PRE-TEST EVALUATION

SPEAKERS: Lee Hyer, PhD
TITLE: Special Impact of Cognition in the Holistic Care among Older Adults
September 24, 2015

PARTICIPANT NAME:

DIRECTIONS: Please circle the best response. Submit the completed post-test to the conference staff person at the break. Thank you!

1. Biopsychosocial theorists assume there are varying levels of physical, cognitive, emotional, behavioral, and environmental factors that contribute to the clinical assessment and conceptualization of the case.
   a. True  b. False

2. The major components if the epigenetics of aging are ______________.
   a. Geoscience
   b. Age, disease, and interaction
   c. Stress - real or imagined
   d. a & b
   e. a, b, & c

3. The features of an effective psychotherapist tend to be counselors who _____________.
   a. offer strong relationships
   b. customize both discrete methods for the person
   c. customize relationship stance based on the needs of the individual and condition
   d. a & b
   e. a, b, & c

4. Some reasons to use the “Watch and Wait” approach are ________________.
   a. research does not show significant differences between the treatment and placebo for mildly depressed and anxious patients
   b. problems actually confess themselves over time
   c. depression does not need perspective as it tends to be recurrent and needs a response that reflects this recurring pattern.
   d. a & b
   e. a, b, & c

5. What is a complication of the “Watch and Wait” approach?
   a. Under-dosing
   b. Team and family involvement
   c. Deciding too slowly to initiate care
   d. a & b
   e. a, b, & c

6. Hyer’s provided review statements. Favored results tend to occur for participants who are monitored; persons with the highest pretest scores; and individuals who are complete with training. Is this statement true or false?
   a. True  b. False
Special Impact of Cognition in the Holistic Care among Older Adults
Lee Hyer, PhD, ABPP

Conflict of Interest
I Have No Conflict of Interest.

Learning Objectives
Participants will be able to:
• Identify and explain diagnoses and treatment of the clinical constructs of cognitive decline.
• Explain problems with current systems of care for older adults.
• Describe a holistic model of the assessment and care for older adults with representative cases.
• Illustrate the co-importance of four domains along with cognition in understanding later life problems.
• Highlight the value of caregiving and family.
Why get rid of old way?

*Jeanne Louise Calment*

### Improvement in Survival Profile of U.S. Population

![Graph showing improvement in survival profile](image)

Increase in Healthspan and Lifespan

#### Biased Psychiatry Truisms Related to Older Adults

Over 50 years of research have suggested the following are more true than not:

1. The efficacy of psychopharmacological and psychological approaches is small.
2. Response is modal, not remission
3. The utility of psychiatric classification as determining the course of Rx is poor: Case formulation is key
4. Identification of and treatment of dementias and depression/anxiety has not improved
5. Psychiatric care is more complicated than medical care: the "more's" apply AND the "subtle thresholds" also apply.
6. Around 23% of depression remit with no Rx: 30% → Upper limit of good care
Things are Changing!

• Medicine likes one answer solutions: We have a clogged artery. Complex diseases are different and medicine is poor here.
• David Brooks: Heroes of uncertainty, Physics envy, treat symptoms
• Physical ability can go UP or DOWN over time.
• 2014: 244 drug compounds investigated in 413 clinical trials: 99.6% failures. Aducanumab, levertiracetum, determine (nasal spray of insulin), with anamides (antioxidant), ultrasound (clear toxic clumps)
• Precision medicine is close (e.g., risk of diabetes)
• 5-10 year rates of decline do go down but are different for cohorts and inra-individually. Gait, IADL, ADL, Depression, Grip strength, Cognition, hospital time, Feeling about life, Dig Sym. The first three declined most.
• DNA tests for better metabolizers for antidepressant and pain meds, among others.
• CNS disabilities abound including atrophy, small vessel disease, infarcts. Need to change the definition of healthy aging.

News!!!

• Neuroscience increasingly emphasizes a view of the brain as a set of information processing circuits of systems, not isolated neurons or regions. Brain disorders then are not deficits in 1 brain region but a problem of information flow across circuits. DBS is a good example. Circuit-guided interventions have the potential to become more widespread.

