medical services. In general, it would appear that depression is often more common amongst people with dementia than in non-dementing populations, raising the suggestion that the disorders might be related. However, the relationship between depression and dementia shows considerable complexity (Woods, 1999).

Despite the availability of drug treatments with some limited efficacy in Alzheimer's, dementia remains essentially a progressive, deteriorating disorder (Bryson & Benfield, 1997; McGuffey, 1997). To receive a diagnosis of a dementing condition may provide an unwelcome reminder of one's own decline and eventual death. The diagnosed person may additionally have many misconceptions regarding the dementing process. Relatively few studies have examined the subjective experiences of individuals with dementia.

In a descriptive account of the coping methods of people with Alzheimer's disease, Bahro, Silber, and Sunderland (1995) identified a number of methods being used, including the following.

1. *Denial*—either complete or partial. Avoidance of naming the illness or seeking information about it.
2. *Dissociation*—exhibition of dissociation of affect, vagueness and circumstantiality in discussing the condition.
3. *Minimization*—decreasing the significance or the severity of the symptoms.
4. *Somatization*—showing somatic symptoms and displacing feelings.

In only one of their seven cases did they find what they interpreted as 'appropriate mourning' for the losses incurred by the illness (Bahro *et al.*, 1995). However, denial may, of course, be an adaptive response at times; Sevush & Leve (1993) found that denial of cognitive impairment correlated negatively with severity of depression scores.

In a qualitative study of the early experience of Alzheimer's disease, Keady and Gilliard (1997) found several issues that were of great importance for the individual but were rarely mentioned in the clinical literature. They highlighted the existence of a 'preclinical phase', which may last for several years before diagnosis. A crucial point

for clinicians to understand, when working with people with dementia and mental health problems, is that dementia does not begin with diagnosis. The individual will often have a long history of psychological experiences. Early, preclinical experiences of Alzheimer's disease may include

1. problem-solving difficulties,
2. being unable to concentrate for prolonged periods,
3. thought block,
4. inability to quickly recall names,
5. losing track of conversations,
6. feeling dissociated from reality,
7. becoming sad and depressed,
8. feeling unduly angry,
9. tearfulness,
10. feeling and becoming lost in familiar surroundings,
11. not being able to fully co-ordinate and control speech and actions,
12. writing block and
13. heightened sense of taste and smell (Keady & Gilliard, 1997, p. 53).

Keady and Gilliard (1997) also described the personal, secretive nature of the process of coping with onset and transition into Alzheimer's disease and stressed how people with dementia are rarely seen as partners in the process of their dementia, with little support provided for the empowerment of their decision making processes. In order to cope with these experiences and in attempting to maintain an appearance of normality, they suggest that the individual has often been forced to develop a number of personal strategies, the maintenance of which can become increasingly difficult with the progression of cognitive decline.

Beck, Rush, Shaw, and Emery (1979) stressed the primacy of cognitive factors in depression. Beck described the depressed person's pattern of regarding himself, his future and his experiences (the cognitive 'triad') in an idiosyncratic negative manner. An important feature of this model is the concept of depressive 'schema', which determine how an individual will interpret and structure different experiences. Beck further stresses the importance of faulty information processing, such as arbitrary inference, selective abstraction and over-generalization, as often leading to a pattern of systematic logical errors, which in turn leads to a depressive state. Even with this brief description of Beck's model of depression, it would appear that some relatively sophisticated thought is necessary to maintain the depression. If this model is to

be accepted, then it might be suggested that there will come a point in a dementing illness where depression is no longer possible because the necessary schema cannot be sustained; in other words, depression will resolve in dementia as the individual loses the ability to think about his/her own condition and situation.

In fact, there is little clinical evidence to support this resolution of depression during the process of dementia (Ott & Fogel, 1992; Verhey, Rozendaal, Ponds, & Jolles, 1993). Verhey *et al.* (1993) found a highly significant correlation between their measures of severity of dementia and awareness of dementia ratings. They did not observe a significant relationship between severity of dementia or awareness of dementia and ratings of depression. However, given the previously described findings relating to the denial of cognitive impairment (Sevush & Leve, 1993), this remains an area for further investigation.

