Utilizing Cognitive Behavioral Therapy among Older Adults with Generalized Anxiety Disorder in Long-Term Care

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Utilizing Cognitive Behavioral Therapy among Older Adults with Generalized Anxiety Disorder in Long-Term Care

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Dedication

This capstone project is dedicated to my family, whose love, support, and encouragement made this achievement a reality. To my husband, Kenneth, and my God’s sent children; Benita, (Ada), Chinedum (Edum) and Onyeka (Ony), who had encouraged me from day one, listened to my daily celebrations and my struggles, and continuously helped me to remain balanced during these last two years. Thank you and I love you all with all my heart.

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Abstract

Background: Generalized anxiety disorder (GAD) among the older adults is characterized by excessive worries and major anxiety. The impairment and disability resulting from GAD indicates a significant mental health problem in long term care settings. In the United States, the lifetime prevalence of The Diagnostic Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) GAD is 5.1% to 11.9%. Evidence-based treatment for GAD in the older adult becomes a challenge due to the concern of frailty, comorbidity and drug side effects. Purpose: To implement the utilization of Cognitive-Behavioral Therapy (CBT) in the older adult population with GAD in a long-term care setting.

Method: Based on an extensive review of research, a project was designed and conducted to offer the basic knowledge of CBT to nurses for the treatment of GAD. Outcome evaluation was based on post-implementation questionnaire. Conclusion: The nurse participants were clear that they valued CBT and perceived it helpful for the older adult with GAD, but they needed to be trained proper and increase utilization of CBT.

Keywords: Generalized anxiety disorder, older adult, cognitive-behavioral therapy.
Generalized anxiety disorder is relatively common and is one of the most prevalent debilitating mental health disorders in the United States. It is a chronic and uncontrollable excessive persistent worries coupled with some other physiological symptoms such as restlessness, fear, difficulty sleeping, muscle tension, and difficulty concentrating (Clark & Beck, 2012). The Diagnostic Statistical Manual of Mental Disorders (DSM, Fourth Edition,) defined Generalized Anxiety Disorder (GAD) as a disorder that is being characterized by exaggerated worries that are uncontrolled with additional three or more related symptoms which include difficulty concentrating, sleep deprivation, fatigue, restlessness, muscle tension and irritability (DSM, Fourth Edition, Text Revision; American Psychiatric Association, 2004). It is a clinical concern and can seriously exacerbate medical and behavioral health disorder. Older adults with GAD can also experience other psychological problems such as distorted thinking, stress and muscle tension that may lead to impaired daily occupational and social functioning.

The reliability of diagnosing GAD is minimally compared to order type of anxiety disorder (Beesdo, Hoyer, Jacobi, Low, Hofler, & Wittchen, 2009, Brown, DiNardo, Lehman, & Campbel, 2001). Generalized anxiety disorder is commonly not recognized in the clinical setting even though it is one of the most common types of psychiatric problems. The presence of GAD impairs the individuals’ ability to solve their problems and their working memory especially in the older adult with mild cognitive impairment. Most research studies have associated GAD in the older adult with limitation in the activities of daily living, mood and behavioral changes, decreased quality of care, depression, increased in hospitalization, increased in placement in the nursing home.
facilities and disability (Brenes, Penninx, & Judd, 2008; De Beurs, Beekman, & Van Balkom, 1999; Tinetti, Inouye Gill & Doucette 1995).

Pharmacotherapy and psychotherapy such as Cognitive-Behavior Therapy (CBT) has been recommended for the treatment of GAD (American Psychiatric Association Steering Committee on Practice Guidelines, 2002). Pharmacological products such as antidepressant or anxiolytics have been frequently used by providers as a first line of treatment. However, the risk of using pharmacological therapy in older adults outweighs the benefits. The consequences leading to adverse drug side effects such as falls, sedation, as well as impaired cognition and poor quality of life have been a concern (Douglas, James, & Bellard, 2004).

**Problem of Statement**

Generalized Anxiety Disorder remains a highly prevalent problem in older adult with studies having estimated lifetime prevalence rates in the United States, as 5.1% to 11.9% (Kessler, et al., 2005, & 2008) and between 2.2-6.6% in developed countries (Henderson, Andrews & Hall, 2000). Generalized Anxiety Disorder among older adults may increase the risk of physical disability, reduced quality of life, and memory problems. It has also been associated with neurotic personality trait, cognitive decline and increased burden on physical health including frailty, worsening physical functioning, increased disability and increased taking of medications (Gale, & Millichamp, 2011). This is an indication that in anxiety, more than mood changes is affected.

Treatment of GAD could be pharmacological or psychotherapy. The pharmacotherapy aspect of the treatment involves psychotropic medications commonly used to manage psychiatric behaviors. It is well documented that the older adults are
more vulnerable to these drugs because of their potential severe side effects (Bulat, Castle, Rutledge & Quigley, 2008). Age-related changes, comorbid medical problems, polypharmacy, and the effect of pharmacodynamics and pharmacokinetic of psychotropic medications may expose the older adult to serious drug reaction (Zubenko & Sunderland, 2000). Anxiolytics are widely prescribed as a first line of treatment for GAD in the older adults. Benzodiazepine is the most common class of anxiolytic prescribed among the older adults (Bulat et al., 2008). Prescribing benzodiazepine among the older adults puts them in an increased risk of drug side effects such as sedation, memory and psychomotor impairment (Mott, Poole, & Kenrick, 2005). In 2008, Bulat et al. stated that the older adults who take benzodiazepines are at risk for falls and fractures because of the drug side effects, particularly over sedation, memory and psychomotor impairment.

A systematic review on falls, fractures and the association with drug use among the older adult was conducted with finding indicating a significant association between the use of benzodiazepines and falls (Hartikainen, Lonnroos, & Louhivuori, 2007). Benzodiazepine is considered to cause a psychological drug dependency contributing to difficulty with discontinuation (Heberlein, Bleich, Kornhuber, & Hillemacher, 2008). Beside psychological drug dependency and increased risk of falling, using benzodiazepine in the older adult patients has been linked with numerous negative health consequences such as depression, impaired cognitive disorder and loss of physical function (Patten, Williams, & Love, 1996, Gary, LaCroix, Blough, Wagner, Koepsell, & Buchner, 2002). Given the numerous side-effects of benzodiazepines in the older adult population, its long-term use is contraindicated; notwithstanding, many older adults are placed on benzodiazepines for a long period of time (Mott et al., 2005)
The purpose of this project is to demonstrate the utilization as well as accessibility to the evidence-based Cognitive-Behavioral Therapy for the treatment of Generalized Anxiety Disorder among older adults in the long-term care setting. The project will be implemented by educating nurses to deliver CBT interventions in their health care facility. Targeting and educating nurses to conduct CBT will increase the availability linking to significant gain with the facility. Significant proportions of nurses who take care of the older adult patients in the long-term facilities are not trained to deliver CBT with their older adult patients (Mullen, 2009). However, if nurses are trained to deliver CBT, significant proportion of the older adult will have access to the therapy (Rossiter, Schofield, & Hazelton, 2009) thereby increasing the utilization of the CBT as the first line of treatment for GAD.

**Background**

Impairment and disability resulting in GAD among the older adult indicates a significant psychiatric disorder. Generalized Anxiety Disorder significantly reduces their quality of life (Jones, Ames, & Jeffries, 2001). Many of the older adults with anxiety disorder tend to develop both psychological and physical problems, which can further worsen and complicate the diagnosis. Older adults most commonly attribute anxiety symptoms to their physical problems which could result to the anxiety not been diagnosed. Older adults refer to persons 65 years of age and older. Older adult is used in this paper since it is commonly used by gero-psychologist and is the recommended term in American Psychological Association (APA) publications (APA, 2010b). With the older population increasing at an unprecedented rate (Beard & Bloom, 2015), these results are concerning, especially given the serious impact of anxiety on the health, daily
functioning and well-being of the older adults (Smalbrugge, Pot, Jongenelisk, Beekman, & Eefsting, 2006)). Understanding the prevalence of anxiety in the long-term care facility is important and has a substantial need for designing an interventions and prevention strategies for this already frail and vulnerable population.

Long-term care institution is a primary care practice that offers a wide range of medical and non-medical services over a long period of time to individual who are unable to manage independently at home due to chronic illness, mental or physical disability. Long term facility includes nursing homes, skilled nursing facility and assisted nursing facility. Luppa, Luck, & Weyerer, (2010) documented that mental disorders commonly precipitate admission of the older adults into the long term-care settings and these older adults represents an increasingly frail and medically ill population at risk for anxiety (Geralimatos, Gregg, & Edelstein 2013).

Creighton, Davison, & Kissane, (2016) recently reviewed nine studies published in the International Journal of Geriatric Psychiatrics. The review discovered that the prevalence rates of anxiety disorders in the long-term care facilities ranged from 3.3% to 20%. The review also found out that their is a high proportion of anxiety disorders among the older adults in the long-term settings that experience symptoms of anxiety that warrants intervention but do not meet the criteria for diagnosis, the estimates ranges from 6.5% to 58.4%. These review findings suggest that anxiety is common among the older adults in the long-term care setting. In view of the various types of anxiety disorders, studies suggest that the generalized anxiety disorder is the most common among the older adults (Cohen, & Eisdorfer, 2011; Creighton, et al. 2016; & Goncalves, Pachana, & Byrne, 2011)
Multiple studies have reported that about 10% of the older adult’s population dwelling in the community has a “diagnosable generalized anxiety disorder” (Beekman, DeBeuers, Balkom, Deeg, Dyck, Tilburg, & Smit, 1998). Beekman et al (1998) continued that regardless of the settings, generalized anxiety disorder in the older adults has not been examined as much as depression and dementia in the older adults. In support of this finding, Wittchen & Hoyer (2001) carried out a study and estimated the rate of Generalized Anxiety disorder (GAD) to be about 8% while 0.1% of the cases were diagnosed by the primary care physician.

Generalized anxiety disorder exposed the older adult limitations in performing activity of daily living and significantly reduces their quality of life (Tinetti et al 1995). Given the risk and occurrence data of generalized anxiety disorder, it continues to be undiagnosed and however inadequately treated (Van Hout et al, 2004). In the United States, the lifetime prevalence of DSM-IV GAD is 5.1% to 11.9%. (Kessler, Berglund, Demler, Merikangas, & Walters, 2005; Kessler, Griuber, Hettema, Hwang, Sampson, & Yonkers, 2008). The prevalence rates of the proportion of the older adult who were diagnosed of anxiety disorder are greater in the health care setting with up to 18% among the older adults with chronic pulmonary disease as well as increase of 24% among the Puerto Rican elderly population (Tolin, Robinson, Gaztambide, & Blank, 2005, Yohannes, Baldwin, & Connolly, 2000). Additionally, growing literature on the prevalence of GAD indicates that it is a highly prevalent mental disorder causing distress, with significant morbidity.

