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SERVICE MODELS, FORMS OF DELIVERY AND CULTURAL ADAPTATIONS OF CBT

ELders AT Ease (ELATE): a description of adapting cognitive behaviour therapy for treating mental health issues in nursing homes

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Abstract
Despite high levels of depression and anxiety, there is relatively little attention to psychological treatment approaches to mental health issues for older adults living in nursing homes. Recent studies support the use of cognitive behaviour therapy (CBT) in this population and here we aim to highlight how CBT can be successfully adapted and implemented with beneficial results. The ELders AT Ease (ELATE) program is a unique service delivery model illustrating delivery of CBT with older adults living in nursing homes. The six modules forming the program, based on CBT, are described. A systems wide approach to delivery is emphasised and illustrated through two clinical case descriptions. Innovative mental health programs can have positive benefits for both residents and staff and support the use of CBT in this vulnerable and under-served client group.

Key learning aims

(1) Knowledge of the content and application of CBT for older adults living in nursing homes.
(2) Understanding of CBT session structure as applied to older adults living in nursing homes.
(3) Recognising and utilising specific strategies to highlight a systemic approach as central to implementing CBT strategies, such as behavioural activation and reminiscence, with considered involvement by staff and family.

Keywords: cognitive behaviour therapy; depression; mental health; older adults

Introduction

Older adults will constitute 23% of the population by 2060, with the population of those aged over 60 doubling by 2050 (Department of the Treasury 2021; World Health Organization 2022). Although over 95% of adults aged 65 and over live in community settings (Australian Bureau of Statistics, 2020), approximately 280,000 live in residential aged care settings in the UK, with the proportion increasing with age (Office for National Statistics, 2023). Residential aged care settings are termed 'care homes' in the UK, 'nursing homes' as a subset of 'long-term care facilities' in the USA or 'residential aged care facilities' in Australia. The term 'nursing home' has been used

throughout this paper to describe a setting that delivers 24-hour professional care for individuals ('residents') with health care needs that require accommodation and assistance with nursing and personal care (Sanford *et al.*, 2015).

Older adults living in nursing homes are significantly more likely to experience symptoms of depression and anxiety, compared with community-dwelling populations in this age group (Amare *et al.*, 2020), yet mental health issues tend to be under-recognised and under-treated (Amare *et al.*, 2020; Snowdon and Fleming, 2008). However, the availability of psychological services in nursing homes is poor, with residents rarely referred to a psychologist (Stargatt *et al.*, 2017). High rates of psychotropic prescription have been reported for this population (Westbury *et al.*, 2018), with a recent Australian study of 106 nursing homes finding 41.4% of residents were prescribed anti-depressant medication in the first 12 months of arrival (Harrison *et al.*, 2020). Associated risks of using anti-depressant medication in this population include stroke (On *et al.*, 2022) and falls (van Poelgeest *et al.*, 2021). This high level of risk highlights the need for other evidence-based treatments for mental health issues in nursing home settings.

Meta-analyses for the effectiveness of cognitive behaviour therapy (CBT) with older adults living in nursing homes report positive effects, regardless of advanced age, cognitive decline and dementia (Cody and Drysdale, 2013). Reviews have reported that CBT is not only positively received by both residents and staff, but is also effective in the treatment of anxiety and depression of residents in nursing homes (Chan *et al.*, 2021). Group and individual programs, such as the BE-ACTIV behavioural intervention (Meeks *et al.*, 2015) and the Coping with Stress in Seniors depression prevention group program (Konnert *et al.*, 2009) have also been effective. Behavioural activation (with its focus on pleasurable activities in reducing depressive symptoms) and reminiscence are two of the most frequently used psychological approaches in nursing homes (Bhar *et al.*, 2022). The need to include staff and family as part of the resident's whole community to work systemically as a team whilst delivering CBT has also been emphasised (Bhar *et al.*, 2022).

