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| The University of North Carolina at Chapel Hill |
| Assessment and Treatment |
| Mrs. Lancaster |
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| **Carly Laper** |
| **SOWO 843 Fall 2012** |

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**Overview**

Mrs. Lancaster is a 78 year old woman who is experiencing cognitive impairment and possible dementia. While there is not a significant risk difference for dementia, there is a higher prevalence of dementia, especially Alzheimer’s dementia, among women compared to men1. Her husband brought her to the doctor for an evaluation of her memory. Mrs. Lancaster scored 17 out of 30 on the Mini Mental State Exam. A score of 22 or less is indicative of cognitive decline. Additionally, Mrs. Lancaster meets the DSM-IV criteria, memory impairment plus disturbances in executive functioning2. This is evidenced by her increasing difficulty with driving and preparing meals. The impairments must have had a gradual onset and continuing decline and represent a significant decline in function2. Mrs. Lancaster’s cognitive impairment has been getting progressively worse over the past five years and she has begun to have some difficulties with instrumental activities of daily living (IADLs), such as driving and meal preparation. Dementia is often a precursor to decline in function and loss of independence1. Generally, IADLs are the first to decline when a person has dementia, followed by activities of daily living (ADLs). Currently, Mrs. Lancaster is still able to complete self-care ADLs independently.

In addition to the dementia, Mrs. Lancaster is showing signs of depression. Depression in the older adult population is not uncommon. Rates in the community range from 1-5%, but combined with the fact that she has some cognitive decline, the rates of depression rise3. The DSM-IV states several elements that are consistent with depression the Mrs. Lancaster presents. These include depressed mood, loss of interest in activities, increased fatigue and thoughts of death or suicide. While the DSM says that a person must exhibit five elements to be considered for depression4, Mrs. Lancaster meets four of the criteria. One additional criterion that she could fit into is the decreased ability to concentrate or think, however more information is needed before drawing this conclusion. This would complete the five required elements. It could also be an effect of the dementia. It is very common for older adults to have symptoms of dementia and depression that overlap.

***Psychosocial Assessment***

*Identifying Information*

Mrs. Lancaster is a 78 year old female living in the community with her husband. Currently, little is known about the home environment or even what type of home they share, apartment, one story, town home, etc. More information is also needed about the neighborhood she lives in as it may point toward resources that are available to them. The family was referred by the physician to address family support needs in regards to the dementia and depression.

*Presenting Problem*

Mrs. Lancaster was brought to their physician over concerns of worsening memory problems. Mrs. Lancaster scored 17 out of 30 on the Mini Mental State Exam indicating cognitive impairment. She is no longer able to perform IADLs, representative a decline in function. Compounding this, Mrs. Lancaster is demonstrating signs of depression. She denies any depressive symptoms, however Mr. Lancaster states that she has thoughts of ending her life and has lost interest in activities that she previously enjoyed. The physician also noticed a sad demeanor. The husband appears attentive to Mrs. Lancaster and states they have adequate family support. Mrs. Lancaster has a tendency to decline their visitation. She also expresses that she cannot handle this on her own and does not know what to do.

It would be important to gather more information about how and if her depression and dementia have progressed and how that has impacted relationships within the family. It would also be valuable to know more about the family interactions and how others have been handling the situation and what they have tried in the past, if anything, for solutions.

*Background History*

Not much is known about her current or past medical history or about Mrs. Lancaster’s past in general. This would be good to know because it would help to determine if there are medical problems or medication that may be contributing to her confusion and depression. It would be useful to know if there have been any major life changes recently, either in health or other life circumstances, which may be contributing to the decline. She has lost interest in her usual activities. What are her interests and activities? Was she active in the past? Has Mrs. Lancaster had any previous incidences of depression? What was her previous employment? These are just a few of the questions that would begin to shed more light and provide greater insight into Mrs. Lancaster’s situation.