Generalized anxiety disorder remains the considerable subjective distress in late life (Ayers, Sorrell, Thorp, & Wetherell, 2007). Despite studies that addressed the
prevalence of GAD in the older adult, its detrimental health outcome is likely to be “chronic and unremitting” (Livingston, Watkin, & Milne, 1997). The high prevalence reports indicate that GAD is a common disability and significant public health burden. In view of the high prevalence of GAD in the older adult, it is necessary to implement an effective and safe management strategy for the GAD. Proper diagnosis and evidence-based treatment becomes critically important in addressing GAD in the older adult. In light of the problem, it is very critical that early assessment, proper diagnosis and safe evidence based treatment by a license health professional is needed.

Many studies have documented the effectiveness of Cognitive-Behavior Therapy (CBT); a non-pharmacological approach in the treatment of Generalized Anxiety Disorder however it has been less clearly demonstrated in the long-term care settings. Cognitive-behavioral therapy is identified and considered as a gold standard in the psychotherapeutic treatment for GAD (Olantunji, Cisler, & Deacon, 2010). Meta-analysis conducted by Gould, Otto, Pollack, & Yap (1997) focused on pharmacotherapy and CBT, both therapies results with effective outcome, however, pharmacotherapy showed loss of efficacy at withdrawal, while the CBT effects where maintained showing a significant difference in treatment outcome.

Similarly, a randomized study by Tennsted, Howland, & Lachman, (1997) monitored the use of CBT to an education control group with fears of falling. The findings reported significant improvement in mobility and activity control post-treatment with overall social improvement in 12month follow up. In view of the success and benefits of the CBT, the therapy should be positioned to be the first line of treatment for GAD as well as a major component of standard care. However, despite the extensive
support for CBT, its adoption and utilization remains difficult to access due to insufficient number of trained therapists in the long-term care setting. Older adults tend to be at risk of medication side effects. Many of them are in multiple prescriptions and over-the-counter medication complicating the complexity and severity of concurrent medical problems. The circumstances of the long-term care setting make the utilization and maintenance of CBT conventions possible as these rely on predictability of availability of older adults. Therefore, this project aims to encourage the implementation and utilization of CBT; a non-pharmacological approach for the treatment of generalized anxiety disorder among the older adults residing in the long-term care facilities.

**Review of Literature**

The literatures that have strongly supported the use of CBT for the treatment of anxiety in the elderly patient were reviewed. To assist with the literature search, the following PICOT (Population, Intervention, Comparison, Outcome and Time) question was formulated: How well does the elderly patient population, diagnosed with generalized anxiety disorder responds to CBT; a non-pharmacological therapy approach.

A comprehensive search of literature was carried out through the electronic library database of major healthcare databases written in English such as the PubMed, Web of Science, Current index to Nursing and Allied Health literature (CINHAL), PsycINFO, and Cochrane. The following Medical Subject Heading (MeSH) was used while performing the search in the PubMed database: Anxiety disorder, anxiety disorder symptoms, older adult population, pharmacological, non-pharmacological therapy, Cognitive-Behavior Therapy, clinical settings and community setting. In this review, non-pharmacological therapy associated with reduction of anxiety symptoms and stability
of positive outcome of post-treatment was considered. The non-pharmacological therapy here concentrated on the Cognitive-Behavior therapy designed to minimize GAD symptoms and improve adaptive functioning.

Several approaches were used to identify studies. Studies eligible for inclusion in the review were randomized controlled trials evaluating pharmacological and non-pharmacological therapy (Cognitive-Behavior Therapy) for the treatment of GAD in the older adult population aged fifty years and older. The search identified and considered relevant papers published from 1990s to 2016. Of two hundred and eighteen articles of the Cognitive-Behavioral Therapy in the older adult with generalized anxiety disorder identified from the initial search, six articles were reviewed. The data source from the six articles was reviewed to collect data on authors, study sample, publication dates, methods and health outcomes. A reference list of relevant systematic review studies was searched to identify additional potential relevant studies. Search started from 6/2/2016 to ended 4/30/2017 and was limited to research published in English language.

**Literature Review on Cognitive-Behavioral Therapy**

A randomized trial study comparing the effectiveness of Cognitive-Behavioral Therapy (CBT) and Supportive Counseling (SC) Therapy in fifty-five years and older adults, who meet up with DSM-IV criteria for generalized anxiety disorder was conduct by Barrowclough, King, Colville, Russell, Burns, & Tarrier, (2001). Samples were collected and participants received a six weeks treatment of either CBT or SC at home. More patients’ self-reported better outcome and showed good response in CBT group than SC after treatment and 12months post treatment follow-up. There is significant improvement maintenance among the CBT when compared to SC groups. The
effectiveness and good outcome of CBT therapy seems to be an evidence of psychological treatment of anxiety disorder in the older adults.

Durham, Chambers, Macdonald, Power, & Major, K. (2003) followed up two randomized clinical trial study of generalized anxiety disorder treatment with CBT. Medication and placebo was used in the randomized trial at the anxiety and stress center while the second randomized trial was based on the Cognitive therapy and analytical psychotherapy at the department of psychiatry. There was improvement with treatment in the participants on both studies, however, CBT intervention showed significantly lower overall severity of GAD symptoms, compared to the non-CBT. Generally, CBT appeared to be better at long-term follow-up.

Dugas, Freeston, Ladouceur, Leger, Langlois, Provencher, & Boisvert, (2003) conducted a randomized study of fifty-two patients diagnosed with generalized anxiety disorder to receive fourteen weekly two hourly sessions of CBT treatment in small groups of four-six participants with two clinical psychologists in a long-term care setting. The study had greater post-test improvement of symptoms. There is sustainability of good treatment outcome in a long-term follow-up of over two years. CBT is a form of psychotherapy developed by Aaron Beck to help patient with their thoughts, behavior and emotional problems as evidenced in GAD patients. CBT is a talk therapy technique that targets cognitive and behavioral symptoms of GAD with goal-oriented systematic approach. Cognitive-behavior therapy approach is based on the theory that cognitions influence feelings and behaviors. While the Behavioral therapy is based on the theory that behavior is learned and is subject to change.
Cognitive-behavioral therapy treatment strategies focus on various cognitive, behavioral and physiological symptoms of GAD. The cognitive skills encourage patient to focus on problem-coping and evidence-based thinking which targets the problem-solving deficits of GAD. The behavioral skill encourages decision making as well as reducing anxiety-provoking situation. Caske, (2003) stated that CBT is based on evidence that GAD patients engage in catastrophizing and overestimations of negative events, worry about worry, deficit in problem solving and decision making; the numerous behavioral and cognitive strategies used in CBT is a counterproductive which helps to maintain self-perpetuating cycle of worry.

Cognitive behavioral therapy (CBT) is a structured; evidence based effective method for the treatment of multiple mental health problems including generalized disorder in the primary care settings (Hopko 2013; Possemato, 2013). Despite strong evidence supporting the effectiveness of CBT, it is not widely utilized in healthcare setting (Blane, Williams, Morrison, Wilson, & Mercer, 2013). It is not routinely offered in the long-term care setting due to implementation barriers (Aschim, Lundevall, Martinsen & Frich, 2011). Primary care providers in healthcare settings encounter challenges in transferring CBT research findings into clinical practice (Fawcett, 2009). This is problematic, in the sense that there is a delay in using evidence based findings to guide practice and patient care. Inadequate utilization of CBT in the long-term care setting is an evidence of delay in moving science into clinical practice. As a result, this well documented evidence-based therapy is not widely offered for the older adults with generalized anxiety disorder.
Various literature demonstrated the effectiveness of CBT clinical practice in the primary care setting (Gibbons, Fournier, Stirman, DeRubeis, Crits-Christoph & Beck, 2010); however, there is poor understanding in the structure of training to enable nurses effectively implement CBT. Improving nurses’ knowledge of CBT is an essential step in enhancing the use of CBT and promoting competent CBT implementation.

Review of literature in several meta-analyses compared psychological therapies with pharmacological treatments, Banderlow, Seidler, Brabdler, Becker, Wedekind & Ruther (2008); Federoff and Taylor (2001) & Gould Buckminster, Pollack & Otto (1997) as well as assessed the efficacy of CBT interventions for generalized anxiety disorder in the older adult (Hunot, Churchill, Texeira & Silva de Lima 2010; Stanly, Beck, Novy, Averill, Swann, Diefenbach, & Hopko, D. 2003; Nohrdus & Pallesen 2003; Evans, Ferrando, Findler, Stonewell, Smart, & Haglin, D. 2008; Craigie, Rees, Marsh & Nathan, 2008). Consistent with the literature, the review emphasizes that CBT demonstrated the efficacy and effectiveness of CBT in treating GAD.

Empirically, CBT have proven to be effective comparable to psychotropic medications (McNaughton, 2009). Cognitive behavioral therapy has been shown to be effective for multiple mental health disorder including GAD (Chanbless, & Ollendick, 2001) and is associated with improvements in quality of life in the older adults with generalized anxiety disorder (Hofmann, Wu, & Boettcher, 2014). Butler, Chapman, Foreman & Beck (2005) conducted meta-analyses review of treatment outcomes for CBT from 1967 to 2003 and identified a total of fifteen methodologically meta-analyses that included 9,128 participants and 332 studies. They examined the effect of CBT outcomes with the control group outcomes for a variety of anxiety disorder. The finding
showed that CBT is an effective treatment for a wide range of disorder including generalized anxiety disorder.

Since 1990, several literature reviews have been written about the treatment of GAD (Butler and Booth 1991; Chambless and Gillis 1993; Durham and Allan 1993). These reviews focused on cognitive-behavioral therapy approach for the treatment of generalized anxiety disorder with findings that CBT is significantly effective for the treatment of GAD in later age. Subsequent result from the Task Force of the Division of Clinical Psychology of the American Psychological Association, involved with identifying empirically supported treatments found that strategic techniques used in CBT meets criteria for treatment of GAD symptoms (Woody and Sanderson 1998).

Butler and Booth (1991) in a literature review of the outcome on psychotherapy for GAD concluded that CBT gains made at posttreatment was maintained at follow-up evaluation. This suggests that GAD appears to be responsive to psychotherapy treatment. Chambless and Gillis (1993) conducted a meta-analytic review, nine studies evaluating the effectiveness of CBT for GAD were reviewed, and seven studies out of nine reported that CBT was more effective than wait-list or placebo control. Follow-up studies reported that CBT technique gains were maintained. Similarly, Durham and Allen (1993) reported in another review that 50% of elderly patients with GAD demonstrated normal behavioral and cognitive functioning following CBT treatment. Posttreatment results showed that 57% of the patients recovered to normal range. Studies indicated that the greatest effects occur among the elderly who were not taking any medication. It supports the notion that CBT should be use as a first line of treatment for GAD more. Patients outside psychiatric settings appeared to make greater CBT treatment gains (Durham et al., 1993). Early
assessment and diagnosis of GAD is very essential in order to benefit significantly from the utilization of the CBT.

Barrera et al., (2014) carried out a randomized controlled trial of CBT for late-life GAD compared with usual care (UC) in a combined sample of community and Veteran participants. The result indicated significant improvement in GAD severity among participants treated with CBT relative to UC.