Despite such promising reports, several limitations have been noted. Sample sizes are small and studies have tended to focus on evaluating specific treatment components (e.g. relaxation, pleasant events, problem solving), rather than implementation of a multi-component comprehensive CBT treatment protocol (Cody and Drysdale, 2013). Descriptive information regarding multi-component treatment protocols, especially how such treatments can be implemented in the nursing home setting, would be valuable for clinicians and researchers alike (Chan *et al.*, 2021). Furthermore, clear examples of how CBT components can be delivered with the active involvement of staff and family are also of practical value to clinicians, as improving mental health literacy amongst nursing home staff has been identified as a potential enabler to accessing psychological therapy in nursing homes (Stargatt *et al.*, 2017). A systemic model of care involves a shift in therapeutic focus from an individual level to an organisational and structural level, where the treatment model broadens from a one-to-one model (practitioner–resident) to one that also involves the resident's family, nursing care staff and specialists. It is helpful to involve residents' personal supporters (e.g. family members, or friends) and nursing home staff members in three ways – as a resource for information, as collaborators in treatment, and as recipients of education and support.

Research is also scarce in examining how CBT can be customised to accommodate the cognitive, physical and relational issues for nursing home populations. Central to CBT is a working conceptualisation of a client, and on the client's unique understanding of self, others and the world. The conceptualisation, or formulation, is a hypothesis about factors that pre-dispose, precipitate and perpetuate the client's problem and/or that interfere with clients' goals. In CBT, such factors include formative experiences (e.g. childhood experiences, family dynamics), beliefs (e.g. core beliefs, assumptions about growing old, and automatic thoughts) and behaviours (e.g. compensatory behaviours, avoidance of situations, e.g. other people, settings, etc). Techniques are justified and delivered in the context of this conceptualisation, as opposed to being prescriptive. Despite flexible delivery of CBT being desirable in clinical settings, treatment

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studies do not tend to allow for the choice of intervention to be based on the conceptualisation of a client's issues.

The present paper provides a detailed description of a CBT intervention: ELders AT Ease (ELATE) and its implementation within a nursing home setting.

The ELders AT Ease program (ELATE): aims and model of care

The ELATE program was developed in an effort to describe and evaluate a systemic CBT treatment approach involving residents, their family members and nursing home staff. Postgraduate students under supervision provided one-to-one psychological services to residents. In addition, family members and nursing home staff were upskilled and supported to better identify and manage depression and anxiety symptoms in residents. The program aimed to address the need to improve the training of nursing home staff in recognising and responding to mental health care needs of the resident. It also addressed the need to involve families/friends in meaningful ways to assist their relatives living in nursing homes. The ELATE program research design was a clustered randomised controlled trial of CBT that included cognitive, behavioural and reminiscence strategies. Residents aged 65 years and over deemed not to have moderate to severe cognitive impairment, their family/friend contact and a staff member nominated by each resident formed the participants of this project. Residents needed to indicate a moderate degree of depression, as measured by a score of 3 or over on the Patient Health Questionnaire-2 (Lowe *et al.*, 2005). Therapy was conducted by provisional psychologists completing their specialisation in clinical psychology, each supervised by a senior clinical psychologist with extensive clinical experience in nursing home settings [Authors: DK, SB]. A detailed protocol of the study is provided in Bhar *et al.* (2023). The trial was approved by the Swinburne University of Technology's Human Research Ethics Committee in line with the *National Statement on Ethical Conduct in Human Research* (Ethics ID: SHR Project 2019/162). Informed consent was obtained from all participants in the ELATE project or their legal guardians.

Treatment was delivered to residents in six modules over 16 sessions; see Bhar *et al.* (2023) for a summary table. The program content was based on the most efficacious aspects of CBT and reminiscence from the literature (Thompson, 2009; Wells *et al.*, 2014), together with adaptations for nursing home settings based on the authors' clinical experience [DK, SB, MS]. The program was systemic in nature, in that therapists met with staff and families monthly to reinforce psychological approaches for the resident. CBT structure, such as setting a collaborative agenda, bridging sessions, active new learning of skills supported by written hand-outs and summarised in a therapy book (Koder *et al.*, 1996) and take away practice, formed the process element of the program (Table 1).

Module 1: Introduction

Older adults have less exposure to psychological therapies for mental health issues (Stargatt *et al.*, 2017) and orientating a client to therapy is key to setting a solid foundation to begin therapy (Coon and Gallagher-Thompson, 2002). This is underscored in the nursing home environment where residents are often the passive recipients of physical care, as opposed to active collaborators in deciding on mental health treatment goals. Identifying potential therapy goals with an emphasis on gaining an understanding of the resident's presenting problem were facilitated by asking residents for recent examples of the problem, how they would like things to be different or to describe a typical day.