Beck (1976) viewed an individual's ability to introspect and reflect on thoughts and fantasies as a factor in determining suitability for cognitive therapy. The ability of a person with dementia to introspect and reflect may be impaired with cognitive decline and therapy made progressively more difficult. The point at which cognitive therapeutic interventions become ineffective in the face of this cognitive decline is unknown. Thompson, Wagner, Zeiss, and Gallagher (1989) suggest that cognitive behaviour therapy is most likely to benefit patients with early dementia, where more insight and cognitive capabilities remain. Of the psychotherapeutic interventions that can be made, cognitive therapy may be one of the therapies of choice because of its short term nature and proven effectiveness. There are not as yet any published controlled studies assessing the effectiveness of cognitive interventions in the treatment of depression in dementia, although Teri and Gallagher-Thompson (1991) described such programmes as being under evaluation. Teri, Logsdon, Uomoto, and McCurry (1997) describe a randomized controlled trial, where depression in people with dementia was treated through an intervention with their family caregivers. They were taught to use simple behavioural techniques with the person with dementia, involving them in more pleasurable activities, and to make use of problem solving strategies. A significant reduction in depression was observed, compared with control patients, and caregivers' depression levels also reduced. The study did not include any one-to-one therapeutic intervention with the person with dementia.

PSYCHOTHERAPY WITH PEOPLE EXPERIENCING DEPRESSION AND DEMENTIA

Accepting that depression is a separate and reversible problem is clearly an issue that must be addressed early in therapy. The view that their compromised health status is the only thing upon which happiness can be based is a view that may be unwittingly reinforced by family and professionals agreeing that the individual has 'every reason' to be depressed (Rybarczyk *et al.*, 1992). This view has in the past been applied to older adults in general and to older people with chronic illness in particular. Treatment techniques have challenged these notions, and may be applicable where depression co-occurs with dementia.

Koder, Brodaty, and Anstey (1996) describe techniques useful for the adaptation of cognitive therapy for older adults.

1. *Therapy induction*—emphasizing the rationale for treatment and challenging negative concepts such as 'I'm too old to change'.
2. *Selection of realistic, concrete goals*—a greater emphasis on activities, behaviours and early achievement of success and less on cognitive restructuring.
3. *Additional reinforcement*—provision of printed handouts, slower pace and a greater reworking of issues.
4. *Group work*—attempting to lessen the isolation and encourage openness.
5. *Attention to common themes of ageing*—such as low self-esteem and anxiety about the future.
6. *Life review and reminiscence*—allowing the incorporation of previous coping strategies and placing current issues within perspective.
7. *Involvement of significant others*—including relatives and close others in the latter stages of therapy to enhance maintenance and generalization.
8. *Gradual termination of therapy*—including a gradual deceleration of frequency of sessions and the offer of additional review.
9. *Follow-up sessions*—appear to be particularly important for maintenance.

Other factors could be added to this list, including an awareness of real social, economic and physical limitations, a more flexible approach to session timing, a more active role from the therapist and consideration of ageism in therapy (Woods, 1994). Dick, Gallagher-Thompson, and Thompson (1996)

also stress the importance of summarizing when working with older adults.

With the older adult who has dementia, assessment and therapy is further complicated by memory loss. The study of this memory loss is not, as yet, sufficiently advanced to state whether information relating to an individual's psychopathology will be better or less well preserved. More specifically, the rates of cognitive decline of coping mechanisms cannot be assumed to conveniently parallel the rate of decline of the material for which they were constructed to manage. More promisingly, despite having cognitive impairments, it seems that many people with dementia can still learn, particularly in terms of implicit memory (Eslinger & Damasio, 1986, Nebes, Brady & Huff, 1989) and where events arouse high levels of emotion.

As previously noted, dementia is typically a progressive disorder. In applying cognitive behavioural psychotherapy to chronically ill older adults, Rybarczyk *et al.* (1992) identified five treatment issues:

1. resolving practical barriers to participation in therapy,
2. accepting depression as a separate and reversible problem,
3. limiting excess disability,
4. counteracting the loss of important social roles and autonomy and
5. challenging the perception of being a 'burden'.