The effectiveness of CBT for GAD in the older adult has received substantial support as a consistent and empirically validated form of psychotherapy for GAD reported in the Consensus Statement on Generalized Anxiety Disorder from the International Consensus Group on Depression and Anxiety (Ballenger, 2001). Additional support from the Canadian Psychiatric Association Clinical Practice Guidelines on the Management of Anxiety Disorders (2006) showed that CBT research demonstrates more effectiveness than no treatment. The Canadian guidelines indicated that the effectiveness of CBT is maintained between six months to two years of follow up.

Cuijpers et al (2014), in their recent reviewed meta-analysis, examining the effects of CBT, included 41 randomized studies of 2132 adult participant diagnosed of GAD. The study compared CBT with pharmacotherapy and with other psychotherapies. Findings showed that CBT is more effective and may have longer lasting effects compared to the other therapies. The study concluded that CBT is as effective as medication in treating GDA in adults and may be the treatment of choice (Cuijpers et al., 2014).

Regardless of the settings, cognitive-behavioral therapy is considered the cornerstone of treatment for GAD in the older adults; targeting the area of patient identify
their thought process, distressing conditions and dysfunctional beliefs with strategic rational and realistic views (Patel et al., 2013).

**Theoretical Framework**

Rogers’ Diffusion of Innovations Theory has been used by many researchers to describe and examine the translation of evidence-based interventions into actual clinical practice (Kramer and Burns, 2008; Dobbins, Ciliska, Cockerill; Barnsley & DiCenso, 2002; Berwick, 2003). In healthcare, instruments, drugs, equipment, services, procedures and programs are all innovations (Dobbins, Ciliska, Estabrooks & Hayward, 2005). The theory of diffusion innovation took a different approach of change in innovation. It is a change approach on reinvention of behaviors or products to fit the individual or group needs rather than changing individuals (Robinson, 2009). The diffusion of innovation theory consists of five stages: Knowledge, Persuasion, Decision, Implementation and Confirmation. The National Collaborating Center for Methods and Tools (2010) endorsed the frameworks attributes such as innovation, environment, organization and the individual to adopt an innovation. In addition, it shapes the implementation of an innovation in an attempt to change practice within an organization (The National Collaborating Center for Methods and Tools, 2010). The framework was reviewed by the National Collaborating Center for Methods and Tools (2010) and it stated that:

**This framework is useful for the selection of evidence-informed innovation especially with the handling of the barriers and facilitators that affects the adoption of the innovation. The method of planning guides the interventions to facilitate the innovation implementation and evaluation of process and outcomes of the innovation adoption.**
Dobbins et al; and other researchers utilized the framework of the diffusion of innovation to guide the implementation of the CBT project innovation. Designing and implementation of this DNP project followed the comprehensive framework by Dobbins et al. (2005) for the adoption of evidence-based practice into an organization and clinical practice. The framework will be a reflective of the methodology of the project as it progressed through the five stages: Knowledge, Persuasion, Decision, Implementation and Confirmation. The performance indicators used to evaluate the utilization of CBT success will be addressed at various point throughout these five stages of the innovation framework. Evaluation will be completed with questionnaires for the participant before the initial CBT training and after the CBT final session training.

**Settings and Resources**

This project took place in a long-term care facility located in a large community with minority population. The long-term facility is the organization where the DNP student once had her clinical practice. This long-term facility was chosen because of the availability of the target population. It is a 123-bedded Joint Commission Accredited, Medicare and Medicaid Certified. It is a facility that serves middle and lower class population as well as diverse cultural groups of families and residents in their community and surrounding communities of the greater Boston area with a large Asian ethnic population. Services rendered in this facility are short-term rehabilitation, long-term care, post-surgical recovery care, wound care, respite care, speech pathology pain management, and hospice as well as physical and occupational therapy. The nursing facility is staffed by nursing administration, director and assistant director of nursing, unit managers, registered nurses, licensed practical nurses, patient care assistants, dieticians,
speech therapist, social workers, recreational therapist, physical and occupational therapist. They also have visiting physicians from teaching hospitals, Nurse Practitioners, Psychotherapist and Psychiatrist. The facility has an electronic medical records and internet websites to promote communication and the flow of information within the facility which according to Dobbins et al (2005) has a positive impact towards the implementation and utilization of the CBT. The facility runs twenty-four -coverage by nurses and other health providers. Nurses run three shifts and each shift is staffed as follow:

- **Day shift:** three nurses and 3-4 nursing assistants and the unit manager
- **Evening shift:** two licensed nurses and 3-4 nursing assistants and a house nursing supervisor
- **Night Shift:** one licensed nurse and a house nursing supervisor

Organizational characteristics contribute to influence over a positive or negative adoption of an innovation. Dobbins et al (2005) documented an estimation of approximately 40% in the variability to adopt innovation for health care professionals. Dobbins et al (2005) went further to state:

“Organizations that have a high differentiation, a culture that values the use of research evidence in practice, effective communication systems, decentralized decision making, managerial support for change, and adequate resources are more likely to adopt innovations. Innovations promoters can assess these characteristics within their organization to identify naturally occurring facilitators and barriers to evidence-based practice and can use that knowledge to optimize the impact of the characteristics that facilitate innovation and minimize those that pose barriers. (p.180)”
According to the framework, this represents a high level of functional differentiation which is a facilitator for implementation. The facility is structured to support a high level of interest in the success of any project that will result to an outstanding outcome and continued commitment to excellence.

**Goals, Objectives and expected outcome**

The goal of this DNP project was to conduct an integrated review of the available evidence based research, as well as to do an educational outreach with nursing to be able to assess and manage Generalized Anxiety Disorder in the older adult residing in the nursing home setting. The objective of this project included:

- Develop a format for the delivery of CBT that will be feasible in the long-term facility
- Increase nurses’ knowledge and confidence to implement CBT
- Increase the utilization and adoption of CBT

The goal and objective were to design a plan based on integrated literature review for health care givers to adapt and incorporate in their treatment protocol of generalized anxiety disorder in the older adult with expected outcome to increase the utilization of the CBT as a first line of treatment for generalized anxiety disorder. Nurses are actively involved with geriatrics in the long-term care settings and are the target groups of health care givers in designing this project.

**Description of the group**

A convenience group of nurses of all three shifts participated in the project. The goal is to have up to six nurses with all the shifts represented. Nurses to be included in the project will not have to sign consent before participating in the CBT training. Participant nurses,
will be invited to participate in the 30 minutes educational session as well as the CBT training.

**Evidence of stakeholder support**

The key stakeholders are administrator, Director of Nurses, and the Assistance Director Nurses as well as nurses who will be delivering the CBT services. This team of health professionals has the intention of providing a meaningful and collaborative care to increase retention and overall satisfaction as well as enhancing quality patient care and patient outcome. Additionally, their interest in providing and maintaining a strong inpatient service will generate more admissions for patients with GAD seeking inpatient behavioral care. Their expectations are high and will endorse any outstanding projects. The DNP student approached all these groups and discuss in detail the plan of the DNP project on the inpatients units for the treatment of generalized anxiety disorder among older age population in their facility; a therapeutic behavior intervention that is not presently occurring in the facility. The discussion was centered on initiating CBT innovation in their organization. The Stakeholders letter of agreement was signed by the Director of Nursing Service.

**Ethics and Human Subjects Projection:**

A memorandum from the Human Subject research determination indicated that the project activity does not meet the federal regulation definition of human subject research, therefore did not require a submission to the IRB. However, permission from the facility was obtained. Since this project is an integrated review and not a research study, the facility will remain in guidelines of the Health Insurance Portability and Accountability Act (HIPPA). There was no mandatory requirement or consent for the
nurses to reveal their identity at any point during the implementation of the project. The project has no contact with the older adult patients.

Project Design and Method

The DNP project is based on an integrated review of available evidence geared towards education and training of nurses to implement the utilization of Cognitive-Behavioral Therapy for the treatment of GAD. The project was designed to offer the basic knowledge of CBT to nurses for the treatment of GAD among the older adult population. The participants were expected to seek more extensive training consistent with adopting and delivering CBT in their clinical practice. The project was also designed as a pilot evaluation for the purpose of determining feasibility and to incorporate feedback from nurse participants. The Diffusion of Innovation theory guided the designing of the project using the five stages described above: Knowledge, Persuasion, Decision making, Implementation and Confirmation.

Framework of the Five Stages of Diffusion Innovation

Knowledge Stage

Knowledge phase is the first stage of the innovation theory. This phase is based on the identification of relevant evidence about a new healthcare intervention and an appraisal of the evidence quality (Dobbins et al., 2005). In this DNP project, CBT utilization is the healthcare intervention. The first stage starts with the identification of problem, the clinical practice that lead to a search of the literature for a potential and sustainable solution. In this author’s clinical practice as a primary health care nurse practitioner, the problem emerged as a result of the complications of benzodiazepines on the older adult patient with GAD. A review of literature on generalized anxiety disorder
demonstrated that CBT was recommended as a gold standard treatment of CBT. In addition, the utilization of CBT was limited due to cost, unawareness, and unavailability. Further review of literature identified CBT as practical in primary health care; notwithstanding some identified barriers and facilitators (Waller & Gilbody, 2009; Churchill, Hunot, Corney, Knapp, Mcguire, & Tylee 2001; Heifedt, Strem, Koistrup, Eisermann, & Waterlo, 2011; Whitfield & Williams, 2003).

The DNP student further explained and recommends CBT to the stakeholders based on the literature search that identified high quality evidence supporting the use of CBT for treating GAD. The training is for nurses to know how to integrate CBT into their practice and is designed to be delivered in two sessions. The pre-implementation questionnaire was prepared to assess participants readiness, confidence and perceived proficiency with practicing CBT as a measure of their CBT skills. In view of the literature search, identifying the significant evidence supporting the use of CBT for treating GAD in the older adults, the second of the framework which is “persuasion” was adopted.

**Persuasion Stage**

Considerations of whether to implement the CBT were reviewed in this stage. It is a very important stage involving the decision-makers in the long term facility and the individual forming a positive attitude towards the CBT innovation. In this DNP project, the DNP student was the individual who started the process of the persuasion and without hesitation received a positive attitude from the decision-makers within the organizational setting. The decision-makers or stakeholder in this project who were needed to authorize and support the implementation of this evidence-base treatment are the administrator and
director of nursing within the organizational setting. Consideration of choosing to implement the CBT was sought from peers who have already adopted the innovation. According to Dobbins et al. (2005), if their experience was positive and innovation is consistent and relevant with both individual’s attitude and the perceived organizational attitude, then motivation to implement the innovation increases. The persuasion stage has considerable breath as it explores the implementation of the CBT. Six nursing staff participant completed a questionnaire before the implementation of the CBT. The CBT project sessions includes a sample of nurses’ user guide (see appendix F) to help instruct participants of what CBT is all about. The Burns Anxiety Inventory (BAI) is a checklist of thirty-three symptoms related to anxiety. It was suggested to the participants to screen the older adults for their level of anxiety using a validated tool such as the BAI. Screening patients’ level of anxiety can help nurses to determine patient’s eligibility for CBT. The Project designed a post-implementation questionnaire to evaluate participants’ satisfaction, confidence in their skill to deliver CBT and their utilization rate.