An essential aspect of early sessions was the therapeutic relationship which can directly influence therapeutic outcome (Mace *et al.*, 2017). Resident expectations were addressed, together with any biases regarding psychological therapy such as 'I'm too old to change'. Problem solving was used to identify and mitigate any potential barriers to therapy (for example, past experiences

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Table 1. Session structure guide

Step	Activity	Minutes guide
Check-in	The check-in involved a brief review about how the resident has been doing since the last session. For example, asking the resident 'How have you been since we last met?'. This customary greeting allowed for the building of engagement and rapport	10
Bridge	The bridge is a short recount of the previous session's material, summarised briefly with any queries answered. This short review allowed the resident to recall important points from the previous session	5
Practice review	Any 'homework' that was assigned to the resident was then reviewed. This review allowed the resident to discuss learnings, experiences and difficulties with such tasks	10
Agenda	The agenda of the session was collaboratively agreed on by asking the resident what they would like to cover or talk about in this session	5
Education and activities	This formed the main therapeutic strategy part of the session, providing education and teaching therapeutic activities. The importance of the activity and its rationale were highlighted, emphasising the need for a link between the resident's presenting issue (e.g. anxiety, avoiding meals, fear of falling) and the intervention (e.g. slow breathing, distraction, etc.) A simple exercise book was also provided, together with several handouts, summarising key messages as well as blank white prompt cards to remind the resident of the main exercise. The therapy book was used to write down key experiences using the resident's preferred words: this personalised the therapy experience. Residents were also encouraged to write in this book, should they have any questions in between therapy sessions. The therapy book was also used for residents to share their therapy experiences and new skills with family and staff, should they so wish	20
Summary and practice	Following a brief summary of the session content, suggested activities that the resident could do between sessions formed the practice element. Some residents did not like the term 'homework'. In such cases, other terms such as 'action plans', 'wellbeing exercises', 'self-therapy' or 'practice' were used. Therapy skills were encouraged to be practised between session times with staff and family where practicable, so the treatment was learnt and generalised. Ensuring deliberate explanations for the need to practise was emphasised using analogies such as learning to drive, learning a new language or a musical instrument	10

with mental health, scheduling appointments). The core aspect of these early sessions was giving the resident a sense of hope and agency, whilst avoiding overwhelming them with too much information.

Module 2: Reminiscence

The Reminiscence module was a natural sequitur to conducting an assessment related to the resident's history. Reminiscence work in older adults has received much support in the research literature, including use in nursing home populations (Bhar, 2014). In this module, therapists encouraged residents to consider their past history, focusing on past challenges, personal strengths and key timeline events to strengthen the resident's sense of identity. Other forms of reminiscence therapy, such as life review therapy, were also used where specific questions were asked regarding past problem-solving successes, designed to prime a positive representation of self, where the resident could feel efficacious by recalling successes in adapting to challenging situations. Another variation was life-review (note, the last word – therapy – is not added to this label): a more systematic form of reminiscence intervention where questions could be asked that have a chronological order. For example, in one session, residents were asked about childhood; in the next about adolescence, then about early adulthood and so on. The purpose of this intervention was to assist the resident to appreciate the common themes throughout their life (i.e. the 'thematic unity of one's life'), and to reach a sense of who they are (a sense of self, called 'narrative identity'). Reminiscing Story Cards were used as visual prompts in sessions with pictures on one side and a question on the other (for example: Beginnings … 'tell me about family celebrations' or Challenges and Wisdom: 'What was a particularly difficult time of your life? How did you get through it?').

Flexibility was strongly encouraged with modules 3 to 5 being able to be implemented in any order.

Module 3: Behavioural activation

Behavioural activation has been one of the most utilised and effective CBT approaches for older adults, including those living in nursing homes (Chan *et al.*, 2021; Orgeta *et al.*, 2017). This module began with an acknowledgement that it can be difficult to become involved in activities, especially when in a new setting or with unfamiliar people. Challenges adjusting to living in a group setting were also validated. The relationship between avoidance and potentially missing out on opportunities for enjoyment and satisfaction was emphasised. Psychoeducation was provided about the lethargy cycle – feeling down in itself can lead to tiredness, low levels of motivation and generally not wanting to do anything. Isolation and avoidance were discussed as factors maintaining negative automatic thoughts (for example, 'I can't do anything, I'm so useless, I can't even get out of bed', 'I've disappointed everyone again'), leading to low self-esteem and low mood, further continuing the cycle. A pictorial representation of this lethargy cycle was provided in such sessions. Residents were asked to keep a record of a week's activity as a form of practice and to review the relationship between activity and emotions. The Pleasant Events Schedule-Nursing Home (PES-NH) (Meeks *et al.*, 2009) was also completed to identify potential sources of enjoyment (Meeks *et al.*, 2009). Subsequent sessions focused on incorporating activities into the resident's routine. Behavioural experiments were also encouraged to examine thoughts related to being unable to perform activities.