Also, home visits are often used with the depressed and dementing client group and any prospective therapist needs to become comfortable with this manner of working, particularly since utilization of psychiatric services by depressed older adults is low when compared with younger adults (Cuijpers, 1998).

Amongst people with dementia, depression provides an additional burden, both for themselves and for their carers (Rosenvinge, Jones, Judge, & Martin, 1998), which may prove to be treatable. The theoretical assumption of the series of interventions reported here was that the extent to which cognitive therapy is useful for people with concurrent dementia and depression is unknown; it cannot be assumed to be either useful or inappropriate whilst the current gap in the understanding of the relationship between dementia and depression remains. Similarly, the boundary point beyond which cognitive psychotherapy cannot be applied has yet to be identified.

THE INTERVENTIONS

Participants

All participants were initially referred to psychology services by a consultant psychiatrist. The consultant psychiatrist had been made aware that a cognitive therapy intervention was available for clients with concurrent dementia and depression. To qualify for inclusion, all participants had to fulfil the following criteria, following the voluntary decision to take part in cognitive therapy.

1. A diagnosis of dementia, following ICD-10 criteria (World Health Organization, 1992) with clinically significant cognitive deficits on standardized psychometric tests.
2. A diagnosis of depression, following ICD-10 criteria (World Health Organization, 1992) supported by a score on the 30-item Geriatric Depression Scale of 11 or above (Yesavage *et al.*, 1983).

A summary description of the participants can be found in Table 1. All participants had received a Mini-Mental State Examination (MMSE) (Folstein, Folstein, & McHugh, 1975) from the referring psychiatrist. The MMSE is fundamentally a screening instrument and can be heavily influenced by a number of factors, including educational level. However, the range of scores (20–30) could be taken as indicating that the participants were experiencing mild to moderate levels of cognitive impairment. Although patient 7 scored 30/30 on the MMSE, her performance on more detailed neuropsychological assessment showed clear evidence of cognitive impairments.

Psychiatric Medication

An obvious confounding factor in any psychotherapy trial is concurrent prescription of psychotropic medication. Four of the participants (2, 3, 6 and 7)

Table 1. Participant characteristics

Case	Participant	Age	Sex	Marital status	MMSE
1	John	83	Male	Widowed	20
2	Eric	69	Male	Married	25
3	June	79	Female	Widowed	26
4	Dafydd	79	Male	Married	21
5	Dilys	64	Female	Widowed	21
6	Norma	72	Female	Married	23
7	Martha	57	Female	Married	30

received no psychotropic medication during the intervention. Participant 1 had a long standing prescription for fluoxetine, with which he was non-compliant. Participant 5 had a long standing (> 4 months) prescription (nefazadone), with which she had been compliant, with little apparent effect noted by her psychiatrist. In one case, however, prescription may have been a confounding factor, as participant 4 was started on citalopram during the intervention.

Measurements

The primary psychometric evaluation of the level of depression was the Geriatric Depression Scale (GDS) (Yesavage *et al.*, 1983). Studies have described how mild to moderate dementia (MMSE > 16) alone does not appear to significantly affect the accuracy of the GDS as a screening tool (O'Riordan *et al.*, 1990; Ryan, Blackburn, Lawley, Ellis, & Musil, 1995; Sheikh & Yesavage, 1986). Although a potentially flawed screening instrument, where a clinical diagnosis has been made the GDS does appear to be one of the better indicators of the level of depression experienced by an individual with dementia. Its 'Yes-No' scoring format places minimum memory load on the person completing the scale. The 30-item version was used pre- and post- the planned eight treatment sessions, in order to evaluate change in mood. The 15-item version (Sheikh & Yesavage, 1986) was used within sessions with some patients, to monitor session-by-session progress.

Structure of the Psychotherapy Sessions

The structure of the therapy sessions was largely based upon the model by Beck *et al.* (1979) with the following modifications.

- As with a 'normal' cognitive therapy approach, an agenda was established for each session. This was jointly developed with the participant, although a slightly more active role was taken by the therapist when memory constraints appeared to be limiting the participant's ability to recall central themes.
- The therapist regularly summarized material and issues covered and attempts were made to elicit participant summaries additionally.
- Discussion of tangential and peripheral topics occurred relatively often. On several occasions the relevance of these discussions emerged later in therapy; they additionally appeared to assist

in establishing rapport, particularly important in this type of work, as none of the participants were self-referrals for a psychotherapeutic intervention. Despite this diversification, attempts were made to address at least one central issue per session.