**Decision Stage**

The third stage of the innovation framework is the decision stage which according to Dobbin et al. (2005) considers the key stakeholders who should be involved in the decision to implement the innovation. The decision making in this project not only considers the research evidence but also the needs, attitude and interest of the key stakeholders as well as the clinical expertise of the nursing staff. According to the framework by Dobbins et al, (2005), for the primary health providers to implement CBT, it must be relevant and in accordance with their values, beliefs and needs. A meeting took place between the author, the administrator and the director of nursing. They showed
interested and supported the implementation of CBT to be available to their older adult patients with GAD.

The interest, needs, competence, expertise and attitudes of the staff nurses were considered in the decision stage of the diffusion innovation theory. Prior to the implementation the CBT innovation, a meeting was held between the DNP student and the staff participants. It was made clear to them that the CBT providers need not only the skills but the interest to the CBT utilization. Participants in this CBT innovation project were self-selected group of registered nurses who were interested in learning to implement and utilize CBT in their clinical practice. The facility recognized the culture that value the knowledge of direct care nurse and empower them to lead the change. The staff nurse job description includes the responsibility to be an advocate for patients with a focus to deliver care that is patient’s centered, self, effective, timely, and efficient including securing necessary resources to care for the patients. In view of the above structure, participants were supported and empowered to involve in the decision-making for the CBT utilization.

**Implementation**

This is the fourth phase of the innovation framework. Once the decision to implement CBT is made, approach that will promote behavioral changes as well as implementation of the CBT innovation must be considered. The implementation activities may start with strategies to translate the research into simplified key message followed by the effort to change clinical practice. To demonstrate these strategies, the CBT innovation was designed to take the research findings around CBT and translate them into useable format to facilitate the implementation of CBT in the long-term facility. It is
well noted that an implementation activity of the CBT is an approach and effort to translate the evidence-based into clinical practice. The integrative review provided a review of generalized anxiety disorder and basic CBT as an educational support to the participants. It is expected that the program will be offered to at least six nursing staff. Sending reminders to participants has been shown to be effective, low-cost and feasible strategy (Dobbins et al, 2005). Nurse participants were reminded with emails and face-to-face encounters. Administrators were sent with email updates on the status of the implementation stage. A pre-implementation questionnaire (appendix C p. 61) was created and given to participants to identify their basic knowledge of CBT. Participants were encouraged to complete the pre-questionnaire before introducing them to things they need to know to get started with basic CBT. The pre-implementation questionnaire was intended to assess participants’ confidence and perceived ability in delivering CBT as a measure to their CBT potential skills. An interactive 30 minutes educational session was conducted and all the participants attended. The strategy of this project is to offer education outreach to nurses by providing them with information (Dobbins et al, 2005). Though there was a time constraint, both on the participant and this author, however the intended information was disseminated as planned. Many questions were addressed during the information session. The participants were advised to call this author at any time with further questions about CBT innovation. Three participants called for information on the cost and duration of CBT training. A follow up 30 minutes lunchtime break “information review booster session” was offered one week after the initial session and was attended by five participants. The one participant that did not attend was on vacation. The adoption framework acknowledges that using multiple interventions is
likely to more effective, and can be combined with any of the less effective strategies. These strategies include giving feedback to nurses on their reflection with the CBT innovation and utilization, including nurses in discussions about the problem; lack of CBT utilization, and appropriate approach to manage it and having older adults engaged and requesting the CBT service. As this was set up as a small-scale evaluation, no attempt was made to engage the older adult patients with GAD to mediate for this CBT innovation. The findings determined the participant’s CBT knowledge and skill at baseline, thereby reinforcing the importance of utilizing CBT. Post-implementation questionnaire (See Appendix D) was designed to be delivered to the entire participant immediately after completing the educational session and implementation instructions. The DNP project goal was an 80% response rate from the participants on both the pre- and post-questionnaire for review of which 100% response rate was achieved. The clinical knowledge of anxiety related issues and experience with CBT was assessed on both pre-test and post-test. Both the pre-test and post-test have some open-ended questions as choice of strongly agree to strongly disagree.

In summary, Information from the nurses was obtained at the initial stage after a response from the Human Subject Research Determination that the project activity does not meet the federal regulation definition of human subject research, and therefore does not require a submission of approval from the IRB. Several meetings with the stakeholders group were conducted to ensure understanding of the project and the potential needs for participant’s support. Time of meetings vary depending on the availability of the participants. The general theme of the message is to provide a cognitive-behavioral therapy, which is non-pharmacological. The implementation
activities of the educational outreach for the utilization of CBT was developed to be delivered in two session and all the participants attended. To provide simplified method, quality handouts was included in each session of the CBT innovation, Web base CBT resources was searched and copyright permission obtained as needed from the originator. Nursing management will endeavor to improve nurse engagement and satisfaction by promoting their practice change, and increasing their confidence in their practice skills as well as providing continues support in the utilization of the CBT. The author taught in a simplified and conducive way during the two day educational sessions of the project to ensure increase knowledge, understanding and satisfaction of CBT utilization by participants. Knowledge and satisfaction will be measured by a post implementation questionnaire

**Confirmation Stage**

This is the final phase of the innovation framework. Results were reviewed in the confirmation stage. The evaluation of both the process and outcome took place in order to validate the success of the innovation utilization. During the confirmation phase, Dobbins et al., (2005) proposed a question to be asked “did the change in practice occur and did it have the intended impact”? Observing the CBT innovation project takes on an important role in the confirmation stage as the reflection indicators that were identified in the pre-and post-questionnaire, now provide direct feedback about the utilization of CBT outcome. The criteria used to evaluate the nurses’ attitudes, beliefs and knowledge of CBT and their thoughts with CBT innovation tool included

- Nurses attitudes about CBT and its suitability for their practice
- Nurses satisfaction with CBT innovation tool
Nurses confidence level in their CBT knowledge and potential skills

The CBT innovation utilization project was evaluated using these performance indicators with respect to both process and outcomes measures. A post implementation questionnaire was used to capture the data (see Appendix D for result). With only six participants providing evaluation data, however, even subtle change in values from baseline will look amplified and need to be cautiously interpreted, more as a trend than an absolute difference.

**Results**

Hofmann and Smith (2008) conducted a quantitative review of randomized placebo-controlled trials, which provided a noteworthy support for the efficacy of CBT, a non-pharmacological approach as a first line treatment therapy for GAD in the older adults. This Capstone project was designed to use educational outreach with long-term licenses nurses to increase utilization of CBT thereby improving the behavior and psychological symptoms of GAD among the older adults. The project aimed to introduce long-term nurses to the underlying theory and practice of CBT for utilization for the older adults with GAD. Result showed significant educational motivation among the six participants in utilizing CBT in their facility.

At the beginning of spring 2017 semester, January 2017, precisely, the project was approved following a memorandum from the Human Subject research determination indicating that the project activity does not meet the federal regulation definition of human subject research, therefore does not require a submission to the IRB. There was a major change in two of nursing director’s position in the organization that delayed the implementation of the project. Following the delay that extended to the month of April
2017, the implementation was initiated and completed with the post implementation data collection and analysis as well as statistical result. April 2017 is the expected completing session of the project pending reviews and feedback from readers.

**Nurses’ attitudes around CBT and its suitability:** At baseline, six of the participants had no knowledge of CBT and could not determine if it was an appropriate and effective treatment for the older adult. Post implementation, however, all the participants believed that CBT will be effective and appropriate for them to deliver for their older adults with GAD. Providers’ attitudes around CBT’s efficacy and suitability for their practice setting would be a perceived benefit for adopting the change in practice.

**Nurses’ satisfaction with the CBT innovation tool:** Nurses’ satisfaction with the CBT innovation tool is evaluated by performance indicators related to structure. Evaluation of structure takes into consideration whether the human and physical resources needed to implement the new practice were available (Dobbins et al, 2005). For the human resources, there were a sufficient number of participants for the evaluation; however, their underlying knowledge and skill of CBT innovation may not have been sufficient to utilize it. In terms of the physical resources required for the delivery of CBT, step-by-step nurses’ user guides as well as good quality patients’ handouts and work sheets were given to each nurse participants.

Measuring participants’ satisfaction with the CBT innovation tool reflects whether it was simple enough for them to adopt (Dobbins et al, 2005). In the post–implementation questionnaire, participants reported a high level of satisfaction with the physical resources, with 100% of participants saying that they strongly agreed with the handout and the user guide were helpful and sufficient to a basic knowledge of CBT.
Evaluation of the two days format being comprehensive enough and being deliverable within a typical shift assignment demonstrated most participants in a high level of acceptant with three participants saying agreed and three saying strongly agreed. This finding demonstrates that the participants were able to further reflect on the CBT information package and desire to utilize it in their clinical setting if CBT trained.

**Nurses’ confidence level in CBT utilization:** Consistently with the literature in this project, the six participants indicated lack of confidence in their skill and knowledge of CBT, as a main barrier encountered during the implementation process. Interestingly, their overall confidence level did increase from baseline. At baseline, all participants rated themselves in the low confidence range but it drastically reduced to zero post-implementation. This suggests that although it was a barrier, their knowledge level of CBT utilization increased remarkably.

The administrative group has a high level of interest in the success of any project that will result to an outstanding outcome and continued commitment to excellence. The administrative group also has the high level of power to support the progress and success of the project. The nursing staff has a high level of interest in pursuing non-pharmacological approaches to anxiety. The DNP student encouraged the participant to use the available information and resources to increase their knowledge and interest in the utilization of CBT and train them in CBT to maintain their interest in the project. Through educational resources, this project will provide interventional support for the older adult to deal with anxiety symptoms and increase their quality of life. The educational resources provided skills and knowledge that will help them cope with the age-related changes.
In conclusion, the scope of this project is a limited evaluation to the nurses’ perspective only, but acknowledges that patients’ access to care or cost associated with changes in practice are all important considerations for future evaluation. The findings obtained during the confirmation stage provides the feedback and rational for recommendation in the utilization and sustainability approach to the CBT development as well as the additional strategies to improve dissemination.