Module 4: Anxiety management

CBT has received comparatively less attention in the literature on treating anxiety with older adults, despite a relatively high (19.4%) prevalence of anxiety disorders in nursing home settings

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(Creighton *et al.*, 2016). The anxiety management module emphasised psychoeducation, self-monitoring, relaxation and graded exposure for any avoidant behaviours.

Psychoeducation was provided regarding the development and nature of anxiety and its impact. For example, feeling scared and nervous could stop a resident from getting about simple tasks – from being able to get out of bed in the morning ('I might fall!') to having a meal with family ('I might say something silly'). Perhaps a resident could become so scared that they may avoid activities they might enjoy, such as group outings or a family get-together. Residents were taught to self-monitor initial symptoms of anxiety and then to use exercises to stop the escalation of such symptoms, to gain more control over anxiety levels. It was emphasised that terms such as 'anxiety' could be substituted with the residents' own words (e.g. 'the wobblies', 'the jitters'). Practising being exposed to uncomfortable situations (for example, sharing meals in the communal dining room) was carried out with the assistance of staff.

Relaxation training was adapted to suit frail older people and structured to prevent a resident feeling overloaded with instructions. Relaxation exercises were tailored to the resident's ability: for example, avoiding too slow breathing with a resident who had chronic obstructive airways disease; using visual cues, such as a prompt with the resident's favourite smell such as perfume, a rose or food. Some residents indicated a preference for imagery-based relaxation, such as a guided imaginal trip to their favourite scene from nature. The type, procedure and timing of these exercises were written down in the resident's therapy book to help the resident remember what to do (e.g. slow breathing) and when to do the exercises (e.g. just before meals).

Module 5: Cognitive restructuring

Strategies focusing on thinking patterns are relatively less utilised in nursing home settings, partly due to the association between declines in cognitive flexibility in older adults and its negative impact on learning cognitive restructuring to lower distress (Johnco *et al.*, 2014). However, the tendency to worry is very common and this cognitive therapy module commenced with psychotherapy regarding the nature and consequences of worrying. For example, people often mistakenly believe that by worrying about a potential catastrophe, they may prevent it happening! This is wrong and an example of magical thinking. Other common worries within the nursing home context could be linked to fears about a terrible consequence (for example: 'my daughter's late, she's had a car accident'; 'the nurse has forgotten me'; 'it's been hours, where is everybody, I'm all on my own').

Therapy sessions aimed to increase awareness of negative automatic thoughts, evaluate the accuracy and helpfulness of these thoughts and to replace these thoughts with more realistic and helpful ones. Therapists worked on helping residents to identify thinking tendencies such as future orientation and catastrophising and the relationship between cognition and emotions. For example, residents were encouraged to discuss a situation that was unsettling for them either recently or in relation to a family event or medical appointment coming up. Automatic thoughts about such situations were identified and linked to emotional reactions such as anticipatory anxiety. Then, the therapist invited the resident to compare the thought to what the resident knew to be true at that time (for example: 'I don't know what she's thinking'; 'I can't see in the future'). It was important therapists did not emphasise simply positive thinking, as the focus of such sessions was on realistic and helpful thinking, not just 'Pollyanna' views of the world.

Module 6: Relapse prevention

This final module was directed at identifying successful strategies and using these systematically to maintain therapeutic gains. The therapist and resident engaged in discussions regarding thoughts and feelings about ending therapy. They reviewed the therapy book to evaluate initial goals. They identified strategies that the resident found helpful, and these were summarised into a written

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wellness plan. Signs of relapse and an early intervention plan, together with possible triggers of distress were identified and formed part of the plan. Performing this task with family/staff was recommended, with one copy of the wellness plan given to the resident and another placed in the resident's file with consent.