Neuroepigenetics

• Biological aging is largely determined by the internal biological clock and accumulation of insults.
• Where the lifespan of the organism is closely related to the biological aging, individual longevity is always a function of specific environmental circumstances, accumulated insults. The two operate at every level of the bio-hierarchy – genes, proteins, cells, organs, and organisms.
• Epigenetics can be defined as the study of changes in gene expression that are mediated by mechanisms other than DNA.
• They shape the environmental influences on brain and behavior.
Big Picture: Biopsychosocial

- Biopsychosocial: Assumes there are varying levels of physical, cognitive, emotional, behavioral and environmental factors that contribute to the clinical assessment and conceptualization of the case (Andrasik, Goodie, & Peterson, 2015)
- PCC Models: STAGED, STAR*D, IMPACT, PROSPECT, RESPECT, etc.
- Engage, Ecosystem Focused Therapy, CALTAP, etc.

Why Doesn’t Treatment Work?

- Wrong Rx: Depression and SSRIs or CBT
- Insufficient time: Noncompliance with meds, dropout of psychotherapy
- Wrong dosage: Too little or not in the “window”
- Interference from other Rxs: Med side effects
- Adherence issues: Pt does not do tasks
- Complex families
- Use of substances: Opioids, other meds
- Wrong diagnosis: Common problem

Too Much Care and Comorbidities

Too Much Care
- 79 y/o Female: Osteoporosis, Type 2 Diabetes, Arthritis, Hypertension, COPD, and Depression.
- 13 medications, dosed for 21 times/day
- Medications costs were greater than $400.00/month
- 18 non-pharmacological activities, such as dieting, self-monitoring medications had a 100% chance of drug/drug interactions and 100% for non-pharmacological intervention interactions (Boyd et al., 2005)

Comorbidities
- Yaffe et al. (2001): Determinants of successful cognitive aging in men and women; 30% were maintainers, 53% were decliners, and 16% were major decliners.
- Problems tend to compound themselves: 68% of adults with mental health conditions also have medical conditions, and 29% of adults with medical conditions have mental health conditions (Clay, 2013).
Precision Medicine + Individual

Optimal Care not Easy:
• Attending to patient preferences
• Implementation of evidence base
• Framing of clinical decisions in the context of risks, patient benefits, burdens, and prognosis
• Assessment of feasibility in light of treatment options
• Optimization of treatments and care plans (AGS, 2012)

Prevention:
• Optimal heart health in middle age allows one to live up to 14 years longer, free of cardiovascular disease, than peers who have two or more cardiovascular disease risk factors (see sciencedaily.com, Nov 5, 2012).
• Think: Interferon-alpha, macular degeneration, melanoma, depression (Smit et al., 2006)

Treatment of Older Adults: A Holistic Approach
Lee Hyer

Mercer Archive Data  
N=325  

- **Factor**  | **% Problem**  
- Depression | 67% (GDS >4)  
- Anxiety | 51% (SAST >21)  
- Health Problems | 57% (SF-12)  
- Pain | 64% (Pain scale >4)  
- Social Problems | 48% (MBMD Social)  
- Stress – Illness App | 62% (MBMD)  
- Stress – Functional Def | 79% (MBMD)  

White/Black Treatment Issues

<table>
<thead>
<tr>
<th>Race</th>
<th>Illness Concern</th>
<th>Functional Deficits</th>
<th>Pain Sensivity</th>
<th>Social Isolation</th>
<th>Future Pessimism</th>
<th>Spiritual Absence</th>
<th>Intervenional Frag</th>
<th>Medication Abuse</th>
<th>Information Disc</th>
<th>Utilization Excess</th>
<th>Problem Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>63.7757</td>
<td>74.2167</td>
<td>72.6806</td>
<td>47.7871</td>
<td>64.4639</td>
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<td>45.7490</td>
<td>45.8859</td>
<td>29.5285</td>
<td>45.2662</td>
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<td>64.2391</td>
<td>73.1087</td>
<td>76.5000</td>
<td>58.8478</td>
<td>64.1522</td>
<td>18.5652</td>
<td>53.4565</td>
<td>51.0000</td>
<td>29.5217</td>
<td>60.4348</td>
<td>42.6522</td>
</tr>
</tbody>
</table>

![Graph: Mild, Moderate, and Severe Problems](image)
Watch and Wait

• Our position is simple:

• Targeting an organized patchwork of psychosocial problems, in this case depression, anxiety, cognitive impairment, adjustment, and some disability, provides for the necessary focus to help the patient adapt and cope with their problems, promoting successful outcomes for the prime target, say depression.