**Facilitators:**

The DNP student has worked in a long-term facilities and hospitals for over twenty-five years and has the understanding and belief in the importance of using evidence-based therapy in clinical practice. Discussion with the director of nursing and the assistance director of nursing demonstrated a positive attitude towards the implementation of the CBT. The administrator, director of nursing and the assistance director of nursing promised to provide support to all the interested participants to attend to all the eight sessions of the CBT training. Participants were excused from their shift assignment to attend the sessions. In-kind, photocopying and assembling of the CBT materials were supported by the management team. Adequate resources such as these are a facilitator for the implementation of an innovation (Dobbins et al., 2005). Materials were reviewed right after the two sessions to build the confidence of the participant which was seen as a good facilitator in utilizing CBT. Good quality handout and a well-tailored educational training session were considered to facilitate the implementation of CBT. The cost-effectiveness of CBT was considered as a facilitator to the long-term facility. Evidence has documented that CBT is more cost-effective than drug treatment for GAD (Hunsley, 2002).
Barriers:

The pre-implementation questionnaire addressed more potential barriers that participants thought might affect their interest and ability to utilize CBT in their clinical practice to GAD patients. Additionally, there was a barrier using the literature and handouts which was seen as too complex and overwhelming. Work overload, distractions and interruption during the education sessions contributed as a barrier to a successful implementation plan. In view of these barriers, it was important to set up a facilitator plan to overcome the barriers to implementing best practice. It is considerably important to promote effective communication strategies, provide supportive and simplified environment and promote policies that advocate for new models of non-pharmacological therapy like CBT.

Discussion

The purpose of this project was to evaluate the perception of nurses in treating GAD in the older adult population using CBT. The project aimed to create an awareness of CBT among nurses to adopt the utilization and delivery of CBT in the long-term facility for the older adults with generalized anxiety disorder. Nurse’s role within a recovery oriented approach such as CBT is well documented in the literature (Elder et al., 2009; Repper & Perkins, 2006; Rickwood, 2006). Nurses are front line staff who work with high volumes of the older adults with GAD and should have the skill sets to identify the older adults that may benefit from the CBT. Cognitive Behavioral Therapy is patient oriented and focused on facilitating the empowerment of the older adults and focusing on patient’s strengths rather than deficits.
Schout, Jong & Zeelen (2009), in their qualitative study identify compassion, loyalty, involvement and tenacity as some of the personal characteristics required by nurses to establish trust and maintain contact with older adults presenting with GAD. Reliability was a feature of being there for the older adults. During the first day of the education session, it was considered important by the participants that nurses delivering CBT to the older adults should follow the undertaken commitments with the patients. Glass (2003, P.53) identifies that being there requires nurses to embed themselves deeply within interpersonal interactions with the older adult patients. The participants portray the importance of maintaining contact with the older adults so that they continue to engage with the CBT service.

All the nurses expressed a high importance for the CBT as a significant and effective treatment for the older adults with GAD and as appropriate for implementation in the long-term facility. The participant rated CBT to have significant benefit and compatible with their needs and values, which according to diffusion innovation framework used for this project, is a valuable and strong facilitator for the adoption of CBT. The comment from three participants that they would like to be certified in delivering CBT certified, significantly indicated their interest in the utilization of the CBT. The Diffusion of innovation Theory is a change theory that emphasizes the importance of adapting the innovation that will not change the individual rather to meet the needs of the individual (Robinson, 2009). It essentially becomes a key consideration for adoption strategies. All the participants gave a helpful feedback that they are pleased with the idea of utilizing CBT in their facility. Three out of the six participant indicated that delivery the method may be extensive and overwhelming and as such not yet
considering the readiness to be trained. One of the participant thought she may not have enough time in her current shift assignment to do CBT. Nurses who have undertaken the CBT certification course have made a significant contribution to the health care of the older adult with GAD in terms of educational leadership and innovation in the development and co-ordination of cognitive behavioral therapy (Newwell & Gournay 1994).

The CBT was accepted by the participants as evidence by their retention and completion of pre-and post-questionnaire. The facility environment characteristic had minimal influence in determining the adoption rate of this CBT innovation. Though the facility underwent major changes in management, it remains a stable organization for the implementation of this project. The Diffusion of Innovation Theory state that continuous improvement is the key to improving uptake, and adaptation process should be one that is dynamic (Robinson, 2009).

Additionally, local adaptation of an innovation, which often involves simplification, is a nearly universal property of successful dissemination (Berwick, 2003, p. 1971). In keeping with these principles, the author encouraged participants to start training for brief method of CBT which is less comprehensive and from there continues utilization will build their competency. This seemed to appeal to all of the participants in attendance and they expressed a desire to learn and practice CBT with a less comprehensive approach.

The brief method to CBT method was perceived by the participant as appealing to not only to them but might also let their anxious older adult experience the benefit of CBT without the perceived burden of commitment. During the period of this
implementation, though there was not enough time to learn more about CBT innovation there was no perceived lack of organizational support which actually worked as a facilitator for the uptake of CBT.

All the participants strongly agreed that user guide and handouts were sufficient and helpful. The administrators and directors in this facility have been very supportive of the CBT innovation, allowing participants to attend the educational training sessions and providing in-kind support for physical resources which also acted as a facilitator for CBT utilization. The participants acknowledged that using any therapies for treatment of GAD in the older adults depends on the individual patient situation, the skills and training of the nurse. However, there was a general agreement that using CBT approach and skills may be the most helpful therapeutic activities for the long-term care nurses.

The unanimous prioritizing of CBT as an important therapeutic tool was an interesting finding, considering the disagreement among the participants as to whether providing CBT will be part of the nurse’s role. Some literatures confirms that the impact of high level of paperwork on the therapeutic ability of nurses has been a serious concern for many years and is viewed as an example of an oppressive management style that is thwarting positive patient care (Barker & Buchana-Baker, 2008; Robinson, Murrells & Smith, 2005). The participants perceived lack of resources, lack of time within workload, and high level documentation as factors that may impact their capability of implementing CBT. However, they identified CBT as an approach that will assist the older adults to develop positive coping strategies to deal with the difficulties associated with GAD; nurturing self-determination, and empowerment, helping the older adults find meaning, purpose and direction; nurturing supportive relationships with family and friends so that
they feel socially included rather isolated. The author identified that helping the older adults to build a satisfying and fulfilling lives is the most important aspect of the CBT adoption and utilization.

Finally, the implementation of the CBT innovation as experienced by this author, demonstrated an important step significant acceptance of CBT utilization in the setting. Participant expressed a high level of satisfaction with CBT, and verbalized their interest in promoting CBT utilization in their setting.

Conducting this project is a personal journey of discovery for me. I discovered that I have grown as an educator by undertaking this journey. The findings show that the respondents learned about CBT and its evidence based benefits and increase confidence in their self-reported readiness to acquire CBT skills and eventually deliver CBT to the older adults with GAD. Further research addressing the limitations and implementation challenges of this project is needed to validate and ensure sustainable delivery of this innovation. More randomized, controlled trial of nurses’ delivery CBT in the long term setting with time management analysis is essential.

Finding: There is enthusiasm among the participants for applying CBT to their practice. There is also a desire for educational training and input on applying the evidence-based CBT into their practice. As Tarrier, Barrowclough, Haddock and McGovern (1999) report that there is a considerable evidence to suggest that the acquisition of clinical skills requires active and practical training in those skills rather than lecture-style didactic teaching. The findings of this project have shown that we can increase nurses’ readiness to utilize CBT in clinical practice and improve willingness to
introduce CBT to their clinical work and with over time improve availability of CBT to the older adults with GAD.

**Relevance of finding to nursing practice:**

The relevance of finding from this project will be significant to nursing practice because the scope of nursing practice includes proper assessment and management of the older adults in a holistic approach. The findings show nursing to be a well-sited provider for delivering CBT to the older adults with GAD in the long-term setting. As such, the initiative of implementing CBT matches well with nursing practice and expectations.

Nurses are encouraged to be committed to evidence-based practice which includes the ability to use research findings in their practice. According to the Canadian Nurses Association, evidence-based practice is essential to optimize outcomes for patients, improve clinical practice, achieve cost-effective care and ensure accountability and transparency in decision making’ (Canadian Nurses Association, November 2002). The U.S. is transforming its health care system to provide quality care leading to improved health outcomes, and nurses can and should play a significant role. As the scope-of-practice reflects nurses’ education and training, the findings of this project exemplify that nurse can be ideal for addressing the increase demand and need for non-pharmacological services like CBT.

Nurses have great potential to lead innovative strategies to positively respond to changes in population health trend as well as designing services that promote healthy living. The institute of medicine (2010) recommended that nurses should practice to the full extent of their education and training to focus on the critical health needs of diverse population across the lifespan. Responding to the critical health needs in our diverse
population encompasses recognizing when there is a gap in services that are needed and taking the opportunity for developing new roles to fulfill this gap. Nurses should seek this opportunity to provide CBT to address this gap in a much-needed older adult population with GAD. The American Nurses Association (ANA) highlights nurses’ quality and innovation contributions in health care by stating that nurses are always engaging in innovations and improving the quality of care in various ways (ANA. 2017). Initiatives aimed at clinical practice innovation such as the CBT can benefit millions of older adult system-wide overcome a troublesome symptom.

Nursing scope-of-practice covers a broad continuum from health promotion, to disease prevention, to coordination of care, to cure when possible and to palliative care when cure is not possible (ANA, 2010). While this continuum is well matched to the needs of the older adults with GAD, nurses should act as leaders to ensure this evidence-based CBT service is well implemented. A stronger emphasis is being placed on creativity, and nurses are being seen as important innovators to improve older adult care at the individual, organizational and system level. Nurses are the forefront of health care innovations each day and everywhere and can improve health care while holding down costs. The findings show that to an extent the project has also made nurses aware of the place of supervision in both maintaining and advancing practice in CBT innovation.

**Limitations:** This project was set up as a pilot evaluation to capture some initial insight and feedback about the implementation and utilization of CBT innovation in terms of nurse’s feedback and feasibility. By nature of being a pilot evaluation project, there were methodological limitations. This was only six, self-selected group of participants who were willing and interested to deliver CBT. Although the finding was
rich for preliminary insight, it was difficult to draw any conclusive causation. Due to the
time constrain of this project, the participants were only followed for one week which is a
short period of time to attempt to apply or register for CBT training.

**Clinical Implication**

As generalized anxiety disorder is common among the older adult and
significantly reduce their quality of life. Treatment strategies that are well designed to
target the population are needed urgently. The finding in the literature review confirmed
that cognitive-behavior therapy may be a good treatment approach and strategy for the
treatment of GAD in the older adult. From a clinical point of view, various age-related
changes occur in late life, it is empirical to say that the elderly are at a higher risk of
pharmacotherapy intervention. Most of the pharmacotherapy such as the benzodiazepines
can cause excessive sedation and cognitive impairment.

All benzodiazepines may produce cognitive impairment, psychomotor slowing
and gait disturbance leading to increased risk for fall and hip fractures (Herrings,
Stricker, & Boer, 1995). To enhance and promote treatment outcome it is important to
adhere to treatments that are safe with evidence-based support. It is anticipated that the
result of this project will have significant improvement in the population-based centered
and individual-centered care of the elderly with generalized anxiety disorder. The result
may show a great need to utilize CBT on home base individual thus decreasing institution
placement while improving on the activity of daily living.