Systemic implementation descriptions

The philosophy of systemic implementation of CBT in nursing homes was centred on engaging with family/friends and staff in a partnership. Each resident was asked to nominate a key staff and friend/family member ('key people') with whom they would like to work. Their involvement allowed therapy with the resident to be reinforced and continued. Family/friends and staff were consulted about (a) activities to be explored with residents, (b) the best methods to engage the resident and (c) progress and changes. They were regularly consulted about treatment approaches, enlisting their help to assist residents to complete tasks and, in some cases, to include them in joint sessions (e.g. have a session with both resident and family/friends or staff member present). Therapists had to be mindful of the resident's right to privacy, confidentiality and autonomy with verbal consent sought and documented prior to discussing the resident's circumstance with these parties.

Therapists also provided a 1-hour education workshop to interested staff and family/friends which provided information about mental health and emotional wellbeing in late life, and an overview of common strategies for helping residents manage anxiety and depression. Workshops were held separately with family/friends and staff and supplemented by written educational material (Beyondblue, 2009; Davison *et al.*, 2010). In addition to workshops, therapists were asked to check in with nominated staff members and family/friends once a month to help reinforce key aspects of the program and 'trouble shoot' any implementation issues. There was a strong focus on any changes noted. Tips to actively involve key people were suggested to therapists (Table 2).

Illustrative examples

Although the treatment was conducted as part of a randomised controlled trial (Bhar *et al.*, 2023) with outcome measures examining the impact on depression, the present focus is not concerning treatment efficacy, but rather on a description of CBT components, model of care and the application of CBT with residents and staff. The amalgamation of several cases into two clinical examples, representing the application of the ELATE program in the real-life setting of the complex nursing home environment, are described. Client names, occupations and other identifying information have been changed to protect anonymity.

Iris

Iris, a retired emergency ward nurse, had been living in the nursing home for one year at the time therapy commenced. She had one son, and none of her family lived close to her. Staff reported they believed Iris would benefit from psychological therapy, as they observed she was having difficulty adjusting to aged care and could often become anxious. Furthermore, she was assisting fellow residents to mobilise, despite being instructed not to do so due to increasing risk of falling. Following an altercation with another resident whom she had tried to assist with walking to the dining room, Iris chose to remain in her room. Her engagement with the nursing home's activities significantly decreased. At the time of commencing therapy, she remained in bed for all meals, rather than attending the dining room.

Iris had several pre-disposing factors that left her vulnerable. As well as past trauma, she described feeling embarrassed about her physical appearance due to being overweight. She was previously a long-term smoker and reported no history of formal exercise. Iris described several

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Table 2. Strategies for active involvement of family and staff

Module	*Strategy*
1. Introduction	Here in this early stage, the aim was trying to gauge both the resident's and their key people's views of their mental health. Knowing what is currently working well was also emphasised, so current coping strategies could be reinforced The key people were asked about what they think are the main concerns regarding the resident. What changes did they think would be helpful for the resident? What had been tried so far? What was the result?
2. Reminiscence	Key people, particularly family members, were asked to prepare photographs, or other prompts for simple reminiscence or for inclusion into a life book, story board or digital story; they were also occasionally directly involved in sessions, enabling reminiscing together. They were also encouraged to ask the resident about their life story periodically between sessions
3. Behavioural activation	Key people were asked to support the resident in their chosen activities, through providing materials (for example, wool for knitting, books, a CD player, magazines) and to be creative and join in activities with the resident
4. Anxiety management	Ensured key people were aware that people describe anxiety in a range of ways like worry, feeling shaky, having the jitters, feeling all funny, or panicky. Therapists worked with key people to highlight discovering and using the word that best described anxiety for the resident. Staff and family were encouraged to highlight early tension signs and suggest relaxation practice, even doing the exercise together at set times. This also served to normalise treatment of anxiety. Staff also facilitated gradual exposure to feared situations, where clinically relevant
5. Cognitive restructuring	The key people were encouraged to prompt the resident when they were feeling upset or down to focus on what they were thinking. These people were asked to prompt the resident in using any helpful coping self-statements that had been written in their therapy book. They were encouraged to reinforce or point out when the resident appeared to be using this strategy so it could be strengthened
6. Relapse prevention	Residents were asked to share the wellness plan with their key people, with an emphasis on the identification of triggers of distress. Residents were asked to consider inviting their key people to participate in the final session and also ask for their input as to any changes made and how they could continue to support the resident in the future

co-morbid physical health issues including chronic obstructive pulmonary disease affecting her breathing and some mild cognitive decline: both potential perpetuating factors for anxiety. Her past role in the helping profession could be seen to be related to her attempts to help other residents, and she seemed to experience rejection when boundaries were reiterated by staff and residents. Protective factors included a supportive friend who visited from interstate, telephone calls with her son, and a love of reading and creative arts. However, she did not provide consent for the therapist to communicate with her family or friends. Staff reported she was generally good humoured, but frequently belligerent to directives.