• Evidence for such multi-faceted approaches to treatment is nascent, and so we must borrow from each problem and look at the efficacy for older adults, as well as what works for younger adults.

Watch and Wait Perspective

• Due to the complexity of patients, the normal application of empirically supported therapies (ESTs) and the nuances of the research and use of predictor variables in care, while helpful, are not robust enough to warrant allegiance beyond just some respect.

• Differences between one antidepressant vs. another, one psychotherapy vs. another, meds vs. psychotherapy) help providers very little. Published reports suggest that attending to novel “significantly better,” or “evidenced-based,” will result in better patient outcomes but doing so with older adults often diverts attention from the real world issues, and has only marginal evidence of benefit.

• Comprehensive algorithm for treating more than one problem in older adults is more important (Thielke, Vannoy, & Unützer, 2007).

• The reality constraints of living into later life make outcomes worse for older adults: client’s readiness to change; acceptability of the treatment and preferences of the patient; caregiver acceptance; availability of desired or needed services; tolerance of incongruous recommendations; prior treatment failures or successes; and side effects; etc.

Why Watch and Wait

• Problems actually confess themselves best over time.

• We know there is mild efficacy for ESTs but often a generally a lack of clinically significant differences between treatment and placebo that applies to mildly depressed and anxious patients. So, a careful waiting process with education and support, as well as a focus, is needed.

• This involves a case formulation, careful monitoring, considerable psycho-education, and a deliberate process of determining the best intervention.

• Make no mistake the patient needs to feel some relief but the need to have this grounded in a context is paramount. Depression needs perspective as it tends to be recurrent and needs a response that reflects this.

• The older adult is also given to other maladies that can be persuasive. These contribute to the construction of reality that can be oppressive. What we need is for the patient to be entered into a “Truman Show” where everything can go their way for a period before reality can be re-asserted. “Corrective emotional experience.” Again, this is done in few sessions.
“One diagnosis, one remedy, and, oh yea, one pharmaceutical”

• “Making a diagnosis on the first visit may completely miss the point. The single most important lesson is to take time. You cannot do it in seven minutes, and often you cannot do it in one meeting. Sometimes you cannot do it in a month. When in doubt, wait, watch, provide support, normalize the situation, see what resources are from within the individual’s own resiliency. All sorts of simple things, including reducing stress, will often make a diagnosis and medication unnecessary.”
  Allan Francis, 2014

Why Watch and Wait

FAILURE POINTS:
1. Deciding too quick to initiate care
2. Under-dosing
3. Inadequate trial duration (6 weeks necessary)
4. Frequency of follow up
5. Lack of monitoring
6. No team or family involvement

Ethics of patient care

• “…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 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
Five Modules

1. Shades of Gray
   But always Involves Brain
   • Major Depressive Disorder
   • Minor depression: 2-4 symptoms, low mood or anhedonia
   • Subsyndromal depression: 16 on CES-D
   • Mixed Dep and Anx
   • Depression without sadness
   • Bereavement; Complicated Grief (Traumatic Grief)
   • Depressive Executive Dysfunction
   • Depression in dementia
   • Post Stroke depression
   • Suicidal Depression: Fatigue, Hopelessness and Negative Outlook (Joiner, et al., 2001)
Poor Depression Response to Rx

- History of psychiatric problems
- Pretreatment depression
- Poor expectations
- Little satisfaction with life's roles
- Concurrent Rx
- Lack of perceived social support: or stressors
- Physical problems
- Older old
- EF problems
- Poor response after 4 weeks
- Suicide attempts
- No perceived mastery
- Not tired of being depressed