- An expansive view of the nature of depressogenic schema was taken so that the focus was not upon logical contradiction of specific examples of 'negative automatic thoughts' but on development and review of alternative interpretation of key issues, on a number of occasions and from a diverse range of perspectives.
- A significant part of therapy with all of the participants was discussion of their diagnosis and the significance of this in terms of the cognitive changes they were currently experiencing and were likely to experience in the future. All of the participants were made aware of their diagnosis to the extent it was known to the therapist. Where requested they were provided with additional information on dementia and their future. In general, participants did not request details of end-state dementia. In this respect, the interventions are similar to those reported by Husband (1999).

The length of the therapeutic intervention was planned as eight sessions, and the results reported here relate to outcome at this point—it was planned to offer further sessions to participants where required. In order to ensure that the therapeutic intervention did indeed follow a cognitive therapy approach, the Competency Checklist for Cognitive Therapists, from Beck *et al.* (1979), was completed after the second therapy session with each participant. Where discrepancies were found, these issues were addressed in later therapy sessions. Additionally, the therapist received weekly supervision for these cases.

OUTCOME

Two participants declined to complete the GDS initially, apparently finding it too intrusive given the brief period in which they had known the therapist. Both were able to later complete GDS short forms (15 items) during the initial therapy session and a full scale GDS on completion of therapy. Their initial full scale GDS scores were estimated *pro rata* from the short form.

The initial and outcome GDS scores are shown in Table 2. The mean initial GDS score was 19.28

Table 2. Initial and outcome Geriatric Depression Scale scores

Case	Initial Geriatric Depression Score ¹	Outcome Geriatric Depression Score (8 sessions)	Reliable Change Index (RCI) ²
1	23	15	2.66 ³
2	12	8	1.33
3	(20)	14	1.99 ³
4	20	17	0.99
5	27	23	1.33
6	(14)	13	0.33
7	19	19	0.33

¹ Figures in brackets indicate estimated scores.

² RCI values > 1.96 indicate a reliable change at the 5% level of significance.

³ Significant at $p = 0.05$.

(s.d. = 5.09). The mean outcome GDS score was 15.57 (s.d. = 4.65). The difference between these measures was statistically significant on a matched-sample t test ($t = 3.86$, $df = 6$, $p = 0.007$). (This difference remains significant if the estimated scores are excluded: $t = 3.51$, $df = 4$, $p = 0.025$).

Several authors have suggested techniques for measuring the clinical significance of therapeutic change (Christensen and Mendoza, 1986; Hageman & Arrindell, 1993; Jacobson, Follette & Revenstorf, 1984; Jacobson & Truax, 1991). The Reliable Change Index (RCI: Jacobson *et al.*, 1984) was designed to determine whether an individual's observed change was greater than the change that would be expected on the basis of the error in the measure. The formula provided by Christensen & Mendoza (1986) is reasonably conservative and has been described as methodologically more sound than the original RCI measure (Hageman & Arrindell, 1993). The GDS scores of two of the eight participants appeared to indicate clinically reliable change (participants 1 & 3), assuming a test-retest reliability score of 0.85 (Koenig, Meador, Cohen, & Blazer, 1988). Although a reliable change in only two out of seven participants represents a modest degree of success, studies of psychotherapy for unipolar depression with non-dementing participants generally show 'moderate' levels of clinical significance (Neitzel, Russell, Hemmings & Gretter, 1987).

DISCUSSION

Though statistically significant, the changes in depression scores at outcome were relatively

modest. Only one participant (participant 2) moved out of the depression range on the scale. It is acknowledged that the improvements demonstrated following psychotherapy may have represented a 'placebo effect' or have simply reflected the normal resolution of the depression that would have occurred with or without cognitive therapy. However, the cognitive shifts made by some of the participants and their descriptions and attributions of changes in their lives over the therapy period suggest that cognitive therapy did have some value.