*Assessment*

Mrs. Lancaster is a 78 year old female with worsening memory and cognitive impairment coupled with her depression that have begun causing concern for her husband and other family members. Mrs. Lancaster has expressed worry and about not being able to do “this” all by herself. This conveys that she does not have family support, which the husband claims does exist and to a fair extent. He states that Mrs. Lancaster repeated refuses family visitation requests.

Mrs. Lancaster has had some decline in functioning as she is unable to perform higher level tasks, IADLs. Mr. Lancaster took his wife to see the physician about her memory impairments. At that time, the physician prescribed antidepressants to Mrs. Lancaster to help mitigate the symptoms of depression that she is also experiencing. The depression may have a negative impact on her memory and could be contributing to more recent declines in her cognitive health.

In Mrs. Lancaster’s case, there are both strengths and challenges to meeting both her and her family’s needs. Some challenges in her case are her worsening cognitive impairment and her perception that she does not have family support and is in this situation alone. Education may need to be aimed that the family for tips that they can implement to help maintain Mrs. Lancaster’s current abilities and strategies to have prevent or slow further decline. Another challenge is her depression, which can make some interventions more challenging because motivating Mrs. Lancaster to participate may prove to be more difficult. A strength is her actual family support, although the extent is not fully known at this time, it is apparent from the husband that the support is there. Family support is going to be a key element throughout Mrs. Lancaster’s care.

Her depression is a priority coupled with Mrs. Lancaster’s perceived lack of family support. These can be addressed simultaneously and if the depression begins to improve, that may also have some positive effects on her cognition. The family would benefit from social work involvement to further assess family and living situation, provide resources to help the family and Mrs. Lancaster make the necessary adjustments to provide adequate care for Mrs. Lancaster while providing the family with resources they may need to maintain their own quality of life.

**Social Work Treatment Plan**

Mrs. Lancaster’s social work treatment plan will be centered around reducing depression and facilitating family relationships. The plan will focus on creating and meeting goals that are appropriate for Mrs. Lancaster as well as her family. The social worker and the family will collaborate to create short and long term goals. Mrs. Lancaster will meet with a geriatric psychologist for treatment and management of her depression at the frequency set by the therapist. The therapist will also have to be knowledgeable about therapy for people with dementia.

She will also meet with a licensed clinical social worker once every two weeks to discuss how things are going and to continually assess for any needs that may arise. The social worker will also organize meetings with the entire family present to assess interactions and allow everyone the opportunity to discuss concerns or things that are going well. During these sessions, they will determine if goals are being met or if they need to be adjusted. The social worker will also help to ensure that Mrs. Lancaster is attending follow-up appointments with her doctor and be adherent to her medication.

**Specific Application of an Intervention Model: Interpersonal Psychotherapy**

Interpersonal psychotherapy (IPT) is commonly used to treat depression in older adults with good success, when used in combination with medication. One added benefit for Mrs. Lancaster especially, is that it has an emphasis on addressing interpersonal problems, which she seems to have with her family, to a certain extent. The therapy aims to help people change, rather than accept their situation5. The ultimate goal of IPT is to allow Mrs. Lancaster to see that her situation is not hopeless. It is also important to keep in mind that an interpersonal relationship does not only refer to the impact of others on her, but also the impact of her mood on others. There are three treatment phases that are included in IPT that occur over about 12 sessions5.

*Initial Sessions*

The initial sessions are meant as a get-to-know-you period. It allows the therapist and the client to establish a working relationship on which to build trust and personal growth. The therapist will get to know Mrs. Lancaster in terms more relevant to interpersonal relationships and explore her feelings. An important step in forming a relationship is for the therapist to provide support for Mrs. Lancaster5. This includes acknowledgement of what Mrs. Lancaster is feeling and experiencing and providing support for how she is managing her situation. It is important to continually consider Mrs. Lancaster’s cognitive impairment throughout all the sessions. She may be confused, but there is some meaning that can be derived from all her stories. They are important to her or she would not be sharing them. It is important to pay close attention and look past the literal meanings of her words in order to best help Mrs. Lancaster through her depression.