<table>
<thead>
<tr>
<th>Measure</th>
<th>Healthy Intact</th>
<th>Mildly Problematic</th>
<th>Problematic or Syndromic</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI-II</td>
<td>≤10</td>
<td>11-22</td>
<td>≥23</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>≤6</td>
<td>7-11</td>
<td>≥12</td>
</tr>
<tr>
<td>GDS-SF</td>
<td>≤5</td>
<td>6-10</td>
<td>≥11</td>
</tr>
</tbody>
</table>

2. Anxiety: “The Silent Giant”

- Symptoms: 10% to 20% among older adults:
- Twice as prevalent as dementias; More prevalent as MDD
- Problems: Physical complications, lower well being, increased mortality, CAD, overutilize services
- If depressed: 38-46% have comorbid anxiety disorders;
- If anxious: 15% depressed
- 50% to 97% are EARLY-ONSET disorders with late-life exacerbations
- Problem: CBT (GAD) are typically 10-20% lower than in younger samples, regardless of disorder.

**Meta-Analyses Comparing Psychotherapy and Medication for Geriatric Depression and Anxiety**

![Graph showing uncontrolled effect: clinician-rated measures for Depression and Anxiety](image)

- 89 studies
- N=5328
- Mean=8.3 weeks
- P<0.05


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**Exercise Rules!**

- 2914 patients: also extracted information regarding potential moderating variables.
- Compared with no treatment conditions, exercise training significantly reduced anxiety symptoms by a mean Delta effect of 0.29.
- Largest anxiety improvements resulted from exercise lasting no more than 12 weeks, using sessions durations of at least 30 minutes.
- Exercise training reduces anxiety symptoms among sedentary patients who have a chronic illness.

*Herring MP, O'Connor PJ, Dishman RK.*

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**Anxiety**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Healthy Intact</th>
<th>Mildly Problematic</th>
<th>Problematic or Syndromic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Daily functioning is not impaired by worry or fear.</td>
<td>Some activities are impaired by worry or fear, but the person is still functional at work and interpersonally.</td>
<td>Some activities are impaired by worry or fear, but the person is still functional at work and interpersonally.</td>
</tr>
<tr>
<td>GAD-7</td>
<td>≤6</td>
<td>7-14</td>
<td>≥15</td>
</tr>
<tr>
<td>BAI</td>
<td>≤9</td>
<td>10-16</td>
<td>≥17</td>
</tr>
<tr>
<td>STAI</td>
<td>≤29</td>
<td>30-44</td>
<td>≥45</td>
</tr>
<tr>
<td>MBMD Anxiety</td>
<td>≤50</td>
<td>51-80</td>
<td>≥81</td>
</tr>
<tr>
<td>SAST</td>
<td>≤21</td>
<td>22-29</td>
<td>≥30</td>
</tr>
</tbody>
</table>
3. Cognitive Health

- Neuropsychological Performance
- Brain Morphology
- Socio-behavioral Resources
- Health Status
- Everyday Function
- Biological Systems affected

MCI: Dance of Cognitive Decline

- Normal
- MCI
- Dementia
- EF-WM
- AAD

Systems affected:
- Cognitive
- Physical function
- Socio-behavioral Resources
- Biological

Cognitive Reserve

AAMI

Function

Level of Cognition
- Frontal Recruitment
- Neurogenesis
- Distributed Processing
- Bilateral

Compensatory scaffolding
- New Learning
- Engagement
- Exercise
- Cognitive Training

Neural Challenges
- Stenosis
- White Matter Changes
- Cortical thinning
- Dopamine Depletion

Aging
- Dendritic sprouting
- Decreased medial temporal recruitment
- Increased default activity
Subjective Memory Impairment: Something is going on!!!!!!

