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Citation:

DAY, Patricia (2018). Treatment of anxiety in elderly housebound patients. *Journal of Community Nursing*, 32 (2), 52-55. [Article]

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Treatment of anxiety in elderly housebound patients

Patricia Day

Anxiety disorders are common amongst elderly housebound clients and are undertreated with detrimental effects to this population. Effective treatment for anxiety includes access to a talking therapy. Cognitive behavioural therapy (CBT) for anxiety is proven to be successful and has a low relapse rate. Elderly housebound clients have poor access to talking therapies which compounds existing health inequalities. District and community nurses could be instrumental in enabling elderly housebound clients to have access to CBT approaches for the treatment of anxiety at an early stage, which could greatly improve outcomes.

KEYWORDS:

■ Mental health ■ Housebound patients ■ Anxiety

Anxiety disorders, particularly generalised anxiety disorder and agoraphobia are common in the elderly but these conditions are often ignored and undertreated (Vink et al, 2008). Comorbidity with depression often results in poorer treatment outcomes (Diefenbach and Goethe, 2006). Generalised anxiety disorder is the most common of the late life anxiety disorders and can be difficult to treat (Hoffman and Smits, 2008). It is characterised by pervasive worry in order to avoid catastrophe and results in cognitive rigidity which precludes rational problem-solving (Laidlaw et al, 2009). The paucity of evidence on CBT for treatment of late life anxiety disorders compounds this challenge (Laidlaw et al, 2009). Further research is needed in this area due to the profoundly debilitating effects of anxiety on function in the elderly.

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EFFECT ON WELLBEING

Older people are less likely to ask for support with anxiety issues (Scott et al, 2010). In the author's clinical experience, the stigma attached to mental health issues is 'alive and kicking', particularly among the elderly who feel they should be able to cope. This can have a profound impact on emotional and physical wellbeing. However, district and community nurses could act as the bridge to their clients having access to talking therapies. They are key in promoting the evidence base for cognitive behavioural therapy (CBT), its lack of pathology, and its collaborative approach as a talking therapy (Day, 2017). Pathological approaches to the treatment of anxiety involve diagnosis and medication. CBT is based on therapeutic communication and psychoeducation, rather than medical treatment.

Thinking patterns are profoundly affected by anxiety (Wells, 2008), which can result in thoughts becoming rapid, 'cloudy' and 'leaping' about, with situations

being interpreted as threatening and dangerous. Threats are then overestimated and catastrophe is anticipated. Worrying thoughts go round and round. This is termed rumination, with 'What if...?' dominating thinking (Wells, 2008). With anxiety, clients become more negatively aware of bodily sensations and underestimate their ability to cope. Perception also becomes distorted, with fear dominating function, and hypervigilance for dangers is also common. Anxiety disorders can cause long-term disability and can result in a lifetime of relapse and remission (National Institute for Health and Care Excellence [NICE], 2014).

Physiological responses to anxiety are unpleasant, such as sweating, tingling and numbness in hands and feet and palpitations, and avoidance is adopted to mitigate symptoms (Wells, 2008). In the author's clinical experience, clients complain of increased heart rate, rapid breathing, feeling hot, sweaty and lightheaded, blurred vision, butterflies in the stomach, being shaky, unsteady and wobbly. As a result, safety behaviours become entrenched to escape the feeling of impending doom, and thoughts become blocked or suppressed and reassurance is often sought. Ironically, the greater the use of these behaviours, the worse the anxiety gets.

ASSESSMENT OF ANXIETY IN ELDERLY HOUSEBOUND CLIENTS

Assessment of anxiety in the elderly may be complicated by existing symptoms of physical conditions, which may mask the anxiety (Dennis et al, 2007). This may apply to clients with chronic

obstructive pulmonary disease (COPD) and acute breathlessness, which compounds their distress. In CBT, the assessment process is used to develop a formulation which guides therapy (James, 2010). The National Institute for Health and Care Excellence (NICE, 2014) recommends factors which should be considered in assessment of clients with anxiety. This includes considering:

- ▶ History of any mental health disorder and chronic physical health problems
- ▶ Response to treatments
- ▶ Interpersonal relationships
- ▶ Living conditions
- ▶ Social isolation
- ▶ Family history of mental illness, domestic violence or sexual abuse
- ▶ Employment and immigration status.

In the author's clinical opinion, most of these issues could apply to elderly housebound clients.

Patterns of behaviour are identified as part of assessment, and recurrent themes should be detected. A list of presenting issues must be exhaustive, concrete and specific.