One of the first steps in IPT is a review of Mrs. Lancaster’s depressive symptoms5. This might be slightly more difficult because she denies feeling depressed. This is when the therapist can ask her about common symptoms of depression without specifically mentioning that these are depressive symptoms. This may allow Mrs. Lancaster to acknowledge some of these signs in a way that is less threatening in terms of the fear or stigma of depression. After the therapist teases the symptoms out, she can explain to Mrs. Lancaster that these are commonly associated with depression and explain that there is nothing wrong with feeling that way and that it is not Mrs. Lancaster’s fault. The therapist will also explain these symptoms as they relate to the interpersonal context and identifying the major problem areas. For Mrs. Lancaster the main problem areas are her fatigue, sad affect and refusal to see family members. She can then explain the purpose and goal of the therapy sessions, giving Mrs. Lancaster the opportunity to ask questions and understand where these sessions are going to head.

Mrs. Lancaster will have the opportunity to freely discuss her relationship with her husband and children, as well as any close friends. This stage is called seeking information5. This is like an interpersonal inventory where the therapist really gets to learn about the people in Mrs. Lancaster’s life, how she views them, how they interact and things they enjoy doing together. An important part of this stage is also learning if Mrs. Lancaster would like anything about their relationship to be different. The therapist would start with her husband. Mrs. Lancaster would describe him and their relationship to the therapist. During this description and subsequent conversations about other people and relationships, the therapist points out significant events, feelings or thoughts. This can help Mrs. Lancaster to see either good aspects or ones that could use improvement in her relationships.

*Intermediate Sessions*

The intermediate sessions focus more on the identified problem area. IPT identifies four problem areas that may be present within the client’s situation. These include interpersonal role disputes, grief, interpersonal deficits and role transitions5. One or multiple of these may be present depending on the client. Mrs. Lancaster may have a couple of these that are contributing to her depression. First, she may be experiencing grief. Depending on her level of cognition and its fluctuating status, she may be occasionally aware of her memory problems, and she may be grieving a loss of her old life. Secondly, interpersonal deficits are likely in her situation. She believes she does not have the family support, although we know that several attempts have been made by her family and she refuses them. There is something going on and it is the therapist’s role to help Mrs. Lancaster sort this out and determine why there might be a rift in the relationships. Lastly, Mrs. Lancaster could be experiencing role transitions. Presumably, she was the care taker of her family, helping everyone when they needed it. Now, she may realize that she is the one who needs help from those whom she has helped in the past. This can be a tough transition for any person to go through. All of these interpersonal problems may be contributing to Mrs. Lancaster’s depression.

Also during this phase, the therapist and Mrs. Lancaster will explore parallels and patterns in relationships and in communication5. The therapist will guide Mrs. Lancaster to think about her past relationships and if any similar situations have arisen before. What did Mrs. Lancaster do during those times? This may be a bit more challenging for Mrs. Lancaster because of her cognitive impairment but many of her long term memories are still likely to be intact. The therapist can also make suggestions about how Mrs. Lancaster can make changes to current and past patterns in her relationships. These will have to be written down so Mrs. Lancaster can review them later, as she is not likely to remember but improvements can be made with some practice. Lastly, Mrs. Lancaster’s communication style and patterns are explored. She is encouraged to experience the situation from the other person’s point of view to help her understand their side. This will help her improve her communication of her thoughts and feelings.

Some techniques that the therapist can use during this stage are exploring affect and problem solving5. Exploring Mrs. Lancaster’s affect will allow her and the therapist to make connections between how she is and was feeling to how she expressed those feelings to others. This can be used most effectively when exploring Mrs. Lancaster’s communication patterns. Problem solving teaches Mrs. Lancaster to approach her issues with problem solving techniques. This one may be difficult with Mrs. Lancaster because getting her to stop and think about situations is not going to be easy. This can be used in the sessions though to go back through experiences and draw connections and learn from them.