- SMI Ss were more likely than people without to show changes in brain activity resembling those seen in the early stages of AD (MRI).
- Not all people with SMI convert to dementia and
- Not all people with dementia went thru SMI.
- Archives of General Psychiatry, 2010:
  - Adults 75 and older (N=2415) asked if memory were a problem
  - and, if so, did they worry
  - Ss with SMI and no worry → 2x to develop AD as no SMI
  - Ss with SMI and worry →6x to develop AD as no SMI
  - Ss with MCI → 10x risk of any dementia and 20x for AD

MCI Diagnosis

- Change in cognition from baseline
- Change in 1 or > cognitive domains
- Preseveration of independence in function (except for maybe complex tasks)
- Not demented

- Prevalance is 9-18%
Graphic Representation of Proposed Staging of AD: Sperling et al. 2011

Stage 1
Asymptomatic amyloidosis
- High PET amyloid tracer retention
- Low CSF Aβ42

Stage 2
Amyloidosis + Neurodegeneration
- Neuronal dysfunction on FDG/PET/MRI
- High CSF tau/p-tau
- Cortical thinning, hippocampal atrophy on sMRI

Amyloidosis + Neurodegeneration + Subtle Cognitive Decline
- Evidence of subtle change from baseline level of cognition; Poor performance on more challenging cognitive tests

MCI → AD

Review Statements

- Best Stuff: Results favored subjects who are motivated, those with the highest pretest scores, and those who complete training.
- Overall: A complex interaction between cognitive reserve factors (education, leisure, premorbid fluid intelligence, etc.) and biomarkers of neuronal injury that can be modulated by CT. This interaction is beyond the bounds of our current science. There is moderate evidence to suggest that CT can generalize to untrained cognitive abilities, but the complexity of the program of CT as well as individual factors play a large role. Definitive statements are hard to assert.
- Jak et al., 2013: "In sum, one can say that the data are promising regarding computer-based CT and any side effects are minimal, but any commercial claims of the efficacy of computerized cognitive enhancement systems is perhaps premature."
- Hudak et al., 2013: The efficacy of CT as promising but inconclusive.
- Melby-Lervag & Hulme, 2013: Data on working memory are suspect.

Over 100 studies on MCI/ Dementia on CT

Hyer, Mullen et al., in press
Cogmed does well, but.....

Holistic Memory Clinic

Cognition

<table>
<thead>
<tr>
<th>Measure</th>
<th>Healthy Intact</th>
<th>Mildly Problematic</th>
<th>Problematic or Syndromic</th>
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</thead>
<tbody>
<tr>
<td>Description</td>
<td>Normal memory and fully oriented; these patients will display good judgment and problem solving skills.</td>
<td>Memory loss that interferes with everyday activities, difficulty with time and/or place orientation, difficulties with abstraction and problem solving, but social judgments are intact.</td>
<td>Severe memory deficits, inability to retain new information, difficulty with orienting time and place, markedly impaired abstraction and social judgments.</td>
</tr>
<tr>
<td>MoCA</td>
<td>27-30</td>
<td>22-26</td>
<td>≤21</td>
</tr>
<tr>
<td>MMSE</td>
<td>27-30</td>
<td>21-26</td>
<td>≤20</td>
</tr>
<tr>
<td>Trails A</td>
<td>≤46s</td>
<td>47-70</td>
<td>≥71</td>
</tr>
<tr>
<td>Trails B</td>
<td>≤115s</td>
<td>116-182</td>
<td>≥183</td>
</tr>
</tbody>
</table>
4. Health Issues

Medical Problems
Lifestyle/Prevention
Stress
Pain
Sleep

Health Markers

- Five habits lead to 70% of morbidity and mortality: how much we eat, what we eat, do we exercise, do we smoke, and do we consume alcohol excessively (deVol & Bedrosian, 2007).
- If we added sleeping, mating, drug use and relationship habits, we accounted for another significant proportion of the burden of chronic and infectious diseases (Chorpita, 2011).
- We treat chronic diseases (Scott, 2009).
- 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 (Cogbill, Dinson, & Duthie, 2010).
- Similarly addressing dementia, Magie Gatz using a longitudinal view of the Swedish Twin Registry looking at a sample of nearly 12,000 twins now over 65 found that diabetes and obesity are among the most significant NON-genetic risk factors for AD and dementia (Chamberlin, 2011).