The hot cross bun framework (Figure 1) is helpful in reducing a client's distress into meaningful units (James, 2010). The four components of the bun are based on:

- ▶ Feelings
- ▶ Thoughts
- ▶ Behaviour
- ▶ Physical sensations.

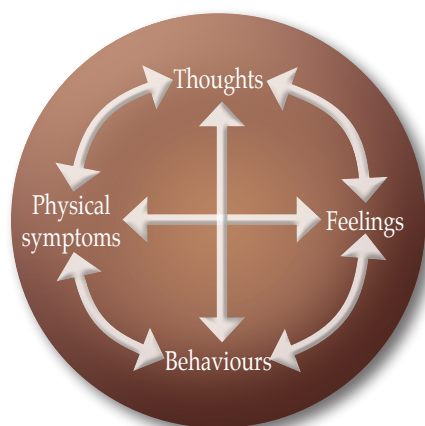


Figure 1. Hot cross bun model. Adapted from Greenberger and Padesky, 2015.

PATIENT SCENARIO

Mary is 85 years old, has severe osteoarthritis and heart failure. She lives on her own. She recently developed leg ulcers and is under the care of district nurses. She has been a 'worrier' all her life. She does not think her ulcers will improve and is in a constant state of anxiety about her medical condition. This has seriously affected her quality of life and means she experiences little enjoyment on a day-to-day basis. Mary's district nurse wants to improve her overall function and suggests she sees the GP for an assessment of her mental health. Mary turns this down, saying it is too late, she has always been like this and nothing will help.

Mary's situation is exacerbating her anxiety. She is socially isolated, immobile and has poor physical health. While many older adults have learnt to deal with worry through coping strategies, Mary's thinking patterns are entrenched in negative core beliefs. Changing these cognitive structures will mean Mary has to challenge her thinking and engage in therapy. With support from district/community nurses educated in cognitive behavioural therapy (CBT), this change may be possible.

'With anxiety the purpose of psychoeducation is to highlight the fact that symptoms are not in themselves harmful and will eventually reduce. Understanding that avoidance and safety seeking behaviours reinforce anxiety is important, with the mantra for treatment being "facing your fears".'

Clients need to become adept at conveying their experiences in these terms. District and community nurses could be key in helping patients to understand the model, and daily monitoring sheets can be helpful in reinforcing this concept.

The progress of therapy is determined by client socialisation to the hot cross bun cycle. An acronym called KISS – 'keep it slow and simple' is used to emphasise the importance of reinforcing the model (James, 2010).

TREATMENT OPTIONS

CBT is considered one of the most effective treatments for anxiety disorders, including generalised anxiety disorder (Cully and Stanley, 2008). It is recommended by NICE for people with generalised anxiety

disorder (GAD), who have severe functional impairment (NICE, 2011). CBT must be delivered by qualified therapists. However, understanding the principles of CBT in the treatment of anxiety could support clients in engaging with therapy and persisting with it.

As far as possible in CBT, anxiety and physical symptoms are separated and attention is paid to how fear exacerbates the condition.

Psychoeducation involves teaching clients the CBT model of

What's CBT?

It is a here-and-now, goal-focused, collaborative, evidence-based theory and therapy.

Therapy is time-limited, structured and based on a skills-based learning approach.

It is a model where thoughts are central; thoughts cause feelings, distorted thoughts cause psychological distress, therapy can only be successful through changing thoughts.

The process of therapy is to help clients identify problems and the thoughts that cause them, and then to help them change their thoughts through thought-challenging and behavioural experiments.

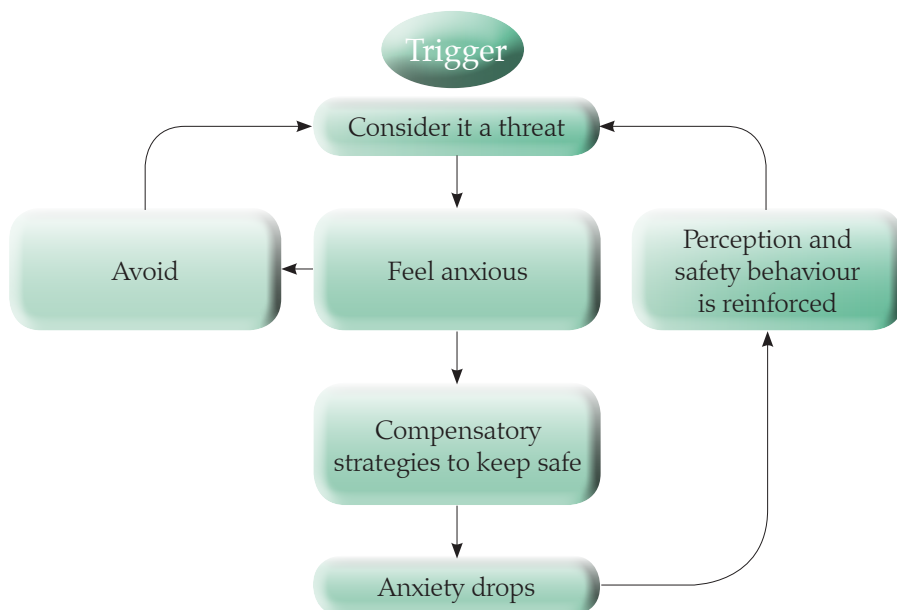


Figure 2. CBT model for anxiety (Wells, 2008).