*Termination Sessions*

The termination sessions are usually only the last couple sessions. This is when the psychotherapy relationship ends and Mrs. Lancaster moves toward recognition of independent competence5. These sessions focus on Mrs. Lancaster’s ability to manage her interpersonal relationships by herself and to understand her role in them. Mrs. Lancaster will have the knowledge and skills to communicate effectively in all her relationships. The last part of the termination sessions is determining maintenance treatment5. Maintenance treatment is essential to prevent recurrence of depressive episodes. These will probably need to be more frequent for Mrs. Lancaster because of her cognitive impairment.

*Strengths and Limitations*

Interpersonal psychotherapy is beneficial for older adults, particularly those with some cognitive decline because it does not require the outside work that cognitive behavior therapy requires. It has been shown to have better adherence and compliance than cognitive behavior therapy5. Another strength is that it is focused around interpersonal relationships. This can be helpful because it allows the participant to focus on outwardly objects, not solely inwardly on their own possible shortcomings.

Limitation is that it is a face-to-face intervention that is time consuming and will require commitment from both Mrs. Lancaster and her husband. Also, it can be expensive, especially if it is not covered by insurance. Not knowing the Lancaster’s financials, the number of sessions may be limited, even though treatment may be required longer for maximal benefit. Additionally, interpersonal psychotherapy works best in conjunction with medication. It would be nice if Mrs. Lancaster did not have to take medication because of the side effects; however, in the long run she may be able to reduce the dose of medication that she is taking. Lastly, depression recurrence is common after IPT ends without maintenance sessions, especially in people with cognitive impairment6. On the other hand, those with cognitive impairment who receive monthly maintenance of IPT do much better and have a longer time period between recurrences than those that receive clinical management alone7.

**Personal and Professional Reflections**

In learning about Mrs. Lancaster and her family, many thoughts and emotions were brought up. First, I felt distressed for Mrs. Lancaster and her family. Mrs. Lancaster is depressed and having cognitive problems, while her husband tries to manage those concerns and seek help for her. Her family seems willing to help out, but Mrs. Lancaster refuses to see them. On the other hand, I feel hopeful for their situation. I think there can be some good and significant improvements made in both Mrs. Lancaster’s depression and possibly in her cognition as well. Also, there is a great deal of improvement that can be made to help restore family bonds so she may receive adequate and loving care.

Mrs. Lancaster feels that she is alone in her situation. Personally, and professionally, I think it is important to explore the reasons why she feels this way. There may have been a situation that occurred after which she no longer felt safe or loved by her family members. This may not be the case at all, and her refusal to see them may be only related to her cognitive impairment. Either way, it is something worth exploring to fully understand the dynamics of the family relationships. This would involve talking to Mrs. Lancaster, her husband and any family member she has and sorting out all the details to determine the actual cause.

**Conclusion**

Mrs. Lancaster has a complex case mixed with troubled family relationships. Her treatment course for depression is complicated by her co-morbid cognitive impairment; however, successful treatment of her depression may result in improvements in her cognitive functioning. The combination of anti-depressant medication along with interpersonal psychotherapy provides Mrs. Lancaster the best opportunity to overcome her depression. Additionally, interpersonal psychotherapy allows Mrs. Lancaster to explore her relationships and possibly develop an understanding as to why there is a rift in those relationships.

The social worker can facilitate family meetings to allow everyone a chance to discuss their own feelings and thoughts in the matter of their relationships and in the care of Mrs. Lancaster. Resolving some of these potential conflicts may afford Mrs. Lancaster a greater chance of improvement and lessen her depression if she sees that she does have substantial family support. Mrs. Lancaster and her family have a considerable amount of work ahead of them and it is probable that her cognitive functioning will continue to decline as time progresses. The goal, both current and continuing, is to provide any support and counseling through this trial and of the ones to come.

References

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