**Nursing Implication**

There is a great need of nurses’ use of CBT in any clinical area. The research
needs to occur so as to enrich the body of nursing knowledge in relation to
implementation and application of CBT within the scope of nursing context. Given that nurses largely practice with multidisciplinary teams, research into the effective delivery of CBT by nurses within the same team needs to be explored. The majority of research relating to CBT has been conducted with Caucasian populations. There are only a few studies available that relate to the application of CBT with other ethnic group. Cultural issues need to be taken into consideration when promoting or delivering CBT to a multicultural population;

Clinically sensitive research needs to be conducted to access the use of and outcome of CBT. Cognitive Behavioral Therapy is the most researched psychotherapeutic intervention with clear evidence for benefit, yet it is not currently being taught in the curriculum of nursing programs. It is a recommendation of this project paper that CBT should be incorporated into the nursing curriculum, ideally in the therapeutic and complimentary therapy module. This would provide future nurses with necessary training to offer this in demand, evidence-based treatment while removing the barrier of additional out-of-pocket expenses.

**Recommendations**

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<td><strong>1</strong></td>
<td>The top management should sponsor and be committed to the ongoing support and development of CBT nurses. As well as to monitor nurses are able to use their CBT skills and continue to develop their self-efficacy and their skills post course completion</td>
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<td><strong>2</strong></td>
<td>The participant who may attend CBT training course should be followed up and complete a further CBT questionnaire to see what progress has been made in practice.</td>
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<td><strong>3</strong></td>
<td>This author recommended further development of the questionnaire to enable data to be gathered pertinent to the actual clinical skill deployment. The management should support nurses and floor managers to identify and remove structural barriers preventing</td>
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nurses fulfilling their CBT therapeutic potentials.

Management should establish a policy to reorganize and restructure the workloads of nurses to ensure that evidence-based CBT is prioritized.

This project focused mainly on nurses, but could be expanded to other interested healthcare providers such as nurse practitioners, and social workers. It may be helpful within the organization to get physicians to agree with the implementation of CBT within their practice. Even being aware of basic CBT methods and strategies, may allow for continuity of care for the older adult with GAD.

Final recommendation is for the ongoing support from the medical and nursing administrators which will be crucial if utilization will be more widespread. Newton and Yardly (2007) found the successful uptake of CBT could easily be achieved by requiring:

“The identification of specific individuals, who will diligently advocate for change, identifies and addresses barriers, promote a commitment from service administrators, and ensure appropriate training. And assist with incorporating the change into routine practice within the context of broader strategic service planning” (p.1497)

In other words, engaging nurses in this leadership role is highly recommended, to embrace this opportunity to develop new skill to improve the older adult care. Adopting and utilizing CBT as a best practice within the organization is a further recommendation. Nurses in this organization can act as pioneers and become trained, more involved in meeting the needs of the older adults with GAD by delivering CBT services, which is effective, first line, preferred treatment for GAD in the other adults.
Conclusion

Although CBT is recommended as a first-line treatment for GAD in the older adults, its utilization in the long-term setting has many challenges. Administrative sponsor and commitment to the ongoing support and development of CBT nurses will attempt to overcome some of the barriers and facilitates its use within the organization. More importantly, however, it will offer valuable insight into what nurses want and need to be able to utilize CBT in their clinical practice. The nurse participants were clear that they valued CBT and perceived it helpful for the older adult with GAD, but they needed to be trained.

The findings show that the analysis of this project evidences a change in the participant’s self-reported readiness to be trained to acquire the CBT skills. This would indicate that the participant’s self-efficacy and belief in their ability to offer CBT to their older adult patients with GAD has developed too. The quest to support and improve the uptake of evidence-based findings into clinical practice is an ongoing venture. As health care providers, nurses are in the most unique and opportune position to embrace this challenge. This author experienced a tremendous sense of satisfaction and reward in offering the educational awareness on CBT adoption and utilization that empowered the participants to desire to be trained to deliver CBT to the older adult with GAD. This author, however, had to independently seek out the learning required and at her own time and expense, to offer CBT as it was not part of the doctoral learning curriculum in the DNP program.

Cognitive-Behavioral Therapy is effective, evidence-based and deserves more attention and utilization as a first-line of treatment in the routine clinical care in long term
setting. Nurses can act as CBT champion and agents of change for the older adults with GAD requiring this much-needed mental health treatment.
References


effectiveness of brief psychological treatments for depression and anxiety. *Health Technology Assessment, 5* (35 Executive Summary)


Newwell, R., & Goumay, K (1994) British nurses in behavioral psychotherapy: a 20year follow-up. Journal of advanced Nursing. 20, 53-60 participants found the experience of the training to be a positive one.


Appendix A: Request Letter

August 10, 2016

To The Director of Nursing Service (DONS)

REQUEST TO IMPLEMENT A CAPSTONE PROJECT IN YOUR FACILITY

My name is Scholastica Nwadiugwu, a Family Nurse Practitioner, presently a student in the Doctorate Nursing Practice (DNP) program at University of Massachusetts Amherst. I humbly wish to use this opportunity to request for your permission to implement my DNP project in your facility. The DNP project is the pinnacle requirement for graduation in the DNP program. The project focuses in translating evidence-based research into clinical practice. The implementation of my project will be through education and training of your staff. It does not require any direct contact with your residents.

The topic of my project is Utilizing Cognitive Behavior Therapy in Elderly with Generalized Anxiety Disorders in an inpatient setting- An Integrative Review. Cognitive Behavior Therapy is based on scientific evidence proven to be effective in treating many psychological problems including generalized anxiety disorder.

Plan: There will be a review of the impact of generalized anxiety disorder in the elderly as an educational support to the participants. The participants will receive a pre-intervention assessment to identify their basic knowledge about generalized anxiety disorder in the older adult. A post-intervention assessment will be conducted for evaluation and feedback of the educational season.

❖ The outcome of the project implementation will be measured by;
❖ Comparing the level of generalized anxiety disorder symptom changes and satisfaction in connection to the CBT intervention

❖ Comparing the knowledge, skill, confidence and acceptability of CBT by the staff through the pre and post-test assessment.

Dr. Ginney Chandler is my Capstone Chair person, Dr. Raeann LeBlanc is my Capstone Committee Advisory team and Dr. Annette Okereke is my non-faculty capstone mentor.

Attached is the stakeholder letter of agreement.

Thank you,

Sincerely Yours,

Scholastica Nwadiugwu
Appendix B

Framework of The Five stages of Diffusion Innovation

<table>
<thead>
<tr>
<th></th>
<th>Knowledge</th>
<th>Persuasion</th>
<th>Decision-making</th>
<th>Implementation</th>
<th>Confirmation</th>
</tr>
</thead>
<tbody>
<tr>
<td>i</td>
<td>The stakeholders were introduced to Basic of CBT through the discussion of Review of GAD CBT Handouts Evidence base text books Literature Review on CBT They gain an understanding of the benefits of the CBT and how it function</td>
<td>ii</td>
<td>Explores the characteristics of CBT, the long term nursing home facility and the Patient population Pre implementation questionnaire The stakeholders Were motivated and forms a favorable attitude towards the CBT.</td>
<td>iii</td>
<td>The interest, need, clinical expertise of nurses and their attitudes where considered. The facility recognized the value of nurses and empowered them to lead the change. Meeting with the nurses</td>
</tr>
</tbody>
</table>
Appendix: C

Pre-Implementation Questionnaire Composite

Are you a License Nurse? Yes (6)

Please rate the following statements:

1-Strongly Disagree   2- Disagree   3- Neither disagree or agree   4- Agree   5- Strongly Agree

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT is an effective treatment for older adults with Generalized Anxiety Disorder</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT is appropriate for licensed nursing staff to do in my setting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>My work setting is appropriate for me to deliver CBT to the older adults with GAD</td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have the ability to identify appropriate patients for CBT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

Please rate your proficiency level in doing CBT

<table>
<thead>
<tr>
<th>Proficiency level</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>My proficiency level in doing CBT</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How satisfied are you with your current care of your older adult patients with GAD

<table>
<thead>
<tr>
<th>Very Dissatisfied</th>
<th>Dissatisfied</th>
<th>Neither satisfied or dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please select barriers you may perceive to delivering CBT in the elderly patient with GAD in your institution (select all that apply)

<table>
<thead>
<tr>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 May not have enough time to do CBT with shift assignment</td>
</tr>
<tr>
<td>6 Workload may be too heavy to learn and develop new skill</td>
</tr>
<tr>
<td>6 Too many disruptions and interruptions in the unit</td>
</tr>
<tr>
<td>6 Lack of confidence and knowledge to do CBT</td>
</tr>
<tr>
<td>1 The older adult with GAD may not be motivated enough for CBT</td>
</tr>
<tr>
<td>0 Lack of support from the institution to utilize CBT to the older adults with GAD</td>
</tr>
<tr>
<td>0 Not interested in utilizing CBT for GAD in older adult patients</td>
</tr>
</tbody>
</table>

Do you perceive any other barrier to offering CBT in your institution? “who will sponsor the cost of training”, “Patients no show”, Other crises”

Have you taken any previous CBT training? No (6)

Are you practicing CBT in any capacity currently in your institution? No (6)
What is your highest academic qualification? LPN (2) RN (4)

Please list the measures/tools/instruments that you routinely use in practice to assess/monitor behavioral and cognitive symptoms of the older adults with generalized anxiety disorder “observation”

Please list the measures/tools/instruments that you routinely use in practice to treat your older adults patient with GAD “Medications such as Ativan” “Trazadone” “Redirection”

Please how do you feel to apply CBT with older adult patients diagnosed with GAD? “Not comfortable” “need more information” “interested to learn more”
Appendix: D

Post-implementation Licensed Nurse Questionnaire

Are you a License Nurse?

Please rate the following statements:

<table>
<thead>
<tr>
<th>1-Strongly Disagree</th>
<th>2- Disagree</th>
<th>3- Neither disagree or agree</th>
<th>4- Agree</th>
<th>5- Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT is an effective treatment for older adults with Generalized Anxiety Disorder</td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT is appropriate for licensed nursing staff to do in my setting</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My work setting is appropriate for me to deliver CBT to the elderly with GAD</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have the ability to identify appropriate patients for CBT</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please rate your proficiency level in doing CBT

<table>
<thead>
<tr>
<th>Proficiency level</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>My proficiency level in doing CBT</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How satisfied are you with your current care of your older adult patients with GAD

<table>
<thead>
<tr>
<th>Very Dissatisfied</th>
<th>Dissatisfied</th>
<th>Neither satisfied or dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please select barriers you may perceive to delivering CBT in the elderly patient with GAD in your institution (select all that apply)

| 5 | May not have enough time to do CBT with shift assignment |
| 6 | Workload may be too heavy to learn and develop new skill |
| 6 | Too many disruptions and interruptions in the unit |
| 0 | Lack of confidence and knowledge to do CBT |
| 1 | The older adult patients with GAD may not be motivated enough for CBT |
| 0 | Lack of support from the institution to utilize CBT to the older adult patients with GAD |
| 0 | Not interested in utilizing CBT for GAD older adult patient |

Did you think you will encounter any other barriers offering CBT in your institution?

How satisfied were you with the level of educational training you received for this CBT project?