This value is difficult to measure psychometrically and may represent something quite different to a shift of a few points in GDS scoring. The therapist's perception from working with these participants was that they were slightly better able to accept their situation. They seemed to be less confused and had better insight into their condition following therapy. However, in terms of GDS questions such as 'Do you think it is wonderful to be alive now?' or 'Do you think most people are better off than you are?' their response remained unchanged.

In a questionnaire study of the practice of consultants in old age psychiatry, Rice and Warner (1994) found that, unlike family care-givers, patients with dementia were rarely told their diagnosis. Within this study all of the participants were made aware of their diagnosis where they responded or requested that they would want to know it. Anecdotally, it appeared that the actual prognosis was no more unpleasant than the experiences that they had imagined they were going to encounter.

Common Themes Arising in Therapy

The following describes the impressions from working with a series of individuals with concurrent depression and dementia.

1. An individual with dementia may have a *fixed conception of the cause of their cognitive impairments*. This may be a harmless feature of the person's individual belief system. Occasionally, however, it may be dysfunctional, in that it leads the person to feel blame, anger and frustration that proves difficult to resolve. The aim of therapy in this situation is to collaboratively examine this attribution, seeking, if possible, to find a more functional view. This conception may fit with professionals' explanations, or it may be one which fits more readily with the individual's construct system.

John, the first participant, was an 83 year old man. The letter from John's GP described how: "much of this gentleman's problems occurred in an incident when he had his cataract operation done... he was extremely concerned as he claimed that he had been assaulted on the operating table... it transpired that an incident happened on the operating table but he had become totally obsessed with the whole situation... while he was having his cataract operation done he fell asleep. He woke during the operation and unfortunately had to be restrained for a short while for his own safety'.

John had left school early, following the death of his father, when he was 14. He had then worked on a farm until the war when he had joined the RAF working in aircraft maintenance. During the war, he was 'blown up' on two occasions, both causing some mild head injury. A multidisciplinary assessment, including a detailed neuropsychological evaluation, revealed cognitive deficits consistent with a diagnosis of Alzheimer's type dementia.

Several issues were raised in therapy that appeared to have a relationship to John's level of depression. John's frustration over the treatment he had received during and following his eye operation was considerable: 'I cannot understand how this operation was still carried on under the circumstances and I will NOT REST until I'm SATISFIED' (from John's written account of his experiences). He felt that he had woken up during the operation as a result of the mishandling of his anaesthetic, at which point he thought he had been 'throttled' into unconsciousness. John had also experienced a 'terrific bang' to his head which he considered worse than the experiences of being 'blown up' during the war. Additionally, as far as John was able to tell, the operation had not improved the vision in his eye. The time of onset of his dementia was unclear, but he clearly attributed his cognitive impairments to the operation.

Therapy with John was quite repetitive, in that these issues would be raised once or twice during each session. This was viewed in a positive fashion, in that it

allowed repeated opportunities to discuss issues important to John at a rate that he determined. With therapy, John appeared to become less fixed on the experiences of this operation, and a particular improvement was noted after he was able to give a written account of his experiences, which was sent to his consultant psychiatrist. In the later stages of therapy, John suggested that he might have experienced a stroke during the operation; this then appeared to allow the resolution of his desire to find someone to blame for his experience of cognitive loss.

2. *A loss of control leading to a state of hopelessness.* The views and opinions of a person with dementia are not generally held in high regard. This may be reinforced by the conduct of medical professionals, which often takes the form of talking and listening to carers before the person themselves. Beyond simply listening and talking to the individual, the therapist can facilitate a clear statement of the views and wishes of that individual and assist in communicating these views to both professional and non-professional carers.
3. *A feeling of insecurity.* The person may be aware of or even hold the belief that the place for a person with dementia is a residential home. This can lead to a situation in which the individual struggles to deny their cognitive impairment or conversely gives up and resigns themselves to the inevitable removal to what may essentially be perceived as a prison.

Dafydd, the fourth participant, lived with his wife. He was a baker by trade, beginning his apprenticeship on leaving school and running his own bakery until his retirement. He had no children. Dafydd had been referred to psychology services three years prior to this intervention for psychometric assessment following deterioration in short-term memory, confidence and motivation. He had received a repeat assessment shortly before this assessment, which had found that although he was 'performing just below the cut-off for dementia of Alzheimer type' he still had 'a number of preserved abilities'.