Life Style

- Socialization: Lonely individuals are twice as likely to be diagnosed with Alzheimer’s disease as those who are not lonely.
- Exercise: Older adults who are healthy or with mild cognitive impairment showed significant improvements on tests of executive function after six months of four-day-a-week aerobic exercise.
- Diet: People who eat a Mediterranean-type diet, rich in fruits, vegetables and omega-3 fatty acids, were 38 percent less likely to develop Alzheimer’s disease over the next four years.
- Stress reduction: Short-term stress leads to an increase in the amount of beta-amyloid protein – a key component in the development of Alzheimer’s – in the brains of mice. Stress reduction decreases the connection between MCI and dementia.
- Relaxation/Meditation: Data now suggest that some form of relaxation can improve cognition. This includes mindfulness where there is a focus on being in the present.
- Identity/Purpose: People who have purpose in life respond better in several areas of their life. In fact, they perform all the other core components of life better. Values clarification allows for this.
- Mental stimulation: Research links higher education and occupational levels to a lower incidence of dementia. The more complex and novel the environment, the lower the risk you have of getting things like Alzheimer’s disease.
Health

<table>
<thead>
<tr>
<th>Measure</th>
<th>Healthy Intact</th>
<th>Mildly Problematic</th>
<th>Problematic or Syndromic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Bodily function is normal. The patient has few or no complaints of pain and no chronic conditions which are likely to shorten life or reduce quality of life.</td>
<td>Minor health concerns which may include lesser chronic conditions. Quality of life is impaired, but not debilitating.</td>
<td>Basic ADL and IADLs are compromised by the patient’s health state. Ability to work and/or enjoy life is drastically impacted by health state. Chronic conditions which are likely to shorten life or contribute to dysfunction are present.</td>
</tr>
<tr>
<td>Number of Chronic Illnesses</td>
<td>≤1</td>
<td>2-3</td>
<td>≥4</td>
</tr>
<tr>
<td>Epworth Sleep Scale</td>
<td>≤10</td>
<td>10-12</td>
<td>≥12</td>
</tr>
<tr>
<td>Pain Visual Analogue Scale</td>
<td>0-44 mm</td>
<td>45-74 mm</td>
<td>≥75 mm</td>
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<tr>
<td>Cigarette Use</td>
<td>Never smoked</td>
<td>Smoked 100 or more but not a current smoker</td>
<td>Current smoker</td>
</tr>
<tr>
<td>Exercise</td>
<td>&gt;30 minutes everyday</td>
<td>30-60 minutes/4 days week</td>
<td>Housework, inactive</td>
</tr>
<tr>
<td>Alcohol Consumption</td>
<td>≤7 drinks per week if the patient is not on medication</td>
<td>≥7 drinks per week if the patient is not on medication</td>
<td>≥7 drinks per week if the patient is on medication</td>
</tr>
</tbody>
</table>

5. Life Issues

- SES
- Adjustment in community
- Caregiving
- Home care
- Community Problems
- Finances
- Competence
- Transportation
- Medical Insurance
- Iatrogenic Disease
- Housing Needs
- Meals on Wheels
- Nutrition
- Practical Functioning
- Relapse Issues
- Long-term care
What are older people like?

<table>
<thead>
<tr>
<th>Age</th>
<th>% No Disability</th>
<th>% LTC</th>
<th>% Married</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>83</td>
<td>3</td>
<td>70</td>
</tr>
<tr>
<td>70-74</td>
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<td>80-84</td>
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<td>85-89</td>
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<td>90-94</td>
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<td>95-99</td>
<td>20</td>
<td>42</td>
<td>10</td>
</tr>
<tr>
<td>100+</td>
<td>18</td>
<td>48</td>
<td>9</td>
</tr>
</tbody>
</table>

Frailty is a multisystem progressive impairment of decreased physiologic reserve. It is due to aging, social factors, health issues and med problems.

Cognition plays a key role. It predicts ... everything.