<table>
<thead>
<tr>
<th>Very Dissatisfied</th>
<th>Dissatisfied</th>
<th>Neither satisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
</tr>
</thead>
</table>
Please rate the following statements:

<table>
<thead>
<tr>
<th></th>
<th>1-Strongly Disagree</th>
<th>2-Disagree</th>
<th>3-Neither disagree or agree</th>
<th>4-Agree</th>
<th>5-Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I found the quality of the patient handouts to be sufficient</td>
<td></td>
<td>2</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I found the CBT nurses guide for each session to be helpful</td>
<td></td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I found the pre-packaged structured format of the CBT sessions to helpful in delivering CBT</td>
<td></td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I found 2 sessions was sufficient to be comprehensive enough to address all the important components of GAD</td>
<td></td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I found the implementation training sufficient as an introduction to CBT and all I need to know to get started with basic CBT for the treatment of GAD in the older adults</td>
<td></td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I found I have developed interest to deliver CBT for the older adults with GAD</td>
<td></td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I found having ongoing support during the training program during the program was necessary for learning needs and questions of CBT</td>
<td></td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I found the ongoing support provided was sufficient for learning needs and questions of CBT</td>
<td></td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Overall I was pleased with the CBT project developed

- Please comment on any aspect of this program that you feel would help improve CBT for further use “Basic skill training sessions”
  “Physicians and Nurse practitioners to endorse and recommend CBT”
- Please how do you feel to apply CBT with older adults patients diagnosed with GAD? “Motivated and comfortable if trained” (3)
- How often will you use the CBT? “As often as I can if trained” (6)
### 1. Cognitive-Behavioral Therapy for the Treatment of GAD

By Scholastica Nwadiugwu FNP
Graduate Student
UMASS Amherst

#### 2. What is anxiety disorder
- A natural emotional and physical response to environmental and/or internal stimuli which acts as a protective factor to keep us safe
- Anxiety and fear are normal emotional states
- They affect over 50 million people over age 18 in the United States
- Many have a median onset as early as 13 years of age
- Indirect and direct economic costs associated with treatment of anxiety disorder was $46.6 billion as late as 2004
- May interfere with being able to form and sustain relationships
- May interfere with obtaining or sustaining employment

### 3. When does anxiety becomes a disorder
- Anxiety responses become anxiety disorders when distorted thinking, stress, physical symptoms and avoidance increase and create significant problems in daily life.
- Generalized Anxiety Disorder
- Is characterized by at least 6 months of persistent and excessive anxiety and worry.

### 4. The Anxiety Disorders
- Panic attack
- Panic Disorder without agoraphobia
- Panic Disorder with agoraphobia
- Obsessive-Compulsive Disorder
- Substance induced Anxiety Disorder
- Post-traumatic Stress Disorder
- Generalized Anxiety Disorder
- Anxiety Disorder due to a general medical condition
- Anxiety Disorder Not otherwise specified

### 5. Generalized Anxiety Disorder:
- The “Basic” Anxiety Disorder
- Excessive uncontrollable anxious apprehension and worry
- Coupled with strong, persistent anxiety
- Persists for 6 months or more
- Somatic symptoms differ from panic (e.g., muscle tension)

### 6. Wells (1999)
- Worry is a chain of catastrophizing thoughts that are predominantly verbal. It consists of the contemplation of potentially dangerous situations and of personal coping strategies. It is intrusive and controllable although it is often experienced as uncontrollable. Worrying is associated with a motivation to prevent or avoid
<table>
<thead>
<tr>
<th>7 Positive Beliefs About Worries</th>
<th>8 Negative problems of Worries</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ Is useful for finding solutions to problems</td>
<td>❖ Problems are threat to well-being</td>
</tr>
<tr>
<td>❖ Is motivating – helps get things done</td>
<td>❖ Doubt about problem-solving ability</td>
</tr>
<tr>
<td>❖ Is protective from negative emotions</td>
<td>❖ Pessimism about problem-solving outcome</td>
</tr>
<tr>
<td>❖ Can prevent negative outcomes</td>
<td>❖ Negative problem orientation is more specific to worry than depression in student samples, and is differentiated from neuroticism</td>
</tr>
<tr>
<td>❖ Is a positive personality trait</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9 Statistics</th>
<th>10 Generalized Anxiety Disorder: Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ Affects about 4% of the general population</td>
<td>❖ Persons with GAD have been called “autonomic restrictors”</td>
</tr>
<tr>
<td>❖ Females outnumber males approximately 2:1</td>
<td>❖ Fail to process emotional component of thoughts and images</td>
</tr>
<tr>
<td>❖ Onset is often insidious, beginning in early adulthood</td>
<td>❖ Treatment of GAD: Generally Weak</td>
</tr>
<tr>
<td>❖ Very prevalent among the elderly</td>
<td>❖ Benzodiazepines – Often Prescribed</td>
</tr>
<tr>
<td>❖ Tends to run in families</td>
<td>❖ Psychological interventions – Cognitive-Behavioral Therapy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11 What is CBT?</th>
<th>12 “Big” Names associated with Cognitive Behavioral Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ Set of ‘talk’ psychotherapies that treat psychiatric conditions.</td>
<td>❖ Epictetus, Greek philosopher. Observed that people are not disturbed by things that happen but by the view they take of things that happen.</td>
</tr>
<tr>
<td>❖ Short-term focused treatment.</td>
<td>❖ Albert Ellis, Ph.D. “grandfather of cognitive behavioral therapy.”</td>
</tr>
<tr>
<td>❖ Strong empirical support with randomized clinical trials.</td>
<td>❖ Aaron Beck, MD, a psychiatrist (University of Pennsylvania)</td>
</tr>
<tr>
<td>❖ As effective as psychiatric medications.</td>
<td>❖ Beck called it cognitive therapy because of the importance it places on thinking. It’s now known as cognitive-behavioral therapy (CBT) because the therapy employs behavioral techniques as well.</td>
</tr>
<tr>
<td>❖ Recommended as critical component of treatment, particularly when medications are contraindicated or ineffective.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13 What is CBT</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ It is a psychotherapeutic approach that uses a combination of behavioral &amp; cognitive therapies</td>
<td>❖ It is a process of teaching, coaching, and reinforcing positive behaviors.</td>
</tr>
<tr>
<td>❖ It addresses dysfunctional emotions, maladaptive behaviors and cognitive processes through goal-directed &amp; systematic procedures.</td>
<td>❖ CBT helps people to identify cognitive patterns or thoughts and emotions that are linked with behaviors.”</td>
</tr>
<tr>
<td>❖ CBT uses practical self-help strategies</td>
<td>❖ Thinking: Different people can think differently about the same event. The way in which we think about an event influences how we feel and how we</td>
</tr>
</tbody>
</table>
behave is based on the way they think

❖ 15: CBT is a collaborative effort between the therapist and the client.
❖ Client role – define goals, express concerns, learn & implement learning
❖ Therapist role - help client define goals, listen, teach, encourage.
❖ Teaches the benefit of remaining calm or at least neutral when faced with difficult situations. (If you are upset by your problems, you now have 2 problems)
❖ The problem, and 2) your upsetness.

16 Theoretical Assumption of CBT
❖ Beck’s is based on the theoretical rationale that the way people feel and behave is determined by how they perceive and structure their experience.
❖ The theoretical assumptions of CBT are 1) that people’s communication is accessible to introspections. 2) that clients’ beliefs have highly personal meanings 3) that these meanings can be discovered by the client rather than being taught or interpreted by the therapists

17 Purpose of CBT
❖ Aims to teach people that it is possible to have control over their thoughts, feelings and behaviors.
❖ Helps to challenge and overcome automatic beliefs, and use practical strategies to change or modify behavior.
❖ The result is more positive feelings, which in turn lead to more positive thoughts and behaviors.
❖ Thus, CBT is a learning process
❖ CBT is thought to be effective for the treatment of a variety of conditions including: • GAD, Phobias, • Addictions • Depression

18 Purpose of CBT
❖ Cognitive therapy aims to change the way patients thinks about the triggers of their disorder.
❖ Because it is the negative cognitions that cause self-destructive feelings and maladaptive behavior
❖ Thus, the Cognitive therapy challenges those thoughts. • It is basically a talking therapy
❖ One approach is cognitive restructuring which involves asking the person to come up with evidence to ‘prove’ their maladaptive thoughts.
❖ Thus, the patient learns to firstly identify and challenge negative thoughts,
❖ Replace them with more realistic and positive thoughts.

19 Characteristics of Cognitive-Behavioral Therapies
❖ Thoughts cause Feelings and Behaviors.
❖ Brief and Time-Limited.
❖ Average # of sessions = 16 VS
❖ Emphasis placed on current behavior

20 Benefits of CBT?
❖ Clear treatment approach for patients
❖ Assumptions make sense to patients
❖ Based on patient’s experience
❖ Encourages practice and compliance
❖ Patients have a sense of control
❖ CBT works

21 Basic Principles of CBT
❖ Cognitions affect behavior and emotion.
❖ Cognitions may be made aware, monitored and altered.

22 Behavior therapy
❖ Behavioral therapy teaches the patient the necessary skills to modify their behavior in a way that makes it adaptive rather than maladaptive.
CBT IN THE OLDER ADULTS

| Desired emotional and behavioral change can be achieved through cognitive change | The negative cognitions and emotions decrease as the patients learn that they can function in social situations.  
| What we do affects how we feel and think  
| CBT helps people to learn new behaviors and new ways of coping with events |

23 **Elements of CBT**
- **ACTIVE:** The client must be involved in the therapeutic process not as an observer or as an occasional visitor, but as a core and key participant.
- **MOTIVATIONAL:** The therapist needs to take responsibility for helping to motivate the client toward a change in behavior, affect, or thinking. The therapist must be able to set up the format, and rationale for the client to consider change of value.
- **DIRECTIVE:** The therapist must be able to develop a treatment plan and then to help the client to understand, contribute to, and see the treatment plan as a template for change.

24 **Comorbidity and Treatment (Newman et al., 2010)**
- 76 treatment seeking adults with GAD
- 14 sessions of treatment
- 60.5% had comorbidity
- Comorbid diagnosis linked to greater GAD severity at pretreatment
- Greater change with treatment for those with comorbid depression, social anxiety disorder, specific phobia
- Normal maintenance of treatment gains
- Benefits to social anxiety disorder and specific phobia were maintained over 2 years, whereas benefits to depression were not

25 **CBT Treatment**
- Overall, this study provides good news for the broad and powerful effects of CBT, despite the presence of comorbidity.

26 **All Current Models**
- All current models tend to underscore avoidance of internal experiences
- Cognitive avoidance
- Emotional avoidance
- Intolerance of uncertainty
- Negative cognitive reactions to emotions
- Combined With
  - Positive beliefs about worry
  - While being concerned about effects of worry

27
- Based on "rational thought." – (Fact not assumptions).
- CBT is structured and directive. (Based on notion that maladaptive behaviors are the result of skill deficits).
- Based on assumption that most

28 **Who is Involved**
- Mental Health Techs, Nurses, Clinicians, Case Managers
- Reinforce/implement cognitive interventions included in the treatment plan.
- Read the treatment plan & reinforce items within your scope of practice
emotional and behavioral reactions are learned. Therefore, the goal of therapy is to help clients a new way of reacting.