Dafydd's consultant psychiatrist had found him a 'difficult man to assess as he is extremely fearful as to what is happening

to him'; he had also noted that Dafydd was getting into 'frequent arguments' with his wife, who was herself chronically ill. Dafydd had good insight into the decline of his cognitive skills. This in itself appeared to be an influential factor in Dafydd's mood. He was also greatly occupied by concerns that he might be forced to leave his home against his wishes.

Although Dafydd and his wife had never had children themselves their roles as carers had been extremely important to them. They had frequently looked after the children of their siblings. They had additionally taken on responsibilities caring for many of the older people who had lived in the street. Dafydd appeared to be finding the transition from 'carer' to 'cared-for' quite difficult. This transition of roles was complicated by his wife's coping mechanisms for her own illness. It seemed that her self-esteem was strongly related to her ability to care for those around her and provided a means by which she could psychologically combat her illness. For Dafydd this meant a change of role that was too extensive and was leading to frustration and argument.

Having seen the process of dementia in several other people and the disinhibited behaviour that they had shown, Dafydd was particularly concerned that he might become violent. This anxiety was heightened by the increased regularity of disputes between himself and his wife. During therapy a strategy that became important to Dafydd was to try to 'take each day as it comes'. This appeared to allow Dafydd to concentrate more on the here-and-now rather than thinking of a future alone and dementing following the death of his wife.

Dafydd described a modest improvement in his mood over the sessions. This was supported by the gradual improvement in his GDS scores over the sessions. It was also interesting to note a modest improvement in Dafydd's psychometric reassessment test scores. Naturally, this might have been due to any number of factors, such as practice effects or a more relaxed test-taking attitude,

but may reflect the interaction of mood and cognitive function.

In follow-up, Dafydd described how the progress made in therapy had been sustained but that this was complicated by his wife's terminal illness. His anxiety with regard to the future had lessened but he remained realistic in that their future contained several 'dark clouds'.

4. *Memory for traumatic events may well be preserved whilst coping strategies can appear to have become dislocated.* Where 'repression' has been a partially functional coping process, it is possible that the cognitive processes that underlie this type of coping schema are more cognitively demanding than the storage of the repressed event, leading to a 'time-bomb' triggered by the process of dementia.

Therapeutically the individual may benefit from the opportunity to 'reframe' the experiences with the assistance of a skilled therapist. This was most strikingly illustrated by a survivor of childhood sexual abuse. Therapy provides an opportunity to challenge the inappropriate guilt and self-blame that can arise from these experiences.

Martha, the seventh participant, was the youngest: aged 57 at the start of therapy. As her psychiatrist noted, Martha had experienced an 'unfair share of physical problems'. She was an insulin-dependent diabetic with problems with vision and hearing, and also had angina and arthritis. Her first CVA had been approximately two years before this intervention and since then she had experienced numerous TIAs. Her psychiatrist concluded that Martha was experiencing progressive vascular dementia.

Martha described having experienced a difficult childhood with considerable physical and emotional abuse. The relationship between Martha and her mother appears to have been extremely poor. From Martha's accounts it appears that her mother may have experienced severe mental health difficulties including features of depression and obsessive-compulsive disorder. Martha's childhood seems to have been extremely strict and punitive. From a relatively early age she

spent weekends and holidays in the local 'work-house'.

Martha disclosed two experiences of sexual abuse. The first, at the age of 11, was perpetrated by a local man known to the family and appears to have been with her mother's knowledge and consent. The second, a few years after, was a sexual assault perpetrated by a man still occasionally seen by Martha. That her mother knew of this abuse and yet still denied that it occurred was particularly distressing for Martha, added to the fact that her mother was a generally respected church going lady.

Despite these experiences, Martha appears to have been a good mother herself and was still providing regular support and advice for her children and grandchildren. However, following her first CVA she had begun to lose confidence and had gradually found it more difficult to cope with her traumatic experiences.