SES

<table>
<thead>
<tr>
<th>SES factors, such as low income and poor educational attainment, are associated with comorbid mental disorders and medical conditions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SES contributes to the onset of mental disorders and is a consequence of the &quot;downward drift&quot; associated with a history of psychiatric disorders (Eaton &amp; Muntaner, 1999).</td>
</tr>
<tr>
<td>NHANES data revealed that poor people in each decade of life (20s through 70s) had higher levels of biological risk than people of similar age who are not poor, thus supporting the notion of premature aging in those who endure poverty.</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Function

<table>
<thead>
<tr>
<th>Well-being is complex.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assimilation and accommodation: Older adults conserve resources and disengage from unattainable goals. The decline in function is progressive, starting out with more sophisticated IADLs (managing finances, driving, handling medications) and segues to the faltering of ADLs.</td>
</tr>
<tr>
<td>Meta-analysis of 11,960 subjects showed a Q value of .88 for the use of function measures to diagnose dementia (Castilla-Ríoi, et al., 2007).</td>
</tr>
<tr>
<td>40% of variance of cognition: Add function to cognition and get best results.</td>
</tr>
<tr>
<td>Best markers for dementia is Trails B and FAQ.</td>
</tr>
</tbody>
</table>
Caregiving

- Based on 1480 family caregivers from the AARP and National Alliance for Caregiving, titled Caregiving in the U.S., it has been estimated that 65.7 million Americans serve as caregivers in 2012. This is 28% of the population.
- Nearly 1/3 of American households reported at least one person serving in an unpaid caregiving role.
- Depression is present in 28% and 34% have depressive symptoms. This results in poorer caregiving, more problems with the identified patient, and causes big problems for CR.

Life Adjustment

<table>
<thead>
<tr>
<th>Measure</th>
<th>Healthy intact</th>
<th>Mildly Problematic</th>
<th>Problematic or Syndromic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Overall/lifestyle is positive, patient engages in the 7 core components of lifestyle. Little or no recreational drug use, including tobacco. Alcohol consumption is at or near the range recommended by the CDC. Lifestyle choices are likely to contribute to disorder or have begun to do so. The patient consumes tobacco and/or higher than recommended amounts of alcohol. up to 3 components of the core components of lifestyle are not being fulfilled. Lifestyle is compromising patient’s mental and/or physical health. Self-care is lacking or not present. Enjoyment of life is severely limited by lifestyle choices.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modified Sheehan Disability Scale</td>
<td>≤9</td>
<td>10-19</td>
<td>≥20</td>
</tr>
<tr>
<td>SF-12</td>
<td>≤10</td>
<td>11-18</td>
<td>≥19</td>
</tr>
<tr>
<td>Duke-UNC FSSQ</td>
<td>≥25</td>
<td>16-24</td>
<td>≤15</td>
</tr>
<tr>
<td>Relationship Status</td>
<td>Married in a relationship</td>
<td>Single/divorced</td>
<td>Widowed in the last five years</td>
</tr>
<tr>
<td>Caregiving</td>
<td>No needs</td>
<td>Part time</td>
<td>Full-time or Part time with problems</td>
</tr>
<tr>
<td>Income by Poverty</td>
<td>≥400%</td>
<td>2001%-399%</td>
<td>≤200%</td>
</tr>
</tbody>
</table>

What are the Necessary Features for Psychosocial Therapy?
Watch and Wait Checklist

<table>
<thead>
<tr>
<th>Watch and Wait Core Category</th>
<th>Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validate Problem</td>
<td></td>
</tr>
<tr>
<td>Psychoeducation of Model</td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td></td>
</tr>
<tr>
<td>Monitoring</td>
<td></td>
</tr>
<tr>
<td>Case Formulation</td>
<td></td>
</tr>
<tr>
<td>Alliance</td>
<td></td>
</tr>
</tbody>
</table>

What Therapists do

- Validate the reality of the symptom
- Develop a functional explanation
- Suggest a script
- Emphasize a lack of harm and a vision for change

**Christof Wieland**, the German man of letters, wrote in 1798 that public opinion was

"... an opinion that gradually takes root among a whole people; especially among those who have the most influence when they work together as a group. In this way it wins the upper hand to such an extent than one meets it everywhere… It then only requires some small opening that will allow it air, and it will break out with force. Then it can change whole nations in a brief time and give whole parts of the world a new configuration."