- Homework is a central feature of CBT.

### 29 Techniques
- The cognitive behavioral therapy techniques are an interesting set of exercises that help modify a persons’ behavioral patterns to bring about positive changes in the personality.
- In this technique, the patient is asked to recall a problematic situation of the past.
- The therapist and patient both work together to find out a solution for the problem or a way in which the difficult situation, if it occurs in the future can be sorted out.
- The therapist asks the patient to rehearse positive thoughts cognitively to make appropriate changes to the letters thought processes.
- Power of imagination proves to be of great use in such exercises.

### 30 Guided Discovery
- The objective or purpose behind using this technique is that of helping patients by enabling them to understand their cognitive distortions.
- Patients are made aware of and assisted by therapists in understanding how they process information.
- The activity of understanding how information is processed allows patients to alter the same (information processing) if required.

### 31 Guided Discovery
- Basically, the patient’s perception of the world undergoes great change and he/she sees things in a different way than earlier.
- This change in perception allows the patient to modify his/her behavior in a better manner.
- It is one of the cognitive therapy techniques in which therapists perform role-playing exercises aimed at responding in a way that is helpful to overcome difficult situations.
- The patient makes use of this behavior of the therapist as a model to solve problems he/she comes across.
### 32 Increasing Homework Compliance
- The homework is a set of assignments given by therapists to patients.
- The patient may have to take notes during sessions with therapists, review a session Set homework collaboratively.
- Set homework collaboratively.
- Provide rationale (or ask client what rationale is).
- Provide explicit instructions (including time, place, frequency, duration, etc., if applicable).
- Insure that patient can do assignment.
- Start assignment in session, if applicable.
- Ask client how likely he/she is to do it.

### 33 Importance of Homework
- Extends therapy contact
- Test of patient motivation
- Opportunity to Practice
- Continuity between Session
- Data gathering
- Significant others
- Relapse Prevention

### 34 HOMEWORK
*Homework* includes activities as:
- Reading
- Self-help exercises
- Experiential activities
- Journaling
- Thought Stopping
- Intentional Reframing

Therapy sessions are really ‘training sessions’, between which the client tries out and uses what they have learned.

### 35


construct validity and specificity to worry. Behavior Research and Therapy, 43, 403–412
Appendix: F

Sample of Nurses User-Guide

Cognitive-Behavioral Therapy Session One-Provider’s Guide

Tell patient the format for each session is always the same: to review homework from last week, do new learning activities then assign new homework for the upcoming week.

❖ **Review Homework and Handout**: Look at their goals for CBT. This becomes a starting point for therapy and we will use these goals for later in the session.

❖ **Exercises** – Goals; Efforts and Reward Chart; Scheduling

❖ **Homework** – Read Increasing Activity; Weekly Activity Schedule

❖ **Feedback**

❖ **Document in EMR** – use standardized phrase “cbt1”

**Exercise 1: TURNING PROBLEMS INTO GOALS**

**Talking Tips:**

“Setting goals is the single most important aspect of CBT. Complaining leads nowhere and complaints need to be re-directed into goals. In every complaint there is a hidden goal. The goal is usually the opposite/antonym to the complaint. eg) if someone complains of feeling worried, the goal might be happiness/calm/joy. For example, patient may complain “I feel sometimes like I should just give up” “I just wish all my problems should just go away”. Getting the patient to get actively involved in the goal setting process is very necessary. The nurse can ask the patient to write down what she can do to feel better. The nurse can suggest, spending more time with friends, joining group activities and doing more fun activities to decrease her worries. The bottom line is “We are responsible for creating our own moods and this is done by having goals for what we


want to see happen and then following through on the behaviors that are needed to achieve this goal.”

If a patient can’t state the goal, then suggest it for them. Pts may need to be interrupted in their habitual complaining and re-directed to state a goal.

Trying to interrupt a complaint stream can be like trying to stop a waterfall. Reframe their energy into a goal. You can say, “Wow, you sound like you have a lot of energy around this and you are motivated to do something about it” or “I can hear in your voice about this”

Goals should be 1) broad (efforts should be specific but goals should be kept broad). 2) Positive. 3) Realistic.

- Use the template “Therapy Goals” and looking at their goals from last week’s homework. Choose 1 or 2 goals at the most and ask them to rank on a scale of 1-10 where they are at now with obtaining their goal. Ask what they are doing that is keeping them from being at a lower number (and congratulate them on their efforts) Ask what they have to do to move higher on the scale (This becomes the efforts in the “Effort and Reward Charts)

**Exercise 2: Efforts and rewards**

Talking Tip: Simply desiring an outcome is not a guarantee it will happen. It will happen unless we put in the “effort” Just like the saying goes “You reap what you sow” or in other words “You get what you give”. If we want a new mood we must behave differently. We are not automatically entitled to happiness- we have to earn our moods by doing the behaviors that encourage a good mood!” Consider asking them how they can get from a bad mood to a good mood in their life? I find it works well to have
“students” apply new material to their own life (this is an adult learning principle (Knowles): adults learn best when new info is built on what they know and applied to their own life. In life, there are NATURAL CONSEQUENCES—it’s not about rewards or punishments but rather just the natural consequences of our actions or inactions-things we should be doing but we aren’t. Anxiety is one of the natural consequences of not doing the behaviors to earn a better mood and only you have the control over that. You are the steward of your own mood!” You can give example of how you perform behaviors that earn you a better mood or seeing others in their life earn a better mood.

Fill in an “Efforts and Rewards Chart” with what they need to do to move closer to achieving their goal (follow the directions on the template). Possible examples of efforts could be: exercise (be specific with times and amounts) ask how they do this for themselves, connecting socially with someone (be specific) ask how they do this for themselves, fun/enjoyable activities ask how they do this for themselves, OR give them the 3: exercise, social & fun and have them break into triads and all come up with examples and report back to the larger group. Put their Efforts and rewards chart at the front of their binder and tell patient you will be looking at it and updating it each week.

EXERCISE 3: SCHEDULING

Talking Tip:

“OK, now we know that anxiety is one of the natural consequences of getting worried and anxious. Regular goal-directed behavior is required for Calmness and happiness- we can’t just “get through” the day. We need to plan activities and follow through. In our jobs, we often have a plan for the day or we wouldn’t get the tasks done that we are being paid to do. Life is the same way- we need a weekly plan or schedule to
make sure we fit in what we need to be doing such as the behaviors we need to do to earn a better mood. It’s important to know you won’t necessarily feel like doing these behaviors initially- but that’s ok- you still need to do them just like the other responsibilities we have in life that we have to follow through on. “Fake it till you make it” Ask how they have done this in their life

Using the “Weekly Activity Schedule” handout teach patient to do strategic planning of their day- plan especially for times when they know their mood might dip such as evenings or weekends etc. Consider having them play with this schedule in their own life as an example Take a pencil and actually pencil in a few of the efforts they need to do for their Effort/reward chart and maybe a fun activity. Monitoring behavior changes makes a big difference so have patient bring in their activity logs each week for review.

“People are less likely to do what you expect and more likely to do what you inspect

HOMEWORK: Nurse should know the importance of giving home works to patient during the CBT treatment session.

Homework assignments facilitate patient skill acquisition, treatment compliance, and symptom reduction by integrating the concepts learned in sessions into daily life. Homework is a key mechanism for facilitating between-session work and progress. Assignments such as readings, behavior monitoring and practicing new skills should be given to the patient to practice and use outside sessions. For example, “Think about what we agreed upon for treatment plan and consider any adjustment it might need”

Give homework assignments throughout treatment.
1. Effort and Rewards Chart - complete it together and review it at the start of each session. This will be an ongoing exercise each week.

Feedback: What did they like about today, what would like to change for next session? Be open to feedbacks
### Sample Therapy Goals

<table>
<thead>
<tr>
<th>Name:</th>
<th>Number/DOB:</th>
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**Goal 1:**

What steps can I make towards achieving this goal?

On a scale of 0 – 10 with 0 being totally not achieved and 10 being totally achieved, how far along the scale am I now, with regard to this goal?

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<tr>
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**Goal 2:**

What steps can I make towards achieving this goal?

On a scale of 0 – 10 with 0 being totally not achieved and 10 being totally achieved, how far along the scale am I now, about this goal?

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**Goal 3:**

What steps can I make towards achieving this goal?
On a scale of 0 – 10 with 0 being totally not achieved and 10 being totally achieved, how far along the scale am I now, with regard to this goal?

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<td>Totally achieved achieved</td>
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Not at all achieved, Moderately achieved, Totally achieved achieved

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## Sample Thought Record Sheet - Anxiety

<table>
<thead>
<tr>
<th>Situation</th>
<th>Emotions / Moods (Rate 0 – 100%)</th>
<th>Physical sensations &amp; reactions</th>
<th>Unhelpful Thoughts / Images</th>
<th>Alternative / realistic thought</th>
<th>More balanced perspective</th>
<th>What I did / What I could do / Diffusion technique / What’s the best response?</th>
<th>Re-rate Emotion 0-100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>What happened?</td>
<td>What emotion did I feel at that time?</td>
<td>What did I notice in my body?</td>
<td>STOPP! Take a breath…. What would someone else say about this situation? What’s the bigger picture? Is there another way of seeing it? What advice would I give someone else in this situation?</td>
<td>What will the consequences of? my action be? Do what works! Act wisely. What will be the most helpful? for me, for others, or the situation? What could I do differently? What would be more effective</td>
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What went through my mind? What disturbed me? What did those thoughts/images/memories mean to me, or say about me or the situation? What am I responding to? What ‘button’ is this pressing for me? What would be the worst thing that could happen? What would be the worst thing about that? Am I overestimating the danger? Am I underestimating my ability to cope? Is this fact or opinion?
Things to Consider in Evaluating Patients for CBT

1. Strong Motivation to Change:
   - Increased distress is often associated with increased motivation to change.
   - Positive treatment expectancies (e.g., knowledge of CBT and perceived benefits of treatment is associated with improved outcomes). Alternatively, the patient does not have negative self-thoughts that might impede progress or change (e.g., "Seeking care means I am crazy"; "Nothing I will do can change things").
   - Patients who have clear goals for treatment are good candidates.

2. Time Commitment
   - Patient is willing to devote the time needed for weekly sessions.
   - Patient is willing to devote energy to out-of-session work (e.g., homework).

3. Life Stressors
   - Too many life stressors may lead to unfocused work and/or frequent "crisis-management" interventions.
   - Patients who are supported by family and friends are more likely to benefit.

4. Cognitive Functioning and Educational Level
   - Not being able to handle the extra independent reading material and/or homework expectations may be a poor prognostic indicator.
   - Patients able to work independently are more likely to carry out between session work
   - Patients who are psychologically minded are more likely to benefit from short term therapy

5. Severity of Psychopathology
   - Generalized anxiety disorder elderly patients with comorbid psychopathology may be more difficult to treat in short-term therapy.
   - Long-standing interpersonal issues often require longer treatment durations