anxiety (Figure 2). The physiological features of anxiety require comprehensive explanation. The effect of common strategies to manage anxiety is explained. Increased heart rate, sweaty palms and tightness in the chest are normal responses to fearful situations (Martin et al, 2007). The autonomic nervous system releases adrenaline, which produces the fight or flight response. This is the body’s natural reaction to stress. With anxiety, the purpose of psychoeducation is to highlight the fact that symptoms are not in themselves harmful and will eventually reduce. Understanding that avoidance and safety seeking behaviours reinforce anxiety is important, with the mantra for treatment being ‘facing your fears’. This requires sensitive application in work with the elderly, who may be in poor health.

In the author’s clinical experience, this model is useful to educate clients about the cycle of anxiety and how anxiety is maintained. Anxiety is a learnt behaviour and can be unlearned. Classical conditioning is the process by which fear is learnt. It involves the association between one stimulus and another until eventually the response is triggered by one stimulus alone. Pavlov’s dogs salivated to food accompanied by the sound of a bell. They became conditioned to salivating when

the bell sounded, even though there was no food (McLeod, 2013). Operant conditioning explains how the behaviour is maintained. Positive reinforcement is the addition of a consequence (perhaps pleasant) following a behaviour. This increases the likelihood of the behaviour being repeated. Negative reinforcement is the removal of an unpleasant experience (pain or fear) immediately after the desired behaviour. This also increases the likelihood of the behaviour being repeated (Martin et al, 2007). Understanding the aetiology of anxiety can help clients manage their anxiety.

CBT treatment for anxiety is to engage with the client in ‘collaborative empiricism’ to reduce anxiety. Exposure, response, prevention (ERP) is the basis for CBT treatment in all anxiety disorders (Wells, 2008). Graded exposure to feared situations is fundamental to the treatment plan. This has to be worked out jointly between the practitioner and client. The situation must evoke anxiety and the client is

What’s mindfulness?

Mindfulness involves harnessing the mind’s capacity for calm and clarity. This can be illustrated by the glass of muddy water: If we keep stirring it will stay cloudy. But if we simply wait the mud will sink to the bottom leaving clear water. Through focus on a neutral object, the mind can become uncluttered. This is often achieved through awareness of our breathing. Feeling the vividness of an experience enables the mind to be intentionally and non-judgmentally present. Doing this with as many everyday experiences as possible: drinking a cup of tea, washing up and having a shower becomes habitual and reduces stress and anxiety (Williams et al, 2007).

required to remain in the situation until the anxiety reduces by half. Elderly clients may find it challenging to engage in these strategies due to lack of social support. Some fears, such as fear of dying, may be well founded. However, it is how these fears are managed which can make a difference to quality of life.

Visual tools can help in tackling fears. Subjective units of distress (SUDs) can be used to track symptoms of anxiety in fearful situations (Wolpe, 1969). A scale of 0 to 10 is used for measuring the subjective distress currently experienced by an individual during a task (Table 1). Examples of tasks include sleeping in a bed rather than a chair, going for a walk after a fall, or avoiding phoning 999 unless there is an emergency. The client self-assesses where they are on the scale. The SUDs may be used as a benchmark for a professional to evaluate the progress of treatment. In ERP, self-

Table 1: Example of a subjective units of distress (SUDs) record

Please rate your level of anxiety and stress between a range of 0–10 (where 0 is no anxiety and 10 is extreme anxiety)

Date and time	Task	SUDs prior to task	SUDs during task	SUDs immediately after task	SUDs 20 minutes after task	SUDs One hour after task

assessments enable the practitioner to track the progress of the individual.

CBT models of anxiety see threat/danger-based interpretations as central. Developing the client's understanding of factors that maintain anxiety is important. CBT for anxiety typically involves developing skills for coping with anxiety, problem-solving, thought challenging and behavioural experiments.