Iris identified goals in early sessions that included gently increasing physical activity to build capacity to engage in activities of interest. Using reminiscence techniques, Iris identified times when she was a nurse supporting patients to build ambulant activity and recalled the benefits for the individual. Iris tended towards negative self-body image commentary stemming from her childhood and pervasive criticism when asked about her resistance to work with the physiotherapist. Furthermore, she tired easily and became anxious when her breathing increased when ambulant.

Initial sessions with Iris were conducted with her in bed and every session was subject to multiple interruptions. However, she appeared to enjoy her therapy sessions which focused on gradual behavioral activation as a way to start to meet her goal of being more active. Psychoeducation focused on the link between activity and mood and a graded exposure approach was used to manage anxiety when around other residents in public areas. Using the Pleasant-Events Schedule-Nursing Home (Meeks *et al.*, 2009) she identified craft as an enjoyable activity, if it could be made available in the nursing home. As part of the graded exposure approach to address her anxiety together with structured relaxation, Iris was assigned a volunteer who read books with her, helped her attend physiotherapy and worked together with clay. Both the volunteer and Iris were educated about how anxiety could develop with breathing difficulties, hence tailored slow breathing exercises were introduced. As Iris practised and experienced a sense of achievement, the volunteer was successful in gradually encouraging her to leave her bed, and eventually her room. Cognitive therapy was used to highlight Iris's strengths, challenge assumptions about her ability to perform certain activities and link positive feelings to enjoyable activities. Behavioral experiments were a key strategy used: for example, curiosity was invited with phrases such as: 'We don't know what will happen if you go to the art group for a few minutes', rather than communication being delivered in a more directive manner leading to feeling obliged to attend.

To maximise and consolidate improvements for Iris, a 'Team Iris' approach was developed where shared communication between staff addressed and managed her needs consistently, offering her opportunities to experience tactile, creative activities and meaningful engagement with others. Structured, brief relaxation strategies were shared with staff along with identifying those behaviours that may not have been understood as manifestations of anxiety. The 'Team Iris' approach was a positive, co-operative way of reframing Iris as a creative person who had wanted to help staff, in identifying as a helper. Tactile work with clay also served to self-soothe, lowering the potential for irritability and altercations with staff. Using her creative skills, Iris was able to channel her energy positively, which improved her connections with staff and residents while creating and sharing her work. Over the ELATE treatment period, her mood improved and staff reported greater engagement outside of her room. A relapse prevention plan ('Keeping Me Well') was shared with staff containing all coping strategies with a focus on reinforcing the need for creative outlets as grounding techniques, as well as a source of pride and productivity.

Ada

Ada, an 87-year-old retired teacher, was referred to the ELATE program due to low mood and chronic hopelessness. This ideation appeared related to deteriorating physical abilities and

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chronic, severe pain. At the time of commencement in the program, Ada was spending most of the day in her room, avoiding residents and expressing to staff that she would rather be 'taken by the Lord'. She reported symptoms of both anxiety and depression, including chronic and persistent low mood, irritability and worry about her health decline. Protective factors were her strong spiritual beliefs and weekly telephone calls with her family who lived overseas.

Ada reported a strong value of the importance of independence, having left home at 16 years, putting herself through university, and being the primary breadwinner and carer to three young children after her husband left her. Ada reported a loss of control over her autonomy and independence when she was moved into the nursing home following hospital discharge. This became a catalyst for increased feelings of helplessness and hopelessness and precipitated self-doubt about whether she had lived a life of purpose. Ada's ongoing pain and requirement of a wheelchair were constant reminders of her deteriorating health and perpetuated her depressive symptoms.