Martha was able to disclose the full extent of her physical and sexual abuse for the first time. The true depth and severity of her mother's own psychopathology began to be revealed. Martha's considerable achievement in breaking the 'chain of psychopathology' from one generation to the next became starkly clear as comparisons between her relationship with her mother and those of her children with herself emerged. She declined to make a statement to the police about her abuse but was grateful that this had finally been taken seriously after over 40 years.

Martha continued to experience periods of depression, which appeared to be preceded by stroke/TIA type episodes.

5. *The therapist must be flexible, patient and tolerant.* Handouts, diaries and homework tasks may all be forgotten or lost. Interpretations of this type of behaviour must be made cautiously, as it is not unusual for a person with dementia to place a precious document in an especially safe location, which is rapidly forgotten. Anecdotal accounts of carers finding documents or money in shoes, on top of wardrobes or in more obscure positions are common. The relationships between the participants' cognitions may not be as clear

and explicit as are typically presented in models of cognitive therapy. The relationship may gradually become clearer with time and patience.

Several members of the assessment team had noted Martha's tendency to digress into apparently irrelevant discussions regarding her children and grandchildren. The protective nature of these digressions and the importance of her successful role as a mother in relation to her traumatic experiences became gradually clearer with therapy.

6. The trigger for depression may be very simple and relate to loss of mobility or daily living skills. Successful liaison with carers and other professionals such as physiotherapists, occupational therapists and social workers may be particularly important.

Eric, the second participant, was a 69 year old man. Eric had been referred to psychology services by a psychiatrist for a neuropsychological assessment, which was carried out approximately one month before this intervention began. The presenting problems were memory and word finding difficulties, which were now straining his marital and social life. Eric's CT scan demonstrated 'widespread cerebral atrophy with ventricular dilation'.

Now that his memory was in decline, both he and his wife appeared to be in a process of mourning its loss and appeared confused over why it should be happening. They were unable to understand the reason for this memory loss, although they had been told by his heart surgeon, in whom they had placed a great deal of faith, that some mild deterioration would be normal following a second heart valve replacement operation. They both seemed reluctant to consider a progressive degenerative disorder as the reason for Eric's continued decline. His wife had repeatedly asked him 'Why can't you be like you used to be?' and stated 'it's like living with a dummy'.

It emerged in individual therapy with Eric that he and his wife had, in the past, discussed the possibility of future invalidity, and had both agreed at that time that the best option would be to place the affected partner in a nursing home so that the other might be able

to live an unhindered life. Now that a genuine progressive illness seemed to be emerging, this conclusion was beginning to weigh more heavily in Eric's mind.

A joint session with Eric and his wife rapidly diminished his fears that she would place him in a home if his memory got worse. Now that such an issue was more immediate she strongly felt that she would like Eric to stay at home for as long as possible and whilst not being a natural 'carer' she expressed considerable determination that it would not be beyond her.

7. Western culture is becoming increasingly dependent upon the motorcar. The frustration a person can experience following the *loss of the ability to drive* or even more so the enforced removal of a driving licence is difficult to underestimate. This can be particularly acute when the individual has poor insight into their own driving abilities. Therapeutically, it can be beneficial if the person with dementia can be made aware of this possibility as early as possible, so that planning and preparations can be made.

The results of this study appear to indicate that modest improvements in mood are possible with this participant group. It is obviously too early to state whether these improvements provide long-term benefit or are worthwhile or cost efficient. However, it is not difficult to conceive that even small changes may reduce the need for the individual to be taken into residential care. Such changes might include the recognition and tolerance of the need for professional home care assistance, increased compliance with medication, better relationships and increased activity levels.

Dementia is not always a benign process in which depressive schema conveniently resolve with cognitive decline. It can be a cruel process in which an individual's coping mechanisms deteriorate long before self-awareness and memories of traumatic experiences. For some people dementia can be a time of depression. This study provides an indication that some individuals with dementia can be assisted by cognitive psychotherapy where depression co-exists with the cognitive impairment, and points the way forward to controlled evaluations. An interesting comparison would be with group cognitive therapy, which has proven useful for some (see e.g. Kipling, Bailey, & Charlesworth, 1999), just as group work more generally for people

in the early stages of dementia appears feasible and productive (Yale, 1995).

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