MINDFULNESS

The practice of mindfulness has a sound evidence base for treatment of low mood, reducing stress and enhancing wellbeing (Burch and Penman, 2013). It is based on transcendental meditation and requires practice. Mindfulness is paying attention to an experience 'differently'. It is about paying attention: on purpose, in the present moment, non-judgmentally, to things as they are. It is now seen as part of the practice of CBT and, in the author's clinical experience, could be helpful for elderly housebound clients through self-help resources. Mindfulness has as its mantra 'being', rather than 'doing', i.e. accepting our thoughts and feelings, understanding where they are coming from and letting them pass and not getting distressed about what's happening. 'Doing' is about reaching pre-set goals, whereas 'being' is not concerned with the gap between how things are and how we want them to be. People can still act with intention and direction, but without being constrained by concepts about their goals (Williams et al, 2007).

District and community nurses could incorporate mindfulness into their strategies to enhance emotional wellbeing in elderly housebound clients. Mental health is inextricably linked with physical health and many elderly housebound clients have poor quality of life due to their anxiety.

CONCLUSION

While district and community nurses are not therapists, they can become educated in CBT strategies, which could greatly

improve the lives of their client group (Day, 2017). District and community nurses are highly skilled in communicating therapeutically with elderly housebound clients. They are trusted and valued by their clients. Educating them in CBT approaches could greatly increase the access of this client group to evidence-based mental health interventions at an early stage. This could have a lasting positive impact on quality of life for vulnerable elderly clients. **JCN**

REFERENCES

- Burch V, Penman D (2013) *Mindfulness for Health*. Piatkus, London
- Cully J, Stanley M (2008) Assessment and treatment of anxiety in later life. In: Laidlaw K, Knight B, eds. *Handbook of emotional disorders in later life: Assessment and treatment*. Oxford University Press, Oxford: 233–56
- Day P (2017) Improving elderly housebound patients' mental health. *J Community Nurs* 31(4): 58–62
- Dennis R, Boddington S, Funnell N (2007) Self report measures of anxiety: are they suitable for older adults? *Ageing Mental Health* 11: 668–77
- Diefenbach G, Goethe J (2006) Clinical interventions for late life anxious depression. *Clin Interventions Ageing* 1: 41–50
- Greenburger D, Padesky C (2015) *Mind over mood*. 2nd edn. Guilford Press, New York
- Hoffman S, Smits J (2008) Cognitive behavioural therapy for adult anxiety disorders: a meta-analysis of randomised placebo-controlled trials. *J Clin Psychiatry* 69: 621–32
- James I (2010) *Cognitive behavioural therapy with older people*. Jessica Kingsley, London
- Laidlaw K, Thompson L, Dick-Silsin L, Gallagher-Thompson D (2009) *Cognitive behaviour therapy with older people*. John Wiley and Sons, Chichester
- Martin G, Carlson N, Buskist W (2007) *Psychology*. 3rd edn. Pearson Education, Harlow
- McLeod SA (2013). Pavlov's dogs. Available online: www.simplypsychology.org/pavlov.html

KEY POINTS

- Anxiety disorders, particularly generalised anxiety disorder (GAD) and agoraphobia are common in the elderly, but these conditions are often ignored and undertreated (Vink et al, 2008).
- Older people are less likely to ask for support with anxiety issues (Scott et al, 2010).
- Assessment of anxiety in the elderly may be complicated by existing symptoms of physical conditions, which may mask the anxiety (Dennis et al, 2007).
- CBT is considered one of the most effective treatments for anxiety disorders, including generalised anxiety disorder (Cully and Stanley, 2008).
- District and community nurses could act as the bridge to their clients having access to talking therapies.

National Institute for Health and Care Excellence (2011) *Generalised anxiety disorder and panic disorder in adults: management*. NICE, London. Available online: www.nice.org.uk/guidance/cg113/chapter/2-Notes-on-the-scope-of-the-guidance

National Institute for Health and Care Excellence (2014) *Anxiety Disorders*. NICE, London. Available online: www.nice.org.uk/Guidance/QS53

Scott T, Mackenzie C, Chipperfield J, Sreen J (2010) Mental health service use among Canadian older adults with anxiety disorders and clinically significant anxiety symptoms. *Ageing Mental Health* 14: 790–800

Vink D, Aarsten M, Schoevers R (2008) Risk factors for anxiety and depression in the elderly: a review. *J Affect Disorders* 106: 27–44

Wells A (2008) *Cognitive therapy of anxiety disorders*. Wiley, Chichester

Williams M, Teasdale J, Segal Z, Kabat-Zinn J (2007) *The Mindful Way through Depression*. Guilford Press, New York

Wolpe J (1969) *The Practice of Behaviour Therapy*. Pergamon Press, New York