The therapeutic approach focused initially on reminiscence to allow Ada to draw lessons from past strengths that had the potential to be harnessed in her current situation. This facilitated the clinician to obtain relevant background information useful for formulation and further intervention planning. Reminiscence techniques also supported the therapeutic alliance, as Ada shared her life story in an atmosphere of trust and empathy. For Ada, other CBT interventions included identifying and engaging in pleasurable activities and using relaxation strategies and cognitive reappraisal to manage her anxiety. Of note was the successful identification of pleasant activities using the PES-NH (Meeks *et al.*, 2009). This came as a pleasant surprise to Ada as she felt she had 'forgotten' some of the things she used to enjoy. She also appeared pleased to discover that these could be adapted to her current surroundings: for example, sorting out wool for knitting, and using audio books. Cognitive restructuring focused on identifying and managing the impact of her unhelpful beliefs through the application of newly learnt coping strategies. Behavioural experiments challenged thoughts such as, 'I couldn't do that', and served as a means of graded exposure to previously avoided activities.

As in the previous case, strategies were shared with staff, with Ada's consent, to maximise therapy gains. Activities she enjoyed were discussed with the activity co-ordinators who were able to facilitate participation in such activities such as craft, attending religious services and listening to music. The need for Ada to feel some element of mastery and control was also emphasised to staff, in keeping with her value of independence. Both Ada and staff reported improved mood, noting that she was more likely to accept suggestions made by staff for her to sit in the communal lounge. Respecting Ada's decisions to choose activities that were more solitary further improved her relationship with staff, and facilitated feelings of being in control.

Discussion

These cases support the use of CBT using a systemic model of care in nursing home environments. Reminiscence aided in orienting residents to the therapy process and relating more to their own lived experiences. This approach provided a safe and natural focus point for sessions, as opposed to a resident feeling like they have 'problems to be treated', or are being formally interviewed. Furthermore, relevant insights gained from conversations around residents' formative experiences were, with the resident's permission, shared with staff, expanding their view of the resident to be more holistic. Focusing on strengths and times in their past when residents had to adapt to change enabled residents to challenge their assumptions about their current ability to cope. These cognitive restructuring strategies were incorporated into sessions without the need to use self-monitoring tools, which can appear obscure for this population (Huh *et al.*, 2013).

The behavioural components of CBT (e.g. activity scheduling, relaxation) appeared to reduce institutional barriers between residents and staff, improving overall activity participation and

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depressive symptoms. Explaining the link between activities and mood was a key aspect of orienting residents to understanding the importance of activities, without the need to necessarily complete an activity as the primary goal as a measure of success. Therefore, the focus was not necessarily on attending an activity, but more on identifying potentially enjoyable activities that the person may have done in the past and then linking them to how the person feels. This focus served to change the dynamics of therapy from being didactic to a collaborative person-centred exploration of activities enjoyable to the client. The use of a formal validated instrument such as the PES-NH (Meeks *et al*., 2009) was a very useful prompt for previously enjoyed activities.

The cases also highlight the importance of therapeutic flexibility in a client-centred approach. Where residents may deny having negative thoughts, they are able to acknowledge the importance of engaging in pleasurable activities to help increase well-being. Respecting and promoting resident autonomy enabled the modules being introduced in a tailored, naturalistic way, depending on the presentation and issues being discussed. Bridging the gap between a resident's past and present circumstances through activities and memories helped integrate their current circumstances into an overall view of their lives.

Conclusion

Adjusting to nursing home care can be challenging for residents who may feel isolated and disempowered, often secondary to multiple physical problems. The ELATE program components and systemic structure enabled a person-centred, non-prescriptive approach to psychological therapy. Further work is required to identify the relative contributions of specific components of CBT to improving resident mood and functioning whilst working systemically in this unique setting.

Key practice points

(1) CBT can be applied to nursing home contexts using a systemic model of care with active involvement of the resident, their family/friends and staff.
(2) A focus on past activities, strengths and challenges through reminiscence can be incorporated in other therapeutic strategies such as behavioural activation and cognitive restructuring.
(3) Working systemically with staff to focus on engagement with the present, together with learnings from the past, can decrease psychological distress.

Further reading

Bhar, S., Koder, D., Jayaram, H., Davison, T., Knight, B., & Laidlaw, K. (2022). Innovative approaches for long term care. In Asmundson, G. J. G. (ed), *Comprehensive Clinical Psychology* (2nd edn), pp. 311–327. Oxford: Elsevier.

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Ethical standards. This project has been approved by the Swinburne University of Technology Human Research Ethics Committee, reference no. SHR Project 2019/162. The ethical conduct of the project conforms to the Declaration of Helsinki. All participants consented to the project with informed consent sought and documented at each stage, with consent forms clearly stating that findings will be published with no participant-identifying information.

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