Christof Wieland, 1798

Questions

POST-TEST EVALUATION

SPEAKERS: Lee Hyer, PhD  
TITLE: Special Impact of Cognition in the Holistic Care among Older Adults  
September 24, 2015

PARTICIPANT NAME:

DIRECTIONS: Please circle the best response. Submit the completed post-test to the conference staff person at the break. Thank you!

1. Biopsychosocial theorists assume there are varying levels of physical, cognitive, emotional, behavioral, and environmental factors that contribute to the clinical assessment and conceptualization of the case.
   a. True  
   b. False

2. The major components of the epigenetics of aging are ______________.
   a. Geoscience  
   b. Age, disease, and interaction  
   c. Stress - real or imagined  
   d. a & b  
   e. a, b, & c

3. The features of an effective psychotherapist tend to counselors who ____________.
   a. offer strong relationships  
   b. customize both discrete methods for the person  
   c. customize relationship stance based on the needs of the individual and condition  
   d. a & b  
   e. a, b, & c

4. Some reasons to use the “Watch and Wait” approach are ______________.
   a. research does not show significant differences between the treatment and placebo for mildly depressed and anxious patients  
   b. problems actually confess themselves over time  
   c. depression does not need perspective as it tends to be recurrent and needs a response that reflects this recurring pattern.  
   d. a & b  
   e. a, b, & c

5. What is a complication of the “Watch and Wait” approach?
   a. Under-dosing  
   b. Team and family involvement  
   c. Deciding too slowly to initiate care  
   d. a & b  
   e. a, b, & c

6. Hyer’s provided review statements. Favored results tend to occur for participants who are monitored; persons with the highest pretest scores; and individuals who are complete with training. Is this statement true or false?
   a. True  
   b. False
PARTICIPANT EVALUATION FORM
SEPTEMBER 24, 2015
WELLNESS: BUILDING THE CAPACITY OF TOMORROW’S OLDER ADULTS
SPEAKER: Lee Hyer, PhD
TITLE: Special Impact of Cognition in the Holistic Care among Older Adults

Your evaluation of the program and faculty is very important. It will help us improve our program & serve you better. We review each evaluation, so please consider each question carefully. Please indicate if you are applying for CE credit. Thank you for your input.

PARTICIPANT NAME: ___________________________ ___________________________ __________________

CE Credit: Nursing  LADC  MSW/LCSW  LPC  LMFT  CFLE  OT  PT  NAB

<table>
<thead>
<tr>
<th>Please indicate how well the speaker met the following objectives:</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Objective 1: Identify and explain diagnoses and treatment of the clinical constructs of cognitive decline.</td>
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<tr>
<td>Learning Objective 2: Explain problems with current systems of care for older adults.</td>
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<tr>
<td>Learning Objective 3: Describe a holistic model of the assessment and care for older adults with representative cases.</td>
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<tr>
<td>Learning Objective 4: Illustrate the co-importance of four domains along with cognition in understanding later life problems.</td>
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</table>

<table>
<thead>
<tr>
<th>Please indicate your answers to the following statements:</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>NA</th>
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</thead>
<tbody>
<tr>
<td>Presentation content enhanced my knowledge of Gerontology and Geriatrics.</td>
<td></td>
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<tr>
<td>Presentation content will be used to alter my professional practice.</td>
<td></td>
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<tr>
<td>Presentation information will be applied to my professional practices.</td>
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</tbody>
</table>
Please indicate your answers on presentation delivered

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Materials were useful.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Speaker was prepared.</td>
<td></td>
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<td></td>
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<tr>
<td>Speaker was knowledgeable.</td>
<td></td>
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<tr>
<td>Speaker was organized.</td>
<td></td>
<td></td>
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<tr>
<td>Speaker’s presentation style was appropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speakers’ presented objective and balanced content that was evidence based</td>
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<tr>
<td>Speaker provided opportunities to ask questions.</td>
<td></td>
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</tr>
</tbody>
</table>

What ideas have you taken away from the “Special Impact of Cognition in the Holistic Care among Older Adults” session?

What suggestion do you have for improving this course/session?

Please explain how session ideas be used to alter your professional practice.

Please explain how session content may be applied to your professional practice.

Please let us know other topics that you might be interested in:

General Comments: