Published in final edited form as:
Am J Geriatr Psychiatry. 2013 March ; 21(3): 215–217. doi:10.1016/j.jagp.2012.11.021.

The future of psychosocial interventions for older adults with severe mental illness

Elizabeth W. Twamley, PhD[1,2]

[1]Department of Psychiatry, University of California, San Diego

[2]Center of Excellence for Stress and Mental Health, VA San Diego Healthcare System

Most of the extant research on psychosocial treatments for schizophrenia and severe mental illness in general has focused on younger participants, so studying the "next-older" age group is an important step forward in establishing the utility of these treatments for older service users (Bartels et al., 2002). This special issue features four articles on psychosocial interventions for middle-aged and older people with schizophrenia or other severe mental illnesses. Cognitive impairment, negative symptoms, functional outcomes, and quality of life are inextricably linked for this population (Bartels & Pratt, 2009), and we know, that given the cognitive deficits of both schizophrenia and normal aging, cognitive impairment tends to worsen among older people with schizophrenia (Cohen et al., 2008). Three of the four articles that follow (Kontis et al., Mueller et al., and Pratt et al.) reported primarily on cognitive outcomes, and one (Granholm et al.) reported primarily on functional outcomes. The mean age of the participants studied was 44 (Mueller et al., in press), 48 (Kontis et al., in press), 55 (Granholm et al., in press), and 60 (Pratt et al., in press) in these four reports, and all four studies included schizophrenia participants exclusively or predominantly, suggesting that their findings apply mainly to middle-aged people with schizophrenia.

Kontis and colleagues (in press) studied a 40-session, thrice-weekly, paper-and-pencil Cognitive Remediation Therapy (CRT) intervention and found that participants aged 40 or older with schizophrenia showed limited cognitive gains from CRT. Furthermore, cognitive reserve (premorbid IQ or vocabulary knowledge) did not predict response. However, in the most recent meta-analysis of all types of cognitive remediation for schizophrenia, Wykes et al. (2011) found no effect of age on treatment outcomes. Thus, it is possible that CRT is not a good fit for older service users, whereas other types of cognitive remediation (e.g., compensatory approaches, computerized cognitive remediation approaches) may work better. Along these lines, there is preliminary evidence that Compensatory Cognitive Training works just as well, if not better, for older people with psychosis compared to younger people (Twamley et al., 2011, 2012).

Mueller and colleagues (in press) conducted a meta-analysis of Integrated Psychological Therapy (IPT) in 15 studies of 632 inpatients with schizophrenia (inpatients were selected because the use of IPS in older people has been restricted to inpatients in the published literature). IPT is a bundled therapy that includes cognitive training, social cognitive training, and social skills training. Studies where the mean age was under 40 vs. 40 or older were compared, and the effects of IPT were almost twice as strong for the 40-plus group in terms of neurocognition and more than twice as strong for social cognition. The authors speculated that perhaps the group-based training in strategy use in IPT was a particularly good fit for older people.

Corresponding Author: Elizabeth W. Twamley, PhD, UCSD Department of Psychiatry, 140 Arbor Drive (0851), San Diego, CA 92103, 619-543-6684, etwamley@ucsd.edu.

Pratt and colleagues (in press) reported on a randomized controlled trial of a one-year skills training program called Helping Older People Experience Success (HOPES) in a large sample of people with severe mental illness, the majority of whom had schizophrenia. They found that HOPES, which targeted inhibition of inappropriate spontaneous responses, resulted in a small effect on a neuropsychological test of response inhibition. The Wykes et al. (2011) meta-analysis of cognitive remediation found that cognitive remediation works best in the context of a psychosocial rehabilitation program. It may be that the converse is also true, that psychosocial rehabilitation programs (such as HOPES) may improve cognition and functioning more if a cognitive remediation component is included.

Finally, Granholm and colleagues (in press) reported on a randomized controlled trial of Cognitive Behavioral Social Skills Training (CBSST) for schizophrenia, which is a bundled, 36-week intervention combining Cognitive Behavioral Therapy and Social Skills Training, two evidence-based treatments for schizophrenia. Compared to a robust goal-focused supportive contact control group, CBSST resulted in improved role functioning in the community (the primary outcome; d=.65), but participants with high levels of defeatist attitudes improved the most (d=1.11), suggesting that CBSST's focus on challenging defeatist attitudes and encouraging clients to try new things was a key component of its success. Defeatist attitudes could conceivably limit treatment gains in any skills-based intervention; this report raises the question of whether more psychosocial treatments for severe mental illness may benefit from targeting defeatist attitudes.

These four reports highlight important features of what psychosocial treatment will look like in the future for this older people with severe mental illness. *Combination therapies* will probably increase in popularity, as we now know that therapies offered within a broader context of psychosocial rehabilitation work better than treatments delivered in isolation (e.g., Wykes et al., 2011). The focus on client goals and achievement of valued roles in the community – living, learning, working, and socializing – may make any stand-alone treatment more meaningful, particularly when aspects of the treatment are overtly linked to goal attainment. Selection of goals that are meaningful to both clients and caregivers will increase the likelihood that caregivers will play a meaningful role in their loved ones' treatment, potentially further bolstering the effects of treatment. Secondly, we can expect to see an increased focus on *motivation and attitudes,* which could affect outcomes of any treatment, psychosocial or pharmacologic. Many people with severe mental illness struggle not only with their psychiatric symptoms, but also with their attitudes toward change. Defeatist attitudes (e.g., "Why bother, I always fail at things, so it's not worth the effort") could conceivably affect willingness of clients to try new things, be they medications, strategies, or behaviors in the community. Indeed, defeatist beliefs have been found to mediate the relationship between cognitive impairment and both functioning and negative symptoms (Grant & Beck, 2009). By directly addressing defeatist attitudes and providing mastery experiences, defeatist attitudes can change (e.g., "Sometimes I succeed, so maybe I will this time"). Finally, all four articles reported on *manualized treatments* that can be more easily disseminated in community settings. It is well-known that most evidence-based psychotherapies are not available to many service users who need them (Insel, 2009). The increased use of treatment manuals will be helpful in moving these therapies from the laboratory to the clinic. Not only must evidence-based treatments be implemented in usual care settings, they must also be made available and accessible to older clients.

References

Bartels SJ, Dums AR, Oxman TE, Schneider LS, Areán PA, Alexopoulos GS, Jeste DV. Evidence-based practices in geriatric mental health care. Psychiatric Services. 2002; 53:1419–31. [PubMed: 12407270]

Bartels SJ, Pratt SI. Psychosocial rehabilitation and quality of life for older adults with serious mental illness: Recent findings and future research directions. Current Opinion in Psychiatry. 2009; 22:381–385. [PubMed: 19417666]

Cohen CI, Vahia I, Reyes P, Diwan S, Bankole AO, Palekar N, Kehn M, Ramirez P. Focus on geriatric psychiatry: Schizophrenia in later life: Clinical symptoms and social well being. Psychiatric Services. 2008; 59:232–234. [PubMed: 18308900]

Granholm E, Holden JL, Link PC, McQuaid JR, Jeste DV. Randomized controlled trial of cognitive behavioral social skills training for older consumers with schizophrenia: Defeatist performance attitudes and functional outcome. American Journal of Geriatric Psychiatry. (in press).

Grant PM, Beck AT. Defeatist beliefs as a mediator of cognitive impairment, negative symptoms, and functioning in schizophrenia. Schizophrenia Bulletin. 2009; 35:798–806. [PubMed: 18308717]

Insel TR. Translating scientific opportunity into public health impact: A strategic plan for research on mental illness. Archives of General Psychiatry. 2009; 66:128–133. [PubMed: 19188534]

Kontis D, Huddy V, Reeder C, Landau S, Wykes T. Effects of age and cognitive reserve on cognitive remediation therapy outcome in patients with schizophrenia. American Journal of Geriatric Psychiatry. (in press).

Mueller DR, Schmidt SJ, Roder V. Integrated Psychological Therapy (IPT): Effectiveness in schizophrenia inpatient settings related to patients' age. American Journal of Geriatric Psychiatry. (in press).

Pratt SI, Mueser KT, Bartels SJ, Wolfe R. The impact of skills training on cognitive functioning in older people with serious mental illness: Results from a randomized controlled trial. American Journal of Geriatric Psychiatry. (in press).

Twamley EW, Burton CZ, Vella L. Cognitive training for psychosis: Who benefits? Who stays in treatment? Schizophrenia Bulletin. 2011; 37:S55–S62. [PubMed: 21860048]

Twamley EW, Vella L, Burton CZ, Heaton RK, Jeste DV. Compensatory Cognitive Training for psychosis: Effects in a randomized controlled trial. Journal of Clinical Psychiatry. 2012; 73:1212–1219. [PubMed: 22939029]

Wykes T, Huddy V, Cellard C, McGurk SR, Czobor P. A meta-analysis of cognitive remediation for schizophrenia: methodology and effect sizes. American Journal of Psychiatry. 2011; 168:472–485. [PubMed: 21406461]